

William L. Rich III, MD

Dr. Rich discusses health policy and the merits of unplugging from technology.

How did you become involved in the area of health care financing?

I first came to the Washington, DC, area as an undergraduate at Georgetown University, where I was exposed to a classic Jesuit education: "glory to God through service to others." I also attended Georgetown University School of Medicine and am a graduate of the residency program there. You cannot live in the DC area for almost 47 years without developing an interest in politics and policy. That exposure, my education as an ophthalmologist, and the Jesuit tradition of service prompted my commitment to volunteerism.

In 1978, the AAO asked me to write a paper on the Health Planning Act, which led to my 33-year commitment as a volunteer. My first involvement was in workforce issues and manpower shortage areas. My long-held interest in economics stimulated me to get involved in practice management, and I was the first chairman of that AAO committee. My involvement in financing and physician payment was a logical next step in 1993, when I first represented the AAO at the AMA Relative Value Update Committee. I have been involved in the intricacies of financing and payment ever since.

Based on your experience, how might the quantity and quality of physicians' work be more accurately measured?

When William Hsaio, PhD, first developed the relative value update scale in 1988, he tried to incorporate patient value and quality but could find no metrics by which to do so. Thus, the emphasis was on work: physicians' time, mental effort and judgment, technical skill, and iatrogenic risk. Today, we are developing new validated tools with which to measure outcomes, patients' satisfaction, patient-reported outcomes (ie, did a "success" really improve functioning?), and the efficiency (resource use = cost) of our care. This approach will drive physicians' payment in the next couple of years and will be more meaningful to patients and payers. The days of payment based purely on volume will be phased out in the next 5 to 10 years.

How do ophthalmology's interests coincide with those of other specialties, and where do they compete in terms of physicians' payment?

Our specialty is unique. For Medicare, ophthalmologists provide two of the top five surgical services in terms of volume, yet we receive more than 55% of our income from office-based examinations. Our services include complex inpatient services, outpatient surgical procedures, consultations, and office-based testing. They encompass all of the service categories physicians provide. As a result, our interests are unique, and our advocacy extends beyond surgical specialties to involve discussions with primary care physicians, pediatricians, radiologists, and medical subspecialists. We straddle the cognitive and procedural silos in Washington.

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FAST FACTS

- Senior partner in Northern Virginia Ophthalmology Associates, 1976 to present
- Clinical faculty member at Georgetown University, 1978 to present
- Medical director of health policy for the AAO, 2009 to present
- Sat on panels at the National Health Policy Forum and the Institute of Medicine, 2003 to 2006 and 1997 to present, respectively
- Consultant to the Robert Wood Johnson Foundation, 1997 to 2001
- AAO representative to the AMA Relative Update Committee and Relative Update Committee chairman, 1993 to 2002 and 2002 to 2008, respectively
- Chair of the Health Professional Council of the National Quality Forum, 2010 to present
- The AAO's representative at the Ambulatory Quality Alliance and Surgical Quality Alliance, 2006 to present
- Past president of the Fairfax County Medical Society, 1984

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5 QUESTIONS

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In order to shape health policy to meet the needs of our patients and members, we must always wear a "white hat." With the AAO's decades-long commitment to quality, education, science, and the underserved, we have established great credibility among decision makers. As a result, we have won substantive victories in the economic arena. As long as we retain that focus, we will retain our influence.

You and your wife are both involved in health policy but for different medical specialties. What have you found most interesting in terms of the similarities and differences in your efforts?

We are both policy geeks, having met at a stultifying National Quality Forum meeting in Baltimore. We passionately discuss art, dance, sports, and our families, but we are really boring in that we discuss health policy continuously. My wife, Janet S. Wright, MD, FACC, practiced invasive cardiology in California for over 22 years but now is senior vice president for science and quality at the American College of Cardiology here in Washington. We have in common a long-term commitment to our professional societies, which just happen to be the two innovators in developing evidence-based guidelines, and we share a dedication to putting patients and quality first. We disagree in that each feels his or her respective national association represents the best in American medicine. As we age, we supply two of the services dearly prized by friends. All we need is a urologist in the family.

What are your favorite outdoor activities, and where are you most likely to be found when you are enjoying them?

I love to ride my road bike on the streets of Southern Maryland but have toured the West and abroad. My wife and I enjoy kayaking on the Chesapeake Bay or hiking and fly fishing in the Tetons. Sailing on the Chesapeake is like entering another world, although my brain is not narcotized.

Today, we are assaulted by unending, meaningless, unproductive interruptions: e-mail, voicemail, and conference calls that impede creative, strategic thought. I have never listened to an iPod (Apple, Inc., Cupertino, CA) when sailing, biking, gardening, or hiking. I let my thoughts wander and ask myself where we should be going and how do we get there. Almost all of the health policy initiatives I have started or supported began with these quiet times of exercise and contemplation. I could not function without these interludes. □