



**Statement of Debra L. Ness
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Senate Finance Committee
Roundtable on Delivery System Reform
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Chairman Baucus, Ranking Member Grassley, and members of the Committee, thank you for the opportunity to participate in this Roundtable on how to reform our health care delivery system.

The National Partnership for Women & Families is a non-profit, non-partisan advocacy organization with over three and a half decades of experience promoting access to quality health care, fairness in the workplace, and policies that help women and men meet the dual demands of work and family. Over the past 15 years, the National Partnership has brought together a wide range of consumer and patient groups to push for meaningful reforms of our health care system - focusing on improving quality, getting costs under control and expanding affordable coverage.

I applaud the Committee for recognizing that these issues -- quality, cost, and coverage -- are inextricably linked, and for beginning these Roundtable discussions in the essential first place, with this discussion of delivery system reform.

The American people know that our health care system is broken and needs transformational change. They see a delivery system that is centered on the provider, rather than the patient. They see a payment system that rewards volume over value, promotes fragmentation over coordination, and rewards specialty care at the expense of primary care. Ours is a system that is largely blind to quality, outcomes, or appropriateness of the care delivered and received.

The American people want you to fix the delivery system in a way that will accomplish three things:

- Improve the quality of the care they receive.
- Make care more affordable - for individuals, families, businesses, and taxpayers.
- Get better value for the health care dollars we spend out of our own pockets, through our employers, and through public programs.

We can accomplish all three of these objectives if we recognize that changing the way we pay for health care can transform the way that health care is delivered. However, we must do so in a way that makes patient-centered care our guiding principle for system reform. Patient-centeredness should be the beacon that guides our efforts, and the ultimate test of our success.

Putting Patients First—Meeting the Needs of the Most Vulnerable Patients

Delivery system reform must put patients first. There are none for whom this is more important than the most vulnerable among us -- those with multiple serious chronic conditions, especially those whose medical conditions are complicated by physical or cognitive impairment or whose access to health care is already limited by their low income, race, or ethnicity.

These are the people who make heaviest use of the current system, at the highest cost, but with the poorest outcomes. While these complex patients exist in every age group, they are heavily concentrated among older adults. It is not surprising that, although they represent only 20% of all Medicare beneficiaries, they account for 68% of Medicare spending. Yet in spite of all that spending, the system is not serving them well because it is oriented toward acute care, not to their chronic care needs. Consider the following:

- They make 37 visits to 14 different doctors who prescribe 50 separate prescriptions in the course of a year. *But that does not mean they get the care they want or need.*
- Because their doctors do not talk to each other or coordinate all of this care, the majority of these patients receive duplicate tests and procedures, different diagnoses from different physicians, and contradictory information on how to manage their conditions. *And they do not get better.*
- Because no one is responsible for managing their care, they experience complications from inappropriately prescribed medications, suffer from preventable medical errors, and are frequently hospitalized for conditions that could be treated in ambulatory settings. *Their lives are put at risk.*
- When they are discharged from the hospital, they go home without the information, support and follow up they need to take care of themselves or recognize symptoms that require attention. As a result, one in 10 is readmitted within 15 days and one in five is back in the hospital within 30 days. *They are getting sicker.*
- They are left on their own to find and arrange the non-medical services they need to live at home and stay out of the hospital or nursing home. *They feel abandoned and overwhelmed.*

If we can make the delivery system work for these most vulnerable and complex patients, we can make it work for everyone. If we fail them, we will never get health care spending under control.

Defining Patient-Centered Care

Patient-centered care is a straightforward concept. It is care that meets the patient's needs and preferences – at the right time, in the right setting, for the right reason, at the right cost. When patients and their families are asked what they want out of the health care system, their answers are just as clear.

- They want to be able to choose their own doctors.
- They want their doctors to talk to each other.

- They want their doctors to have the time, the information, and the support to do the best job they can.
- They want to better understand their conditions, how to take care of themselves or their loved ones, and how to recognize symptoms that should be cause for concern.
- They want someone who knows them and recommends care that makes sense based on their needs, wants and life circumstances.

We have good models of patient-centered care from research and clinical practice, which show that it is possible to deliver better care and reduce health care costs. Some of the best of these are represented at this Roundtable this morning.

These models have within them common elements on which we can build to reshape the delivery system and to pay for the care that patients want and need. The National Partnership for Women & Families has developed a yardstick for defining and evaluating patient-centered care, based on these successful models and our own work with patients and caregivers across the country. These are the elements we will use to measure our success in transforming the delivery system.

- *Care is comprehensive, coordinated, personalized and planned, based on an assessment of the total needs of the patient and, where applicable, his or her caregiver.*
- *Patients' experience of care is routinely assessed and improved.*
- *Patients and their caregivers are full partners in their care, assisted with management of chronic illnesses and health care decision-making.*
- *Transitions between settings of care are smooth, safe, effective and efficient.*
- *Patients can get care when and where they want and need it.*
- *Care is connected to and integrates the community resources patients and caregivers need to maintain their health and well-being.*
- *Continuous quality improvement and the elimination of disparities are a top priority.*

Achieving a patient-centered delivery system will require significant change in *what* we provide and *how* we provide it. Toward that end, we must pursue two key strategies: a payment system that rewards and encourages better coordinated, integrated and accountable care, and a health care infrastructure that supports the delivery of this care.

Shift Payment Incentives to Reward and Encourage Better Coordinated, Integrated and Accountable Care

Twenty-first century medicine requires team-based coordinated care that is anchored in primary care. This will require a fundamental shift in payment systems that will foster – perhaps force –

redesign of physician practice and the management of transitions among settings of care. We have four specific recommendations:

- ***First, immediately revalue primary care.*** This means increasing payment to primary care physicians and eliminating the distortions in physician fee schedules that have produced an over-supply of procedure-based specialist services at the expense of the chronic care management, coordination, and support that patients desperately want and need.
- ***Second, we need to change the way CMS makes decisions about payment under the physician fee schedule.*** We can no longer justify a process for deciding payment values that is solely driven by the providers of care. Those who receive and pay for care must have a voice in shaping the payment decisions that ultimately define what and how care gets delivered.
- ***Third, provide adequate risk-adjusted payment to primary care practices for care coordination and management services*** that are not currently reimbursed, for patients who need such services.
- ***Fourth, provide payment incentives to specifically encourage safe and effective transitions*** among settings of care, coordinated with primary care providers.

Delivery system reform must, at a minimum, address the needs of a Medicare population that is living longer with multiple chronic illnesses. Old models that reward acute care interventions at the expense of chronic care management must be replaced by new models that support high-quality, coordinated, comprehensive care, particularly for the highest risk and most vulnerable patients.

I commend this Committee for its foresight in authorizing the Medicare Medical Home Demonstration. This is a step in the right direction. The National Partnership has convened consumer organizations representing a broad and diverse array of patients and families, who want to ensure that this new model of care genuinely transforms practice and moves us to truly patient and family-centered care. Toward that end, we have adopted a set of core consumer principles for patient-centered care in the medical home. These principles are available at www.nationalpartnership.org/medicalhome.

We need to recognize, however, that as currently conceived, the Medicare Medical Home Demonstration will not adequately meet the needs of the most vulnerable and complex patients without further evolution. Other models, including those incorporated in Senator Wyden's Independence at Home proposal and Senator Lincoln's Geriatric Assessment and Chronic Care coordination approach, should be considered alongside the current demonstration.

Ultimately, the issue is not which of the several successful models is in place, but whether you have provided the payment incentives that encourage redesign of practice and whether you have linked payment to patient-centered criteria and outcomes. Toward that end, we encourage the following:

- ***Risk-adjusted payment for team-based primary care*** that is tied to the severity and complexity of the patient's needs, including the number and nature of chronic conditions, physical and cognitive limitations, mental health needs, and social and environmental factors.
- ***Payment for an appropriate range of multi-disciplinary care management and coordination services***, based on the patient's level of needs. This would include a full geriatric assessment including a caregiver assessment, a total plan of care developed with the patient and caregiver, education and training of the patient and caregiver in ongoing management of their conditions, regular consultation with the patient and caregiver, coordination with all health care providers treating the patient across all settings, and proactive linkages to community services and supports for patients who need them.
- ***Adequate payment and incentives to support effective transitions of care*** as patients and caregivers move between hospital, home, and nursing facilities. Such payments must compensate for effective management of their medications and ongoing needs and appropriate follow-up care. Payment should be sufficiently flexible to support successful models that are based in a hospital, primary care practice, or community setting.
- ***Provide a range of pathways for primary care practices to achieve practice transformation***. As we move towards payment models that reward better and more coordinated primary care, the enhanced payment needs to be tied to increased accountability and commitment to achieving truly patient-centered outcomes. However, we need to also recognize that there is great diversity among primary care practitioners in their ability to engage in the transformative practice re-design.
- ***Create incentives and pathways for primary care practices to engage as part of larger integrated systems of care***. To best serve the diverse and complex needs of patients with chronic and acute care issues, our payment models need to promote integrated delivery systems. Most of you are familiar with the best of these – such as the Permanente Medical Group, the Mayo Clinic, Intermountain Healthcare, and the Geisinger Health System. Integrated systems can promote collaborative team-based care to better serve patients' complex needs, share accountability, and generate savings from better management of patients' conditions.
- ***Better integrate Medicare and Medicaid services for dual eligible individuals***. We have built a system of care that splits responsibility for services between states and the federal government, with our frailest citizens caught in the tug-of-war between Medicare and Medicaid. I congratulate Senator Baucus for recognizing this problem in *Call to Action*, the white paper on health care reform. It is imperative that we implement strategies to facilitate coordination of Medicare and Medicaid services for these vulnerable individuals.

Transformed Health Care Delivery Requires New Infrastructure

As we adopt new models of care and move towards a transformed delivery system, it will require a set of critical infrastructure elements:

- A strong foundation of ***measurement, reporting and ongoing quality improvement***.
- Widespread adoption of ***health information technology (HIT)*** that helps us improve quality, coordination, and safety, engages patients and caregivers, reduces costs, and allows assessment of quality and improvement.
- ***Comparative effectiveness research*** that gives clinicians and patients better information about what works and what doesn't, and enables them to make good decisions about treatments and services.
- The right tools and strategies to ***engage patients and caregivers*** in managing their health and making health care decisions.
- An ***adequate workforce***, appropriately trained, in sufficient numbers, and effectively deployed to meet the needs of our population – particularly those who have been traditionally underserved, and the rapidly growing number of individuals with multiple chronic conditions and geriatric syndromes.

Measurement, Reporting and Quality Improvement

We spend billions of dollars on health care services that do not improve patient outcomes while millions of Americans are uninsured or underinsured. Racial and ethnic minorities, the poor, those with less education or language barriers, and those with chronic and multiple chronic conditions are disproportionately affected. Effective measurement and reporting, linked to ongoing quality improvement, are essential for improving quality, making sure care is patient-centered, eliminating disparities, and reducing costs.

There are a number of key elements to ensuring that measurement and reporting yields these results:

- ***First, we need the right measures.*** We are currently lacking measures in critical areas, such as: outcomes and functional status, care coordination and transitions, measures of care for patients with multiple conditions, measures of “patient-centeredness,” measures that help us address disparities, and measures of efficiency and resource use. We therefore need clear national priorities for measure development, and adequate resources to develop, test, endorse, and keep measures up to date. We also need effective strategies for collecting, analyzing and reporting this data, as well as translating this information into effective tools to help clinicians improve the quality of care they deliver.
- ***Second, we need an effective process*** for ensuring that all stakeholders – including those who provide the care, receive the care, and pay for care have input in building this foundation for measurement and quality improvement *and* determining how measurement is used for reporting and payment.

- ***Third, we need the federal government to invest in building this foundation.*** To that end, more than 170 organizations, representing consumers, clinicians and other health care professionals, hospitals, employers, and health plans have recently come together to support such an investment in an initiative called *Stand for Quality*. They are united in their belief that building this foundation of measurement, reporting, and quality improvement is essential to transforming our delivery system, improving quality, and reducing costs.¹

Widespread Adoption of Health Information Technology

We know that good health care is possible without HIT. But we also know that the best health care – and the patient-centered system of care people want and deserve – is not. The provisions in the American Recovery and Reinvestment Act of 2009 – particularly those related to incentives, meaningful use and privacy – were a terrific step forward, and I applaud Congress for the strength of this effort.

Creating a system that is patient-centered and reduces costs requires that we demand and reward the effective use of electronic clinical information to improve patient status and health outcomes. HIT is a key tool that can support each of the elements of patient-centered care defined above – including delivering better quality, more coordinated care, facilitating transitions of care, enabling the collection of quality and performance information, supporting patient and clinician decision-making, and connecting patients and families with health care providers and giving them better tools to manage their own health.

As the federal government prepares to provide financial incentives for the adoption and use of HIT, we must ensure that those incentives are linked to meaningful use of information to provide better quality, more patient-centered care that improves health outcomes.

Comparative Effectiveness Research

Patients and clinicians need access to the latest research comparing the effectiveness of different treatments and which drugs have the best results. And this research needs to be expanded in scope to take into account the critical needs of subpopulations, such as children, people of color, women, and the older adults with multiple chronic conditions. Armed with better information, patients and their doctors can choose the wisest course of action that is right for them and their situation and not waste time or money on unnecessary tests and less effective treatments or drugs. To achieve this we need a robust federal commitment to comparative effectiveness research. I want to thank Chairman Baucus and other members of this Committee that supported the \$1.1 billion in the American Recovery and Reinvestment Act for comparative effectiveness research. It was a tremendous start. Now we need to establish a long-term framework, such as that proposed by Chairman Baucus and Senator Conrad, so that the research is driven by a open and transparent priority-setting process that reflects the views of all stakeholders – most especially consumers.

¹ See Stand for Quality at www.standforquality.org (Apr. 16, 2009).

Tools and Strategies to Engage Patients and Caregivers

We need a health care delivery system that helps empower patients and caregivers to recognize and demand high quality care, make sound health care decisions, and become true partners – with their clinicians – in managing their own care.

- ***First, performance measurement needs to be coupled with consumer-friendly public reporting***, so that patients and their caregivers can make informed decisions about where to seek their care. Today, despite the fact we live in an information age, consumers are left in the dark about the quality of care provided by the pediatrician who treats their child, or the cardiologist caring for their aging parent. Consumers have a right to information about the quality, cost, and relative effectiveness of the providers and treatments they choose. We simply cannot expect consumers to make wise decisions about how to spend their health care dollars without the right information.
- ***Second, patients and caregivers need to be asked for feedback on their experience of care***, and that feedback should be used to improve care and reduce disparities. All health care organizations and settings, including individual and group physician practices, hospitals, nursing homes, assisted living facilities, community health centers, ambulatory settings, and hospice, home health, end stage renal disease, and behavioral health providers should administer and publicly report on patient experience surveys. Those results should then be made available to help providers improve the care they provide, and help patients and caregivers make informed choices about where they seek treatment and services. We simply cannot make claims about achieving a patient-centered health care system unless asking patients about their experience of care is a routine practice in every care setting.
- ***Third, “shared decision-making” must become an integral component of the patient-clinician relationship***. A patient’s treatment choices should be based on clear understanding of their options and their trade-offs and should be consistent with the patient’s values, preferences, and life situation. Truly informed patients can play a more active role in decisions about their care, working with their health care providers to pursue treatment that matches their needs and preferences. Numerous studies have documented that patient’s use of shared decision aids results in reduced rates of elective surgery in favor of more conservative options.² The Foundation for Informed Medical Decision Making found that for 70 percent of people who have a heart bypass operation, the result would have been the same if they had chosen medication alone.³ Many of those patients were probably unaware that they had more than one treatment option, and would likely have chosen differently.
- ***Fourth, we need to re-design public and private insurance benefits*** to give consumers incentives to make truly value-based decisions. Benefit design can support consumers in their ability to take actions to prevent and manage disease, select quality care at the best

² MedPAC Public Meeting Transcript, p. 9, Apr. 8, 2009.

³ Foundation for Informed Medical Decision Making, “Did You Know”, <http://www.informedmedicaldecisions.org/> (Apr. 16, 2009).

price, and use clinicians or settings that deliver better quality more affordably. Benefit re-design based on value can dramatically achieve both better health outcomes and lower costs. For example, in 2001, Pitney Bowes lowered co-payments for asthma and diabetes medications for their employees. They reported a \$1 million savings from reduced complications in the first year, and \$2.5 million in savings in the second year.⁴

Building an Adequate Workforce

The demographic shift occurring in our population as the first of the baby boomers reach age 65 calls into sharp relief the fact that we have a health care workforce largely untrained in caring for an aging generation. As Americans live longer with multiple and more complex conditions, we face a tsunami that will overwhelm our ability to deliver care, regardless of how well designed and organized the delivery system is. Without “boots on the ground” to directly care for patients and their families, we cannot achieve our goal of providing patient-centered high quality care to all Americans.

The health care workforce is suffering from problems related to both size and training – we need a larger primary care workforce and a workforce that is trained in effective ways of caring for the high-risk, high-cost patients with multiple chronic conditions that are increasingly becoming our “typical” patients. But the pipeline for training physicians in geriatrics is long and dry; very few medical school students take a course in geriatrics, and less than 300 physicians completed geriatrics training in 2007.⁵

Addressing these workforce challenges requires providing better compensation and incentives. Redesigning our payment system to reward and encourage primary care will help. Other incentives like loan forgiveness and scholarships can make a difference, as will improved working conditions and benefits so we can retain our current practitioners. As a pragmatic first step, we urge that every primary care clinician gets trained in the principles of high quality geriatric care.

Conclusion

We have an extraordinary opportunity for transformational change of our health care delivery system. The magnitude and urgency of the crisis we face in today’s health care system demands that we act boldly. To do anything else is morally and fiscally irresponsible.

Yet the process for transforming our system is also extraordinarily complex. Each change is fraught with consequences, intended and otherwise, and at every turn there is much we will learn only by taking action.

⁴ Fuhrmans, V., “A Radical Prescription,” Wall Street Journal, May 10, 2004, and “Value Based Benefits Designs,” Presentation by Hom, D., Pitney Bowes, Inc., Inaugural University of Michigan VBID Conference, December 15, 2005.

⁵ Gawande, Atul. *The Way We Age Now*, New Yorker Magazine. April 30, 2007.

We must take into account the tremendous variation in our current system. Providers and payers will have different capacities to respond to change, and patients vary tremendously in their needs and preferences. We must therefore avoid a “one size fits all” approach.

This calls for a mix of vision and pragmatism. We must set our sights high. Be clear about direction. But also chart a course that creates multiple pathways for providers to reach our goals. We must establish mechanisms for rapidly testing, assessing, and implementing what we learn. And most importantly, we must hold ourselves to our commitment to forge an effective system that delivers high quality, patient-centered care for everyone. Patients and their families are counting on us.