SustiNet Health Partnership

Healthcare Quality & Provider Advisory Committee

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SustiNet Healthcare Quality and Provider Advisory Committee Regular Meeting
December 17, 2009
Meeting Transcription

Committee Attendees: *C. Todd Staub, Co-chair; Margaret Flinter, Co-chair; Francois de Brantes; Tina Brown-Stevenson; Claudia Gruss; Jerry Hardison; Alison Hong; Mike Hudson; Willard Kasoff; Matt Pagano; Rodney Hornbake; Steve Karp; Sarah Long; Robert McLean; Marcia Petrillo; Arthur Tedesco; Paul Grady; Nelson Shub; Joseph Treadwell; Lynne Garner; Pieter Joost van Wattum; Mark Belsky; William Kohlhepp; Rick Liva; Jean Rexford; Jody Rowell; Christine Shea Bianchi; Sara Parker McKernan; Linda Ross; Richard Torres; Jeff Walter; Teresa Dotson*

Office of the Healthcare Advocate: *Vicki Veltri*

Absent:

Margaret Flinter and Todd Staub, the co-chairs of this Committee, welcomed all members. Margaret introduced Paul Grady from the SustiNet Board of Directors who will serve as the liaison to the Board. Members were asked to introduce themselves. Both Margaret and Todd thanked members for participating in this effort. Margaret reminded everyone that all meetings will be audio taped and many of them will be video recorded. Margaret commented on the broad range of talent and interests among members of this Committee. She said that in forming this group, they pursued recommendations for people who had a particular focus area, with an interest in reform efforts in CT.

Paul Grady said that in looking at what's happening in Washington, he gets a sense that there is going to be some sort of health reform, but it won't happen quickly. In Medicare, which has a tremendous influence on the healthcare delivery system, there are pilot programs being proposed. If the nation is going to address improving healthcare costs and quality, it has to happen in CT. This Committee is a great place to begin those discussions. Paul said that the SustiNet Board had its first meeting in September. The Board has met five or six times since then, with the initial focus being on staffing the Committees. In addition to this

Provider Advisory Committee, the other Committees are: Health Information Technology, Medical Home Advisory, Preventive Healthcare (and Health Disparities and Equity). The SustiNet Board was charged with staffing these Committees. In addition to these Committees, there are three Task Forces whose members were appointed by the legislature. These Task Forces are: Childhood and Adult Obesity, Tobacco and Smoking Cessation and Healthcare Work Force. All of these groups have been formed and have held meetings, so already a lot of important work has taken place. To step back for a minute, the vision of SustiNet is to create a delivery platform that will be the basis for expanding coverage to the uninsured as envisioned by the legislature for small businesses and maybe beyond that. Rather than taking an existing healthcare delivery system that may be flawed, the idea was to spend some time creating a delivery platform that is more effective than what's in place today. Paul said that this is the Committee's charge, to shape that delivery platform. He continued by saying that from his perspective, it's important that this is done for SustiNet, but he felt that it's even more important to do this for the rest of the state's citizens. It's time to start addressing the changes that need to happen.

Margaret said that last year there was a lot going on, with the Primary Care Act Authority, the Health First Authority, and SustiNet, which was approved by the legislature, then vetoed by the governor, and finally overturned and approved by the legislature. An unidentified speaker said that it seems like the bill sets out a significant framework of work to be done. Paul said that from a practical perspective, the foundation for the SustiNet plan is going to be the state employee health plan. He continued by saying that he felt that the role of SustiNet is to recommend best practices in terms of a plan for payment reform and quality standards for that plan. In his mind, he sees an RFP going out to health plans, saying here are the criteria, and looking for them to respond. SustiNet will be developing the criteria for that RFP. Vicki Veltri said that currently SustiNet is a planning effort and not an actual plan. She said that there are groups under SustiNet; there are individuals who don't have insurance and individuals who may have insurance but would rather be on whatever SustiNet plan there is. There will be groups of employees and the group of state employees who hopefully will be part of the plan. There will be public programs under the plan. The idea is to take the incredible purchasing power that exists in CT, with state employees, the Medicaid plan and other state public programs combined with the number of people needing insurance, to strengthen SustiNet's position in increasing quality and lowering costs. The vision is to have these programs still exist as they are, but they will be part of this umbrella effort to try to take advantage of that purchasing power.

An unidentified speaker asked if by doing this pooling, the end product will apply to everyone equally. For example, if there is a given fee structure, will that be the same fee whether one is a state employee or a Medicaid recipient. Another unidentified speaker said that idealistically that would be the case, but that is something that will be learned. He said that he has asked around, and he doesn't feel that is what is happening around the country. He also said that this is one of the things this Committee will explore. An unidentified speaker said that the next big responsibility for the SustiNet Board will be 60 days after federal healthcare reform is passed, when the SustiNet Board has to provide a report to the

legislature on how federal reform affects what's in SustiNet. Federal legislation will have a significant impact on SustiNet because of the expansion of Medicaid and whether federal exchanges are part of the federal reform. Nelson Shub said that everybody has been talking about cutting costs, but no one is talking about the method for doing so. He said that the purchase power of a large group still doesn't address the unnecessary tests, waste, fraud and abuse. Right now, the entire system in the US is running a cost shifting format. Everybody pays this, so people who can't pay get this. If there isn't a cost cutting format developed, whatever gets done won't be enough. If there are a billion dollars saved, there will need to be 2 billion dollars, if there are 10 billion dollars saved, there will need to be 20 billion. Nelson gave the example of someone going to the emergency room because they banged their head. In the emergency room a CT scan is ordered. The CT scan is ordered so that the hospital doesn't get sued. It is necessary to develop codified criteria that allows for the practice of medicine in all disciplines to be "with the speed limit" so that all tests by all providers are ordered for all patients, not by who or what they are, but by what the disease is or what the injury is. That's the only way to measure how and where to cut costs. Nelson apologized for jumping into that right away, but he said that every time he hears "cost cutting" it bothers him when people think that between that and Washington, this is fixed. This isn't even close to being fixed. There will eventually be 50 million more people; healthcare costs $18,000 to $20,000 a year for a family of four, and for those who don't need healthcare, that insurance works fine. What people don't know is that when they get sick, when they go home there is a $10,000, $20,000 or $30,000 bill waiting for them. Nelson said that he thinks that what needs to be looked at is the end product and then to work backwards.

An unidentified speaker said that part of the charge to SustiNet was to reform the delivery system, particularly around the patient centered medical home. He asked if the focus is on leveraging state purchasing power, what is the platform and the vehicle for achieving that kind of reform in a delivery system. Paul said that he thinks that the people responsible for the state employees' health plan right now would say they are very interested in the development of a medical home. Independent of what SustiNet is doing, they are in the process of sending out an RFP now. In that RFP, they are asking respondents to address how they are going to promote a medical home. So there is an interest in the part of the people who manage the state employees' health plan to foster the medical home. Paul also said that there have been some initial efforts around the medical home, so that is the start of reform.

Margaret said she wanted to go over the charge to this Committee. She said that the charge includes making recommendations by July, so there is a short time frame to accomplish this. The charge drives at quality and safety of care, access to care, and payment methodology. Margaret said that she and Todd have spent a lot of time thinking about how to best use everybody's time. She said that the Committee represents multiple perspectives, with great representation from primary care, acute care, specialty care, rural and urban geographies, child psychiatry, substance abuse, and lots of disciplines from podiatry to naturopathy and chiropractic. Margaret said that a lot has already been done in CT and other parts of the

country. The co-chairs feel strongly that if the Committee goes back to the beginning of the discussions that other groups have had on safety, quality and performance measures, nothing new will ever be looked at. Margaret said that she and Todd felt that this Committee should start with the issue of payment methodology reform as a driver of access to quality and safety and see if that takes the Committee in some new directions that might provide valuable input to the SustiNet Board of Directors. That doesn't mean that various people on the group won't have to look at specifically pulling together some of the recommendations that have already been studied around these issues, but it means that the Committee won't have to devote whole meetings to everything that's on its charge, because there isn't enough time between now and July. Bob McLean said that the state of MA has done a lot of this already; he wondered if this Committee should be looking at what has been done there and carefully deciding what applies in CT and using this as a starting point. Vicki said that one of the charges to this Committee which is quite ambitious is to develop guidelines for provision of care. Even if this Committee starts by looking at payment as a driver, eventually there will need to be a lot of time invested in developing clinical guidelines. Margaret said that there should be a discussion on the wisdom of having as diverse a group as this for developing clinical guidelines for specific issues. Nelson said that clinical guidelines are pretty well established for every discipline. The idea is to get those groups together to agree to what their guidelines should be. He said that he's an Ob-Gyn, and that he couldn't begin to say what the guidelines are for an orthopedic doctor. Those groups need to come together, and they could use AMA guidelines. Nelson continued by saying that this Committee doesn't need to develop guidelines, but rather it needs to be sure that the guidelines developed by the people using them are brought to the Committee, and then the guidelines can be brought to the legislature and be codified. Nelson reiterated that he felt that is exactly what should be done, and then there could be measurement.

Rodney Hornbake said that he agreed with Nelson's viewpoint. He said that one of the opportunities to reform the delivery system is to use existing guidelines to influence payment policy, and he offered two real life examples. First, he said that the American College of Cardiology and the American Heart Association offer excellent guidelines on when to do cardiac stress tests; yet those guidelines are violated day after day when a patient who had an angioplasty in April is back at six month or twelve month intervals asymptomatic and put on a treadmill. That activity generates procedures, complications and hospitalizations that are frankly, all medically unnecessary, and everyone pays for that. Second, the American Gastroenterologic Association and the Joint Task Force that the AGA participates in have come up with excellent guidelines on the interval for colonoscopies; yet those guidelines are violated again and again. We have an opportunity to expand access to the system simply by applying existing, off the shelf, evidence based and widely endorsed guidelines to influence payment policy. An unidentified speaker agreed with Rodney, but he spoke of a case where a friend of his, an internist, had a patient with profuse abdominal pain. The patient didn't meet the guidelines for admission to the hospital. The internist told the hospital that he wasn't going to discharge the patient; he wanted a CT scan, an MRI, and whatever. The hospital denied the doctor's request, but he said that he wasn't sending the patient home. It turns out that the patient had a dissecting aneurysm, which means that above his kidney the

main artery was bleeding into itself, and that's a fatal condition. Although the guidelines are established, that doesn't mean that it should be assumed that clinical expertise is thrown under the bus. That's what makes this situation so difficult.

An unidentified speaker asked about cross fertilization between the various committees. She said that as far as guidelines, she sees the issue being not so much developing them but using them. The only way to effectively use guidelines is to get feedback, and that seems like an area for IT. The same speaker asked if there will be opportunities for cross fertilization between SustiNet committees. Todd said that the co-chairs of all the committees have been invited to attend SustiNet Board meetings. Meeting minutes are being kept for all committee meetings, and they will be shared among committees. He also said that all Committee members are welcome to attend Board meetings.

An unidentified speaker said that he is a naturopathic physician and that although he doesn't traffic in the medical world, he knows it extremely well and is also a licensed pharmacist. In speaking about guidelines and following guidelines, there was a case brought up where the guidelines are not followed and something more than the guidelines is done and it's not medically necessary. There was a case brought up where the guidelines should have been overstepped because of better clinical judgment and it was in the best interest of the patient. The same speaker said that the guidelines were underutilized in certain circumstances and situations, and he offered an example of what he deals with every day in his practice. He said that he was rushed to the hospital a couple of months ago in an ambulance, puking his guts out because he had a massive vertigo attack that came on like Niagara Falls. He spent three or four hours in the emergency room where they didn't do very much. He had a CT scan done, which he thought was probably not necessary. He ended up with a bill of $6,000, which he didn't pay for; his insurance did because he was well covered. But he was left with recurrent syncope and it was interfering with his life. He was scheduled for an MRI, which he really didn't want, so he took things into his own hands and saw a chiropractor. He had four visits to the chiropractor, and he hasn't had any dizziness since then. He hasn't been on any medications and he cancelled the MRI. He continued by saying that the guideline was to do an MRI, and the guideline might have been to do x, y or z. The same speaker said that he just wanted to throw on the table that maybe sometimes the guidelines have to be underutilized as a possibility.

Jean Rexford said that she is very interested in the science and data that often is far ahead of the clinical guidelines. She noted the recent mammogram studies where the knee jerk reaction in a consumer society is that more is better. She said that she feels that this is a problem and a strategy that this Committee will need to work on.

Todd said that this Committee has a charge to address problems of quality, safety and reimbursement by July. He said that when he was asked to be co-chair, he thought that it was no problem, that it was manageable. Then he wondered how to approach this charge, and how to do it without replicating what's already been done. There have been a lot of committees and other things that have been done around the state; his feeling is that it needs

to be approached at a higher level. There isn't a right way to do this; like a lot of things in life an approach needs to be picked and then it just gets going and the course can be adjusted. The challenge is for the Committee to take this quality and safety reimbursement thing and go at it within a timeframe. Todd continued by saying that maybe reimbursement is the place to start, but to start with very high level principles about what characteristics a reimbursement structure should have. He said that the current system that is in place is largely driven by a reimbursement structure. For example, a stent probably shouldn't have been done in the first place because it doesn't affect mortality except in certain circumstances. The follow-up on that was unnecessary. A study done by Dartmouth showed that approximately a third of care in this country is either unnecessary or harmful. Todd said that what he sees as a problem is that there's a lack of accountability in the system for that type of treatment. This is somewhat like the financial markets where mortgages were packaged together and then passed up the line and no one was accountable. In the current system, accountability is someone else's job. There needs to be a system that incentivizes accountability, and Todd said that he sees this as one of the principles that is lacking. Reimbursement should support accountability and reduce that type of behavior. There are 500, 700 or more guidelines being used and they conflict with each other. Some guidelines are produced by special interests that want to promote their activity. Primary care doctors need to sort through these all the time; when a person is being treated it is necessary to figure out what to do for that person.

There is a lack of a way to adjudicate those guidelines in a rational way and prioritize them. In considering the charge to the Commission, there are state employees, there is Medicaid, and there is this big pile of money, $20 billion or something like that, and there is a need to be figure out how to best spend that money. It's a little like having a school board and figuring out if there will be football or band; how is the community going to best spend its resources. Todd also said that part of the issue is the lack of systemness within the state and across the country. The task is to have a reimbursement structure that supports "systemness," which means organizational thinking, a way to prioritize things, and a way to allocate resources. In looking at our transportation system, it doesn't work perfectly but roads go from point A to point B. When roads are built they don't dead end, there aren't parallel roads that are built in competition with each other; there is systemness. Todd said that in looking at the charge, the reimbursement part of the charge should be approached using principles of reimbursement that the Committee agrees on. Once these are established, the Committee could look at quality and safety considering accountability and systemness. The Committee should consider how to use SustiNet to improve the general environment of care delivery within the state and move on from where it is today to a place where it's more rational, prioritized, organized, and with money being spent wisely on things that bring value to keep people well.

An unidentified speaker agreed with Todd. He said that one of his concerns in incentivizing reimbursement is how to measure quality and patient satisfaction. He feels that outcome measures need to be discussed. These measures would include questions on patient satisfaction, not only as to the appropriateness of treatment, but also to the timeliness of

treatment, the efficacy and the financial burden upon the patient, and to not just look at clinical outcomes. An unidentified speaker agreed, saying that he felt that outcome measures, clinical and otherwise, are worthwhile. He also said that he was perplexed by patients who see multiple medical doctors; he said that as a naturopathic physician he sees some of the worst cases, because people often see him as a last resort, saying that no one else has been able to help them. He often finds that the simplest things work in helping people, not drugs or procedures. He said that overall in medicine, no matter who's practicing it, there should be accountability and responsibility for the patient adopting and living a clean lifestyle. He said that most clinicians don't talk to their patients about lifestyle, other than to give them very rudimentary advice, such as telling them to lose weight. If someone comes into his office with hypertension and is already on one or more medications, he finds that no one has really spoken with them about all the various things they could do to lose weight, reduce blood pressure, and use less medication. The same speaker said that this is what he does all day long. He asked where this fits in here; is it drug-centric or procedure-centric, which is how medicine is. By and large, medicine ignores a huge amount of data and a possibility for how to handle this without using drugs or procedures first.

Todd said that he wanted to discuss efforts that have been done in MA. That group has developed a nice framework and a good set of options. He said that he would urge the Committee to begin using that document as a starting point to frame its discussions. He said that he was concerned that an RFP to existing health plans will tend to be a variation on the status quo rather than a redesign and rethinking of reimbursement around not incentivizing volume but rather incentivizing value to patients in the system. Margaret asked if all Committee members received the recommendations of the Special Commission that she had sent out.

Mike Hudson said that he agreed with the comments about accountability and systemness. He said that he has been involved in a number of different payment reform initiatives, and he has become familiar with what works and what doesn't. Frequently what didn't work was surprising, and surprises can often be bad things. Things that failed were profoundly driven by the lack of healthcare information technology and exchange. There is good news and bad news with this. The bad news is that the technology doesn't yet exist and it's in its infancy; the good news is that it's being developed now, so things are heading in the right direction. This effort is well timed, because if the systems were already in place it would be difficult to change them, instead they can be designed to meet current needs. Mike said that while there are a lot of problems in the current reimbursement system, it does work from a transactional perspective. That's not a rational reason to maintain the status quo, but as this moves forward it's necessary to ensure that the transactions work with no surprises. To give some perspective to this, at Aetna 5 million claims a year are paid; almost all of them are paid electronically with no human intervention. The current system has many problems but it does keep money moving through the economy. Mike said although it's clear that reform is needed, it's important not to create unintended consequences as well.

An unidentified speaker said that she agreed with Mike. She said that she also feels that while there's an opportunity to start fresh, there are a lot of issues with data interoperability and the way in which providers exchange information, and that there's a lot of work to do. What concerns her most as the principles of payment are developed is access. She is on the board of the CT Health Foundation and she chairs the Program Committee there; many of the grants that they provide are around the issue of access. As payment reform is developed, it is necessary to be sure that people who are on the potentially less favorable end of the payment scale aren't the ones who get the least access. The same speaker continued by saying that she is a former resident of MA and has lots of relatives there, and that there are many issues with access in the new program. She has heard stories of people waiting up to 16 weeks for primary care visits and experiencing skyrocketing premiums. While the principles are good, it is essential to be careful about how this is done, because there can be negative consequences. Secondly, she said that she had been an executive in a big tertiary care system in the Boston area, and she feels there is a need for incentives to take care of really sick people. Burn units need to be available 24/7, 365 days a year, even if sometimes they are empty for a week. On both ends, there just needs to be access for folks who need generalized care and the ability to fund the best specialized care.

Another unidentified speaker agreed with those comments, for not only the patient's side but also the primary care provider's side. She continued by saying that this is a great opportunity in many ways; our neighbors in MA are ahead of CT in this experiment. With their first step, they have shown that just giving patients insurance does not solve the problem. There are tremendous problems in access to primary care providers, and it has been shown that ED visits have not fallen in MA, unlike what was expected. This same speaker said that the fundamental reform of payment for adult primary care that's being proposed in MA is very interesting; however it has not been implemented yet. The Committee needs to decide if CT wants to be doing that experiment, or should MA get the kinks out first before CT commits to it. She said that she is concerned, because first of all, primary care physicians are incredibly over stressed right now. She said that she thinks they all want to provide the type of counseling that was mentioned by a previous speaker. She said that she thinks that doctors mention to their patients should they stop smoking or lose weight, and hopefully there would be referrals given and information handed out to them.

Unfortunately, counseling by physicians is not generally a reimbursable procedure, and when primary care physicians have to see 25 – 30 patients a day just to make their overhead, this poses a problem that needs to be addressed in any kind of payment plan. The same speaker said that it's necessary to understand that in CT, the great majority of primary care physicians have solo practices or are part of very small groups, so they don't have the resources to implement a lot of the policies that this Committee may want to implement for programs of this type. She said that the Committee also has to look at various mechanisms to provide the primary care physicians with the tools to implement the type of programs that are being considered. The same speaker said that in looking at the inner city situation, those physicians are under even more stress, especially in looking at quality and outcome indicators as a means of payment. There have been some attempts to correct for acuity issues in the

inner city situation, but these attempts have not been as robust as they should be. For any of this, whether it's an inner city or suburban environment, there must be patient buy in for this to work as well. She said that in Fairfield County this is a gigantic problem, for the patients to be willing to agree to a medical home and not want the latest in technology or want to go to NY, Boston or Yale for that tertiary consult.

An unidentified speaker said that from the personal perspective of a family doctor, he asked what he's going to have to deal with over the next twelve months. He needs to start looking at getting EMR's starting in February, which will be incredibly stressful, since he's been in practice for 25 years and will need to convert everything to EMR. He said that yesterday he had a meeting with someone from Medicaid about creating a medical home for about 800 Medicaid patients. Their incentive is to pay him a capitated fee of $7.50 per patient per month for being a medical home and filling out reports, doing diabetic projects, a (inaudible) project besides quality of care. The same speaker continued by saying that he's also a member of the Physician Hospital Organization at St. Francis Hospital where they want to do further disease management which means that they are gearing up to become an accountable care organization. He is also involved with residents in the mornings and he sees them ordering CT scans or labwork, all very expensive, but they have no responsibility from a financial viewpoint for things that they order, so whatever the Committee comes up with to be an inducement for family doctors, internists, pediatricians, etc. to become medical homes will need to be practical. Although it will be difficult, and the transition will be difficult, this speaker totally agreed that the payment method does drive the system in terms of quality and what is being sought, you get what you pay for. If a practice gets paid for doing stress tests, more stress tests will be done and more money made. The same speaker said that a lot of doctors are honorable, but there is an incentive to go home and live a certain lifestyle.

An unidentified speaker commented on MA's Payment Reform Commission's recommendations, saying that he thinks it is important to know that the conclusions to the commission were very highly influenced by one of its members, Blue Cross and Blue Shield of MA. It is important to understand the context in which the discussions were going on as well as how the recommendations were made. A second point related to that is that the Payment Reform Commission had hired Rand to do a number of studies using data from MA and projecting what the potential impact would be of various interventions on payment reform. The results of that were published a few weeks ago in the New England Journal of Medicine, and this speaker encouraged everyone to look at it. He said that in particular there is an interesting disconnect between's Rand's conclusions and the Payment Reform Commission's conclusions, because Payment Reform concluded that global capitation is the way to go, and Rand essentially concluded that there is no evidence that global capitation will work any better this time than it did last time.

There are concerns of having principles translating to an RFP that would go out to plans not leading to fundamental change and therefore trying to go a little deeper. This same speaker said that just for comparison, it took three years to develop the Prometheus payment model;

three years of meeting almost every month and sometimes twice a month, and it's still in development because they are realizing, unsurprisingly, that there is no such thing as a one size fits all solution. The sites of care, the geography and the geopolitics all create idiosyncrasies in markets which require differences in the implementation of different types of payment systems. The same speaker said that he is personally fully convinced, having been doing this for 15 years, that there will be contemporaneously in any situation or any market, a number of different types of incentives based on different types of programs, whether it is forms of capitation, forms of episode of care payment or (inaudible) of service. It behooves this Committee to think about how to maximize value out of these different modes as opposed to simply selecting one which invariably will be the wrong decision.

He said that in addition to outlining principles, which are essential, they will need to be translated into actionable information in an RFP to try to get some kind of reform through the health plans to add some measure of accountability for outcome. This is where the crux of change comes in; in healthcare, for reasons that the speaker said he still doesn't understand after fifty years of being part of it, there is a tendency to suspend the normal laws of business and economics. In the rest of the world and the rest of industry, one starts at looking at what the outcomes are, and then processes are created for change to improve those outcomes, and hopefully the macroeconomic financial incentives are going to drive in the right direction. Principles are great, but there needs to be some baseline measure of how well the current system in CT is doing, something that's objective and outcome oriented, focused on cost and on quality of care. CT is far behind in terms of public transparency of any data which makes this task relatively difficult. It is necessary to tie measurable improvements in that data to the RFP tied to the principles and ask for recommendations from health plans. If this is going to be done on the basis of an RFP, then you hold their feet to the fire in terms of improving that data. This Committee won't be able to design anything new in the next seven months, and the Committee won't even be able to delve deeply into reform, but this speaker said that he would encourage everyone to look seriously at how to create some robust baseline measurement of real outcomes of clinical management of patients in this state and reasonable assessments of costs of care, and use those data publicly to hold people accountable for improvement. That and the principles might yield something worthwhile.

Nelson said that regarding focusing on payment reform, he hasn't heard any discussion on healthcare reform yet, and therein lies the difference. Instead of going after the payment, he suggested that the Committee should focus on a very strong base, something that could measure quality and that affects responsibility, and that should be standard. If everybody practiced a standard of care for CT, then it could be measured and a payment could be assigned to that. Nelson continued by saying that everybody wants a single payor; if you have your appendix out in Greenwich, that cost will be different than if you have your appendix out in Hartford. There is no such thing as single payor, so this Committee could take a very large step and focus on healthcare reform and how healthcare is delivered. He gave the example of an area with three hospitals; maybe there should be two emergency care centers instead that are staffed by the hospitals. It's already paid for; this would empty the

emergency rooms. This Committee needs to really focus on healthcare delivery and then address costs, payments and responsibility, and how to fix those things. Nelson continued by saying that he thinks CT is doing the same thing everybody else is doing, polishing the same doorknobs, just with a different rag. The Committee needs to change how it's thinking about delivering healthcare.

Teresa Dotson said that she wanted to refer to a study of primary care physicians conducted by Hart Research Associates. The study found that 96% of them said that nutrition should be part of chronic disease management; however, 83% of them said that they do not refer for nutrition because reimbursement is an issue. She said that this shows both ends of the problem. There are physicians that believe this standard of care should be delivered to their patients; however the barrier is that they don't refer them because they know it won't be a reimbursed service. This shows where the barrier is between what one would like to see prescribed or recommended versus the reality of what people are able to afford or what they are eligible to receive due to reimbursement issues.

Willard Kasoff commented that with regard to MA and the Rand Corporation, having some data on which to base a plan, and deciding whether CT should be doing a similar thing and where to go with this, he asked whether SustiNet or other agencies are already doing this. He said that he felt that this is something that should probably be done.

Christine Shea Bianchi said that she thinks it's important to talk about methodology for reform, but it seems that in every context of healthcare, whether it be maternal child health, mental health, or disease management, she consistently hears that the things that are needed are not paid for, whether it's nutrition, care coordination, etc. That certainly applies in most cases for inner city, lower income, or underserved populations. Christine said that she knows this personally, because she was available to be a care coordinator for two ill family members, but that is not always the case. She said that she testified for Health First that within the current system, the more one knows and who one knows drives the quality and access of care received. She said that she's very concerned about this, and hopes that this Commission gets to the point where it is concrete enough and brave enough to make recommendations that include services that consistently are not reimbursed.

Robert said that he agreed completely with Nelson's previous comments that healthcare reform is the crux of the matter; however, it is delivered because of payment, so he agrees with Todd that payment reform has to be addressed. There won't be more primary care doctors unless they are being paid more, unless they are part of a patient centered medical home; concerns about nutrition and access to other things are all part of a medical home. If this Committee looks at this and figures out how to do this, that will address a significant number of concerns around this table on providing the appropriate mental health, dietary care, counseling, etc. All those kinds of things are there, it just remains to be figured out how to use that construct as a starting point. This is being done all across the country, so this Committee isn't venturing out into new territory, because everyone recognizes that this is a comprehensive way to address both delivery and payment reform, at least at the primary

care level. How to include subspecialists and affiliate them with the medical home neighborhood is a completely different idea. Robert said that he feels that the Committee needs to focus on the patient centered medical home, figure out how to start off with that, and maybe branch off into care organizations, because accountability will clearly be key to this effort. This will be a start in the right direction.

Todd said that in listening to the group, it seems that reimbursement is a reasonable starting point. Some of the ideas that have been presented are: going after principles, incentivizing value as opposed to volume, getting accountability into the system, getting the system to work in a more coordinated, rational way, the need for HIT, the need for standardization, and providing access to people that heretofore have not had it. Todd said that Francoise de Brantes had brought up some very good points about knowing where things are and where to go to, how to measure that and what the important measures are. He said he particularly agreed with Francoise saying that this won't be solved by one payment system. Todd said that he's very much aware of this in his own practice. In Pro Health, they took scattered, small practices and tried to create a larger, organized structure where care could be delivered rationally, based on principles that deliver value. They have tried to improve the health of people at lower cost, as individuals and as a population. There is no payment system that has told them to do this, they are just doing it. There is no one thing that will make the system change, but it has to start somewhere. Todd said that he thinks that approaching the payment aspects makes sense with the provisos that have been voiced here.

Margaret said that between now and the next meeting, there are a couple of things that people can do. She asked that everyone give some thought to today's discussion and offer opinions, or take the charge to the Committee, identifying the areas that are of particular interest and in members' area of expertise, and do some work in those areas, sending findings to Todd or her via email. Margaret said that the co-chairs hope to hold meetings in other parts of the state, and asked for members to volunteer suggestions for this. An unidentified speaker said that meetings could be held at CHA, which is located in Wallingford, providing a central location.

Vicki reminded everyone of the SustiNet website www.ct.gov/sustinet where each Task Force and Committee has its own page, containing minutes, member lists and other information. She suggested that Committee members register for e-alerts, which offer reminders of meetings, agendas and other relevant information. She also mentioned that the state is under a directive to not use paper unless necessary, so she asked that all members provide information electronically, so that it can be posted on the web and shared with members by email. Margaret said that she thought that this was a great way for members to review minutes between meetings.

Meeting was adjourned.

Next meeting will be 1/21/10 at 8:00 am.

SustiNet Health Partnership