AMERICAN ACADEMY OF FAMILY PHYSICIANS
STRONG MEDICINE FOR AMERICA

Statement of the American Academy of Family Physicians

Senate Committee on Finance
Hearing on "Chronic Illness: Addressing Patients' Unmet Needs"

July 15, 2014

The American Academy of Family Physicians (AAFP), representing 115,900 family physicians and medical students nationwide, thanks the Committee for holding this important hearing and submits the following statement for the record:

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Preliminarily, the AAFP thanks the Committee for its ongoing efforts to repeal the Medicare Sustainable Growth Rate (SGR) formula, and to replace it with a system that encourages physicians to transform their practices away from fee-for-service and toward value-based models such as medical homes. To that end the AAFP has endorsed the bipartisan, bicameral SGR repeal-and-replace package that the Committee unveiled this year, and stands ready to help the Committee see this legislation enacted into law.

Turning to the subject of this hearing, the AAFP shares the Committee's goals: improving population health in the United States, and at the same time reducing the overall cost of care. We encourage the Committee to continue exploring the notion that addressing the needs of Americans with chronic illness is a promising way to achieve these goals. In addition, the AAFP believes that Family Medicine is uniquely situated to play a key role in the nation's efforts to prevent and manage chronic illness.

The AAFP Is Dedicated to Achieving Better Population Health at Lower Cost.

The 115,900 members of the AAFP have dedicated their practices and professional lives to delivering high-quality, comprehensive primary care to their patients. The AAFP defines primary care as "health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health settings."[1] Hence, a core element of Family Medicine is not only diagnosing and treating illness as it arises, but also improving population health through prevention of illness. Family physicians do this by establishing continuing healing relationships with patients and overseeing and managing all of their health needs—often collaborating with other health professionals, and utilizing consultation or referral as appropriate.

Family Medicine as a discipline is also concerned with the overall cost of health care. Beginning with residency, family-medicine training must "incorporate considerations of cost awareness and risk-benefit

[1] American Academy of Family Physicians, "Primary Care," at http://www.aafp.org/about/policies/all/primary-care.html; *see also id.* (Primary-care physicians are "trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern . . . not limited by problem origin . . . organ system, or diagnosis.").

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analysis in patient and/or population-based care as appropriate."[2] The AAFP also engages in ongoing efforts "to provide public education which emphasizes the responsibility of the individual patient for his/her personal health and for rising health care costs."[3] These efforts "emphasize the positive effects of exercise, nutrition, highway safety, and the detriments of drug and substance abuse, obesity, and smoking."[4] In short, improving health and simultaneously reducing health costs have always been central to the work of Family Medicine.

The AAFP Believes That Actively Managing Chronic Illness Can Improve Health and Reduce Costs.

According to the U.S. Centers for Disease Control and Prevention, 75 percent of the nation's health-care spending is now dedicated to treatment of chronic diseases.[5] These include persistent and often debilitating conditions like Alzheimer's Disease, arthritis, cancer, chronic obstructive pulmonary disease (COPD), diabetes, end-stage renal disease, heart disease, mental illness, and many others—often occurring in combination with one another. Particularly as scientific advances have allowed us to prevent and cure so many infectious diseases, it is these non-communicable conditions that have now taken center stage in our national debate over achieving better health and controlling costs. Based on this trend, preventing, treating, and managing chronic illnesses before they become unmanageable are essential to improve health and lower costs.

As documented in the July 15 hearing, as well as in recent media reports, private health payers are now acting on this and seeing positive outcomes. For example, the testimony of Chet Burrell, president and CEO of CareFirst BlueCross BlueShield, indicates that under CareFirst's patient-centered medical home (PCMH) program, CareFirst works with primary-care physicians to develop "formal, detailed care plans" that "address all the pharmacy, behavioral health, and medical services needed."[6] CareFirst's PCMH provides "strong financial incentives and rewards to PCPs [primary care physicians] to allow them to differentially focus on the care of the multi-chronic patient and to encourage them to actively follow these patients carefully through all the care settings and services they receive at the direction of specialists."[7] Through this effort, CareFirst has documented "$267 million in avoided costs, a 6.4% reduction in hospital admissions, an 8.1% reduction in all-cause readmissions, and improvements in other quality measures."[8]

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[2] Accreditation Council for Graduate Medical Education, ACGME Program Requirements for Graduate Medical Education in Family Medicine (2014), at 15.

[3] American Academy of Family Physicians, "Health Care Costs, Methods for Reducing," at http://www.aafp.org/about/policies/all/health-costs.html.

[4] *Id.*

[5] See Centers for Disease Control and Prevention, "Chronic Disease Prevention and Health Promotion," at http://www.cdc.gov/chronicdisease/.

[6] Testimony of Chet Burrell, President and CEO, CareFirst BlueCross BlueShield, "Chronic Illness: Addressing Patients' Unmet Needs." Written Testimony before Senate Committee on Finance (July 15, 2014), at 2.

[7] *Id.* at 3.

[8] *Id.* at 2.

Further, CareFirst is only one of many BCBS companies that now spend one in five reimbursement dollars in similar programs that pay for quality outcomes rather than volume of services.[9] In addition, according to *The New York Times*, "Aetna, Cigna, and UnitedHealth Group, among others, are also all exploring similar ways of rewarding doctors and hospitals."[10] These payers recognize that keeping their patient-members well rather than merely treating them when they get sick is a more promising model for their business and for the patients. The AAFP believes that these new payment models (e.g. blended payments for primary care, global payment for defined primary-care services) hold immense promise for both improving care and lowering costs, as well as enhancing the quality of physician practice and the physician-patient relationship. The Finance Committee, with its wide jurisdiction over federal health programs, is well positioned to derive lessons from the experience of these private health payers.

Family Medicine Can and Should Play a Central Role.

Given Family Medicine's focus on comprehensive primary care, including mental health, family doctors can and should be at the center of the nation's collective efforts to prevent and manage complex chronic illness. Indeed, one of the AAFP's stated objectives is to "assume a leadership role in health promotion, disease prevention, and chronic disease management."[11]

Importantly, Family Medicine, which "encompasses all ages, both sexes, each organ system, and every disease entity,"[12] is the broadest and most general of all medical specialties, and therefore poised to play a prominent role in reforming the delivery of American health care. The work of family physicians—beginning from the first day of residency training—emanates from principles and traditions that value the doctor-patient relationship, and the continuous active management of patients, particularly those with chronic conditions.

First, family medicine training is based on managing a panel of patients over the three-year residency period, rather than reporting to the clinic or hospital and treating cases one at a time as they arrive. Family medicine residents are "primarily responsible for a panel of continuity patients, integrating each patient's care across all settings, including the home, long-term care facilities, the FMP [family medicine practice] site, specialty care facilities, and inpatient care facilities."[13] Family medicine has led medicine in training doctors in this way, so that physicians are thinking about the whole patient, over a span of time, from the first day of residency. Additionally, "[r]esidents should participate in and assume progressive leadership of appropriate care teams to coordinate and optimize care for a panel of continuity patients."[14] Successfully addressing chronic illness in the United States will necessitate this very type of longitudinal and team-based care.

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[9] Blue Cross Blue Shield Association, "Blue Cross and Blue Shield Companies Direct More Than $65 Billion in Medical Spending to Value-Based Care Programs" (July 9, 2014), at http://www.bcbs.com/healthcare-news/bcbsa/bcbs-companies-direct-more-than-65b-in-medical-spending-to-value-based-care-programs.html.

[10] Reed Abelson, "Health Insurers are Trying New Payment Models, Study Shows." N.Y. Times, July 9, 2014.

[11] American Academy of Family Physicians, "Vision and Strategic Plan," at http://www.aafp.org/about/the-aafp/vision.html

[12] American Academy of Family Physicians, "Family Medicine, Definition of," at http://www.aafp.org/about/policies/all/family-medicine-definition.html.

[13] Accreditation Council for Graduate Medical Education, ACGME Program Requirements for Graduate Medical Education in Family Medicine (2014), at 16.

[14] *Id.*

Second, family-medicine training incorporates mental health to a much greater degree than other primary-care specialties. In fact, to be an accredited family-medicine residency program there "must be faculty members dedicated to the integration of behavioral health into the educational program."[15] This integration of mental health is unique to family medicine. To use just one example of this interaction, chronic illness often leads to depression, and depression and mental illness can lead to other chronic illness. Family physicians are trained to understand these links and treat them.

Lastly, the family-medicine tradition emanates from "a personal doctor-patient relationship" and "*an appreciation for the individual, family, and community connections*."[16] Family physicians not only treat the whole patient—they also recognize that illness is often connected to events outside the clinic: a woman experiences debilitating depression because her husband is drinking excessively; a man experiences similar depression after the death of a loved one. Family doctors are trained to recognize how the external context of illness can often be instrumental in diagnosing and treating the whole patient.

In sum, Family Medicine views the movement toward active management of chronic illness as positive for both patients and health payers. The AAFP urges the Committee to continue pursuing policy solutions in this vein.

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Thank you for the opportunity to provide family medicine's views on the evolving efforts to improve health and lower costs. If the Chairman or any committee members have any questions about this statement or about the AAFP, the AAFP encourages them to have their staff contact Andrew Adair, Government Relations Representative, at (202) 232-9033 or aadair@aafp.org.

[15] *Id.* at 8.

[16] *Id.* at 1 (emphasis added).