

TESTIMONY OF STEVEN SCHLOSSBERG, M.D.
BEFORE THE SENATE COMMITTEE ON
HEALTH, EDUCATION, LABOR AND PENSIONS (HELP)
THURSDAY, MAY 14, 2009

*“Delivery Reform: The Roles of Primary and Specialty Care
in Innovative New Delivery Models”*

Mr. Chairman and members of the Committee, thank you for inviting me to testify regarding the role of specialty care.

My name is Steven Schlossberg from Norfolk, Virginia. I am the chair of Health Policy for the American Urological Association, a member organization of the Alliance of Specialty Medicine, which I am here to represent. The Alliance was founded in 2001 and its mission is to develop sound federal health care policy that fosters patient access to the highest quality specialty care and improves timely access to high quality medical care for all Americans. As patient and physician advocates, the Alliance welcomes the opportunity to be here today and participate in the national health care reform debate.

I am a practicing urologist and part of the management team of a 400 physician multi-specialty group practice. This makes me keenly aware of the necessary collaboration between primary care and specialists.

Effective partnerships between specialty care and primary care are absolutely essential to the delivery of high quality, cost effective, patient centered care. Through the dissemination of clinical guidelines, offering of continuing medical education (CME) courses, and innovative collaborations among primary care and specialty practices; specialties educate primary care providers and ensure timely and appropriate referrals and resource use. Not everything can be prevented. People get sick. They need specialists. They need surgeons. They need hospitals and emergency rooms.

Primary care will not always be the most cost efficient and effective provider for every condition and disease. In fact, evidence indicates that specialists achieve better outcomes in the treatment of the diseases they focus on than primary care providers and other specialists. For example, an article in the American Journal of Medicine looked at treatment of arthritis, rheumatic and musculoskeletal conditions and found that primary care providers often lack adequate rheumatologic training. They are less skilled in the diagnosis and management of these diseases and may order more diagnostic studies, drugs, consultations and follow-up visits than rheumatologists, making the care they provide lower quality and more costly. Rheumatologic care for these conditions provides better patient outcomes and is less costly to the health care system.¹

¹ Katz JN, Solomon DH, Schaffer JL, Horsky J, Burdick E, Bates DW. “Outcomes of care and resource utilization among patients with knee or shoulder disorders treated by general internists, rheumatologists, or orthopedic surgeons.” American Journal of Medicine Jan 2000: 108 (1) pp 28-35.

A recent article in the Journal of the American Medical Association (JAMA)², directly relates subspecialty training to improved patient outcomes. This particular case looked at outcomes for implantable cardioverter-defibrillators (ICD) and used cases submitted to the ICD Registry. The study confirms that specialized training enables physicians to lower risk of complication and select the most appropriate treatment for the patient's unique needs.

To foster collaboration, Congress should not divide medicine and strive to strengthen primary care at the expense of specialty care – whether through budget neutral changes to reimbursement or by limiting access to specialty care.

Reimbursement

Congress must address the underlying physician payment problem. Without a long term solution to the flawed Medicare payment formula, our health care delivery system cannot truly be reformed. When the government programs do not provide stable and fair reimbursement, it equally impacts the private insurance programs and leads to discrepancies in the true cost of care. Nor should Congress rob Peter to pay Paul. The Alliance recognizes the importance of improving access to primary care and strengthening the role of primary care providers. The Alliance can not support proposals that would provide additional payments to primary care physicians at the expense of specialists, e.g., through budget neutral adjustments in payments made to specialists.

Innovative Delivery Models

One of the innovative delivery models being discussed is the Patient-Centered Medical Home -- a healthcare delivery model intended to promote patient-centered, longitudinal, integrated care. A key feature of Medical Home is a personal physician responsible for overseeing all of a patient's health care and appropriately coordinating care with other qualified professionals to enhance access, improve integration, and increase safety and quality.

Unfortunately, the current Medical Home models do not include all qualified physicians able to provide Medical Homes and may, in fact, result in limiting access to some specialists. Through the Tax Relief and Health Care Act of 2006, the Center for Medicare and Medicaid Services (CMS) was directed to launch a Medical Home demonstration. However, the design of the CMS-proposed Medical Home excludes many specialties such as surgery. Urology is a surgical specialty and may be the most appropriate Medical Home for patients with certain chronic urologic conditions, such as prostate cancer or bladder control problems. These patients often have long-established relationships with their urologists and have trust and confidence in their care. Arbitrary severance of this relationship through exclusion of surgical specialties does not serve the goals of this program. We should think in terms of having a "*principal*" provider and not assume it always will be a primary care provider. Rather than having government decide which providers are most appropriate, let individual physicians, in consultation with their patients, together decide if they want to participate; many may not. I believe that will foster the patient-centeredness care around which this program is built.

² Curtis JP, Luebbert JJ, Wang Y, Rathore SS, Chen J, Heidenreich PA, Hammill SC, Lampert RI, Krumholz HM. "Association of Physician Certification and Outcomes Among Patients Receiving an Implantable Cardioverter-Defibrillator." Journal of the American Medical Association Apr 22/29 2009 – Vol 301, No 16, pp 1661-1670.

Finally, the Alliance requests that Congress, before enacting Medical Home as a permanent model, fully analyze the data after the completion of the demonstration to determine if Medical Home significantly improved care coordination, was patient-centered, delivered improved patient outcomes and saved money. Currently, implementation of the demonstration project is slated to begin January 2010.

If Medical Home or other innovative delivery systems are to succeed, there must be collaboration between primary care and specialty medicine. Specialists are working with primary care physicians to ensure appropriate referral and promote continuity of care. For example, the American Urological Association has spearheaded a free continuing medical education (CME) update tailored exclusively to primary care practitioners on major urologic conditions, reaching out to the American Academy of Family Physicians (AAFP) and the American College of Physicians (ACP).

The North American Spine Society/National Association of Spine Specialists (NASS) is unique in that it encompasses multi-specialty care including non-operative and surgical care from entry into the healthcare system through all phases and types of care, thus demanding routine coordination among a range of practitioners, including primary care providers. NASS provides specific evidence-based guidance to spine care providers in the form of clinical guidelines to benefit patient care, helping them diagnose, treat, and properly manage, among other conditions, back pain.

The American Gastroenterological Association (AGA) provides educational materials for primary care providers on such highly prevalent GI conditions as appropriate management/evaluation of diarrhea, Gastroesophageal reflux Disease (GERD), colorectal cancer screening and polyp/cancer surveillance. Additionally, some larger gastroenterological practices are working closely with primary care practices to develop clinical care protocols for four areas: pediatric chronic diarrhea, adult chronic diarrhea, acute abdominal pain and chronic abdominal pain. These protocols include, for example, what diagnostic steps should occur at the primary care level and then what should be included in the information transfer. Having electronic medical record (EMR) interface will help with the proper information flow and the development of future protocols.

These are just a few examples of the kinds of essential exchange of clinical knowledge and practice expertise that specialists are proactively providing to primary care professionals to promote cost effective, timely, efficient and clinically appropriate patient care. Other Alliance member organizations also have developed similar tools for primary care physicians. We ask that such fruitful and functional partnerships be explicitly recognized and actively fostered by supportive government policies that unite diverse segments of medicine around the *patient as the center of attention*, rather than artificially, through divisive payment policies and arbitrary definitions, perpetuate dysfunctional silos of care that both patient and physician must struggle to navigate. Specialty care is and can continue to be an effective, knowledgeable contributor to a reformed healthcare system and is able and willing to do so.

Health Information Technology (HIT)

Health information technology (HIT) provides a building block for innovation and the delivery systems of the future. It has the potential to increase collaboration, efficiency and quality of care, and to lower health care costs significantly. The Alliance strongly supports the development of an electronic health information network that is reliable, interoperable, secure, and protects patient privacy. Congress made significant strides towards the implementation of HIT with the passage of the “American Recovery and Reinvestment Act of 2009” (ARRA)(PL11-5), and the specialty community is appreciative for the opportunities available for physicians to receive enhanced Medicare payments to support the adoption and effective utilization of HIT.

My practice has moved forward in this area. We viewed this as a shared responsibility. The only reason my practice was successful is because we had the resources to do this. If I was in a small or solo practice, I could not have done it. Smaller physician practices, which include the majority of the physicians practicing medicine in this country, continue to face barriers to purchasing HIT systems. In addition, for those practices that manage to adopt HIT, it takes a further investment of significant time and resources to use their systems to the fullest capacity.

However, the Alliance is concerned that many specialty physicians will not be able to take advantage of the enhanced payments to purchase HIT because of the ambitious bonus and penalty timelines and the fact that current specialty systems lack certification and interoperability standards. Further, the current certified HIT systems have been developed for primary care settings and have not yet been fully adapted for specialty or surgical care. The financial incentives and penalties are based on the adoption and “meaningful use” of certified HIT systems and will have a profound impact on our members and their ability to adopt and become meaningful users. Physicians are hesitant to make the considerable investment until certified systems are available that meet their unique needs.

I call your attention to the fact that there are surgical specialties that have made significant accomplishments toward achieving interoperable HIT solutions for their members and have been placed on the Certification Commission for Health Information Technology (CCHIT); the only recognized certification body, roadmap for HIT Certification. However, due to the obstacles that must be overcome to be identified by CCHIT as one of the planned expansion areas, and the lack of CCHIT financing and staff, most specialties are not even in the pipeline. In addition, even those who are on the roadmap are facing challenges in the timelines that have been outlined by the Commission.

As a result, and under the current timelines, it will be virtually impossible for the majority of surgical specialty physicians to purchase certified systems that are designed for their specialty, become meaningful users, and qualify for the majority of the vitally necessary financial incentives. Specialty medicine continually strives to provide quality care, and the Alliance recognizes that HIT can play an important role in achieving and maintaining high performance. Therefore, the Alliance urges you to consider amending the current HIT bonus and penalty timelines.

Quality

Likewise, quality improvement programs cannot be one-size-fits-all. Each of the Alliance's specialty association members has been actively engaged in the process of developing evidence-based and clinically relevant quality measures and establishing data registries through initiatives within their own specialty and/or through the AMA's Physician Consortium for Performance Improvement. While much progress has been made, it takes time to develop the extensive quality infrastructure needed for quality improvement which simply is not yet established for the majority of specialty physicians. That makes participation in quality measurement and improvement efforts very different from other providers to whom most physicians are readily compared. Since many times the private market follows Medicare's lead, I would like to share the Alliance's concerns with implementation of the Physician Quality Reporting Initiative (PQRI).

Process of care measures may be more relevant for primary care, but we need to move to a quality system that focuses also on clinical outcomes. For the program to succeed, it first needs to extend the timeline for full implementation so that physicians can catch up to other providers, some of whom have had decades to create, test, and report on measures; it must provide physicians with access to their data in a timely manner and it must have a reasonable appeals process. Also, the information should be verified before it is made public and quality reporting should be voluntary, not punitive. Congress should consider establishing a public private partnership to provide long-term support for clinical data registries and measure development currently undertaken solely through the limited resources of medical specialty societies. Additionally, the PQRI program could reward physicians who report clinical data to such registries. Finally, Congress must recognize the increased cost to report quality measures and should provide physicians with adequate funding to implement reporting requirements.

Physician Workforce

Specialists are an integral part of American medicine. As a Nation, we pride ourselves on having the best medical care has to offer. Regardless of what insurance product people have, Americans want to know they may see their doctor of choice when needed. However, we can not take for granted that those specialists will be there.

The Council on Graduate Medical Education (COGME), reported that *"In rural areas, there is a clear need for specialty care."*³ The report goes on to say that *"Though primary care would be an essential area of medical service and training, subspecialty and surgical disciplines are also sorely needed in underserved areas."*⁴

The Bureau of Health Professions (BHP) has cited significant workforce challenges across the surgical specialties. Between 2005 and 2020, BHP projects an increase of only 3 percent among practicing surgeons – with projected significant declines in a number of surgical specialties. Over the same time period, BHP projects that the number of practicing primary care physicians will increase by 19 percent.

³ COGME 18th Report: "New Paradigms for Physician Training for Improving Access to Health Care," Sept 2007, page 5

⁴ Ibid, page 13

The Association of American Medical Colleges (AAMC) published an updated physician workforce study demonstrating essentially equivalent shortages between primary care and surgery. Specifically, the study projects physician supply and demand through 2025 and finds that *“in terms of the general projected shortage of 124,000 FTE physicians, while 37% of the shortage will be in primary care [46,000], 33% will be in surgery [41,000]...”* In addition, the study projects a shortage of 8,000 medical specialty physicians.⁵

It is important to consider workforce issues as you consider health reform because it takes more than 12 years to produce a specialist. Like many specialists, urology requires years of training. In my case, four years of undergraduate education,, four years of medical school, five years of urology residency; some then also do an additional two or three years of Fellowship training. As a professor of urology at Eastern Virginia Medical School, I caution you against going too far and discouraging young physicians from entering specialty medicine. By the time a true crisis is visible, we will be unable to quickly correct it. Already, there are shortages in many specialty areas and as I mentioned earlier, the projections are that the problem gets worse.

Mr. Chairman, thank you again for including the Alliance of Specialty Medicine. I'm happy to answer any questions.

⁵ The Complexities of Physician Supply and Deman: Projections through 2025, Michael J. Dill and Edward S. Salsberg, Center for Workforce Studies, Nov 2008