

I reported on P4P last year and it is only gaining momentum as time goes on. This is something we all have to come to grips with and prepare ourselves. The background includes:

- The cost of healthcare in this country is totally unsustainable.
- Employers are screaming about the rise in costs and are considering substantial increases in out-of-pocket expenses and looking at the Medical Savings Accounts as a way to get consumers in the decision-making process about how their healthcare dollars are spent.
- It is estimated that \$30 billion per year is wasted in the Medicare program through duplication of services, unnecessary care and unproven care.
- 150-300 preventable deaths occur everyday in the hospital setting and 5,000 mistakes are made daily in the outpatient setting, that includes our offices.
- Only 55% of the population receives what is considered recommended and established quality of care.

Quality has got to go up, as does efficiency. This is the basis for the P4P program.

We are expected to provide quality care, based on evidence-based medicine and to provide this as efficiently as possible. APMA is working on our representation into this arena. We will be asked by the powers to be to provide them with evidence-based protocols for the various ailments we treat. We need to be ready to provide these or they will be provided for us. No longer can we just start doing procedures on our patients without some justification based on scientific evidence. For example: shockwave therapy. There is very little good scientific studies showing that it is a superior treatment for plantar fasciitis. The insurance companies get charged a ton of money for this and eventually, coverage is withdrawn. Another example is diagnostic ultrasound. In the vast majority of times, does performing this procedure improve

outcomes or is it being used to increase reimbursement? US guided injections is another instance. The utilization of this modality has increased from 30-40,000 claims a year to 130,000! Is there any research showing that it increases successful outcomes? NO!!

I anticipate the first conditions that will be implemented for the podiatric community will be care of wounds, Diabetic foot exams, peripheral neuropathy, PVD and perhaps heel pain. All specialties will be involved in this and will include evidence-based care by the primary caregivers for patients with diabetes, heart disease, hypertension, etc.

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Hopefully there will be some pressure placed on the consumers of the health care dollars to start taking responsibility for their choices in life style. Obesity contributes to all of the major diseases that are costing our country so much money. It is estimated that avoidable costs from obesity is around **\$200 billion!** We are in a great position in that we keep people walking. Studies are being performed now that are showing how 30 minutes of walking each day can improve obesity, heart disease, hypertension, diabetes and depression.

We will be expected to totally jump on the information technology bandwagon. We will all need to be utilizing electronic medical records within the next few years if you want to be in the P4P wave. There will be databases we can access to see patients records. Just having access to a patients current labs results can save \$ millions in unnecessary and repeated labs.

Included in this increased efficiency and uniformity in care will be the availability of tons of information including data on all of our practices. It is already starting with UnitedHealthcare releasing information. One of the speakers at this year's meeting asked: if

we can find out virtually anything about a new or used care, why can't we access information on our healthcare providers? Good question. Anticipate possible patient satisfaction surveys and your costs and outcomes being available on the Web. Fun, huh?

Initially, there will be "G" codes that we will use to document that we did with various patients, i.e. 2028F is a code that was implemented on July 1, 2006 and is one of 47 new CPT Category II "measurement codes. 2028F will indicate that a diabetic foot exam was carried out and includes: examination through visual inspection, sensory exam with monofilament and pulse exam. There are already codes for various specialists to use regarding HgA1c control, initial treatment for acute MI, etc. These will be use to gather initial data on how care is being rendered to patients by us and will help shape the plan of action for the next step.

The Pay portion of P4P is supposed to mean that we will be incentivized through increased payments to join this wave. Questions being raised include: will the increased payments offset the costs involved with offices paying for the technological costs, issues of security of information and not being penalized for not getting involved or having a mix of patients that are out of the normal bell curve.

That is my assessment of P4P in a short space. This force is coming and I recommend that you keep on top of news as it comes from APMA and myself. If you know of anyone who is not a member of CPMA and APMA I implore you to speak to them. They are reaping the rewards of your money and the APMA Board and staff's incredible work. There's a name for them. Anyway, read on and you will receive more in-depth information.