

Testimony before the Senate Committee on Health, Education, Labor, and Pensions

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

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Senator Brown, Ranking Member Enzi and Distinguished Members of the Committee, it is an honor to speak to you today about the role of primary and specialty care physicians in current and proposed health care delivery models. Thank you for inviting me to submit this testimony.

I am Michael Nochomovitz, the President and Chief Medical Officer of University Hospitals Medical Practices (UHMP) and its associated Management Services Organization (UHMSO) in Cleveland, Ohio.

I am a practicing physician and lead a 450-member multi-specialty physician network in Northeast Ohio. This includes the largest primary care network in the region, complemented by a diverse group of specialty practices, seven urgent care centers and five hospitalist programs.

I have led the development of these organizations through the last decade. The enterprise has evolved into a regional force that in 2008 provided 1.2 million office visits at more than 100 locations in 42 communities. The network cared for 600,000 patients requiring more than one million electronic prescriptions.

I am acutely aware of the challenges primary care physicians face in attempting to coordinate care and also am cognizant that the optimal and most cost-effective health care cannot rely on one single specialty or service.

UHMP is the largest portal of patient entry into the University Hospitals system and accounts for more than 50 percent of the patients utilizing system services.

## **Primary Care Focus**

From the outset, primary care has been the foundation of the organization. There always has been a clear vision of the critical nature of primary care physicians in the delivery and coordination of care. This view was unrelated to considerations of health care reform but rather to the practice of medicine and the vision of University Hospitals.

The organization has grown largely by merger of key established primary care practices into the organization in many diverse communities. Within UHMP, we are fortunate to count numerous examples of the finest-trained and seasoned physicians in all primary and many specialty care disciplines. The care provided by our primary care physicians associated with regional multi-service ambulatory facilities translates into an exceptionally high level of continuity of care. This is, indeed, the type of care any of us in this room would want.

## **Limitations**

Our success does not tell the entire story. Despite the enhanced infrastructure and resources available to the physicians in our University Hospitals (UH) system, the challenges of coordinating care on a daily basis remain formidable. We all are familiar with the patchwork of components that make up our current health care system and the potential obstacles to patient and physician satisfaction. Our organization spans Northeast Ohio and includes suburban, rural and urban locations each with varying levels of access to the full scope of physician and allied health services. In the best situations, there are still significant limitations on physicians who seek to provide comprehensive services and continuity of care. The limitations include our overly complex administrative and payer system, inadequate payer recognition for cognitive work of primary care physicians, pressures to practice defensive medicine, a shortage of new primary care providers to replace the mature workforce, and the challenge of providing necessary care to the uninsured and the working poor.

The lessons learned from our specific experience are cogent, as our model, despite physician employment, has unique features to meet physician and local community needs. Our model gives the local community primary care physicians unique authority and responsibility for managing their practices and staff in a manner akin to private practice. We utilize our resources to grow these practices, provide the leverage of the integrated delivery system and ensure replacement for any attrition. The model is characterized by unusual physician empowerment and autonomy and has promoted significant physician engagement and physician satisfaction. Their alignment with University Hospitals has allowed us to introduce new technology and quality measures, which would have been impossible in the current private practice environment. The pressures in recent years on human and financial capital and lack of leverage with payers have impeded progress in many ways in traditional models for the majority of physicians in the United States.

We have a real life experience in diverse communities that represent a microcosm of regional health care delivery in the heartland of the country.

### **The Scope of an Integrated Delivery System**

The University Hospitals system was founded upon its academic hub, University Hospitals Case Medical Center and Rainbow Babies & Children's Hospital. Its physician network has become the backbone of this system. These institutions were created more than a century ago to serve the community and to serve as the teaching and research hospitals affiliated with the Case Western Reserve University School of Medicine. Today, UH has expanded to include seven hospitals, which consist of critical access hospitals, suburban hospitals, a long-term care hospital and skilled nursing facility, a children's hospital, and a 900-bed adult academic medical center. Currently, UH has two new hospitals under construction: a free-standing Cancer Hospital and a community hospital. In addition to the community-based physician practices, UH also employs its full-time academic physicians, the Case Western Reserve University School of Medicine faculty, in an integrated practice plan. These physicians, who include national and international leaders in their fields, serve the tertiary and quaternary needs of our regional system at UH Case Medical Center. This tertiary and quaternary component is a critical part of the ultimate continuity of care to which we all aspire.

### **The Medical Home Concept**

Many hearings have addressed the glaring gaps and weaknesses in health care coverage in our country, as well as the dislocation and fractionation of care that many citizens experience, whether insured or uninsured. The idea of continuity of care provided through a Medical Home with access and comprehensive services is under substantial discussion. These concepts cannot be grounded in jargon, but need to address the substance of patient care delivered appropriately in an evidence-based fashion in the appropriate setting for an affordable cost. The Medical Home is likely to be a methodology within a more global approach to continuity of care.

### **Health Care Reform: Quality of Care, Coordination of Care and Cost Control**

There will be critical success factors to change the direction of health care in the decades to come. Some of the critical success factors include:

#### *Wellness*

It is a truism that our health care must be grounded in the lifelong pursuit of wellness and prevention.<sup>1</sup> The latter realistically is a more difficult long term challenge as it involves population behavioral change. Major impacts on population behavior will require both public and private programs to promote wellness as an integral part of our society. Incentives for employers to promote wellness in the workplace will need to be instituted.

#### *The Role of Primary Care*

It is on this background that primary care providers evaluate symptoms and abnormal findings for evaluation and diagnosis. Subsequently, the best treatment will result in either cure or the transition into chronic disease management. The latter accounts for a significant percentage of our health care costs and offers the most opportunity for the care coordination provided access to the necessary resources are made available and reimbursement for care management is provided in an unequivocal manner.<sup>2</sup>

It should be apparent that this ideal state will not be unidimensional and will require a multi-disciplinary approach that involves access to coordinated, convenient, affordable and humanistic care for an array of medical providers. These will include primary care physicians, specialists, and a wide variety of allied health professionals who cover the entire spectrum of care from cradle to grave.

### *Structures of Care Delivery*

There will not be one solution that meets the needs of every community and all constituencies of patients and providers.

We will need to create vehicles for integrated care that could affect the necessary changes in all our communities. These would provide opportunities for participating providers to be eligible for quality and outcome based bonus payments as well as benefit from more global savings. Accountable Care Organizations (ACO) and existing structures such as integrated delivery systems could be empowered to manage the continuum of care.

The consolidation of health care in recent years could turn out to be a distinct advantage in many communities in terms of building on existing infrastructures to deliver coordinated care. Further modeling will no doubt result in a variety of unique public and private vehicles which would be evaluated in demonstration projects. In some areas we should anticipate a growth in community health centers, and an expansion of the National Health Service Corps locations, as well as the optimal use of the Veterans Administration Health System and the Indian Health Service.

There are a number of significant risks that must be called out:

- We must not damage what already is working well
- We must not remove patient choice or disrupt existing doctor patient relationships
- All physicians should have an opportunity to participate on the basis of standards to be determined
- The imperative of cutting costs to pay for reform could result in creating new shortages<sup>3</sup>
- The infrastructure for quality and performance reporting will likely be more expensive and challenging in implementation than predicted.
- The reporting methodology for quality measures must be timely and accurate

- Health care is a local phenomenon and there will be unique regional and community specific challenges, which may or may not be associated with cost-differentials.
- The cost to expand coverage may exceed the projected savings in the early years.
- The exclusion of physicians from any component of the planning implementation process is likely to limit the effectiveness of implementation.

### **Lessons Learned From the UHMP Experience: Making Choices**

In our own experience, we have created a large, regional network built mostly on aligning the best physicians in local communities who were previously in traditional private practice. We have taken these physician practices empowered them to succeed by investing in an enhanced infrastructure and the ability to introduce new technologies, quality measures and outcome evaluation which would not have been possible in their former states

Over the last few years despite the presence of incentives we have chosen to make significant expenditures to position the physicians in their local communities for quality measurement and outcome evaluation. In a growing organization which was merging physicians from the private practice environment we were required to make choices to achieve in our mind the maximum impact on patient care.

The following were areas of focus:

#### a. Electronic Prescribing

Five years ago, we targeted electronic prescribing as the most useful technology for a primary care physician office. We were early adopters long before health information technology incentives were a reality. Indeed, we created our own incentives by affording those physicians who utilized e-prescribing a discount on their malpractice insurance. The cost was borne by UH because we felt that it was a critical technology to enhance quality of patient care. We subsequently were one of the five national sites selected by CMS for the e-prescribing demonstration project to develop foundation standards for the current program. In the past year our physicians submitted more than 1 million electronic prescriptions and the number continues to grow. This has greatly increased patient satisfaction and assured increased awareness of drug interaction and oversight on dosage and compliance.

#### b. Chronic Disease Management: Diabetes

We also embarked on an ambitious program targeting diabetic care as a prototype for chronic disease management. We funded the necessary initiatives for the following components:

- Adopted the American Diabetes Association Diabetes Self Management Programs:

We obtained ADA certification for six regional locations to deliver educational/instructional programs with diabetic nurse educators working closely with primary care physicians and endocrinologists. Particularly in the management of diabetes, there is a need for collaboration among primary care providers, specialists and allied health professionals. We have recruited six full-time endocrinologists to our network to provide the specialty services needed by the primary care physicians and their patients, and to complement the work of diabetic nurse educators, podiatrists, nutritionists and other professionals. This is an excellent example of what some might call a “Medical Home” for diabetic patients and in relates to the establishment of an appropriate continuity of care for diabetic patients in any setting or structure.

- National Committee for Quality Assurance (NCQA)

We have systematically worked with our adult primary care physicians to obtain recognition from NCQA for diabetic care. This was achieved through an extended and ongoing educational program for physicians and their staffs. We hired additional staff to audit medical records through our document imaging system which has been an outstanding transitional modality for establishing a paperless workflow and preparing physicians and practices for our new University Hospitals electronic medical records.

#### c. Alternative Sites of Care

- Urgent Care Centers

UH has established a total of seven regionally based Urgent Care centers to provide care for patients who need urgent but not emergent care in convenient locations, as well as care after regular hours. We have instituted a national model for an urgent care Fellowship program. This is done in collaboration with the Department of Family Medicine at Case Western Reserve University at University Hospitals Case Medical Center.

These regionally based centers serve as an extension of the primary care physicians’ office as well as a site where non-emergent presentations are evaluated in a more sophisticated fashion and at lower cost than an emergency department.

We have introduced a variety of system-wide protocols that can be delivered in this low cost environment. These include management of dehydration, asthma, fracture care, minor trauma as well as a protocol for chest pain which includes measuring serum troponins, a diagnostic indicator for heart attacks, which may be positive in the presence of a normal EKG. We also are able to

rule out other serious conditions like pulmonary embolism with the appropriate care paths established.

### **Retail Clinics**

We also are investigating and evaluating the prospects for retail clinics staffed by nurse practitioners linked directly to our urgent care centers for both incidental care and work-related health care. As more payers recognize this environment as a site of care, there should be ongoing reporting of the outcomes of this model and its cost-effectiveness as part of a broader continuum.

### **Primary and Specialty Care Needs**

The primary care disciplines do need help. They will be the backbone of any cost effective health system provided they have the resources to provide necessary care for their patients. There are also specific specialty shortages that significantly impact the provision of cost effective care in our communities.

Support for these deficiencies could come in a variety of methods including:

- a. Increase reimbursement for primary care physicians, with appropriate change to the Medicare SGR methodology. Increases in reimbursement must be guaranteed as increments to the current base over the next number of years and not be subject to SGR related cuts. The methodology must recognize realistic practice costs for physicians and other health professionals. These increases should not be at the expense of other physicians' reimbursement.
- b. Reimbursement for care coordination and management for selected chronic disease beyond the confines of the office encounter and the acute hospitalization.
- c. Lift and expand the Medicare resident cap, established in 1998. Achieving an increase in the physician supply requires lifting residency training caps as well as increasing medical school enrollment.
- d. Enhance government sponsored loan options and loan repayment programs to increase the supply and retention of primary care physicians, nurses, mid-level providers and practitioners who will be critical in ensuring better coordination of patient care. Loan forgiveness should be offered in exchange for true long term commitment to primary care practice in any location.
- e. Early identification of medical students interested in primary and selected specialty care that could make long term commitments to a clinical career. Increase funding for the National Health Service Corps (NHSC). The number of NHSC awards should be increased by at least 1,500 per year to help more physicians practice in underserved areas while enabling more new physicians to practice primary care.

## **Integrated Care Delivery**

It is necessary to reiterate the paradox that for those in a stable health care delivery environment in the United States, we have arguably the most advanced and refined health care in the world. The lack of uniformity, the exclusion of many and the spiraling costs are mandating change for what is not sustainable.

Medicine does not have simple metrics and most complex conditions are multi-factorial. The current luxury and advantage derived by those who have access to strong stable and supported primary care would be an important component of our health care reform but not a sole solution. We must target the development of a new “Continuum of Care for America” which would achieve the goals of necessary care for all our citizens and optimal utilization of resources while maintaining international leadership in specialty innovation and advancements.

This approach could include concepts such as value-based purchasing, bundling of hospital and physician payments, and Accountable Care Organizations (ACO). Each of these efforts would need to be substantiated with voluntary demonstration projects for validation before any system-wide expansion. The substantive background for many relates to the commonsense components of access, prevention, acute care management, chronic disease coordination and prudent use of the full spectrum of specialty services needed to practice evidence based medicine and meet the needs of our patients.

Remove legal and regulatory impediments to delivering coordinated care:

- a. Make targeted changes to laws and regulations to allow physicians, hospitals and others to work together as teams, able to use financial incentives to reduce cost and improve care.
- b. Establish a simpler, consistent set of federal rules for how hospitals, physicians and others may structure their financial and contractual relationships.
- c. Provide clearer guidelines under federal antitrust law to enable clinical integration and joint hospital-physician contracting with payers to ensure aligned performance incentives and to facilitate continuity of care, particularly in light of electronic health record technology.
- d. Provide a simple and meaningful “safe harbor” under federal laws and regulations to encourage the development of real or virtual delivery “networks” (such as Accountable Care Organizations).
- e. Ensure HIPAA continues to enable providers to share information to enable patients to receive higher quality, safer care. Misunderstanding HIPAA requirements has led to reluctance among providers to share information, even though doing so is in the best interest of patient care.

There are numerous critical success factors for the massive undertaking of health care reform. In recent days, numerous major provider organizations and associations have petitioned our Congressional leaders with their concepts and concerns relating to health care reform implementation.

As these ideas relate to primary and specialty physicians, there are a number of key recommendations that I will highlight.

1. Ensure health care coverage for all Americans through a combination of existing payers, employment-based coverage, and expansion of safety-net government programs.
2. Drive the introduction of physician and patient-friendly technologies to facilitate care and the physician practice environment.
3. Drive cost-reduction through evidence-based quality and outcome measures, which are established through federally-sanctioned quality organizations, national specialty societies and organized medicine.
4. Eliminate unnecessary administrative complexity and cost through the establishment of uniform, interoperable technologies that promote both clinical and administrative data-sharing.
5. Reduce the impact of malpractice claims on defensive medicine through federal tort reform

Thank you again for the opportunity to address you today. I welcome any questions you may have.

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<sup>1</sup> Ross DeVol and Armen Bedroussian, et al, An Unhealthy America: The Economic Burden of Chronic Disease, The Milken Institute, 2007: 4-5.

<sup>2</sup> Ibid, 184.

<sup>3</sup> Elliott Fisher, M.D., MPH, "Building a Medical Neighborhood for the Medical Home," New England Journal of Medicine 359 : (2008) 1202-5.