

Donald Fisher

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Dear Governor:

Thank you very much for the opportunity to offer you some insights on health care reform. We hope you'll find our remarks helpful as you consider healthcare reform ideas in the months ahead.

The American Medical Group Association (AMGA) represents multi-specialty medical groups and other organized systems of care, including some of the nation's largest, most prestigious integrated health care delivery systems. The members of AMGA deliver healthcare to 80 million patients in 44 states, including patients in Washington State. AMGA advocates for continuously improving patient care through innovation, information sharing, benchmarking, and creation of sound public policy.

Briefly, we focus our thoughts on delivery system reform. Until we're successful in transforming health care from the current patchwork of providers to an actual "system" of care, nibbling away at financing changes and coverage

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reform will produce little change. Real reform is possible by focusing on whom and what provides the care.

Delivery System Reform

As you know, the nation is experiencing a health care crisis, the result of a system that is fragmented, costly, and unable to provide coverage to millions of Americans. In its seminal work published in 2001, “Crossing the Quality Chasm,” the Institute of Medicine (IOM) emphasized that the fragmented health care delivery system yields a complex morass that is difficult for patients to navigate and produces care that is largely uncoordinated, inefficient, often of questionable effectiveness, and with great geographical variation of treatment and utilization. As the IOM surmised:

The current care systems cannot do the job. Trying harder will not work. Changing systems of care will.

In order to transform the current environment into a high performing and coordinated system, the IOM recommends the following structural changes: Use of evidence based care practices; Effective use of information technology; Knowledge and skills management; Developing effective teams; Coordinating care; and Measuring quality improvement and accountability.

The IoM's recommendations have been described as a virtual blueprint for utilizing multi-specialty medical groups, and other organized systems of care, as the foundation for a 21st century health care system.

A majority of large medical groups utilize health information technology such as electronic prescribing and electronic medical records. Multi-specialty medical groups practice team-based care where physicians, nurses, physical therapists and other providers work together to provide care. Multi-specialty medical groups coordinate care, so a patient's internist knows what test their cardiologist ordered and what the results were. Multi-specialty medical groups disseminate the latest clinical knowledge and skills to ensure its clinical staff is up to date on ever changing techniques and conditions. And, multi-specialty medical groups often utilize evidence-based protocols when treating their patients. Use of these protocols is linked to better patient outcomes.

Luckily, there are over 25 medical groups in Washington State that provide care to millions of Washingtonians! These medical groups can form the foundation for reform changes you might consider in your state.

Medical Group Incentives

Health policy researchers have considered ways to incentivize medical group formation. In its March 2007

report to the Congress, the Medicare Payment Advisory Commission (MedPAC) addressed developing payment incentives for what it termed “desired activities”. MedPAC’s report stated:

“Creating incentives to encourage physicians to form or join high-performing multispecialty groups could achieve more organized systems of care and thereby improve the health care provided to Medicare beneficiaries while reducing costs. Many studies cited in this section suggest that physicians in multispecialty groups may have different practice patterns than physicians in solo, small, or single-specialty practices. That is, they may be more likely to use care management processes and IT and may use fewer resources. Large groups may more easily foster consultation among physicians in different specialties, which could improve quality and manage costs. Team-based care may also be easier in group practices.”

Options that encourage medical group accountability may encourage patients and physicians to develop stronger relationships and perhaps establish more regular sources of care. Rewarding desired activities may provide incentives for physicians to organize into the types of groups that can best perform them—namely, multispecialty group practices and integrated delivery systems.” MedPAC defined “Desired activities” as:

Quality Measurement and Improvement; Use of Evidence-based medicine; Care Coordination; IT use; and Efficient provision of care.

As you consider reform possibilities, you may wish to develop incentives for “desired activities.” Also, to further provide support for a more efficient model of health care, you may consider support for tax breaks, subsidies/incentives, and other legislative and regulatory means to foster creation, growth, and development of multispecialty group medical practices and other organized systems of care which would promote integration and coordination of health care delivery for Washingtonians.

Additionally, as Governor, I would ask that you consider advocating for Federal reimbursement and incentives to support the use of health information technology (HIT) such as electronic medical records, eRx, patient registries, etc.

Care Coordination

As you are all too aware, the costs for treating chronically ill patients are astronomical, and can bankrupt a state. It’s been estimated that the costs for treating the chronically ill amount to more than 75% of Medicare costs. Of course, as the population ages, further financial stress will be placed on the national and state governments.

Patients with chronic illnesses typically see multiple physicians and are prescribed multiple medications. Due largely to the complexity of treating these beneficiaries, health care for patients with chronic illnesses is often fragmented and poorly coordinated across providers and practice settings.

This lack of coordinated care has negative ramifications. According to a 2005 international patient survey, patients who reported seeing four or more physicians were three times as likely to report at least one type of adverse event (e.g., medicine, medication, or lab). Additionally, 40 percent of U.S. patients who were taking more than 4 medications reported that their physician sometimes, rarely, or never had their medication use reviewed during the past year. Not surprisingly, these complications increase the likelihood of hospital re-admissions, and additional office visits and procedures. Further, lack of coordination among providers can lead to costly inefficiencies such as duplicative testing, and unnecessary or inappropriate treatment.

Another way to meet the IOM's challenges for a new system of care is to focus on incentivizing care coordination. "Real" care coordination holds promise in improving patient care, streamlining health care delivery and providing savings. The lack of care coordination results in costly inefficiencies due to duplicate testing,

unnecessary hospital stays, improper medication regimes, and poor patient outcomes.

AMGA supports a model of care for chronic illness that encourages care coordination across practice settings and disease conditions and focuses on patient-centered care that includes proactive monitoring of health status; reinforcement of self-care behaviors; early detection of problems and intervention; and coordination of, and collaboration, among health care disciplines.

This approach to caring for the chronically ill is fundamentally different than the traditional episodic care geared toward “fixing” patients when they develop a problem. Echoing the IOM recommendations, it calls for indicators of care coordination or “system-ness” that go beyond typical measures for specific disease states. These indicators include: professional care coordinators, use of health information technology to identify, enroll and track chronically ill patients; proactive monitoring of patients; the use of structured or planned visits; multi-disciplinary case management; and maintenance of treatment plans based on individual patient needs rather than disease-specific treatment guidelines.

Care coordination is most successful when supported by technology, most notably electronic medical records, patient registries and home monitoring devices. In 2007, first year results of Medicare’s Physician Group Practice demonstration (which includes Everett Clinic, a

Washington State multi-specialty medical group) provided further confirmation of the value of care coordination. Year one of the demonstration project focused on patients with diabetes mellitus and implemented performance measures developed from evidence-based guidelines to manage the disease. Through increased communication with patients, a focus on prevention, and use of “health coaches,” all of the medical group practice participants were able to improve the clinical management of diabetes patients and decrease hospitalizations in this patient population.

Positive outcomes from care coordination include reduced hospitalizations, re-admissions and bed days of care, a reduction in emergency room visits, and a reduction in nursing home admissions, all of which can lead to significant cost savings while dramatically improving patient care.

As you consider reform issues, you could consider reimbursement of and incentives to encourage coordinated care in Washington State. Specifically, we would recommend incentives for providers that meet these performance measures:

- Structural Measures: EMR systems, electronic patient registries, home or telephonic monitoring devices, professional care coordinator(s), integrated teams of primary and specialty care.

- Process Measures:** proactive monitoring, case management, medication management, written (electronic or paper) feedback between primary and specialty physicians regarding treatment changes and referrals, multi-specialty treatment plans, patient self-management training.

- Outcomes Measures:** Reduced hospitalizations, re-admissions, bed days of care, reduced nursing home admissions, reduced ER visits, patient satisfaction surveys, and savings compared to Medicare fee-for-service baseline.

Thank you for your time in considering some of our views. We are available at any time to discuss delivery system reform with you or any member of the Washington legislature.

Sincerely,

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