AMERICAN ACADEMY OF FAMILY PHYSICIANS

STRONG MEDICINE FOR AMERICA

May 29, 2009

Senate Committee on Health, Education, Labor, and Pensions (HELP)

Dear Senator:

The 94,600 members of the American Academy of Family Physicians are pleased to submit our views regarding health care reform, specifically, health care coverage, system reform and workforce issues. The Academy has called for fundamental restructuring of the US health care system for two decades and we commend Congress and the Administration for their leadership and the commitment to find solutions to this complex national priority. We also applaud the desire of the HELP and Finance Committee members to work together on this issue.

Background

Health care in the United States is an enterprise of uncoordinated, fragmented care that emphasizes intervention rather than prevention and comprehensive management of health. Health care costs are increasing rapidly and quality is far from ideal. The growing number of uninsured people in the United States is staggering: approximately 45.7 million in 2007, according to the US Bureau of the Census, despite Americans spending more than 16 percent of the country's gross domestic product – nearly twice that of most industrialized countries – on health care.

Family physicians witness every day the true costs of this costly and confusing heath care system. Nearly one in four of all office visits are made to family physicians. That is 208 million office visits each year – nearly 83 million more than the next largest medical specialty.

In our increasingly fragmented world of health care, family physicians are dedicated to treating the whole person, across the full spectrum of ages. The cornerstone of family medicine is an ongoing, personal patient-physician relationship focused on integrated care.

As a result of the number of patients we see each day, and our "cradle to grave" relationship with them, the AAFP is committed to health care coverage for all. We offer the following comments on health care coverage, system reform and changes to workforce policies.

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Health Care Coverage for All
Ensuring that all people in the US have health care coverage is essential for a healthier and more productive society. However, according to the Commonwealth Fund, the design of the system to provide health care coverage to all people "will have a deep impact on the United States' ability to make

sustainable and systematic improvements in access to care, equity, quality of care, efficiency, and cost control." The AAFP believes that now is the time to design a health care system based on primary care to provide high quality, cost effective care for all.

Focus on Primary Care: Key to Reform
The AAFP believes that any new health care system must be based on primary care. It is the *only* form of health delivery charged with the long term care of the whole person. The primary care relationship, with its comprehensive nature, has the most effect on health care outcomes.

More specifically, primary care is defined as **"**that care provided by physicians specifically trained for and skilled in comprehensive first contact and continuing care for persons with any undiagnosed sign, symptom, or health concern (the 'undifferentiated' patient) not limited by problem origin (biological, behavioral, or social), organ system, or diagnosis" a definition included *in Health Care for All: A Framework for Moving to a Primary Care-Based Health Care System in the United States*, AAFP.

In addition, primary care includes health promotion, disease prevention, health maintenance, counseling, patient education, diagnosis and treatment of acute and chronic illnesses in a variety of health care settings (e.g., office, inpatient, critical care, long-term care, home care and day care). Primary care is performed and managed by a personal physician collaborating with other health professionals, and using consultation or referral, as appropriate. Primary care uses a team approach to a patient's health care, which may include nurse practitioners and physician assistants and other health care providers. All of these attributes will be imperative in a reformed heath care system.

Primary care is cost-effective because it includes coordination of health care services. It also promotes active communication between patients and the health care team and makes the patient a partner in his or her health. We describe this as "patient self management support," which emphasizes the partnership aspect of this mode of care.

Family physicians in medical practice are always primary care providers. And, not surprisingly, more Americans depend on family physicians than on any other medical specialty. Specifically, family physicians are the main source of primary health care for the Medicare population. Sixty percent of people aged 65 and older identify a family doctor as their usual source of health care. Rural and Hispanic seniors also are more likely to identify a family physician as their source of health care. In addition, nearly one-half of the physicians who staff the nation's Community Health Centers are family physicians. And, since 1971, the National Health Service Corps has placed more than 18,000 health care providers in underserved areas – and almost half of the doctors were family physicians.

AAFP Recommendations on Health Care Reform
The Academy believes the key to designing a new health care system is to reemphasize the centrality of primary care by:

- Increasing payment for primary care services;
- Redesigning the manner of primary care delivery modeled on a "patient-centered medical home;"
- Aligning financial incentives to support this system, and;
- Reinvigorating the primary care workforce.

The issues under the jurisdiction of the HELP Committee are articulated below.

The Current US Health Care System: Minimal Reliance on Primary Care=Higher Costs and Lower Quality

According to the American Medical Association Masterfile, the US physician workforce includes 32 percent primary care physicians and 68 percent subspecialty physicians. However, as shown by the article entitled, *Variation in the Ecology of Medical Care*, Annals of Family Medicine, July 2003, the majority of medical care is provided not in the hospital but in outpatient sites including physicians' offices, ambulatory care sites, home visits, nursing homes and clinics.

Unfortunately, research shows that the US focus on subspecialty care has created fragmentation, decreased quality, and increased cost. Yet, studies confirm that if primary care practices were to redesign how they operated so that they were more accessible, promoted prevention, worked collaboratively with patients with chronic illness and engaged patients in self-management and decision-making, health care quality would improve along with cost efficiency. Unfortunately, the current US health care system has failed to deliver this kind of comprehensive primary care because of the *way we finance health care*. The system rewards procedures, rather than preventive care and the management of chronic disease.

According to the Center for Evaluative Clinical Sciences at Dartmouth, states that rely more on primary care have lower Medicare spending (inpatient reimbursements and Part B payments), lower resource inputs (hospital beds, ICU beds, total physician labor, primary care labor and medical specialist labor), lower utilization rates (physician visits, days in ICUs, days in the hospital, and fewer patients seeing 10 or more physicians), and better quality of care (fewer ICU deaths and a higher composite quality score per beneficiary).

For people with chronic health conditions, the Robert Graham Center for Policy Studies in Family Medicine and Primary Care found that there are reductions in expenditures with no significant differences in self-rated health status when people have a family physician as their usual source of care as reported in *Health Affairs*, 2009. For example, if the 21 million people with hypertension had a family physician or general internist as their usual source of care, it could save as much as $14.5 billion per year in health care expenditures. Patients with a primary care physician as their usual source of care have been shown to have better health outcomes and reduced expenditures. Movement to a primary care-based system could have enormous ramifications for future quality and costs in Medicare.

Alternative: The Patient-Centered Medical Home

The AAFP supports the Patient-Centered Medical Home (PCMH) as the building block for a primary care-based health care system. The PCMH is a model that facilitates partnerships between individual patients, their personal health care team, and when appropriate, the patient's family. Each patient has an ongoing relationship with a physician-led practice trained to provide first contact and then continuous and comprehensive care. The team collectively takes responsibility for the ongoing care of patients, with the patient at the center.

The Academy agrees with and supports the basis for reform as described in the MedPAC June 2008 report, which recognizes that "patient access to high quality primary care is essential for a well-functioning health care delivery system." The report makes recommendations regarding the development of patient-centered medical homes and increased payments for primary care physicians.

Right now, a medical home can be measured by the National Committee on Quality Assurance (NCQA) through the Physician Practice Connection-Patient Centered Medical Home (PCC-PCMH) recognition program. A practice seeking this NCQA recognition must complete an extensive and thorough survey and

provide documentation to validate responses. There are three levels (basic, intermediate and advanced) of the medical home, depending on the practice's ability to meet nine standards and 166 measures.

The medical home is not a new concept. The American Academy of Pediatrics (AAP) introduced it in 1967, initially referring to a central location for archiving a child's medical record. In its 2002 policy statement, the AAP expanded the medical home concept to include these operational characteristics: accessible, continuous, comprehensive, family-centered, coordinated, compassionate, and culturally effective care.

The AAFP and the American College of Physicians (ACP) have since developed their own models for improving patient care called the "medical home" (AAFP, 2004) or "advanced medical home" (ACP, 2006). Further, the AAFP, American Academy of Pediatrics, American College of Physicians and the American Osteopathic Association (AOA), representing approximately 333,000 physicians, have developed principles to illustrate the characteristics of the PCMH. These principles can be found at the end of this statement in the Appendix.

Finally, the AAFP supports a "primary care extension program" in any health care reform bill. Similar to the longstanding Cooperative Extension Service, which is administered by the Department of Agriculture, the program would assist practices in their redesign; provide technical assistance for electronic health records; and generate and disseminate research, among other goals. The overarching purpose would be to improve health care quality around the US by providing assistance to practices.

Changes in Workforce Policy Needed to Support the Medical Home

Fundamental change will be required system-wide in any movement to a primary-care based system. These changes will include payment policy and workforce issues. However, since payment policy is out of the scope of the HELP committee, our comments will focus on workforce issues. In addition, the AAFP, American College of Physicians and the American Osteopathic Association have submitted a separate statement to HELP committee members outlining our recommendations for workforce issues.

In a primary care based system, workforce policies must ensure a strong cadre of family physicians, other primary care physicians and non-physician clinicians who are integral to a high functioning health care team. The following programs must be supported and or altered to place a greater emphasis on primary care.

Section 747 of the Public Health Service Act

Currently, the only federal program to support family physician training, education and faculty development, as well as for other primary care physicians, dentists and physician assistants, is Section 747 of the Public Health Service Act. Although our nation is facing an alarming shortage of primary care physicians, annual appropriations for Section 747 have steadily eroded since 2003. Increasing the level of federal funding for primary care training would not only reinvigorate medical education, residency programs, and faculty development, but also prepare physicians to support the patient centered medical home model. In addition, Section 747 is crucial to prepare current and future primary care providers for their critical role in responding to demographic changes in the population, increased prevalence of chronic conditions, increased access to care and a need for effective first-response strategies in instances of acts of terrorism or natural disasters.

Other organizations back up the claim for directing more resources to primary care training. In December 2008, the Institute of Medicine (IOM) released *HHS in the 21st Century: Charting a New Course for a Healthier America*, which points to the drastic decline in Title VII funding. The IOM describes HRSA's workforce training programs as "an undervalued asset." In addition, data show that medical schools and primary care residency programs funded by Section 747 serve disproportionately as the medical education

pipeline that produces physicians who go on to work in Community Health Centers and participate in the National Health Service Corps to treat underserved populations.

In addition to adequate funding for Section 747, Congress should enact other means of providing encouragement and incentives to medical students to select primary care and family medicine as their chosen specialty. Such methods include loan forgiveness and tax credits.

Medicare Graduate Medical Education
While the HELP committee does not have jurisdiction over graduate medical education, we are working with the Finance committee to reform how the Medicare Graduate Medical Education (GME) program pays for physician training to place a greater emphasis on primary care. Currently, Medicare GME does not pay for training in many appropriate sites and for certain valuable types of training (e.g., care management, working in teams, supervision of nursing students, quality improvement). We must change this payment structure so that GME pays for appropriate sites and types of training.

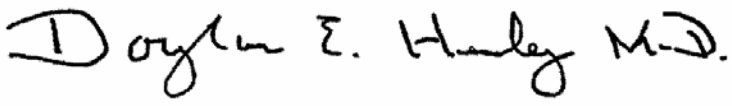
MedPAC agrees: for example, their June 2008 report recommends that "policy makers should also consider ways to use some of the Medicare subsidies for teaching hospitals to promote primary care. Such efforts in medical training and practice may improve our future supply of primary care clinicians and thus increase beneficiary access to them." Lastly, the Commission recognizes that "medical education subsidies could also be used to help pay student loans for clinicians committed to primary care specialties."

Evidence Supporting the Value of Primary Care
One of the criticisms leveled periodically at primary care and the patient-centered medical home is the purported lack of data supporting its quality and cost effectiveness. As a result, we direct the committee to a comprehensive summary of evidence supporting the value of primary care at http://www.pcpcc.net/content/evidence-quality, and copies of numerous key studies found at http://www.aafp.org/online/en/home/policy/familymedvalue.html.

Summary
This framework to move the United States toward a health care system based on primary care that is available to all, offers everyone a patient-centered medical home, primary care-oriented benefits and protects everyone from financial ruin can be achieved.

All people in the United States must have health care coverage, but this is not sufficient to address issues of access, quality and cost. A fundamental change in the health care system to move toward a primary care based system is essential to improve access, quality and efficiency. Extensive research supports the value of a primary care based health care system in which all people are covered. The framework is grounded upon the documented value of primary care in achieving better health outcomes, higher patient satisfaction, and more efficient use of resources. Only through this framework of "health care coverage for all," built on primary care with the patient-centered medical home, will the United States achieve the type of health care system that we need and our nation deserves.

Sincerely,



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Executive Vice President

Appendix: Principles of the Patient-Centered Medical Home

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.

Quality and safety are hallmarks of the medical home:

- Practices advocate for their patients to support the attainment of optimal, patient-centered outcomes that are defined by a care planning process driven by a compassionate, robust partnership between physicians, patients, and the patient's family.
- Evidence-based medicine and clinical decision-support tools guide decision making
- Physicians in the practice accept accountability for continuous quality improvement through voluntary engagement in performance measurement and improvement.

- Patients actively participate in decision-making and feedback is sought to ensure patients' expectations are being met
- Information technology is utilized appropriately to support optimal patient care, performance measurement, patient education, and enhanced communication
- Practices go through a voluntary recognition process by an appropriate non-governmental entity to demonstrate that they have the capabilities to provide patient centered services consistent with the medical home model.
- Patients and families participate in quality improvement activities at the practice level.

Enhanced access to care is available through systems such as open scheduling, expanded hours and new options for communication between patients, their personal physician, and practice staff.

Payment appropriately recognizes the added value provided to patients who have a patient-centered medical home. The payment structure should be based on the following framework:

- It should reflect the value of physician and non-physician staff patient-centered care management work that falls outside of the face-to-face visit.
- It should pay for services associated with coordination of care both within a given practice and between consultants, ancillary providers, and community resources.

- It should support adoption and use of health information technology for quality improvement;
- It should support provision of enhanced communication access such as secure e-mail and telephone consultation;
- It should recognize the value of physician work associated with remote monitoring of clinical data using technology.
- It should allow for separate fee-for-service payments for face-to-face visits. (Payments for care management services that fall outside of the face-to-face visit, as described above, should not result in a reduction in the payments for face-to-face visits).
- It should recognize case mix differences in the patient population being treated within the practice.
- It should allow physicians to share in savings from reduced hospitalizations associated with physician-guided care management in the office setting.
- It should allow for additional payments for achieving measurable and continuous quality improvements.