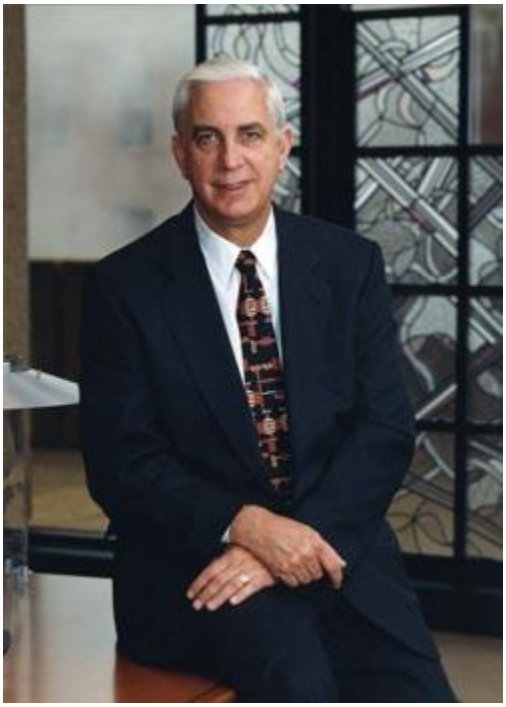
Hopkins Medicine Dean/CEO Edward Miller Discusses Health Care Reform at the National Press Club



Edward Miller, Dean and CEO of Johns Hopkins Medicine, shared his concerns regarding a critical aspect of the new health care law: a massive increase of 32 million newly insured individuals, including 16 million new Medicaid beneficiaries.

Listen to an interview with Dr. Miller

Here is his speech:

Edward D. Miller, M.D.,
Dean and Chief Executive Officer
Johns Hopkins Medicine
Remarks at the National Press Club
The Promise of Medicine: The Hopkins Population Health Model and the Medicaid Expansion
June 21, 2010
Washington, D.C.

I. The Promise of Medicine

Let me start with a short story: It was the summer of 1971. I had just finished my training in anesthesia at the Peter Bent Brigham Hospital and was about to embark on a two-year fellowship in physiology at Harvard. I was asked if I wanted to be "the" anesthesiologist for the month of August on Martha's Vineyard. It was to be part vacation and part work, and I needed the money.

Shortly after arriving, a young woman (who now runs a well-known tavern in that community), needed a surgical procedure. She had no insurance but was able to pay the medical bills out of pocket. She, however, could not afford the normal three-day stay in the hospital. She pleaded with me to have the minimal amount of medicine so she could be discharged the same day. To this day, I vividly recall helping her out to her car so that she could recover at home. You see, at the time, there was really no such thing as outpatient surgery.

Thanks to a revolution in anesthetics, outpatient surgery is a very common norm today. In fact, at Johns Hopkins Medicine facilities, we performed twenty-four hundred such procedures just last month.

My point here is to demonstrate the ceaseless, ongoing research and discovery that is the promise of medicine. You will find the promise of medicine at Johns Hopkins — and you will also find it in labs and classes and operating rooms in the 127 academic medical centers throughout the nation. Research, education, and patient care are our core missions.

That's the first and last anecdote you're going to hear from me. That's because science and medicine cannot and do not rely on anecdotes.

Instead, we rely on experimentation, action -- and results that endure.

II. The Patient Protection and Affordable Care Act

All of us in this room are familiar, if not weary, with the yearlong health care debate. We at Hopkins supported the final legislation because its goal is to increase coverage for those unable to afford health care. That ethos was the single-minded drive of our founder, Johns Hopkins, who established Johns Hopkins Hospital one hundred and twenty years ago to specifically care for the poor in the Baltimore community. We were caring for the disadvantaged seventy-five years before the creation of Medicaid.

The central themes of the new law are clear: coverage, quality, and cost.

The central numbers of the bill, for those of us at Hopkins, are clear as well: 32 and 16.

32 million is the number of individuals to gain health care insurance by 2019.

16 million is the number of individuals who will gain insurance through Medicaid eligibility.

Let me emphasize: This Medicaid expansion could be the most important, problematic, and I want to underscore this — the most rewarding aspect — of the entire law.

What I'll address today is a basic question: How do the themes of coverage, quality, and cost in the law relate to the real-world growth of Medicaid?

We at Johns Hopkins Medicine believe we have a model that could provide the answer.

Before I explain, let me tell you about Johns Hopkins Medicine. Probably all of you have a sketchy idea of who we are. Let me fill in the blanks.

III. The Reach of Johns Hopkins Medicine

Johns Hopkins has been a leading force in discovery and excellence in medicine for more than half the life of this nation. Yes, we have many firsts: the first direct heart surgery, the first breast cancer surgery, the first medical school to allow women equal status with male medical students, the first developers of CPR, the first to implant a battery operated internal defibrillator. Just a year ago, we led an historic eight-way kidney swap among sixteen patients.

U.S. News and World Report has ranked us as the number-one hospital in the United States for nineteen years in a row. We receive nearly a half-a-billion dollars annually in National Institutes of Health funding. We are affiliated with two institutions in the top of their class, the Johns Hopkins School of Nursing, and the Bloomberg School of Public Health. Just eight months ago, a Hopkins researcher, Dr. Carol Greider, won our institutions' 20th Nobel Prize for her discovery of telomerase, which maintains the integrity of chromosomes and is critical for the health and survival of all living cells and organisms. I venture to say that many of you in this room, as well as your family members and friends, have benefitted from a Hopkins discovery.

But Hopkins is more than the awards. Johns Hopkins Medicine is a vast, integrated health system. We manage four hospitals and are on the verge of integrating with Sibley Hospital, just six miles away from this room. We run a comprehensive, statewide network of twenty-five outpatient and surgery centers, staffed by more than two hundred and thirty primary care physicians. We are sometimes noted for not producing enough primary care physicians, but we make every effort to have them in our system. We have a thriving home care business serving eighty-five thousand patients. We have large international operations in more than a dozen nations.

And most important, for this audience, we do something that few academic medical centers do: we run managed care plans. Our employee health plan has fifty-one thousand members. We run a health plan for thirty-two thousand military retirees and their families.

And, last, we run a very large Medicaid managed care organization, Priority Partners, responsible for one hundred and seventy five thousand lives.

IV. The Priority Partners Medicaid Managed Care Organization

Why did a research and education engine get involved in such an endeavor? We decided to administer our own program because we had a nascent system of care in place and because we thought we could do it better than other insurers in the marketplace. And, we believed we wouldn't lose the money typically associated with caring for disadvantaged populations.

Now, running a managed care operation is worlds away from research labs, classrooms and Nobel Prizes.

In fact, the real heart of managed care is a shop floor: big, loud rooms full of customer service reps on the phone, handling claims, appointments, health plan dynamics, and yes, customer feedback.

In 1995, Priority Partners was created and within its first few years enrolled approximately twenty-five percent of Maryland's Medicaid beneficiaries.

Here's what happened, and it's a cautionary tale for every policymaker in the room:

A flood of new patients came to us seeking health services. Many had never seen a doctor on more than a sporadic basis. Some had multiple and costly chronic conditions. And almost all came from poor or disadvantaged backgrounds.

This — with all of its considerable medical and socioeconomic challenges — is the population poised to enter the health care system in 2014.

V. The Johns Hopkins Medicine Model: Population Health

What happened when this wave of newly insured broke upon Hopkins? I'll be frank — because we in this profession sometimes have to deliver the bad news:

We lost fifty-seven million dollars in nine years taking care of these patients. Although these losses were not enough to place the entire enterprise at risk, the situation certainly made us wonder if we could continue to honor our mission to care for the poor under this economic model.

There was plenty of reason to panic. But we didn't.

Instead, we turned it around.

How?

Well, what do world-famous researchers and policy experts do when confronted with a challenge? We turn to data, facts, experimentation. We designed — and more importantly to you sitting here — we actually put to the test in the real world, the population health model.

Population health: Get used to that term. It will become ubiquitous, like the term "bending the cost curve." Generally defined, population health examines coverage through the lens of cost data in order to identify quality health outcomes.

Sound familiar? It's an echo of the law's themes — coverage, quality, and cost.

Let me outline our Priority Partners population health strategy in general terms.

First, for each member, we develop a Risk Score, taking into account numerous factors — age, gender, frailty, medication patterns, lab results, claims history, clinical events, secondary medical conditions and hospital-dominant conditions.

We give each person in our program — all one-hundred and seventy five thousand — a risk score every month.

We determine who needs what kind of help, focusing on self-management, behavior modification, and when necessary, intervention. We use a team approach — caregivers, family members, social workers, nurses and nurse practitioners, with the primary care physician acting as a quarterback.

We've found that an informed, motivated patient with an action plan, backed up by a proactive medical team, backstopped by electronic health records, and transitional care, is going to have improved, higher quality health outcomes.

Second, we stratify this population, from low scorers to high scorers.

Think of a pyramid. At the base of the pyramid, are our low-severity patients, approximately seventy to eighty percent of our population.

In the middle of the pyramid, we have more challenging patients — approximately fifteen to twenty percent of our population — where we combine specific interventions, including technology-assisted home monitoring, health coaching and care coordination, to encourage people to manage their own health.

At the top of the pyramid there are approximately five to seven percent of our patients, those with high severity and with

multiple chronic conditions. These are our most costly patients. For these, we have individual case-management plans, registered nurse telemonitoring, and visits by RN case managers: This is intensive, complex case management.

VI. Priority Partners and Population Health Results

Yes, it does sound like a lot of theory — good intentions on power point slides displayed at Congressional hearings and think-tank briefings.

That's why I come back again to the idea of the promise of medicine. At Hopkins, we translate theories into real-world action and results.

And we've done it for our Priority Partners members.

I'll give you two examples, in two of the Medicaid program's most difficult and costly areas: end-stage renal disease, or ESRD, and prenatal and high-risk infant care.

End Stage Renal Disease

End-stage renal disease occurs when the kidneys are no longer able to function at a level needed for day-to-day life. It's treated with renal dialysis, which Hopkins researchers first developed 98 years ago. The most common causes of ESRD in the United States are diabetes and high blood pressure. These are all too common in the Medicaid population, and increasingly in the U.S. population as a whole. Traditionally, the ESRD Medicaid population has overall poor compliance, lower literacy rates, and comorbid conditions.

In the past four years in Priority Partners, through the methods that I described above — data compilation, intervention, care coordination — has addressed coverage, quality and cost, with these results:

* We have reduced the total costs of our end-stage renal disease patients by forty-seven percent. Let me give you an idea of the magnitude of ESRD costs. At enrollment, ESRD treatment for one patient costs more than ten thousand dollars a month. Yes, ten thousand dollars a month. After three years in our program, we are able to reduce that figure to about fifty-nine hundred dollars.

* Nine out of ten of our ESRD patients meet or exceed measures defined by the Dialysis Outcomes Quality Initatives, and are better than the numbers for all ESRD patients nationally. Consider that for a moment: Our Medicaid population, on quality measures, is outperforming a national population.

Prenatal and High-Risk Infant Care

Example two: Our work in prenatal and high-risk infant care. We know that every year, twelve percent of babies in this nation are born premature, and eight percent are born with low or very low birth weights. These very low birth babies account for half the spending on births annually. They remain in the hospital fifteen times longer than normal weight babies. For very low birth weight babies, the cost is eighty-four thousand dollars per birth; for normal weight, the cost is twenty-three hundred dollars per birth.

Four out of ten babies in Maryland are paid for by Medicaid and the state. Because these women are of low socioeconomic status, they have a strong potential for very low birth weight outcomes. Hence, a frustratingly large percentage of Medicaid dollars are spent on Neonatal Intensive Care Unit, or NICU, expenses.

We run a program called "Partners With Mom." Sounds like just another catchy, well-meaning term in the pantheon of social-program speak.

It's not. It's action into results.

"Partners With Mom" begins with data. We identify expectant mothers within Priority Partners. We already know their risk factors — maternal age, substance abuse, smoking, poor nutrition, low level of education, jarring life events, and chronic conditions.

What we want to do is improve maternal fetal wellness, so we can cut down on low birth weight babies.

We do face-to-face assessments and follow-up on the member's condition, determine the available benefits, develop care-management plans with goals, monitor the expectant mother, and intervene when necessary. We even do postpartum care-management to guard against readmissions.

And, as with our ESRD population, we get quantifiable and solid cost and quality results.

* Priority Partners has Very Low Birth rates similar to the national average for the U.S. population. Consider that for a moment: We are almost even in outcomes, in a Medicaid population, with the entire American population, despite the fact we are treating a high percent of high-risk women.

* We have “NICU” admission rates that are lower than those of the state’s Medicaid population as a whole and lower than the national Medicaid population.

* Our length-of-stay numbers related to maternal risk factors are lower than the national Medicaid average.

* Our program shows higher rates of prenatal care compliance than the national Medicaid average.

I don’t have time to go into them here, but Priority Partners has other quality and cost successes: We’ve reduced the odds of hospital admissions for patients at the end of life and reduced per-member per-month expenditures for patients with a history of substance abuse and highly complex medical needs.

And, finally, and perhaps most importantly, our patient satisfaction rates, I am proud to say, equal the satisfaction rates of private plans in Maryland and private plans nationwide, as measured by J.D. Power and Associates just two months ago.

Now, to follow the themes of the new law: I’ve talked about coverage. I’ve explained our quality outcomes. Let’s talk about costs.

You may recall we lost fifty-seven million dollars in nine years as we began to implement the population health model. And today, as I’ve noted, we care for one hundred and seventy five thousand Medicaid beneficiaries.

To give you an idea of the scope of our population: Priority Partners is caring for one-and-a-half times the total number of Medicaid individuals in the District of Columbia, where we meet today.

Moreover, of that total, approximately thirty thousand patients were added to our plan in 2009 by the state of Maryland. And yes, these are the kind of patients that consume enormous resources before our population health model can assist them.

Nevertheless, and despite this surging, challenged population, we are showing a small profit in calendar year 2010. Now, don’t get me wrong. We had to do a lot of things, like ensure that the payments coming from the state matched the acuity of the patient populations we serve. We also had to ensure that we were using the most cost-effective venues for services. And unfortunately, we had to reduce payments to some providers.

But the fact remains, and it deserves great emphasis here: All of these cost-management strategies — and our quality outcomes — were done in the context of our population health, patient-centered care model.

Harriet Lane Clinic

If I could somehow capture all of the good works of Priority Partners and put them in one place, that would be the Harriet Lane Clinic, staffed by pediatric residents — young doctors in training, offering a wide range of clinical and social services.

Eighty-five percent of the Clinic’s patient load is Priority Partners members, and its operations are a model of the primary care, teamwork, and intervention that is the key to quality health outcomes. In fact, in the HEDIS scores used to measure health plan quality, Harriet Lane is in the 90th percentile nationally on several measures, and in the 98th percentile for the all-important measure of primary care physician access.

VII. The Promise of Medicine and the Affordable Care Act

I began these remarks with a decades-old anecdote.

I have ended with quantifiable, real-world results achieved in some of the toughest environments of health care.

Tying these examples together is the promise of medicine — the ability of Johns Hopkins Medicine clinicians, researchers, and administrators to confront and discover new ways to solve a health care challenge.

Against the backdrop of the new health care law’s themes of coverage, quality and cost, is our population health model.

It’s in place. It works.

It’s a system of care that can be duplicated around the nation. It’s a model that can inform the federal government, the states, and health care systems around the country as they begin planning for Medicaid expansion.

The new health care law is a huge step for the citizens, the physicians, and hospitals of this nation. And as I said at the beginning of my remarks, to those of us who have historically provided care to less-fortunate populations, the expansion of Medicaid, done correctly, could well be the most rewarding result of this historic legislation.

Thank you.

######