

HealthFirst Connecticut Authority

Co-Chairs
Margaret Flinter
Tom Swan



Quality, Access and Safety Workgroup

Meeting Summary

April 10th, 2008

9:00 AM, Room 1D of the LOB

The following members were present: Margaret Flinter, Tom Swan, Daren Anderson, Kirsten Anderson, Richard Antonelli, Pat Baker, Jamey Bell, Angelo Carrabba, Shanti Carter, Dan Cave, Tanya Court, Lisa Davis, Frank Gerratana, Bruce Gould, Shawn Grunwald, Jennifer Jackson, Jennifer Jaff, Betty Jenkins-Donahue, Steve Karp, Mary Alice Lee, Estela Lopez, Jane Nadel, Matt Pagano, Jean Rexford, Lisa Reynolds, Bob Scalettar, Maureen Smith, Joe Treadwell, Victor Villagra, Lenny Winkler, and Teresa Younger

Margaret Flinter asked that the Quality, Access and Safety Workgroup minutes of March 10th be amended to reflect Marcia Petrillo's presentation.

Margaret Flinter updated the Quality, Access and Safety Workgroup on the progress of the HealthFirst Connecticut and the Primary Care Access Authorities.

Tom Swan reported to the Workgroup that Academy Health had secured two facilitators for the Connecticut HealthFirst Authority and State-Wide Primary Care Access Authorities. This will help the Authorities surface key issues and utilize time effectively. A framework will be established for several models of state-based reform including: 1.) building off of the current employer based model, 2.) an all payor or single payor system, 3.) a combination of the two. One role of the Primary Care Access Authority is to investigate and determine a delivery system that guarantees universal access to primary care for everyone, with insurance covering non primary care services such as hospitalization. At the most recent Primary Care Access Authority meeting, Dr. Steve Wegner presented on the North Carolina model of regionally organized physician networks that organize and delivery primary care with the support of care management. North Carolina has been able to achieve a very high percentage of participation in Medicaid (85%) and has a very strong medical home program.

Margaret introduced Dr. Victor Villagra, an internal medicine physician and expert in disease management, to the Quality, Access and Safety Workgroup.

Dr. Villagra gave an overview of chronic diseases in the United States. Nearly half of the United States population (125 million Americans), lives with some type of chronic condition defined as a condition

which lasts a year or longer, limits what one can do and may require ongoing care. Sixty million Americans live with multiple chronic conditions.

He defined disease management as an organized, proactive, multi-component approach to healthcare delivery, involving all members of a population with a specific disease such as diabetes.

- Care is focused on and integrated across the spectrum of the disease and its complications, the prevention of co-morbid conditions, and the relevant aspects of the delivery system.
- Disease management's essential components are: 1) identification of the population, 2) care guidelines or performance standards, 3) management of identified people, and 4) tracking and monitoring systems.
- Disease management's goal is to improve short-term and long-term health and/or economic outcomes among people with the disease

Disease Management is a system of coordinated healthcare interventions and communications for populations with conditions in which patient self-care efforts are significant.

The disease management concept should be owned and molded by patients and primary care providers. Both patients and primary care providers stand to gain the most by successful reform.

Victor emphasized that we must keep in mind that an individual diagnosed with a chronic condition must continue to work or maintain family obligations. A chronic medical condition will often complicate that person's ability to perform daily tasks. Disease management is necessary to care for those people diagnosed with chronic conditions.

Excerpts from Dr. Villagra's presentation:

The actual patient experience can include visits to hospitals, doctors, health care providers, pharmacies, acupuncturists, health stores, diet centers, grocery stores and neighbors.

A typical visit to a doctor is usually a 17 minute visit which includes a clinical history, focused physical exam, prescription refills or adjustments of dose and frequency, and finally, patient education. Seventeen minutes is not enough time to perform all of these functions effectively. The model of healthcare that we use in Connecticut is not set up to care for patients with chronic conditions.

The complex role of primary care physicians includes delivery of basic primary care, between-visits supportive care, and coordination of care.

There is no infrastructure to support between-visits supportive care, and coordination of care is not set up in Connecticut because there is no data, no information system, limited staffing, no mass communication infrastructure, and role definitions that do not fit the need, and no reimbursement for care coordination or between-visits supportive care.

There is reason to be concerned that the primary care system will soon be overwhelmed. There are not enough primary care providers and primary care providers are not organized to provide chronic care or

reimbursed for their services. The coming of age of baby boomers and the potential for universal healthcare in Connecticut will contribute to the inundation of the healthcare system.

Two models of care that have developed in parallel during the last 15 years are the patient centered model and the payer sponsored model. The patient centered or chronic care model describes how the system will improve towards meeting the needs of chronically ill patients. It calls for delivery system re-design, decision support, clinical information systems, self-management support at a community level, and resources that support the creation of an informed, activated patient that participates in their own care decisions.

The other system is the payer-sponsored system. Instead of building on the delivery system as it is, this system builds on the enormous amount of data housed by payers in the form of provider files. Information is moved to call centers where nurses are in constant communication with the patients. Nurses then speak with the patient about maintenance care, motivating the patient, passing on information, and providing tools for self-care.

Each of these forms of care failed to communicate with each other despite good intentions of doing so. The payer sponsored model is successful but failed to link with the provider community.

In the payer sponsored model, nurses located in a “command center,” who have access to decision support tools, speak with patients by phone in a user-friendly way by providing information and support. These organizations receive money and data from the payer. The chronic care model would not need a disease management entity in the middle because the physician office becomes the epicenter of the expanded role. In this model, reimbursement and data will flow directly to physicians’ offices. A blend of the payer sponsored model and the delivery center model would be ideal for Connecticut.

The community based care coordination center leverages different strengths from the payer based system and the delivery center system. In this model, both money and data would flow to a care coordination center. The functionalities of this center would go well beyond providing information and support for chronically ill patients. It must be based in the community. In addition to data and money flowing to a community based care center, data and money will flow to providers. This model may be difficult to create in the time allotted before Authority offers a proposal to the Legislature.

Margaret Flinter introduced Jennifer Jaff and asked her to comment on the patient perspective on disease management and advocacy.

Jennifer Jaff agreed with Dr. Villagra that it is up to the patient to coordinate care. Patients need to know how to deal with health insurance, disability insurance, the social security disability system, employment issues, family medical leave, school based accommodation, and many other issues. This is a tremendous burden on patients and it cannot be done without help. Patients would prefer to use as little healthcare as possible. Patients and payers have an antagonistic relationship and that must change. In the name of disease management, insurance companies create obstacles to effective disease management. Rather than using experienced based medicine, insurers are denying coverage based on evidence based grounds. If patients, health care providers and insurers do not work as a team, we cannot have effective chronic disease management. Our healthcare system must educate patients and treat them

like partners. Jennifer Jaff suggested the following legislative proposals: 1.) doctors should be reimbursed for the time they spend teaching patients about their disease. 2.) There should be educational programs on major chronic illnesses that are sponsored by payers. 3.) Specific disease groups could be given grants to produce short videos. 4.) There could be better brochures provided to doctors who can give that information to newly diagnosed patients. 5.) There should be government funded grant programs of chronic disease management training and grants for patient navigators with a focus on insurance and planning issues. 6.) Insurers should be required to pay the cost of all health insurance appeals that they lose.

Dr. Carrabba commented on the difficulty of incorporating treatment plans, protocols, and patient education in the office visit. Jennifer Jaff agreed that many doctors feel that way and added that if a doctor can't be completely responsible for patient education, there must be someone else in the healthcare system who can provide that help. Patients need to be able to understand what is happening in their bodies and they need to be able to be a partner in the decision-making process.

Jennifer Jaff asked about the evidence based standard of care and how it fits into the model described by Victor. He responded that evidence based standard of care is an integral part of the hybrid community based care coordination center. Evidence based care is a core element of the contents of the patients education, provider feedback, and standards of care.

Scott Cleary suggested that there is technology available to create interoperable health information exchange, but that technology is not being utilized because the necessary coordination is lacking. That coordination must be proposed to the legislature.

Pat Baker asked the Workgroup to keep all of this in mind with regard to health reform as a proposal to the legislature is constructed. Both presentations suggested a new design for an optimal delivery system of health care. Simply covering everyone is not enough. She asked Victor what recommendations he could offer the Authority to help move the model he suggested into creation. Victor answered that the model must be created with thoughtful care and responsibility. He suggested a series of contained regional pilot projects to test the proposals in an incremental way. A rigorous evaluation of the pilots would also be necessary.

Matt Pagano asked what room there may be for experience based interventions such as acupuncture. Dr. Villagra answered there is ample room. Patient autonomy is vital and the ability of a patient to participate in their own care if they are well-informed is important. Jane Nadel suggested that the Workgroup create specific definitions for terms such as "evidence-based care," that are functional and useful. Angelo Carrabba asked the Workgroup to keep in mind that there is a problem with health literacy in America that affects the ability to participate in care and disease management..

Margaret Flinter then introduced Dr. Richard Antonelli to the Workgroup for a presentation on the Medical Home.

Dr. Antonelli reported that the original policy statement of the medical home was as a central repository for a child with special health care needs. It was a physical place where health information could be stored that was family centered. The joint statement of the patient centered medical home (PCMH) includes personal orientation, identification of a personal physician, integrated and coordinated care

across sectors, emphasis on quality and safety, enhanced access to care, reimbursement, and financing to support the model. It is a major focus of advocacy for all the primary care specialties in the United States.

Excerpts from Dr. Antonelli's presentation:

We must talk about the need to put more people in the healthcare pipeline. There are decreasing numbers of medical students choosing primary care specialties. There are more people retiring out of all of the primary care specialties than there are people coming in. Baby boomer will need a lot of health care service in the next ten years. Doing nothing is not an option. A medical home is one way to help relieve the inequity in health coverage. For a medical home to be effective, there must be a system redesign from financing. The healthcare system must not be driven only by reimbursement.

We must define terms such as care coordination, case management, care management, chronic condition management, and disease management. The American Academy of Pediatrics defines a process of facilitating a linkage of children and families with appropriate services and resources across the community to achieve good health.

This care cannot be provided only by telephone. It must be performed by someone with which you have a personal relationship. The American College of Physicians encourages communication among specialists and the primary care providers and the family. Referral tracking and a system to prevent errors and tracking test results is also a part of care coordination.

Case management is a way of ensuring access to appropriate benefits within the allowed benefits of a family.

Only about two thirds of care coordination in a primary care pediatric medical home is medical. The other third is broken up into Referral Management, Social Services, Educational / School, Developmental / Behavioral, Mental Health, Growth / Nutrition / Legal / Judicial. Office based primary care nurses performing care coordination save money. Care coordination is the driver of equity, safety, quality, and cost efficacy.

The stakeholders of coordinated care are families, employers, providers, community based organizations, payers, state and federal agencies, and legislators.

There are several recommendations for system re-design. Implementation of Results Based Accountability is one. CT-CHIP is a means of providing that infrastructure for pediatric healthcare, building capacity in Primary Care, building capacity in Subspecialty Care, co-management in Medical Home, creation of a system to support coordinated care, electronic health records, and alignment of incentives with goals.

Margaret Flinter introduced Dr. Kirsten Anderson of Aetna and asked her to comment on the Medical Home. Dr. Anderson provided a perspective from the insurer viewpoint. There is a crisis in primary care and a shortage of physicians. There must be a change in the delivery of primary care and ensure that there are enough primary care physicians to care for patients. Aetna is committed to exploring and supporting the medical home concept as a way to improve the primary care system in Connecticut.

Lenny Winkler observed that the issue of tort reform had not been addressed during their presentations. It is an issue that drives up healthcare costs. Richard Antonelli explained that in a patient centered or family centered environment, there is a significant reduction in the risk of litigations. The reason is that the patient is not a passive recipient of the services in that healthcare transaction. A true partnership would allow the patient to drive the nature of the conversation.

Dr. Bruce Gould explained to the Workgroup that the City of Hartford is focusing on the problem of large numbers of uninsured. We need more healthcare workers to track people through the health care system. That lack of tracking results in more emergency room visits and this would be preventable with more healthcare staff.

Estela Lopez emphasized the need to take three things into account: multicultural aspects, language aspects and literacy; we need to be sensitive to each of these.

Victor Villagra explained his belief that a true care coordination entity accomplishes many of the goals of the Quality, Access and Safety Workgroup, and such an entity should not exist in a physician's office. The infrastructure necessary is extraordinary. We must consider a new entity that has not yet been invented that exists outside of the clinic and is used by the community. It should service all providers within a certain area. The majority of the care coordination function deals with complex administrative responsibility that includes gathering information, summarizing it and providing it to the community. Much of the work of this new care coordination entity will be non-clinical.

Richard Antonelli suggested that the key to healthcare reform is creating the linkage between practices to the broader community.

Margaret Flinter announced the next Quality Access and Safety Workgroup meeting will be on Thursday, May 8th, 2008 at 9:00 AM.

The Quality Access and Safety Workgroup adjourned at 11:10 AM.