

SustiNet Health Partnership

Healthcare Quality & Provider Advisory Committee

Co-Chairs
Margaret Flinter
C. Todd Staub

Board of Directors Liaison
Paul Grady



Phone:
866.466.4446

Facsimile
860.297.3992

E-Mail
SustiNet@CT.Gov

Post Office Box 1543
Hartford, CT 06144-1543
www.ct.gov/SustiNet

SustiNet Healthcare Quality and Provider Advisory Committee Regular Meeting February 18, 2010 Meeting Minutes

Committee Attendees: *Margaret Flinter, Co-chair; Todd Staub, Co-chair; Christine Bianchi; Teresa Dotson; Rodney Hornbake; Tina Stevenson; Arthur Tedesco; Mark Thompson; Claudia Gruss; Steve Karp; Jeff Walter; Marcia Petrillo; Robert Scalettar; Jean Rexford; Lynne Garner; Linda Ross; Jerry Hardison; Sarah Long; Mike Hudson; Joseph Treadwell; Alison Hong; William Kohlbepp; Pieter Joost van Wattum; Matt Pagano; Robert McLean; Nelson Shub; Paul Grady; Tina Brown-Stevenson; Willard Kasoff; Clarice Begemann; (1inaudible name)*

Office of the Healthcare Advocate: *Vicki Veltri; Africka Hinds-Ayala*

Absent: *Tom McLarney; Kathy Grimaud; Kevin Galvin; Jane Deane Clark; Francois de Brantes; William Handelman; Lisa Reynolds; Bryte Johnson; Richard Torres; Mark Thompson; Rick Liva; Jody Rowell; Sara Parker McKernan; Mark Belsky*

Margaret Flinter and Todd Staub, the co-chairs of the Committee, welcomed all members. Minutes from the January meeting were approved without any corrections and/or changes.

There was a discussion about Principles for Quality Assessment Measures, an outline that was created by a group of Committee members. This was distributed with the agenda and is posted on the SustiNet website as page two of this meeting's agenda. Robert McLean spoke positively about the outline, saying that he feels very strongly that electronic health records (EHRs) should be required for all practices, as data management is crucial. Jean Rexford mentioned that it was important to learn what other SustiNet Committees are working on, to avoid working on the same things. She said that she thinks this group should address fragmentation of care delivery and communication and how these things can support quality. Mike Hudson said that this Committee should also be considering how to adequately attribute patients to a physician. This is an area where EHRs would be especially valuable, because attribution is an area where purely claims-based quality reporting is often not clear. Rod Hornbake said that he feels that relying on claims-based data would be a serious error. He said that while this Committee should build in added incentives for physicians to adopt EHRs, there is another option that falls between claims and full EHRs. There are existing registry methods which are in widespread use in CT. Rod gave as an example the Anthem AQI website, where physicians can add

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patient data, so that not only tests ordered but also test results can be collected electronically. Additionally, Rod said that healthcare disparities should be tracked as part of quality measures.

Nelson Shub emphasized the importance of standardization of care. He said that this should be a first step, and that then the cost issues could be tackled. Claudia Gruss said that certain chronic diseases make up the majority of healthcare spending. Focusing on these chronic diseases makes a big difference in cost savings and improved care, so this Committee may want to keep this in mind while looking at outpatient settings. Claudia said that the ongoing costs of EHRs will be significant, affecting the overhead of practices. She also said that the registry on the Anthem website previously noted has drawbacks, notably in how time consuming it is to enter data. She said that she thought an office based disease registry would work better.

Marcia Petrillo said that one more database should be added to the long term data set noted on 5c. within the outline, and that is home care. Jean wanted to add problems that have been noted with new technology as part of the outline. Tina Brown-Stevenson commented about claims based data, saying that quality of service and patient interaction cannot be assessed using this data, but that it is valuable for prescribing adherence and consistency of medication use. As a result of this, it proves to be a good marker of the health of certain patients. Robert McLean disagreed with this, saying that claims data is completely unreliable. Todd said that claims data is good for visit data, and that it deserves consideration because it's already in place and requires no added costs to utilize. It is also useful in looking at where quality is lacking. Jeff Walter said that there are two levels of quality measures. One is at the patient level to improve and measure quality within a practice or an institution, and the other is to look at quality from a population based or health plan membership level.

An unidentified speaker said that the category of special populations will need to be examined carefully, to ensure that the mental health and addiction population is included. Nelson said that it is time to connect quality of care, measurement and cost to what this Committee is trying to accomplish. He said that the Committee must address the many unnecessary tests that are being performed at great cost. Again he emphasized the importance of standardization. Claudia said that there could be an educational component put into place for physicians and patients to improve quality of care. Matt Pagano said that in looking at outcome measures, a survey tool is needed to assess patient satisfaction. This survey should also include the type of care being provided, because there are so many different levels of care, and this would accurately show how outcomes were achieved. He said that he would do some research to see what types of survey tools were available.

Robert McLean said that there are many survey tools available, and that this Committee needs to select which ones would work best for this effort. He said that the original SustiNet bill had liability protection, so that if providers followed liability standards, they would be protected. This was removed from the SustiNet bill, but Robert said that this was a crucial aspect of cost saving. He suggested that perhaps this Committee could endorse this important issue through pilot projects. Additionally, he said that when using EHRs in his own practice, he has found that there are standards and recommendations that include lifestyle counseling. When he makes recommendations such as to lose weight, for example, this data is entered, and he can then analyze this data to see how many patients received this counseling. Jerry Hardison stated the importance of not only gathering data, but also using it effectively.

Rod said that it is important to understand where PQRI is going. The next transition from PQRI is meaningful use of an EHR. Rod said that he has used the 2010 PQRI measures integrated into the

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workflow process in a certified EHR, and it makes the process extremely easy, with constant prompts and reminders of things that must be done. Rod continued by saying that the obvious next step is to link payment to quality. He referred to what's been done in England and Wales, where the first step was to provide every family physician with an EHR system that featured a built-in quality data collection process that contained more than 120 quality measures. Year end bonuses that amounted to between 25 – 33% of physicians' salaries were offered based on the successful utilization of those measures. Almost all of the physicians submitted data, reported favorable experiences and received bonuses the first year, and the program is now in its fourth year. Rod said that CT could phase this in, using incentives for EHR and then using claims-based and registry reporting as interim steps to achieve the ultimate goal, which is quality measurement built in to the normal work flow inside an EHR.

The Committee reviewed the list of principles briefly, to clearly define each one and allow Committee members to comment. Claudia said that during this process, it will be important to use care with certain patient populations, or physicians may be driven away from caring for the most severely ill patients. She specifically mentioned inner city physicians, whose quality measures may be low due to patient noncompliance and access problems. An unidentified speaker said that measures would be risk adjusted, so that this would be taken into consideration. Alison Hong said that in her experience, certain quality measures can't be tied to outcomes, but rather should be used for quality improvement. There was a discussion about standards and measures. Willard Kasoff said that this plan will also need to decide how transparent it will be about reimbursements. Paul Grady said that he thinks physicians who are early adopters of changes that will result in better quality of care should be rewarded, and emphasized the urgency of this effort. Margaret agreed that urgency is of the utmost importance to this Committee, and she also emphasized clarity.

The following people agreed to research the key domains named and share findings at the next meeting.

Outpatient, focusing on prevention	Rodney Hornbake
Inpatient	Alison Hong
Long term/Home care	Marcia Petrillo
Pediatrics/Family Planning	Clarice Begemann
Special Populations	Margaret Flinter
Mental Health	Vicki Veltri

Paul Grady spoke briefly regarding SustiNet Board of Directors' activities. There is a Board retreat being planned for the Board and SustiNet Committee co-chairs, to provide a forum for various Committees and Task Forces to learn of each other's efforts. Paul encouraged all Committee members to access the SustiNet website to keep current on all events and meetings and to review minutes of others' meetings.

Meeting was adjourned.

Next meeting will be held on March 18, 2010.