# Fee Schedule Debated

**Medicare** *from page 1*

Medical Association, who spoke as an individual rather than as a representative of the AAN.

The SGR is a systemic problem that's been present for a number of years now that could be fixed either administratively or by Congress, "and has to be done completely separate from quality improvement measures," said Dr. Charles of Vanderbilt University in Nashville, Tenn.

The problem with pay for performance is it doesn't exist yet, he continued. "There's no way of knowing how the nuts and bolts of the program are going to work."

In announcing the final rule on the 2006 fee schedule, Dr. McClellan clarified that the 1% increase contained in the Senate legislation "would link to creating a pay-for-performance fund for physician services. While we have not endorsed that approach and think that in the short term, it may be better to get more quality reporting in place effectively, we definitely want to work with interested members [of Congress] on payment reform for physicians in 2006," he told reporters.

Mary Frank, M.D., board chair of the American Academy of Family Physicians, said the hope is that the budget-reconciliation package will incorporate the 1% increase with provisions from Rep. Nancy Johnson's (R-Conn.) pay-for-performance bill, which also would repeal the sustainable growth rate (SGR) and base future payments on the Medicare Economic Index.

As has been the case for years, the SGR is driving the cut in Medicare physician pay.

The SGR is a component in the Medicare payment formula that determines the conversion factor update each year. Errors made to the formula in 1998 and 1999 led to a 5.4% decrease in physician payments in 2002—decreases that will continue unless the payment formula is corrected. Indeed, only congressional intervention has stopped payment cuts in the years since 2002; instead, short-term laws have provided small increases in pay.

The SGR is determined in part by the projected increase in the gross domestic product; in essence, it ties medical spending to the ups and downs of the national economy.

Several medical organizations oppose the "value-based purchasing" pay-for-performance bill sponsored by Sen. Grassley, which would link 2% of physician Medicare payments to reporting of quality data and demonstrated progress toward quality and efficiency measures but would not fix the SGR. Although the program would be voluntary, those choosing not to participate would lose the 2%.

**Pay for performance is less about judging physicians on the quality of their care and more about the role of the third-party payers.**

Value-based measures require physicians to deliver more services, Michael Maves, M.D., executive vice president of the American Medical Association, recently wrote in a letter to Sen. Grassley. "Under the SGR, more physician services will result in a series of severe cuts, compounding current problems. This would make future SGR reforms more expensive."

The Medicare physician-fee schedule was the subject of debate at the interim meeting of the AMA's House of Delegates.

The AMA's support for any type of pay for performance or other type of quality reporting program "is dependent on stopping the Medicare pay cuts," said AMA president J. Edward Hill, M.D.

In a resolution, the House of Delegates asked the organization to advocate for a repeal of the SGR without compromising the organization's principles on pay for performance.

"While external forces work to link pay for performance to physician payments, we assert that pay for performance is incompatible with the SGR," Jack Armstrong, M.D., of the AMA's Board of Trustees, said during House floor debate. This resolution will enable the AMA to continue its aggressive campaign to protect Medicare patients without compromising its pay-for-performance principles, he said.

"Until we establish a practice environment where physician payments match practice costs, pay for performance won't work," said Dr. Armstrong, an AMA trustee.

The 1% Medicare pay increase is a start, but Congress should be looking for a permanent fix to the payment problem, not a temporary one, as this reconciliation bill proposes, he said.

The AMA's member societies have been divided on whether to link the pay-for-performance issue to the Medicare physician fee schedule. It's a question of what physicians are willing to ultimately accept, William Golden, M.D., American College of Physicians delegate to the AMA, said in an interview. The ACP has its concerns about implementing performance reporting "but is willing to accept its concept in order to avoid the SGR cuts," Dr. Golden said, adding that there are certain higher-earning specialty societies within the AMA that would take the impending 4.4% hit to their paychecks as a concession for not having to comply with any performance measures.

Pay for performance in general "seems to be about judging doctors on their performance, but what it's really about is the role of third-party payers," Richard Warner, M.D., a clinical psychiatrist from Kansas, said during committee debate.

For years, payers have been saying, "We're going to save you money." That hasn't happened, as the rising cost of health care has shown, he said. "Now their fallback position is, 'We can't save you money, but we're going to give you your money's worth.' " This will ultimately have an impact on the physician/patient relationship, he said.

In announcing the fee schedule, Dr. McClellan insisted Medicare did not have the authority to change the way the fee schedule is calculated. ■

*Joyce Frieden, Associate Editor for Practice Trends, contributed to this report.*

# What Are You Prepared to Do to Manage Mass Casualties?

BY ROBERT FINN
*San Francisco Bureau*

SAN FRANCISCO — Every physician should consider how he or she would manage as the only medical professional in a mass-casualty situation, Lt. Cormac J. O'Connor, MC, USN, said at the annual meeting of the American Academy of Family Physicians.

Dr. O'Connor, a second-year resident in family medicine at Naval Hospital Camp Pendleton (Calif.), offered a mnemonic—SAGGY PRIDE—to help physicians remember the critical steps in managing mass casualties. Dr. O'Connor emphasized that his suggestions are his own and do not represent official positions of the U.S. Navy or the Department of Defense.

SAGGY PRIDE stands for Situational Awareness, Gather a Group and Yell, Plan Rapidly, Issue Directives, and Execute.

A "mass casualty" is any situation in which the number of casualties overwhelms the medical capabilities available. This can range from a single, critically ill person in a remote location to thousands of people in an urban area who are victims of a natural disaster or a terrorist attack.

"Civilian physicians are not trained to deal with mass casualty events," said Dr. O'Connor, who has served in combat with the U.S. Marine Corps in Iraq. "[Regardless of your specialty] as a physician, you're expected to know what to do."

### Situational Awareness

In less than 1 minute, if possible, you need to get a grasp of what has happened. What is the nature of the calamity? How many people are involved? What is the location's condition and physical layout? What resources are likely to be available?

### Gather a Group and Yell

Using a loud voice, identify yourself as a physician and bring all the able-bodied people together. You will not be able to handle the situation alone and will need as much help as you can muster. "You need to be the puppeteer," Dr. O'Connor said.

Identify any other medically trained personnel available to assist you. You need everybody's help, but you must have control and confidence, something that physicians who practice emergency medicine gain with experience but which may not come as easily to other physicians.

### Plan Rapidly

Divide the work. The short game is to do the best for the people who are going to die or suffer a serious injury if you don't act immediately. The long game is to consider how you're going to evacuate all of the injured to a higher level of care.

Triage is the first step in the short game. Don't waste time with people who are not seriously injured; conversely, don't focus your resources on those who are likely to die given the resources you have available.

Extremity exsanguination and pneumothorax are the two major causes of preventable death in mass casualty situations as in combat , Dr. O'Connor said. Since a physician who happens on a mass casualty is unlikely to have the equipment needed to help a patient with pneumothorax, the best thing he or she can do is to keep patients from bleeding to death from a hemorrhage of the extremity.

The best way to do this is to apply direct pressure, but even if you had a group large enough to apply direct pressure to every injured person, consider whether that is the best use of your resources.

The other alternative is to use tourniquets. Dr. O'Connor disagrees that tourniquets use can lead to the loss of a limb. He described one combat casualty he treated who had a leg wound so severe he could see the man's sciatic nerve. He applied a tourniquet that stayed on for a full 8 hours. The man lived and has full use of his leg. Peripheral muscle can stand to be deprived of oxygen for extended periods.

For the long game, think first about communicating to emergency services. These days almost everyone carries a mobile phone, but what are you going to do if cell service is down? Perhaps someone has a working BlackBerry, a CB radio, or maybe there's even a working land line.

Think about how emergency services are going to get to the site and how they're going to leave. Plan a route that gives one way for emergency vehicles (possibly including helicopters) to get in, and another way to get out. Put the people in need of evacuation at sensible collection points, and move less seriously injured people, the dead, and the dying out of the way.

### Issue Directives

Be very specific and speak directly to individuals. Don't say, "Somebody, please phone for help," Dr. O'Connor recommended. Instead say, "Ma'am, I see you have a cell phone. Call 911 right now!"

Have able-bodied people move the dead out of the way, and preferably out of sight. Designate an assistant to move the walking wounded to another location.

If possible, assign someone to stay with those who are likely to die within a short time. Get them to a quiet area. Find somebody who is mature, but who may not be physically very strong, to stay with these folks and comfort them during their last minutes or hours.

### Execute

Have a group of worker bees search for heavy extremity bleeding and apply pressure dressings or tourniquets. Instruct them to use any available materials, including belts, shirts, and bras.

Finally, don't forget to continually reevaluate the situation. This may include retriaging the injured as their situations change. ■