Testimony before the
PA House Insurance Committee

Eric Gertner, MD MPH
Associate Chief, External Programs
Division of General Internal Medicine
Lehigh Valley Health Network
Allentown, PA

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Mr. Chairman, members of the House Insurance Committee, and fellow Pennsylvanians.

Thank you for inviting me here today to testify on House Bill 2106 and, more specifically, on the benefits of amending it to include not only the Pennsylvania Health Information Exchange, but also the Chronic Care Commission. I have been fortunate to have served on the Chronic Care Commission as the Co-Chair of the Committee on Community Practice Redesign, and I take great pride in the accomplishments to date of our collective work here in Pennsylvania. I am also one of the over 900 primary care practitioners involved in one of the Learning Collaboratives; as a primary care general internist in Allentown, affiliated with the Lehigh Valley Health Network, my practice participates in the South Central PA Collaborative. So the insight I can provide comes both from my active participation on the Commission as well as my in-the-trenches care for patients in Pennsylvania who daily struggle with chronic diseases such as diabetes.

Why are we concerned about chronic diseases? Simply put, chronic diseases such as diabetes and asthma, congestive heart failure, hypertension, rheumatoid arthritis, have an enormous impact not only on an individual's physical health, but also their quality of life, their sense of well being, their ability to go to work each day, contribute to society and to provide for their families. The burden of chronic disease, from a financial standpoint, is great, and is borne not only by the individual who can't afford to purchase her medications but also by the rising costs of healthcare.

Overall, you've seen the statistics, but they bear repeating. We know that Chronic Diseases are the Leading Causes of Death and Disability in the U.S.

- 7 out of 10 deaths among Americans each year are from chronic diseases. Heart disease, cancer and stroke account for more than 50% of all deaths each year.
- Patients with chronic diseases account for up to 80% of all health care-*related costs, 76% of hospital admissions,* and 91% of all prescription medications filled.
- In 2005, 133 million Americans – almost 1 out of every 2 adults – had at least one chronic illness.
- About one-fourth of people with chronic conditions have one or more daily activity limitations.
- Arthritis is the most common cause of disability, with nearly 19 million Americans reporting activity limitations.
- Diabetes continues to be the leading cause of kidney failure, non-traumatic lower-extremity amputations, and blindness among adults, aged 20-74.

- Hospital charges in Pennsylvania alone exceed $4 billion for "avoidable" admissions for patients with chronic diseases.

As a primary care physician, this is my reality. Patients come in to see their physician, we take a history, perform an examination, order tests and prescribe medications, and at the end of the day, what have we done to improve health? How have we provided care that meets the needs of the patient and her family? As we run on the hamster-wheel of primary care, we suffer from the constraints of a system that was not intended to care longitudinally for patients with long term conditions, but rather a system set up to treat acute illnesses. Another way of stating this comes from Dr. Ed Wagner, the creator of the Chronic Care Model who has been a consultant to the Commission:

> *The current system cannot do the job.*
> *Trying harder will not work.*
> *Changing systems will.*

In Pennsylvania, that's exactly what the Chronic Care Commission has done. It has promoted, facilitated, and overseen changing the systems of care in the outpatient setting to improve health. We've created teams of health care professionals in offices and clinics focused on practice transformation. Through learning collaboratives, providers have learned about best practice methods, what has worked elsewhere. We've shamelessly shared our work, so that the patient education I use in Allentown was adapted for a practice in York, and the office protocols developed in Hershey were adapted for practices in Pittsburgh. We've expanded use of electronic medical records and developed robust patient registries, with data that is meaningful to both providers and patients. Making the data we generate meaningful to improve patient care – not just using an EMR as a glorified word processing program – that's how this collaborative can change patient care, and patient lives.

The data that helps at the point of care is, in many ways, different than data that is collected regarding hospitalizations and hospital care. It's the data that allows you to see your practice from the population level, not just on a patient by patient basis. It's the data that helps you integrate the care you provide for your patients with the most recent and evidence-based medical recommendations. A very meaningful example for me, early on, was our use of registry data looking at our rate of documenting dilated retinal examinations in our primarily Medicaid clinic population in Allentown. As well-trained physicians, of course we know the evidence related to this, and the recommendation is for annual examination; we truly thought we were recommending this for patients. How wrong we were! When we put together our first patient registry, we found that we were screening only about 8% of our diabetic patients annually for retinopathy, a leading cause of blindness among diabetics. I mention this not to highlight a problem, but rather a solution. We would never have recognized how great a problem this was without the use of a patient registry. It turned out that the reason for such low

screening was simply that there was no ophthalmologist on the city's bus route. So a simple intervention – bringing an ophthalmologist to the clinic once per month, resulted in increasing our screening to over 50% in just a few months. How many cases of blindness did we prevent?

Or the example of the integrated team approach to the care of our diabetic patients. When a patient returned from Iraq 30 pounds lighter, we could easily have attributed it to his military service. But heightened awareness led us quickly to recognize that he had new-onset diabetes. Through coordinated care efforts and a team approach, we brought his diabetes under control not in the usual matter of months, but within several weeks, his fasting glucose levels were under 100 and his HBA1c went from over 15 to 7.1, just about at goal.

One of my pediatric colleagues told the story of a little boy who missed many days of school each year due to asthma, so he was falling behind in his class. Also, his family was hoping to go to DisneyWorld, but decided that they couldn't given his symptoms. Their team got together, taught the boy and his family how to monitor his symptoms more carefully, checked in with him consistently, and modified his medications. That little boy didn't miss a day of school through this winter, and he did make it down to Disney. Another success. Every one of the 173 participating practices has similar stories, similar achievements. Integrated, team based care made these possible, and the work of the Chronic Care Commission facilitated these stories.

The work of the Chronic Care Commission has crossed the state, but has also been very local. While there are seven collaboratives up and running, using the same basic format and education, in many ways, each is guided by the needs of the local health care communities. What works for a pediatric practice in Montgomery County may not work for a family medicine group in Adams County. The incentives provided to practices in Danville may not work for practices in Philadelphia. The Pennsylvania collaboratives are unique around the country in their abilities to innovate based on regional needs and regional realities, to adjust when necessary to new information and new data, to introduce new concepts at a pace that assures practices can implement them, all while providing guidance and oversight. This could not have occurred on the scale it has without the public-private partnership forged by the Chronic Care Commission.

Another important innovation in Pennsylvania has been our focus on care management. Each of the practices in the collaboratives now has or will have an individual in the practice that focuses on helping patients meet their goals of care. A care manager that helps with the transition from the inpatient to outpatient settings, that ensures enhanced access for high-risk patients. Practices have care managers that can help educate patients about their conditions, not forced within the confines of a 15-minute office visit, but a care manager can take her time with the patient to provide that disease specific education that is necessary to become a better self-manager. Patients are also

taught skills that can help them cope with their conditions, to live every day with a chronic disease, beyond the disease-specific education they receive. Patients will have a greater stake in their own health care as a result, and the data suggests this will improve outcomes.

You've heard today about the importance of the Chronic Care Commission, as convener and as facilitator of practice change. The Chronic Care Commission has provided leadership and a forum for discussion and education, an opportunity for stakeholders to come together to focus on quality improvement for everyone, not just your patients or my patients, but for everyone, for all Pennsylvanians. You've heard about the transformation of our practices, a transformation toward a more patient-centered approach, consistent with the ideals of the Patient Centered Medical Home. You won't be surprised, then, to learn that Pennsylvania is home to the most practices certified as patient centered medical homes by the National Committee on Quality Assurance in the nation, and the most Level 3 NCQA certified medical homes. And Pennsylvania truly is considered a model state regarding its efforts at quality improvement, cost containment and reform; you can't go to a medical home meeting anywhere in the country without seeing someone from Pennsylvania presenting their work that started as part of this effort. Continuing this work, continuing to engage our many stakeholders, continuing to transform our primary care practices is in our compelling interest.

Amending House Bill 2106 to include the Chronic Care Commission along with the Pennsylvania Health Information Exchange under one Authority makes sense. Both require multiple stakeholders, from insurers and provider organizations, to consumer advocacy groups and concerned citizens, and adequate state presence for continued spread and success. Both focus on collecting data from multiple sources, and using that data to improve patient care, especially in the outpatient setting. The additional potential for integration and coordination will serve to enhance the work of both groups, and ensure the sustainability of the Authority.

The transformation of primary care, facilitated in Pennsylvania by the Chronic Care Commission, continues to be a model nationally, a testament to the results of collaboration, innovation and integration. Amending House Bill 2106 to allow the Chronic Care Commission to join the Pennsylvania Health Information Exchange under one Authority will ensure the continuation of the work not only of the Commission and the 900 plus activated providers around the state, but also the over one million patients who are becoming better self-managers of their diseases, who are waking up each morning feeling a little better than they did the day before. For my colleagues, for my patients, thank you for the opportunity to testify before you today.