HealthFirst Connecticut Authority

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Quality, Access and Safety Workgroup

Revised Meeting Summary

June 18th, 2008

9:00 AM, Room 1E of the LOB

The following members were present: Tom Swan, Margaret Flinter, Jamey Bell, Wendy Furniss, John Erlingheuser, Teresa Younger, Bob Scalettar, Jane Nadel, Jean Rexford, Brian Fillipo, Kathleen Brandt, Shanti Carter, Alejandro Melendez-Cooper, Estela Lopez, Dan Cave, Bruce Gould, Jennifer Jaff, Maureen Smith, Lisa Reynolds, Martin Kodish, Matt Fair, Betty Jenkins-Donahue, Joe Treadwell, Frank Gerratana, Bob Patricelli, Rob Zavoski, Scott Cleary, Mary Alice Lee and Dave Gammon.

Margaret Flinter welcomed members to the meeting. Margaret updated the Workgroup on the progress of the HealthFirst Authority and Primary Care Access Authority. The HealthFirst Authority has begun to look at several broad reform possibilities of the healthcare system. The Authority will begin to narrow down their selections for reform in upcoming meetings.

Margaret Flinter noted that she believes there is an error in the Minutes related to rates of obesity for certain ethnic groups and will ask Jim Rawlings to review for the next meeting.
The meeting minutes were approved as amended.

Tom Swan reported that the money reserved by the Legislature has not yet been released for use by the HealthFirst Authority. At this point, the focus is on getting the funds carried forward into the next fiscal year. The statewide Primary Care Access Authority has not been able to get started on its charge of conducting a primary care inventory for Connecticut because of the tie-up of the funding. The Primary Care Access Authority will meet next week and look at ambulatory care sensitive hospital admissions in Connecticut. The Cost, Cost Containment and Finance Workgroup will hear several presentations at the next meeting and will begin to identify areas where the workgroup can help delve into more details on the cost and potential cost containment of particular healthcare plans.

Margaret Flinter thanked members for giving their time to the Workgroup and introduced Senate President Pro Tempore Donald E. Williams.

Senator Don Williams expressed his feeling that we would have to do more than simply extend the healthcare system that currently exists. The Legislature has looked at systems in other parts of the country. If a healthcare system was to be built anew, it would probably not look like the one we currently have. Quality and Access need to be improved. Healthcare costs are out of control and we need to reform our system to make it sustainable over time.

Margaret Flinter discussed the second phase of work for the Workgroup: the work towards the final report. Margaret Flinter restated issues that had been agreed upon by the Workgroup already. Agreed upon components and principles include:

-a strong element of public health prevention and health promotion beyond health insurance, particularly around tobacco cessation and obesity;
-a strong medical home system where every individual will have a primary care provider, accelerated adoption of health records and health information exchange
-a strategy to enroll the eligible but not enrolled Medicaid beneficiaries, and the eligible but not participating primary care providers in Medicaid and its products;
-effective approach to chronic disease management
-legislative initiatives to promote healthy lifestyles, gain transparency of health data, support evidence based practices.

Jennifer Jaff spoke about the concept of the patient being the center of the medical home. The doctor may not be the right hub of the medical home.

Jean Rexford and several members of the QAS group are working as a sub-group, focused on health reform that is not just driven by financial models. A full report will be given at the July meeting. The report will include the elements that need to be put into place for a health Connecticut, including a better defined medical home, better prevention of oral and mental health problems, and studying the consumer based driven system.

Bruce Gould explained that the Massachusetts model has strained the pool of primary care providers and there aren’t enough to meet the demand for the newly insured population. He noted that we need to produce primary care providers in Ct. and get them into the workforce.

Robert Patricelli discussed the need to consider tort reform, including in support of evidence based practices.

Robert Zavoski noted that a key element of the medical home model is patient activity and responsibility for self-care.

Kathleen Brandt suggested that the tort reform issue needs to have a full and fair hearing. It cannot be dealt with in a healthcare reform plan.

Frank Gerratana agreed that you cannot disregard the need for medical liability reform. It affects the workforce and impacts the number of healthcare workers that may or may not come to the State, and also affects graduating residents are more likely to leave the state because of it.

Robert Zavoski added that it negatively affected peoples’ abilities to change and improve practices.

Jean Rexford discussed technology as a cost driver. Community Catalyst touched on that issue but it has not been fully discussed.

Margaret Flinter noted that the Workgroup has had a chance to hear and consider multiple presentations on the concerns that the group is charged with addressing. She asked it to consider taking each of the key areas and to begin to synthesize the previous presentations, discussions, and background reading in more specific recommendations and strategies for change that the Workgroup will want to see incorporated into the final report tot he Legislature. The follow comments were recorded:

Estela Lopez asked the Workgroup to promote a patient centered system that is culturally competent and health literate.

Jennifer Jaff suggested that consensus was growing in the state around a patient driven model. That system requires patient education and training. The Workgroup should support development of a program for patient education and training that is not necessarily performed by doctors. We should support this is a way of empowering patients so that the patient can become the hub for their own medical home.

Estela Lopez said that any system that requires patient training is not well-built. One should feel that they can navigate the healthcare system without fear or misunderstanding.

Dave Gammon suggested that the schools are a good place to begin patient education.

Jane Nadel discussed a need for more education for providers.

Bruce Gould described the differences between patients. Some are very motivated to work to meet their own healthcare needs. Many other patients need a patient centered medical home even though some are very conscious of their own medical history. Bruce Gould expressed his feeling that health students need to be encouraged to practice primary care in Connecticut.

Dan Cave asked for a definition of “primary care provider.” If we have a system that waits until people need care than it is not an effective system. Primary care needs to include the goal of preventing disease before it becomes a problem. Therefore, the definition must be expanded considerably.

Dave Gammon explained that child psychiatrists are considered sub-specialists and therefore do not get Medicare funding. It may be difficult to deal with that problem at the state level but one possible solution is pilot funding of child psychiatric services.

Joe Treadwell agreed with Dan Cave that the definition of primary care needed to be expanded and he offered several examples of preventive medical services that should be considered primary care.

Dan Cave emphasized that a primary care provider needs to deal with wellness. Other countries have begun to move in this direction. As an example, Japan has had a drastic onset of diabetes and the government has mandated girth measurements as a reaction.

Jenniffer Jaff made the Workgroup aware that Health and Human Services has submitted a patient navigator program that will result in the collection of a tremendous amount of data.

Wendy Furniss suggested a rebalancing of the nursing workforce that includes an educator component for registered nurses.

Teresa Younger discussed public act 08-171 that establishes a Commission on Health Equity. This bill establishes a Minority Health Council.

Alejandro Melendez-Cooper discussed the possibility of incorporating workers from other countries in the healthcare system in Connecticut.

Dan Cave discussed the challenge Massachusetts faces in the western portion of the state. Transportation costs will make it even more difficult for the rural poor to get to a provider.

Bruce Gould cautioned the Workgroup that increasing reimbursement to private offices shifts attention away from community health centers that benefit vulnerable populations.

Margaret Flinter suggested that the Department of Social Services should be encouraged to move forward with electronic and auto enrollment at the point of service.

Margaret Flinter asked for discussion on how to get all citizens a primary care provider.

Maureen Smith suggested there is a need for easy access to specialists and for specialist to be recognized as a primary care provider.

Bob Patricelli suggested that if the Authority was serious about assigning primary care providers to all Connecticut citizens, the State would need to require it. The Department of Social Services could help provide such a service by taking certification away from programs that do not offer the appropriate services.

Margaret Flinter asked for discussion of chronic disease management and how it could be better managed.

Bob Patricelli suggested that this is a program that may have to begin with Medicaid. Private carriers often do not agree on methodology and that State is probably not going to enforce methodology on the private carriers. The Department of Social Services should at least pilot models of chronic care management. Fee for service medicine reimbursement must be changed and doctors are not paid to be chronic care disease managers. A performance based payment mechanism will be necessary for success in the private sector. Providers should take responsibility for this.

Dan Cave disagreed that chronic illness could be managed with the traditional physician based system. The cost for physicians to manage chronic illness, even over the phone, would be incredible. There is an inability to connect with the physician community at large. A new model is now necessary. We should try several approaches in the state to see what will work.

Jennifer Jaff suggested it is not appropriate for doctors to be care managers. Doctors are already overburdened. Responsibility needs to lie with the patient. A person with a chronic illness needs to learn how to navigate the healthcare system. Jennifer Jaff suggested a grant program for providers and non-providers to run pilot programs and see if they could create a system that operates in an efficient way.

Dan Cave agreed that the goal is to get people to a point where they can manage their own care. Providing information to some patients is not enough, and motivation is also necessary. Less motivated patients may need more help and more encouragement or pressure.

Bob Patricelli agreed with the previous speakers that there is a big role for patients and patient education but doctors must not be ignored. Fee for service payment mechanisms will defeat chronic care management unless incentives are changed.

Maureen Smith suggested that patients should be rewarded for compliance in the pay for performance system.

Bob Patricelli asked what work had been done to mandate electronic health prescribing as a health safety issue.

Brian Fillipo felt that the issues of improving safety and quality are tied to communication among segments of the healthcare community.

Jean Rexford explained to the Authority that a data driven system like the system in Pennsylvania should be structured by an independent authority that has access to aggregate data.

Bruce Gould agreed that E-prescribing should be mandated. It makes sure that handwriting doesn’t get in the way of appropriate medication as well as allowing cross checking of drug interaction.

Jean Rexford suggested that the portability of E-prescribing systems must be discussed.

Jennifer Jaff added that patients should have access to their own E-records.

Jamey Bell urged caution when it came time to chose what type of E-records to use.

Bob Patricelli suggested he was confused as to why the payer community has accepted that idea that physician investments in information technology in their practices don’t deserved to be reimbursed.

Bruce Gould suggested that the cost of implementation of an electronic medical records system is very high.

Dan Cave agreed with Bruce Gould. Claims could be processed at a very inexpensive rate by a large corporate group.

Frank Gerratana told the Authority that electronic records are not perfect and there are current laws that make it difficult for pharmacists to fill prescriptions electronically.

Jean Rexford suggested that transparency was necessary and the one thing that could empower the consumer and provide greater access and safety.

Bob Patricelli suggested that electronic medical records will merge with practice management systems, and those should be considered separately from personal health records. Bob Patricelli also suggested tort reform which is difficult to deal with. Something must be done about the way provider practices are influenced by fear of litigation. The only procedural device may be a base closing commission. Leadership should appoint a body of experts to make a recommendation to the Legislature dealing with tort reform.

Frank Gerratana added that the threat of litigation has caused problems and there must be agreement that there is a problem caused as a result.

Tom Swan responded that the issue being discussed could be debated intensely and the Cost, Cost Containment and Finance Workgroup will raise the issue.

Bob Patricelli suggested that the issue of tort reform is necessarily related to the issue of quality.

The meeting adjourned at 11:00 AM.