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Senate Finance Committee Hearing

"Chronic Illness: Addressing Patients' Unmet Needs"

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Thank you, Chairman Wyden, Ranking Member Hatch, and members of the Senate Finance Committee, for inviting me to discuss Emory Healthcare's efforts related to caring for our chronic care patients. I also wish to extend a special thanks to Senator Johnny Isakson who is Emory's Senator. He is a good friend and strong supporter of our work.

As the chief medical officer of Emory Healthcare in Atlanta and as a practicing endocrinologist, I know firsthand the challenges faced by our patients with multiple chronic medical conditions. Let me give you an example that is typical for my diabetes patients. Most patients with diabetes have other medical problems, like hypertension, coronary disease, kidney disease and other often related medical problems. Many of these patients see multiple specialists—they may be seeing me for diabetes care, a cardiologist for their coronary artery disease, a nephrologist for their kidney disease, etc. Everything each of us does affects the whole patient. Many problems, like elevated blood pressure and elevated cholesterol, overlap each of our specialties. The challenge is in how we make sure all the care is coordinated.

Coordination of care requires more than technology and good intentions—it requires re-allocation of time away from face-to-face interactions with patients to devote time to coordinate efforts among providers and allow for more non-face-to-face (phone, email, etc) interactions with patients. At Emory, each of us involved in the care of these patients attempts to address their problems in a patient- and family-centered way. However, the real challenge is coordinating this patient-centered care to take into account the whole patient. Technology, especially the electronic health record, is an important tool. At Emory, we have a highly sophisticated single electronic medical record system spanning our hospitals and

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outpatient clinics, so all providers can see the entire medical record. Yet, technology alone will not be sufficient to achieve the levels of care coordination we are seeking. So, in addition, we are hiring and training nurse care coordinators. We embed these nurses into primary care practices and feed them data that identifies high-risk patients. These nurses work with those patients who have the greatest risk of a downward spiral of health, based on the types of diseases they have and recent emergency room visits and hospitalizations. The nurse coordinators then stay in touch with those patients and help them get their medical needs taken care of proactively. At the same time, we are helping primary care practices become "medical homes," a practice model in which care coordination is an intrinsic feature.

We have our own patient-centered medical home, the Emory Patient-Centered Primary Care Clinic. This is a practice model that aims to improve the overall health care experience by creating a new care model emphasizing personalized, evidence-based medicine and greater coordination of care. By enhancing access to care, we can reduce expensive and unnecessary utilization and close gaps in care, such as proactively recognizing and treating diseases like diabetes or hypertension before they get out of control. Using a team of healthcare professionals devoted to providing general healthcare needs, the Patient-Centered Primary Care Clinic provides both preventive care and management of ongoing complex illnesses. The goal is coordination of care to keep our patients healthy and mitigate rising risk in those who have early- or mid-stage diseases. We are using the expertise we have developed in building this clinic to help the other practices in our network become equally effective medical homes. In a fee-for-service payment system, the extra costs entailed in care coordination are not reimbursed, and the reduction in face-to-face patient time would result in adverse financial consequences for the provider. In other words, the cost savings that such efforts achieve accrue to the payer at the expense of the provider. We need payment structures that facilitate and reward these activities, rather than those that reward doing more to patients (tests, procedures, etc.) independent of outcome.

Let's take a look at the costs of and reimbursements to our Patient-Centered Primary Care (PCPC) Clinic. EHC's FY2014 projected per-member per-month (PMPM) care coordination fee for the commercial (Emory Aetna plan) enrollee population is $365,000, with 35,437 total member months. This is the PMPM care coordination fee that Aetna pays (via the Emory self-insured Health Plan) for the PCPC population. In terms of cost for additional resources (i.e. care coordinator, non-fee-for-service activities, etc.) this PMPM is intended to subsidize those resources/time/activities. In FY2014, we are projected to have a positive net operating income of $134K. Without the $365K PMPM, EHC would run a loss of approximately $231K (or ~$85K loss per provider FTE). For FY2015, EHC is budgeting a PMPM care coordination fee of $440,000, with 42,718 total member months.

At Emory Healthcare, we care for the most complex patients in Georgia, and as a leading academic health center, we care for some of the most complex cases in the country. We do our best within, and despite, the constraints of the current options. Emory has a large group of patient and family advisors to help us

understand what is important to patients about access to care, how they want their care coordinated, and how to involve their loved ones in decision making. We hear from patients that they want to feel that someone is thinking about them as a whole patient. They know each of the specialists is very focused on the individual diseases they are treating, but they often feel like nobody is thinking about how to put the pieces together in a coordinated fashion. So, our patient and family advisors are routinely invited to sit in on high level, decision-making committees. We want their input to be heard so as to positively affect our value-based care transformation.

At Emory, we have formed a clinically integrated Emory Healthcare Network (EHN), which provides extensive infrastructure and support for physicians in a collaborative and quality-based environment to drive outstanding performance, improve care coordination, enhance quality outcomes, and control costs for our patients and our community. The Emory Healthcare Network includes all of our faculty and employed physicians, as well as high quality private practice physicians, and encompasses our own hospitals, as well as affiliated hospitals. The EHN is our accountable care organization (ACO) through which we are contracting with payers in ways that liberate us from the constraints of fee for service and move us toward better alignment of needs among patients, providers, and payers. We now have a "shared savings" contract with Blue Cross Blue Shield and are negotiating similar contracts with other commercial payers. Under this contract, if we are able to lower the total cost of care through better coordination of care, we share in the savings. This is important because, as noted earlier, better care coordination requires a large and continuing investment and may also reduce revenue to the provider. Shared savings can help offset provider costs invested to improve patient care. A key feature of these contracts is that savings are shared with us if, and only if, we achieve mutually agreed upon quality goals. Running the EHN costs in the range of $6 million to $10 million dollars annually. The American Hospital Association has estimated that, for a five-hospital system starting an ACO, the start-up cost is about $12 million and the annual operating cost is about $14 million.

Our own medical home (the PCPC clinic) was started as a new practice intentionally designed to manage populations of patients, rather than acute care episodes. However, in our network, we have more than 80 primary care practices that need to learn new population management skills, such as disease registry management and collaborative goal setting. They also need to learn how to move from a physician-centric care delivery system, which focuses mostly on the patients who come to the office, to an entire care team, whose focus is the entire panel of patients whether they come to the office or not. As our evidence-based medical knowledge has exploded, it is now beyond the individual provider's capacity to provide all the services and interventions needed by patients with chronic conditions. A recent study demonstrated that it would require 2 ½ primary care physicians to provide all the care indicated by the medical evidence for health maintenance, care of chronic conditions, and any acute care that their patients may need.

As our network has embarked on value-based contracting, we have an urgent need to manage not just our chronic-care patients but also those of the

highest complexity who have recently been hospitalized, frequently use the emergency department, or otherwise have great needs. To meet their acute needs, we have invested almost $880,000 for care coordinators in primary care practices. This cost will exceed $1 million annually as our attributed populations grow from 42,000 to more than 200,000 in the next five years.

So that our other primary care practices develop the skills and expertise to manage populations of patients like our Patient Centered Primary Care practice, we are also spending nearly $250,000 annually for the next five to seven years in training. In this way, our practices will have the innate capacity themselves to manage more complex patients, rather than relying on the more expensive care coordinators.

Data and analytics are vital tools for effective population management. However, traditional electronic medical records do not effectively aggregate and display population-level reporting with data from disparate sources. As a result, it is necessary for our network to invest more than $5.6 million over the next six years to gain the capacity to use data generated anywhere across our network to manage our attributed population.

However, we do not know whether new payer alignments will allow organizations such as ours to remain fiscally solvent and able to provide high quality care. This is especially true for organizations that care for patients who are challenged by suboptimal socioeconomics, including dual eligible beneficiaries. These patients often require more intensive, community based, outreach tactics so that care can be delivered in their (sometimes shocking) home environment. Some organizations, like CareMore (now owned by Wellpoint) have excelled in caring for these types of patients, but they have only been able to do within a framework of payer realignment. Some elements of payment reform, which have not been forward-thinking, have threatened such precarious successes. A significant portion of these patients include the aging, baby boomer, Medicare beneficiaries who will begin to suffer from co-morbid neurodegenerative diseases and other brain disorders, such as Alzheimer's, Parkinson's, and depression. Emory is heavily investing in a Brain Health Initiative to innovate the way we care for these patients, both in our own network and as a model to share globally. One of the projects receiving major focus is the dementia medical home, an advanced practice provider-led care model in which geriatric care coordination and caregiver education are central tenets. Our goal is to positively shape this challenging healthcare landscape.

Data sharing among providers is another important element in care coordination. Emory is investing heavily in its own health information exchange (the Emory HIE) to connect the Emory electronic medical record system (EMR) with EMRs in other hospitals and physician practices. Connecting to the Emory HIE is a requirement for participation in the Emory Healthcare Network but entails considerable expense both for Emory and for physician practices in its network. Over the past year, Emory has begun "on-boarding" the EMRs of other private practices in its network to its health information exchange. The goal is for doctors to be able to access current patient records wherever and whenever the patient is

seen, thereby avoiding duplication of testing, providing ready access to the patient's entire medical record, and thereby improving quality of care. The HIE also provides us with better clinical data to drive analytics that we use for continual improvement of quality and cost-effectiveness across the network.

In February, Emory became the first provider to join the Georgia Health Information Network (GaHIN). Now most major provider systems in Georgia have become GaHIN members or are in the queue to connect. This private nonprofit serves as a hub for Georgia providers to share patient data securely with one another. GaHIN connects health-related state agencies, service-area health information exchanges, hospitals, clinics, physician practices, long-term care facilities, payers, labs, pharmacies, and academic health centers, and just recently, a nonprofit, public-private collaborative that operationally supports the national eHealth Exchange. Due in no small part to Emory's efforts, the Centers for Medicare and Medicaid Services recently identified Georgia as one of the leading states in health information exchange.

Our physicians, nurses, and staff make heroic efforts every day but are frustrated by a payment system that is focused on individual encounters and procedures rather than long-term relationships that continue to exist between office visits and hospitalizations. Emory has been remarkably successful in working within the current constraints. As an academic medical center, we take care of the most complex and highest acuity patients and we make major contributions to discovering better treatments and training the caregivers of the future. Emory is the only health system in America to have more than one hospital ranked among the top 10 in the prestigious University HealthSystem Consortium Quality and Accountability Scorecard. Indeed, both of our eligible hospitals, Emory University Hospital and Emory University Hospital Midtown, have been in the top 10 for the past two years and are currently ranked No. 2 and No. 3 respectively. We are proud of this achievement, most importantly because of what this means for our patients. However, we are by no means satisfied. We need to apply and extend these achievements across the continuum to achieve the triple aim—better health, better health care, and lower costs—for the population we serve. We can only achieve this through better coordination of care. It takes significant time and resources to coordinate care and these efforts are not only *not* reimbursed under current payment models but are actually *penalized*. The payment deficit resulting from the current payment system goes beyond stressing our provider capacity to adversely impacting our technology and infrastructure capabilities. On top of this, Medicare provider payment cuts, like the 2% sequester cut, make care coordination even more challenging. The lack of a fix to the current physician payment formula—the Medicare sustainable growth rate—is similarly a major threat that, in the long run, will directly impact Medicare beneficiaries.

Our patients need care plans that encompass all of their medical needs and that are carried out by multi-disciplinary teams, members of which are all operating at the top of their licenses (nurse practitioners and physician assistants applying the full extent of their training, for example). Such plans need to be implemented continuously, not just when patients are physically at our facilities. Fee-for-service

payment models and highly complex regulations create barriers to what we are trying to accomplish. CMS's accountable care models, which are meant to coordinate care, are stymied by the patient attribution method in which providers often do not even know the patients for whose care they are responsible, making it nearly impossible for them to optimize quality care and reduce financial risk.

Our physicians and staff desperately want to take better care of these patients—that's why we practice medicine. Current structures create frustration among our providers as well as our patients. Our primary care teams feel these frustrations most acutely.

The stress felt by our teams is indicative of what is happening nationally. One result has been less interest in the practice of primary care and other non-procedural specialties that serve the needs of those with chronic conditions. Our country's capacity to grow its physician workforce is predicated on the ability of doctors to do what they enter medicine to do—care for their patients in the best way possible.

We need additional innovative structures that encourage the development and implementation of multi-disciplinary care plans for those with chronic illnesses. These patients incur the highest costs, have the greatest needs, and will benefit most from integrated models of care. In fact, our entire healthcare system will benefit from these commonsense approaches. To be successful, chronic care models must recognize and account for what is needed to ensure quality of care—these models must reimburse for the increased costs of technology and, most important, for the time of physicians and other professionals needed to deliver high-quality, high value, coordinated, comprehensive care.

Thank you for shining a spotlight on the challenging issue of chronic care. I look forward to answering any questions you may have.