TESTIMONY IS EMBARGOED UNTIL 10:00 AM TUESDAY, JULY 24, 2012

American College of Physician Executives
The Home for Physician Leaders

Statement from:

The American College of Physician Executives (ACPE)

Presented by:

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Before:

Committee on Ways and Means - Health Subcommittee

Regarding:

Physician Organization Efforts to Promote High Quality Care and Implications for Medicare Physician Payment Reform

Tuesday, July 24, 2012

Executive Summary

The American College of Physician Executives (ACPE) is the nation's largest health care organization for physician leaders and executives. Since its founding in 1975, the primary focus of the College is providing superior leadership and management education to physicians and facilitating their engagement with active leadership roles inside health care organizations of all types and sizes. These physician leaders come to ACPE from virtually all disciplines.

Beyond the thousands of physicians who have received ACPE training, the organization has grown to 11,000 U.S. members – including chief executive officers (CEOs), chief operating officers (COOs), chief medical officers (CMOs), vice-presidents of medical affairs (VPMAs), chief medical information officers (CMIOs), chief quality and safety officers, medical directors and a host of other physician leadership positions from across the entire industry.

Especially, ACPE is nationally and internationally recognized for its expertise with change management, physician engagement and physician integration, and has:

- More than **65** faculty across dozens of disciplines
- More than **50** physician leadership courses
- More than **3,100** online courses sold annually
- **150** in-house leadership courses taught onsite each year at hospitals and health systems
- **4** Master's degree programs with **1,000** graduates
- More than **2,000** physicians with ACPE board certification as Physician Executive (CPE)
- More than **20,000** physicians who have completed Physician in Management Seminars

ACPE believes the following ***nine elements*** are pivotal components for the next Medicare physician payment system and critical to a successful outcome for true patient-centered care. The ***nine ACPE elements*** are: 1) quality-centered; 2) safe for all; 3) streamlined and efficient; 4) measurement-based; 5) evidence-based; 6) value-driven; 7) innovative; 8) fair and equitable; and 9) physician-led.

Chairman Herger, Ranking Member Stark, and Members of the House Ways and Means Health Subcommittee, on behalf of the American College of Physician Executives (ACPE), representing nearly 11,000 high-level physician leaders and executives in all types of health care organizations across the U.S., we thank you for inviting us to testify before the Subcommittee and to share our insights about the Medicare reimbursement solution. While ACPE itself does not provide direct patient care, many of our thousands of physician leaders are successfully implementing innovative and cost-saving initiatives in their hospitals, health systems, group practices and other types of health care organizations. We include some examples of these experiences throughout our testimony.

As we all know, the Sustainable Growth Rate (SGR) is not working. We encourage your Subcommittee to take an entirely fresh look at physician reimbursement issues in order to create a permanent solution that is value-based and equitable across physician disciplines.

Up front, ACPE wants to emphasize that preserving physician income is not the primary focus of this complex policy discussion. The desired endpoint needs to be timely, open access to sustainable, high-quality health care that is physician-led. ACPE believes we are uniquely positioned to assist with implementation of a new reimbursement plan, especially in the areas of physician buy-in and physician engagement, which are critical to the success of a new payment system.

ACPE recommends development of a new payment system that is transferable and scalable across geographic regions while emphasizing patient-centered care and focusing on ***nine key elements***:

1. Quality-centered

Consistent delivery of high quality care has remained elusive despite intense efforts and numerous initiatives to create the needed improvements. Our health care system is highly fragmented and its alignment of financial reimbursements within the system contributes to the problem. Current physician reimbursement that is primarily based on volumes of patients cared for and numbers of procedures completed, perpetuates the ineffectiveness of transforming to higher quality health care. A new reimbursement system must include compensation strategies

for providing high-quality care. ACPE believes there should be ongoing efforts to drive quality improvement that occurs, in part, through physician reimbursement reform.

Hospital readmissions can be viewed as an indirect marker, among many, of poor quality. When high-quality care is being delivered across the continuum of care, there are fewer hospital readmissions and improved outcomes for patients. Although readmissions may occur for reasons beyond physicians' control (e.g., patient resources and lifestyle choices), physicians and physician leaders are well positioned to address this costly issue. Specifically, physicians with the combination of clinical skills, leadership expertise and management knowledge are best qualified to employ quality measures, ensure compliance and evaluate the success of patient outcomes based upon the constellation of issues present during patient care episodes.

There are documented ways to reduce readmissions. For example, in 2005, a large, North Carolina-based nonprofit hospital system showed that patients 65 and over were twice as likely as other patients to be treated in the emergency room for an adverse drug event and more than seven times as likely to be readmitted. Based upon physician leadership, a new team-based approach was designed and created to improve referral processes, reduce ER wait times, and streamline care after discharge. The results of this program were overwhelming. Readmissions due to adverse drug events were reduced dramatically, and the overall costs of care in patients with chronic disease and multiple medications were reduced by more than 20 percent.

2. Safe for all

Likewise, physicians should be rewarded for putting patient safety first and avoiding costly medical mistakes. Examples of safety improvements that improve care and reduce costs can be found in many hospitals and health systems. These initiatives, however, have largely been unreimbursed efforts. A new payment system should take into account reductions in adverse events, days without safety-related problems, and success with a range of other relevant patient safety indicators or clinical measures.

Based primarily on physician leadership passion and commitment that was able to be translated into system management support, a children's hospital in Michigan has been on a five-year journey to transform the patient safety culture at their 212-bed facility. The results have been

outstanding: the serious safety event rate has decreased in the entire hospital by more than 90 percent in four years. The Pediatric Critical Care Unit (PCCU) went two years without a case of ventilator-associated pneumonia (VAP) and the Neonatal ICU went more than one year without one case of VAP. There were no central line associated blood stream infections (CLABSI's) in the PCCU for more than 12 months while hand hygiene rates remain over 95 percent hospital-wide annually. Incident reporting rose more than 148 percent from 2010 to 2011. The efforts for instigating these initiatives, plus maintaining the buy-in from other participating physicians and clinical providers, were not supported by physician reimbursement. For propagation across health care of other successes similar to this example, physician reimbursement reform is critical.

Safe for all implies more than safety for patients. When errors occur in health care, the physicians and other providers are also at risk for physical and emotional harm. A well-functioning system has streamlined reporting in order to become aware of the errors and provides a supportive infrastructure to manage the adverse outcomes that directly impact these providers. Organizations that follow the principles of high reliability are pre-occupied with safety and the protection of all within their environment and processes. Overall safety improves as a result.

For quality and safety issues, ACPE is particularly well positioned to make an impact. ACPE works with expert faculty from across the country to produce numerous courses on quality, high reliability and safety. Thousands of physicians have completed these courses and learned to implement quality and safety programs. Most recently, ACPE partnered with Thomas Jefferson University to create a Master of Science degree in Health Care Quality and Safety Management.

3. Streamlined and Efficient

The new payment system and the information required to execute it must be streamlined, making it as easy as possible for physicians and health care organizations to collect reimbursement. We frequently hear from ACPE members about the burden of reporting requirements surrounding Medicare payments – especially with the collective burden imposed when coupled with those from other non-Medicare payers. Time, effort and money spent on highly detailed reporting could be much better spent providing quality patient care.

The majority of physician time, and the clinical teams' efforts, should be focused on patient care. Overuse, underuse and misuse of resources are common problems recognized as creating an excess utilization rate of 25-30 percent. Inefficiencies magnify this problem.

Strive for simplicity. The more complex a payment system, the greater possibility for error and confusion. Efforts toward common measures, common data elements and common reporting requirements are underway and should be encouraged. Simplified measurement and reporting allows for transferability and scalability of information such that local, state and national data collection can occur with a more rapid evaluation process that is efficient and streamlined.

4. Measurement-based

While measurement as a science in health care is immature and continues to evolve, available clinical and patient care measurements that have been endorsed by the National Quality Forum (NQF) should be publicly reported and should represent all types of relevant measures (e.g., structural, process, outcomes and composite). ACPE recognizes that measurement directly related to physicians is highly complex due to the multiplicity of variables and uncontrollable factors (e.g., patient lifestyle choices). However, ACPE encourages ongoing development of physician-focused measurement and reporting, but it must be clinically relevant, balanced and realistic in its interpretation of outcomes. Efforts from initiatives by entities such as the AQA alliance (originally known as Ambulatory Care Quality Alliance) and Physician Consortium for Performance Improvement (PCPI) should be supported and measurement results collated in order that those results can contribute to the evolving nature of a new payment system.

Public education efforts regarding the ongoing evolution of measurement and reporting should be developed in order for the public to better understand and comprehend these components of health care. Ultimately, health care delivery and clinical care practices should have outcome measures related to wellness and health. The potential for development of patient outcome oriented measures and reporting remains untapped, however. This is due in part to the immaturity of measurement science as well as the slow progression of developing supportive evidence in this regard.

5. Evidence-based

All health care is based on scientific research and, clearly, evidence-based approaches are becoming more popular. While evidence-based medicine (EBM) is an emerging field, physicians, in particular, are much more likely to comply with guidelines if strong data are available to support them. Physicians should be rewarded for following evidence-based guidelines and clinical pathways that are proven to provide safe, reliable care to patients.

One area that continues to need further clarification with evidence-based medicine, however, is the balance between following EBM guidelines and allowing for innovation with evolving research, implementation of technologies or clinical care practices. Accommodation for managing this balance between EBM and innovation should be considered at some level within next generation physician reimbursement models.

Many professional societies and specialty organizations are generating evidence-based guidelines and clinical pathways of care. But in most circumstances, unfortunately, the proven guidelines are not effectively implemented within health care organizations or by physicians. A federally sponsored guideline clearinghouse has a large reservoir of guidelines but utilization remains comparatively low. Financial incentives within physician reimbursement would help improve this low utilization rate and should be seriously considered.

A good example of how following clinical pathways can improve patient outcomes and reduce costs was recently shared by an ACPE member: A 2010 study by US Oncology and Aetna of 1,409 patients with lung cancer showed 35 percent lower costs for those patients treated on the clinical pathway versus those patients who were off the pathway ($18,042 versus $27,737).

6. Value-driven

Future reimbursement models must be focused on value-based care, not volumes of patients seen or procedures conducted. The Centers for Medicare and Medicaid Services (CMS) has already established numerous pilot projects exploring value-based purchasing, and other government groups have trial programs under way, as well. Similarly, numerous private sector initiatives have also begun to spring up around the country. Clearly, value-based care and reimbursement is gaining traction and ACPE believes any reimbursement system should support this new focus.

The shift toward value drives innovation with different models of care that orient toward patient-centered care and improved outcomes. Ongoing attention to clinical care improves, while simultaneously creating increased attention to health care systems efficiencies – a double win.

7. Innovative

Instilling a culture of innovation (not creative billing) within physician practice settings should be a positive outcome from a new payment model. The payment system should take innovative practice strategies into account and encourage physicians and health care organizations to implement new processes and procedures that create cost savings while simultaneously improving quality and keeping patients safe.

As one example, prevention of errors in health care can result with concerted efforts towards identification of inherent risks already present within health care organizations that are related to process flaws and the potential for error related to inherent human behaviors. Once identified, proactive risk-mitigation can then be planned into health care system redesign in order to decrease and prevent errors from occurring. So-called systems engineering and human factors engineering are highly successful disciplines in other industries and financial incentives for their implementation by physicians within health organizations should be promoted.

A host of innovative activities are in motion across the country. Developing a method to nationally scale the successful efforts and to have them promulgated should be a priority. ACPE supports and encourages the efforts emanating from both the public and private sectors.

8. Fair and Equitable

Any new payment system must be fair and equitable for all physicians, and should not create conflict among procedural specialties, cognitive specialties and primary care physicians. ACPE again stresses, however, that preserving physician income is not at the heart of this complex predicament. While reimbursing providers in a fair, equitable manner is critically important, we do not believe our physician members—and indeed most physicians across the country—are primarily concerned about payment for their services. Physicians are altruistic at their core and truly want to do what's best for optimal patient care outcomes.

Physician efforts toward the promotion of population health, individual wellness and support of public health initiatives are a composite in this equation if full success is to occur. Reimbursement models should take these aspects of health care into consideration. Fair and equitable access to care for patients with an improved distribution of resources is certainly paramount in support of these aspects as well.

9. Physician-led

Creation of a new physician payment system must, ideally, be physician-led. The most successful and progressive health care organizations throughout the U.S. tend to be physician-led. This occurs because physician leaders not only have a strong understanding of the clinical side of health care, but they also have a deep understanding of how to lead and run a successful enterprise. The ability to relate with peer group physicians and other clinical providers enables a level of trust and confidence to be more readily accomplished compared with non-physician leadership. Physicians are much more likely to accept a revised payment and delivery system if it is developed with physician input.

An ACPE recommendation toward SGR reform would be establishing a new independent, non-partisan commission—composed of physicians and other health care providers, health care financial experts, quality and patient safety experts, business leaders, and patient representatives—to further evaluate the overall Medicare funding dilemma with a fresh perspective. This commission would research and analyze best practices, deliberate on the evidence and then bring physician-developed recommendations to the Health Subcommittee for consideration. Obviously the expected outcome would be oriented to creating a payment system and situation that is beneficial to the health care economy and not be focused on embellishing physician compensation.

ACPE’s cadre of physician leaders throughout the U.S. is perfectly positioned to engage all disciplines of physicians in contributing ideas to formulate an improved reimbursement plan and our members are also well-suited to influencing fellow physicians to follow the plan’s guidelines and meet its goals. ACPE’s recognized expertise is with physician engagement and integration.

We strongly believe in the importance of including the ***nine ACPE elements*** within the next payment system and that they are pivotal for a successful outcome. Again, ACPE is pleased to offer these insights to the House Ways and Means Subcommittee on Health and stands ready to assist further on this most important initiative to bring a permanent, measured, disciplined, bi-partisan and fair approach to Medicare funding. Thank you for this opportunity to provide comment for the Subcommittee and its members.