

**Hill Briefing – March 23, 2007**  
**Lynne M. Kirk, MD, FACP, president of the American College of Physicians**  
**Oral Remarks**

We're here today to discuss with you the American College of Physicians policy recommendations to reform Medicare, Medicaid, S-CHIP and other programs supported by the federal government to advance a model of health-care delivery—called the patient-centered medical home-- that has been proven to result in better quality, more efficient use of resources, reduced utilization, and higher patient satisfaction.

I'm very pleased – as president of the American College of Physicians – to be representing over 120,000 internal medicine physicians and medical students.

As a practicing internist, I know that a patient's relationship with their primary care physician is something that develops and continues over the course of years. I have seen my patients through major life changes as they both grow up and grow old.

You develop an understanding of your patients' medical histories. And, this understanding doesn't limit itself to just physical knowledge. You get to know your patients' value systems and important relationships and sources of emotional support. That's why I—and so many of my colleagues—are so frustrated by our health care system.

We are frustrated by the fact that we spend more on health care in the United States than any other industrialized nation, yet we do poorer than other developed countries on most quality measures.

We are frustrated because we know that a patient's relationship with their personal physician is the *single most important factor* in determining the quality of care they receive and how much it costs, yet this relationship is systematically undervalued and undermined by Medicare and other payers.

We are frustrated by a payment system that rewards doctors for increasing the volume of visits and procedures, but that will not reimburse us for providing preventive services, controlling common chronic disease, or for the work involved in coordinating care that takes place outside of a traditional office visit.

We are frustrated by the fact that our nation tolerates having more than 46 million persons without health insurance, because these patients are the least likely to have access to an ongoing relationship with a personal physician.

Let me share with you data on why the relationship between a patient and their primary or principal care physician is the single most important factor in influencing outcomes and costs:

- Research by Barbara Starfield at Johns Hopkins has found that nations that organize their health systems around the relationship between primary care

physicians and patients consistently have better outcomes—including lower mortality rates and lower per capita costs—than countries that have de-emphasized the role of primary care. Of countries she studied, the United States has the lowest “primary care score”—that is the degree that a country organizes care around a patient’s relationship with a primary care physician—and accordingly has the highest costs and poorest outcomes.

- She also found that within the United States, states that have a higher proportion of primary care physicians in the workforce are positively associated with reduced mortality rates and lower costs.
- Investigators at Dartmouth similarly found that states that have more primary care physicians have lower total Medicare costs, fewer deaths in the ICU, lower Medicare utilization, and better composite quality scores.
- The Commonwealth Fund reports that there are many chronic diseases in the Medicare population where hospitalization rates are sensitive to effective management in the ambulatory primary care setting. In other words, a patient who has a long-term relationship with a primary care physician is less likely to suffer complications from their chronic illnesses that may later lead to a hospital admission or re-admission.

1

Today, the American College of Physicians proposes a roadmap for the federal government to restructure payment and delivery systems that support the relationship between patients and their primary and principal care physicians. This would involve applying systems-based models that have been proven to work in other nations’ health systems – adapting them to the unique circumstances and needs of the United States – and in successful patient-centered health programs within the U.S. In a few minutes, Mr. Doherty will summarize our detailed policy recommendations.

Our legislative recommendations build upon a joint statement of principles adopted and released earlier this month by ACP, the American Academy of Family Physicians, the American Academy of Pediatrics and the American Osteopathic Association. The joint principles on “a patient centered medical home” are provided in your packets.

The four groups represent some 333,000 physicians and medical students. The pediatricians, family physicians, internists and osteopathic physicians represented by these four organizations provide the vast majority of primary care services to children, adolescents, and adult patients in the United States.

What is a patient-centered medical home?

It is a model of care that facilitates partnerships between individual patients and their personal physicians and – when appropriate – the patient’s family. The Joint Principles define the following key characteristics of the PC-MH:

***Personal physician*** - each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.

***Physician directed medical practice*** – the personal physician leads a team of individuals at the practice level who collectively take responsibility for the ongoing care of patients.

***Whole person orientation*** – the personal physician is responsible for providing for all the patient’s health care needs or taking responsibility for appropriately arranging care with other qualified professionals. This includes care for all stages of life; acute care; chronic care; preventive services; and end of life care.

***Care is coordinated and/or integrated*** across all elements of the complex health care system (e.g., subspecialty care, hospitals, home health agencies, nursing homes) and the patient’s community (e.g., family, public and private community-based services). Care is facilitated by registries, information technology, health information exchange and other means to assure that patients get the indicated care when and where they need and want it in a culturally and linguistically appropriate manner.

The Joint Principles state that quality and safety are hallmarks of the PC-MH. The statement features eight sub-points highlighting specific responsibilities, education, decision making, technology, participation and other necessary elements to improve quality and safety.

By its very definition, a medical home is an approach to quality improvement that promotes a partnership between the patient and the clinical care team. This partnership not only optimizes quality care, but also minimizes patient risk because the medical home forges a safe bond and quality connection between the care delivered and the specific needs of the patient and his or her family when appropriate.

Many U.S. physicians already are providing some of the characteristics of patient-centered care, but few provide all of them. In comparison, many other industrialized countries have made a deliberate policy decision to build their health care systems around patient-centered care, and physicians in those countries are far more likely to report that they have all or most of the characteristics associated with patient-centered care.

A recent Commonwealth Fund study found that “a gap exists between knowledge and practice—between physicians' endorsement of patient-centered care and their adoption of practices to promote it. Physicians reported several barriers to their adoption of patient-centered care practices, including lack of training and knowledge (63 percent) and costs (84 percent). Education, professional and technical assistance, and financial incentives would facilitate broader adoption of patient-centered care practices. With the right knowledge, tools, and practice environment, and in partnership with their patients, physicians would be well positioned to provide the services and care that their patients want and have the right to expect.”

Patient-centered primary care—supported by a better reimbursement structure--can accelerate the transformation of physician practices by making the business case for physicians, including those in small practice settings, to acquire and implement health information technologies and other systems-based improvements that contribute to better outcomes.

Our vision of patient-centered primary care will not be achieved, however, without fundamental redesign of Medicare payment policies. A principal reason why the United States does not consistently deliver patient-centered care is that payment systems used by Medicare, Medicaid, and most private payers reward physicians for the volume of procedures generated and number of office visits performed, rather than for ongoing, continuous and longitudinal management of the patients' whole health, supported by systems-based practice improvements that lead to better results.

Redesign of payment policies must include providing positive and sustained incentives for physician practices that organize themselves as a patient centered medical home.

It should include payment for care coordination that falls outside of a face-to-face visit. It must allow physicians to share in savings in other parts of Medicare, such as from reduced hospital admissions that result from patient-centered care in the office setting.

And it must eliminate the sustainable growth rate (SGR) formula. The SGR will force many primary care physicians to close their practices or limit the number of Medicare patients they can see. Those that are able to stay open will not be able to afford the systems needed to help improve care coordination for patients with multiple chronic illnesses.

The 109<sup>th</sup> Congress enacted legislation that mandates a demonstration project of a Medicare medical home, which will include payment for care coordination by physicians. This is an excellent start to restructuring Medicare payment policies to support patient-centered primary care, but results from the demonstration likely will not be available until 2012 or later. The ACP believes that there are many other steps that Congress can take right now to support redesign of payment policies to support a patient-centered medical home.

I am pleased to introduce Robert Berenson, MD, FACP, a Senior Fellow at The Urban Institute and Clinical Professor of Health Care Sciences and Medicine at the George Washington University School of Medicine. Dr. Berenson is one of the nation's foremost experts on redesigning physician payment policies. He will provide his perspectives on what is wrong with our current payment system and why it needs fundamental redesign.

Immediately following Dr. Berenson's remarks, Mr. Doherty will outline ACP's specific legislative recommendations to support patient-centered care. We will then hear from Ms. Christine Dodd, who will explain why IBM and many other large employers have joined with ACP to advocate for patient-centered care and the medical home.