Invited Testimony
House Insurance Committee Public Hearing
House Bill 2106
Establishing the Pennsylvania Health Quality Improvement, Payment Reform and Cost Reduction Authority.

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Thank you for the opportunity to provide testimony in support of House Bill 2106 specifically in regards to establishing an Authority and creating governance structure for continuation of the Commonwealth's Chronic Care Initiative. This critical initiative represents a shining example of how primary care can be transformed to improve both outcomes for patients and contain health care costs. As faculty chair for the initiative, I have seen firsthand the extraordinary benefit it has brought to practices, healthcare providers, and patients. Herein is described the rationale for the ongoing initiative and need for creation of an Authority to sustain and propel the Commonwealth forward as a leader in innovative health care for the benefit of its citizens.

The Quality Chasm

Chronic diseases are responsible for most deaths and three quarters of healthcare costs in the United States. Almost half of Americans live with one or more chronic diseases. In the Commonwealth of Pennsylvania chronic diseases are the single most significant threat to the health of Pennsylvanian residents. Almost 70% of all deaths in Pennsylvania are caused by chronic diseases. The number of persons with chronic illnesses is growing at an astonishing rate because of the rapid aging of the population and the greater longevity of persons with many chronic conditions.

Despite the vital importance of chronic illnesses to healthcare costs and to the overall health of the Commonwealth, care is suboptimal. Studies show nationally that patients receive roughly only half of recommended care following a visit to a physician. A significant quality chasm for chronic illness care has been well documented by the Institute of Medicine. For example, for diabetes one of the most costly chronic illnesses, only 7% of individuals with diabetes are at recommended goals for blood sugar, blood pressure and cholesterol.

Poor quality care leads to high costs.

Not only is the high morbidity and mortality related to poor chronic disease management adversely affecting the Commonwealth but spiraling health care costs are largely driven by improper treatment of chronic illnesses. Chronic illnesses account for **80%** of all health care costs in hospitalizations, **76%** of all physician visits and **91%** of all filled prescriptions. These numbers are even higher in public payer systems where, for example, 83% of Medicaid spending is for chronic illness care. The unfortunate gap in quality care translates into enormous health care costs to the Commonwealth with almost $1,000,000,000 in avoidable hospitalizations occurring because of diabetes alone. Overall, suboptimal chronic disease care costs the Commonwealth over $4 billion in avoidable hospitalizations. Coordinated care lead by a primary care team has been conclusively shown to reduce healthcare costs by providing better treatment of chronic illnesses.

Why are we not achieving better quality and cost containment?

Our health care system has been largely designed to react to acute illnesses. The U.S. medical system evolved in an era when acute infectious diseases were the leading cause of death and illness. Advances in public health and drug discovery have brought care to a new level where chronic diseases are now the major health care challenge. Overall, the problem is not bad patients or bad providers but a system-based problem. Care needs to be transformed to be more coordinated, pro-active and organized to meet the needs of those with chronic illnesses.

Fortunately, an effective model for improved chronic disease management is available – the Chronic Care Model. This model describes the elements necessary to insure high quality care between a prepared pro-active practiced team and an activated informed patient. This model is the basis for the Patient-Centered Medical Home, an effort that is beginning to transform primary care in many states. The Patient-Centered Medical Home has been endorsed by The American College of Physicians, The American Association of Family Practice, The American Medical Association, and pediatric organizations as the future of primary care.

The Chronic Care Model has been clearly demonstrated to result in better quality of care in multiple venues and is currently the best evidence-based model for improving chronic disease care. Despite widespread recognition of the value of the Chronic Care Model (CCM) to improve outcomes, it generally has been adopted only within large healthcare organizations. This is in part due to the mismatch between who bears the cost of implementation and who receives the financial benefits from care improvement. Needed changes in reimbursements necessary to cover the costs of implementation of ongoing care delivery using a team-based care model are typically not available.

Ultimately, the only solution to improve chronic disease care is to focus on the available infrastructure within primary care to re-tool and transform these practices to deliver optimal care. Practices transformed along the Patient-Centered Medical Home and Chronic Care Model result in cost reductions and improved outcomes for their patients. Over time, these savings will bend the cost curve for Pennsylvania employers, employees and their families. Pennsylvania can pave the way for the rest of the nation.

How is Pennsylvania meeting these challenges?

The Commonwealth can be proud of a unique initiative over the last two years that is transforming primary care practice across the state. The initiative has brought practices, providers purchasers of health care, third party payers, and patients to develop an innovative solution to the joint challenges of high health care costs and poor quality. Key aspects of the initiative are the following: 1) Learning Collaboratives – practices are brought together (25 to 30 practices at a time) to meet quarterly to learn the transformation process, implement changes and report and share experiences 2) Practice Coaches – visit individual practices and guide them through the implementation process, identifying barriers and providing solutions 3) Monthly Reporting of quality data using an Health Information Technology based registry system (practices can only change what they measure, and for the first time many practices are looking at their quality data and developing strategies to improve their outcomes) and finally 4) Multi-Payer Consensus-based Payment Reform with infrastructure payments linked to Patient-Centered Medical Home certification by NCQA. The focus of the effort is to redesign primary care delivery with diabetes as the initial prototype chronic illness based on its high cost, morbidity and mortality and clear evidence based guidelines.

Previous efforts of payment reform based on pay for performance have had limited impact. This is primarily because primary care providers are typically already working at capacity and lack the knowledge and skills to transform the way they deliver care to those with chromic illnesses. They are mired within the same old system and don't know how to transform. The solution involves not only providing added reimbursement for infrastructure changes within those practices but, most importantly, guiding practices through this transformation process to deliver better chronic illness care. Simply asking practices to work harder and not smarter will not work. Our efforts have taught practices how to transform their health care delivery system to a more prepared proactive coordinated approach.

There are currently 170 practices with 780 providers serving a total of one million patients in Pennsylvania that are adopting the Patient-Centered Medical Home and Chronic Care Model in this initiative. **This is the largest multi-payer Patient-Centered Medical Home initiative in the country!**

It has been astonishing how engaged providers, patients, practices, and payers have been in this initiative. Many providers describe that, for the first time, they are really enjoying the practice of medicine in ways that initially drew them to the profession years ago. Practices are operating as a team with all members working toward a common goal- improving the lives of their patients. Team members are empowered to insure that the right thing is the natural thing to do within the flow of their practice.

One unique feature of the initiative is the broad scope and wide variety of practice settings that are engaged in transformation. Engaged practices mirror the diversity of the Commonwealth itself with both rural and urban practices, small and large practices, federally qualified community health centers, academic practices and training programs, with patient populations that reflect the ethnic and racial diversity of the Commonwealth to address health disparities. The reach of this initiative to small practices in particular is noteworthy since not only do these represent a significant percentage of practicing primary care health clinics in PA but they are often overlooked in quality improvement initiatives. The 7 rollouts to date cover all regions of PA (SE, SC, SW, NW, NC, and NE). One of the remarkable findings is that the approach being used is highly relevant and applicable to such diverse practice environments and patient population

Practices have utilized a variety of innovative approaches to transform care and make it more centered on the patient. One practice in Southeastern PA, realizing that healthy food choices were limited in the local area, leveraged community resources and now host a weekly farmers' market that brings healthy choices to the neighborhood. A number of practices have engaged patients to help redesign and inform practices changes. Many, for the first time, are truly engaging their patients to ask them how to meet their needs most effectively. This is unprecedented and invigorating.

There are early results where the initiative is already demonstrating robust improvement. For example in Southeastern PA where the initiative began in May 2008, NCQA Physician Practice Connections Patient-Centered Medical Home Model (PPC-PCMH) recognition program was received by all practices. In fact, PA now has the most NCQA recognized Patient-Centered Medical Home Model in the country. Evidence-based guidelines are being adhered to and appropriate medications are being delivered to patients that will undoubtedly lead to a reduction in morbidity and mortality. For example in Southeastern PA a dramatic rise in the use of medications known to reduce morbidity and mortality in diabetes patients has been seen in the 10.000 patients studied. Early cost data from one of the Southeastern Pennsylvania insurers indicate a 26% decrease in hospital admissions, 30% decrease in emergency room visits and 16% decrease in overall costs. These highly impressive results speak to the potential impact of the initiative on the health of Pennsylvanians.

What is unique?

The Patient Centered Medical Home (PCMH), which incorporates the CCM, is being implemented in a number of health care organizations and regions around the US but has typically been lead by a limited number of payers within a given region. This unfortunately leads to limiting potential benefits to only a subgroup of patients within a practice and unfortunately leads to further fragmentation of care and potentially widening health disparities. The PA initiative is unique in bringing 17 different payers together to participate, allowing practices to transform care for all patients in their practice and provides the incentive to truly recognize healthcare delivery overall

I have had the opportunity to speak to leaders around the country about the phenomenal work that is happening in Pennsylvania. There is literally no state that is anywhere close to what we are accomplishing here in Pennsylvania as we implement the Patient-Centered Medical Home. There are currently 170 practices with 780 providers affecting one million patients in the Commonwealth. This is the single largest multi-payer Patient-Centered Medical Home Initiative in the U.S. There are 17 payers

that are all working together in various regions across the state partnering with practices in a way that has never occurred here before this initiative was implemented

I have been asked to speak at a number of national and international conferences to share what is happening in Pennsylvania as a model for what other regions of the country can engage. Presentations at the National Patient-Centered Medical Home Conference, Institute for Health Care Improvement Annual Meeting, American Diabetes Association and International Diabetes Federation amongst others have generated phenomenal interest in our innovative approach in Pennsylvania. I was also asked to present our efforts at an international conference in Hong Kong where there is great interest in using a similar approach in Asia. This effort is clearly something that we as Pennsylvanians can be quite proud of and must sustain, as we are a leader in innovative healthcare delivery.

Sustaining the effort and preparing for the future

The ability to bring purchasers of health care, third party payers and providers to collectively negotiate agreements and pioneer innovative reimbursement structures to foster optimal care and practice transformation has been critical to the success of the program. Continuing to have a public private partnership institutionalized through the Pennsylvania Health Quality Improvement, Payment Reform and Cost Reduction Authority is critical to the sustainability of this initiative. The Commonwealth cannot afford to not perpetuate the current successes and must provide a long-term home for the initiative. The Authority will allow the current work to continue but also provide the infrastructure to develop innovative consensus-based payment reform for the Commonwealth.

A critical element of coordinated care within the Chronic Care Model and Patient Centered Medical Home is having the necessary Health Information Technology to insure that all patients receive optimal care. These clinical information systems help to identify those at high risk and anticipate and prevent potential costly hospitalizations and health care costs while insuring that patients stay healthy. The Pennsylvania Health Information Exchange Authority is the most appropriate organizational structure to sustain the current initiative and expand it to other key sectors. For example, despite overwhelming evidence that hospital readmission rates can be reduced by contacting patients within 48-72 hours of hospital discharge, this practice happens in only a minority of cases. The reason is that there is typically no organized mechanism to connect Hospital information systems with those of regional providers. Through the Chronic care initiative practices are reaching out to local hospitals to improve coordination of care and health information exchange.

As the challenges of rising health care costs continue to grow and the federal government explores new reimbursement models such as Accountable Care Organizations, PA must remain posed to capitalize on these opportunities. Consensus based payment reform can provide value based purchasing of health care to control costs and improve quality. The established Authority would provide the necessary infrastructure to seize new opportunities and rapidly translate new innovations. As successful as the initiative has been to date to improve the lives of those in the Commonwealth and control spiraling health care costs, establishing the proposed Authority through a public-private partnership will be essential to not only continue to spread the current approach but to capitalize on new opportunities to innovate.