The State of the Nation's Health Care:

A Report from America's Internists
On Strategies to
Improve Quality, Reduce Costs, and Expand Access
Centered on Strengthening the Patient-physician Relationship

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Executive Summary

Over the past several years, growing concern has been expressed by purchasers (particularly the federal government and large employers), patients, physicians, and consumers about the state of the nation's health care system. Specifically, concern has been expressed about the large number of Americans who still lack health insurance coverage; rising costs (as reflected in higher premiums and increased spending on Medicare and Medicaid); too many medical errors; and what the Institute of Medicine has called the quality chasm[i]: the gap between what is known to be appropriate care based on scientific evidence, and the level of care that most Americans routinely receive. Such concerns have led to increased discussion in public policy arenas about ways to reform the health care system to encourage quality improvement, achieve cost efficiencies and expand access.

The American College of Physicians is the nation's largest medical specialty society, representing 116,000 physician and medical student members. The College shares in the belief that major reforms are needed to support quality improvement, more efficiently utilize resources, and expand access. We believe, however, that the most effective strategies will be ones that *support the relationship between patients and their own doctors*, since "quality begins with the patient-physician relationship"[ii] and it is within this relationship that decisions are made on the quality, appropriateness, and effectiveness of the services that patients receive. Policies that neglect or even undermine the patient-physician relationship will be unsuccessful in achieving quality improvements, cost efficiencies, and improved access.

Unfortunately, the reality today is external factors are endangering the patient-physician relationship. *Dysfunctional payment systems and excessive paperwork requirements* employed by Medicare and other payers make it difficult--and at times, impossible--for physicians and patients to take the time required to develop and sustain the level of communication, trust and confidence needed to deliver optimal care. Time pressures, real or perceived, can impact the quality of patient-physician communication, impairing shared decision making and informed consent discussions and discouraging patients from discussing important psychosocial issues.[iii] Medicare payment policies favor *episodic* treatment of patients with *acute* illnesses, rather than supporting the physician's roles as the *patient advocate and coordinator* of quality care of patients with *chronic* diseases.

Current payment policies also do not encourage use of electronic medical records, evidence-based clinical performance measures, and other innovative models of practice improvement that are intended to improve the effectiveness of physicians' interactions with their patients.

The majority of Americans have demonstrated a preference for a sustained relationship with a primary care provider and studies indicate that a continuous patient-physician relationship correlates with patient satisfaction, improved health, positive outcomes, reduced malpractice litigation, as well as reduced emergency department use and reduced health care costs per patient.[iv] Yet, the systematic undervaluation of cognitive primary care services is one of the key factors behind the rapid and troubling decline in the number of physicians choosing internal medicine, family practice, or pediatrics. With fewer physicians going into primary care, many patients will soon find it difficult to establish an ongoing relationship with a primary care doctor, because those still in practice will be too busy to take on new patients, and not enough new doctors will be coming into practice to keep up with increased demand.[v] Since general internists are ideally suited to the integrated care of elderly patients with multiple problems, our aging society will pose an additional challenge.

Today, the American College of Physicians proposes a policy framework to support and enhance the patient-physician relationship by:

- Reforming the dysfunctional physician payment systems used by Medicare and most other payers.
- Creating incentives for practice innovation and improvement, including use of electronic medical records and other health information technology to support evidence-based practice improvement; incorporation of clinical decision support tools into daily practice at the point of care; and new practice models to improve coordination of care of patients with chronic diseases; and improved overall efficiency.

ACP's Proposals to Support and Strengthen the Patient-physician Relationship

1. **As a first but essential step to fixing the dysfunctional Medicare payment system, Congress and the Administration must act immediately to permanently stabilize Medicare physician payments by averting future cuts from the sustainable growth rate formula**.

The Sustainable Growth Rate (SGR) will cause annual cuts of 5 percent or more per year through the end of the decade. (The SGR is a complex formula that cuts Medicare physician payments whenever the growth in expenditures on services included in the formula exceeds changes in per capita GDP, after adjustment based on enrollment, changes in law and regulation and other factors). The 108th Congress, as part of the Medicare Modernization Act (MMA), temporarily halted cuts from the SGR by guaranteeing annual updates of 1.5 percent in 2004 and 2005. However, without new legislation this year, the SGR will trigger cuts in excess of 5 percent in 2006, and

additional cuts of at least that amount are projected to occur each year thereafter until at least the end of the decade. The cuts would occur even as physicians' costs of providing services increases.

Continued Medicare cuts will make it impossible for physicians to invest in electronic medical records and other practice innovations to support quality improvement and will accelerate the trend of physicians choosing not to practice in internal medicine and other primary care specialties that are heavily dependent on Medicare revenue.

The College specifically advocates that (1) President Bush and Centers for Medicare and Medicaid Services (CMS) officials should take an immediate action to reduce the cuts that will occur under the SGR (and the costs of legislation to permanently replace the SGR) by removing from the SGR formula drugs administered in physician offices, retroactive to the April 1, 1996-March 31, 1997 base period, since drugs are not a physician service and were improperly put in the SGR in the first place; (2) Congress should enact legislation to permanently replace the SGR with a formula that links future increases to the costs of providing services in physicians' offices, as recommended by the Medicare Payment Advisory Commission (MedPAC) and (3) Congress should guarantee a 2006 update that is no lower than the 2.7% increase recommended by MedPAC. Fixing the current physician payment system will preserve access to care by eliminating the physician's need to cut back on care and caseloads and enhance the patient-physician relationship.

2. **Congress should enact a "National Health Information Incentive Act" to provide initial and sustained funding for physicians to invest in electronic medical records and other essential health information technology (HIT) to support quality improvement. The legislation would:**

- Require HHS to develop or adopt standards for transactions and data elements for building a national health information infrastructure, in consultation with standard setting organizations, physicians, and other health professionals; require that the standards not impose an undue administrative or financial burden on the practice of medicine, particularly on small physician practices and rural practices; and require that HHS conduct a pilot program to test the impact and effectiveness of trial standards in various health care facilities, including small physician practices, in both rural and urban sites. A 2002 analysis found evidence that more physicians are opting to practice in smaller settings than they were five years ago.[vi]
- Authorize financial incentives (revolving loans and/or grants) to assure that physicians and other health professionals in small practices have the capability to acquire electronic health record systems and other health information technologies, conditioned on their voluntary participation in studies or demonstration projects to evaluate the use of HIT to measure and report quality data based on accepted clinical performance measures and on improving patient care, reducing costs or increasing efficiencies.

- Create a refundable tax credit, equal to up to 10-15 percent of the amounts paid by a qualified health care provider, of the costs incurred in acquiring electronic medical records and other HIT that meets standards as defined in the legislation.
- Direct the Secretary to provide for additional Medicare payments to physicians and other health professionals in small practices to implement and adapt electronic health record and other HIT, including one or more of the following incentives: care management fees for physicians who use HIT to manage care of patients with chronic diseases, payments for structured e-mail consultations, and add-ons to payment for evaluation and management services.

The College has been working with members of Congress on the development of a "National Health Information Incentive" bill that includes the incentives presented above. The bill is designed to provide *initial* funding, through grants, tax credits or revolving loans, to support the ability of physicians and other provider in small practices to acquire electronic medical records. It also provides *sustained* funding, through changes in Medicare reimbursement policies to support continued use of such technologies, including authorizing an add-on payment to Medicare office visits when supported by such technologies and separate payment for e-mail consultations that meet defined standards of appropriateness. This bipartisan legislation, which will be introduced by Representatives John McHugh (R-NY), Charles Gonzalez (D-TX) and other members of Congress, will help support the goal set by President Bush of establishing a national network of interoperable health information technology within 10 years.

Expanded use of such technologies will directly support the patient-physician relationship by providing physicians with timely access—before, during, and after the encounter with the patient—to information that will lead to better outcomes, including immediate access to lab test results, information and alerts on potential drug interactions, and tests and treatments ordered by other physicians. HIT will also support the ability of physicians to participate voluntarily in programs to report and measure their performance based on evidence-based clinical performance measures, by giving them immediate access, at the point of care, to evidence-based decision support tools. Such tools provide physicians with "actionable" recommendations on how best to treat a particular patient consistent with the measures. HIT can also simplify the administrative burden on physicians of collecting and reporting data on how treatment compares to the measures. But most importantly, HIT can help save the lives of the tens of thousands of Americans that the IOM reported die each year as a result of medical errors.[vii]

3. **Congress should enact legislation to authorize a new federal pilot to test the effectiveness of an innovative patient-centered, physician-guided chronic care management program in small and mid-size medical practices, which would include financial incentives, use of health information technology, and other practice improvements to support and strengthen supporting the patient-physician relationship. Such a program would include the following elements as proposed in ACP's new Position Paper "Patient-Centered, Physician-Guided Care for the Chronically Ill: The American College of Physicians Prescription for Change:"**[viii]

- Patients with complex and multiple chronic diseases would be encouraged to select a personal physician whose practice will serve as their "medical home" (a single point of care where they can go to get treatment and trusted advice on navigating the complex health care system).
- Physicians would be encouraged to volunteer to make their practices available as the "medical home" for eligible patients who agree to participate in the pilot.
- Physicians who participate as a "medical home" would agree to incorporate practice improvements, based on a chronic care model developed by Edward Wagner, MD, FACP.[ix] Practice improvements would include such elements as: defining roles and distributing tasks among care team members, providing clinical case management services for complex patients, ensuring regular follow up by the care team; embedding evidence-based guidelines into clinical practice, implementing information systems to facilitate efficient and effective care; and using online, real-time evidence-based clinical decision support tools to support quality improvement.
- Physicians who participate in the program would receive a "care management" fee to reimburse them for services relating to coordinating and managing the care of participating patients.
- Participating physicians would also be eligible to share in a bonus pool of payments based on performance according to accepted evidence-based clinical performance measures.
- The program would be designed so that any analysis of the success of the pilot would permit comparisons of how practices that incorporate the patient-centered, physician coordinated model of chronic care management, including financial incentives and practice improvement interventions, compare with practices that do not participate in the program (i.e. practice-level randomization).

Today, ACP is releasing a new position paper, "Patient Centered, Physician Guided Care for the Chronically Ill: The American College of Physicians' Prescription for Change." The paper elaborates on a patient-centered, physician-guided model of chronic care management that includes each of the key elements described above.

We are calling on Congress to enact legislation to allow for a pilot test of the patient-centered, physician-guided model. A pilot test of the new model would allow CMS to consider different models for improving the care of patients with chronic diseases other than those authorized by Section 721 of the Medicare Modernization Act (MMA).

Section 721 authorizes a Chronic Care Improvement pilot to evaluate the effectiveness of programs to help patients with chronic diseases manage their own illnesses more effectively and help them with decision-making as they obtain needed health care services. On December 8, 2004, CMS announced awards to bidders in nine sites around the country; each of the successful bidders agreed to institute programs to improve quality and achieve costs savings for patients with diabetes and/or congestive heart failure. ACP is supportive of the program mandated by Section 721, and has reached an understanding with two of the companies who received the CMS award to provide advice

and assistance as the program is being implemented. Both of these companies have agreed to support physicians' roles in chronic care improvement linked to disease management interventions with the patient.

However, other requirements of Section 721 make it a less than ideal vehicle for evaluating the patient centered, physician directed model proposed in ACP's paper. Section 721 requires that the awards go only to companies that accept sufficient financial risk to achieve a five percent savings for Medicare. It also requires that the companies be able to sign up 15,000 to 30,000 patients. Because most physician practices do not have the resources to accept financial risk or the ability to reach this many patients, they could not qualify directly for the program. In addition, the Section 721 pilot will compare how the care of individual patients who sign up for the program compare with those who do not sign up, *not how well the care provided by physician practices* that incorporate the practice improvements described in the College's position paper compare with those practices that do not. For these reasons, ACP believes that Congress and CMS would benefit by creation of another pilot program that would specifically allow for evaluation of the effectiveness of the practices using the patient-centered, physician directed chronic care management program, while at the same time allowing continuing evaluation of the effectiveness of alternative programs as authorized under section 721. ACP has also endorsed S. 40, bipartisan legislation introduced by Senator Blanche Lincoln that would provide annual assessments and chronic care management for those with five or more chronic conditions in the Medicare program.

4. **Congress should expand the small practice pay-for-performance demonstration project created by Section 649 of the Medicare Modernization Act. The expanded program would include the following elements:**

    - Provide financial incentives to physicians in small practices who work with their state Quality Improvement Organizations (QIO) to voluntarily acquire health information and who voluntarily agree to have their performance measured and reported to their QIO based on evidence-based clinical performance measures. Such incentives would include: financial incentives for acquiring and using health information technology and evidence-based clinical decision support tools and pay-for-performance bonuses.
    - Include a much larger number of states beyond the four states authorized by Section 649 and to a larger number of physician practices in each state.
    - Allow for *all* physicians who participate in the program to be eligible for incentives. The current demonstration includes a study and control group, providing incentives only to those who CMS randomly assigns to the study group.

CMS has initiated the Doctor's Office Quality Information Technology (DOQ-IT) program in four states (Massachusetts, California, Arkansas, and Utah). Under this program, physicians in small practices get consultative help from QIOs on selecting and

using electronic medical record systems. They also agree to voluntarily report their performance for selected chronic care and preventive services based on evidence-based clinical performance measures. CMS is expected to announce soon that a study group of participating physicians in each of the four DOQ-IT states will be eligible for financial incentives, including receiving additional Medicare payments for having electronic health record (EHR) systems that meet certain standards, per patient per month administrative support fees, and potentially, pay-for-performance bonus payments. Because participating physicians will be randomly assigned into a control or study group, only those in the study group will receive the financial incentives.

ACP strongly supports that DOQ-IT program and has urged CMS to provide financial incentives to all physicians participating in the program, not just those who are randomly assigned to a study group. However, the relatively small scale of the program (limited to a few hundred practices in four states) does not allow for sufficient evaluation of the effectiveness of financial incentives on physician performance and use of EHRs in diverse practice settings. Therefore, the College is calling on Congress to authorize an expansion of this program to a larger number of states and a larger number of practices and to authorize financial incentives to all those who sign up to participate in the program.

5. **Congress should enact legislation to reform the medical liability system, which undermines the patient-physician relationship. The current system encourages a defensive, distrustful and adversarial relationship between patients and their physicians rather than the kind of collaborative relationship between patient and physician that leads to better care and fewer medical errors.**

The medical liability tort system undermines the patient-physician relationship by creating a climate of distrust and defensiveness between patients and their doctors. Lawsuits that lack merit, excessive jury awards, and the high cost of settlements causes physicians to view their interactions with patients from a defensive—how do I protect myself from being sued?—perspective. Patients, in turn, are encouraged to approach their relationship with their doctor in a distrustful manner, often incorrectly associating bad outcomes with physician negligence. For both patients and doctors, the judicial system was designed to deter physician negligence, provide timely compensation to injured patients, or resolve disputes fairly in favor of the injured party. Unfortunately, our system has failed to accomplish any of these. The current malpractice system is extraordinarily unpredictable and seemingly random in its impact—a system that some have described as being more akin to a "lottery" than an equitable way of compensating individuals for inappropriate and harmful care. Rising medical liability premiums are also forcing some physicians to turn away high risk patients, relocate to states where they are less likely to be sued, limit the scope of services that they will provide to patients, or retire from the practice of medicine entirely – actions which may be necessary but that are all extremely detrimental to the patient-physician relationship.

The College believes it is essential that the 109th Congress take action to reform the medical liability system. Caps on non-economic damages, allowing juries to know about collateral payments, a sliding scale of attorney fees, joint and several liability and periodic repayment of claims are reforms that have shown to be effective in California and other states and, therefore, should be incorporated into federal legislation. The College further believes that other approaches – such as enterprise liability (where a health service agency assumes vicarious liability for the acts and omissions of its employees providing clinical services), "no-fault" compensation systems, insurance market reforms, screening panels, and alternative dispute resolution—should also be studied and considered, but should be accepted as a basis for federal legislation only to the extent that solid evidence exists they would be effective in deterring physician negligence, providing timely compensation to injured patients, or resolving disputes fairly in favor of the injured party, and strengthening the patient-physician relationship.

6. **Congress should enact legislation to substantially reduce the number of uninsured Americans and, at a minimum, should assure that existing safety-net programs for the poor are not undermined.**

Patients without coverage are the least likely to have an ongoing patient-physician relationship. Because they do not have a regular source of care from a personal physician, they are less likely to take needed prescribed medications, less likely to participate in disease prevention programs and disease prevention, more likely to delay obtaining needed care, and more likely to experience poorer outcomes.[x] Uninsured patients are also the least likely to benefit from use of health information technology and performance improvement programs.

The College has developed a proposal to provide affordable coverage to all Americans within seven years through a combination of tax credits for low-income individuals, purchasing arrangements for small employers, and new state options for expanding safety net programs. Bipartisan legislation based on the College's proposal, the Health Coverage, Affordability, Responsibility and Equity Act, was introduced in the 108th Congress, and we hope to see a similar bill introduced in the new Congress. Even if it is not possible right now to attain ACP's goal of ensuring that all Americans are covered within a realistic but defined period of time, the College strongly urges Congress to work on a bipartisan basis to expand coverage in steps to the most vulnerable individuals: low income workers and their families who do not have access to employer-based coverage and who are not eligible for coverage under public safety net programs. At a minimum, the College urges Congress to reject budget caps on Medicaid. Medicaid should be reformed to provide more options to states, but not under federal budget constraints that will leave states with no option but to reduce eligibility and cut benefits to vulnerable persons.

In addition, Congress, the administration, and the medical profession should continue to work on developing policies to reduce health care disparities based on race, gender or ethnicity. Minorities are disproportionately represented in the uninsured population, with Latinos being the least likely of all racial and ethnic groups to be insured.[xi] Providing all

Americans with affordable health insurance is an essential part of eliminating racial and ethnic disparities in health care.

Conclusions

The College believes that an historic opportunity exists for Congress and the administration to work with the medical profession to institute reforms to support the patient-physician relationship. For too long, the importance of the relationship between doctors and patients has been overlooked, taken for granted or even considered to be unimportant to achieving system-wide changes. There has been a tendency to impose policies and reforms without considering the unintended consequences of such measures on the pivotal relationship between patients and their own doctors.

The College believes that many of the woes of the current health care system—including insufficient attention to quality, rising patient and physician dissatisfaction, higher costs, inefficient use of resources, and fewer physicians choosing to go into primary care—can be attributed to the erosion of the patient-physician relationship. Dysfunctional payment policies devalue the patient-physician relationship and administrative burdens take doctors away from patient care in order to fill out forms. Regardless of the setting or payer type, health plans, purchasers, clinicians, and patients should recognize and support the intimacy and importance of patient-clinician relationships and the ethical obligations of clinicians to patients.[xii] We believe that the best care is provided when patients and their doctor can spend the time to develop the level of trust and confidence required to work together as partners for better health.

It is not enough to simply remove reimbursement and administrative barriers to the patient-physician relationship, however. Instead, the proposals the College is releasing today would *support and strengthen* the patient-physician relationship by:

- Stabilizing Medicare payments by eliminating cuts caused by the sustainable growth rate formula that would further undervalue the patient-physician relationship and make it impossible for physicians to invest in practice improvement systems.
- Creating targeted upfront and sustained incentives for physicians in small practices to use health information technology to improve care.
- Encouraging use of high-level evidence-based decision support at the point-of-care, so that physicians have easy access to the best and most up-to-date guidelines on care of their patients.
- Allowing for implementation of a new pilot program to evaluate an innovative practice based model to improve care of patients with chronic disease.
- Expanding on demonstration projects to use financial incentives to support use of HIT and performance measurement in small physician practices.
- Reducing the adversarial and unpredictable nature of the medical liability tort system.
- Expanding health insurance coverage to those who are most vulnerable.

Even with the improvements recommended today by ACP, more work will need to be done to strengthen the patient-physician relationship by reforming dysfunctional payment system, employing health information technology to support quality improvement, facilitating physicians' role in managing the care of their patients with chronic disease, and expanding health insurance coverage to all Americans. But the implementation of the proposals put forth today will be an essential first step toward creating a better health care system for all Americans, centered on strengthening the patient-physician relationship and improving the quality of health care.

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