SustiNet Health Partnership

Medical Home Advisory Committee

Co-Chairs
Ellen Andrews
Tory Westbrook

Board of Directors Liaison
Bruce Gould
Joseph McDonagh

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

Patient Centered Medical Home Committee Meeting by Webinar
April 28, 2010
Meeting Minutes

Webinar Participants: *Ellen Andrews, Co-chair; Tory Westbrook, Co-chair; Maureen Smith; Mark Borton; Domenique Thornton; Jennifer Jaff; Ken Lalime; Joanna Douglass; Rick Duenas; Keith vom Eigen; Jody Terranova; Margherita Giuliano; Les Holcomb for James Stirling; Bruce Gould; Sheldon Toubman*

Excused: *Jim Augur; Evelyn Barnum; Lisa Cannella; Sandi Carbonari; James Cox-Chapman; Amy Casavina Hall; Sylvia Kelly; Joseph McDonagh; Judith Meyers; Drew Morten; Deborah Poerio; Rose Stamilio; Scott Wolf; Thomas Woodruff*

Ellen Andrews opened the meeting by welcoming all participants. She said that this meeting will focus on federal healthcare reform legislation and its impact on SustiNet, and began by looking at section 3502 of the federal act. To access a document containing sections of the federal act, click here. The Committee needs to make some decisions concerning federal funding. Federal legislation calls for establishing health teams to support patient centered medical homes. Teams will be based on hospital service areas. Domenique Thornton asked if there will be public/private partnerships for these teams, such as the ones in NC. Ellen said that NC's model is wonderful and might be a goal for this Committee, but realistically it couldn't be put into place by January 2011. Jennifer Jaff said that it might be more effective to have nonprofits contract with hospitals rather than hospitals starting from scratch. Ellen said the center of the medical home can vary from area to area, with some centers being hospitals and others being nonprofits or private providers. An unidentified speaker asked if this Committee needs to decide the level of SustiNet involvement or if this is something that others will take the lead on with support from SustiNet. Ellen said that SustiNet intends to be an operating model, but practices won't do this for SustiNet or just one payor. Their practices will be transformed for all payors or not at all. This Committee can make broad recommendations or take a leadership role. Ellen said that initially the majority of people in SustiNet will be Medicaid clients. For the first two years, CT can get a Medicaid match of 90% for care management services. SustiNet will be part of a multi-payor model, and this should be in place by 1/11, with DSS involved also.

Ellen spoke about the grant, beginning with a summary of what is involved with the development of community health teams. She said that the list of interdisciplinary team members was not an exhaustive list and can be revisited as needed.

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There was discussion about the development of care plans. Ellen said that patients and primary care providers should develop care plans, with teams reviewing them, filing them and holding providers and patients accountable for following the plans. An unidentified speaker said the team should plan what their involvement will be. Ellen said flexibility is needed to allow for discussion of people moving from one provider to another. An unidentified speaker said that not every patient will need an interdisciplinary care plan. Another unidentified speaker said that this is not necessarily at the individual level but at the system level, specifically to determine protocol, such as how this team will handle certain care needs. Another unidentified speaker said CT has many small practices and not enough staff to form care teams. This may force practices to have more depth. For simple patient visits, there won't be a team involved because it's just not affordable. Jennifer Jaff said that the care plan has to be on a systemic level, although there needs to be a care management plan for every patient, especially those with multiple chronic conditions. She said that many CT patients who see providers in other states who won't be participating in SustiNet gives just one example of why this Committee must stay flexible in planning as it builds a structure that supports patients and providers but also allows for best care for patients. Ellen agreed, but said that she doesn't want to give the locus of accountability to a team that is a hospital region. Sometimes that's the best choice, but for the vast majority it should start with a single primary care provider who can consult a team when needed. Jennifer said that development of systems doesn't happen on that level. Ellen said that this Committee needs to decide how this should look. Keith vom Eigen said that care coordination teams can have some initiatives that they want to control within the care plan. Ellen said that this Committee needs to figure out what needs to be done, what the ideal is, and how to make it work financially.

An unidentified speaker said that from a payor's perspective, the payors will want a single point in order to know what the care plan is and how it works, so they can coordinate payments to providers. Ellen said consumers also want a single point of contact. An unidentified speaker said that visiting nurses create care plans that physicians sign off, showing people working together but having different responsibilities.

Ellen discussed team support as described in the federal act. Bruce Gould said that there has been discussion in Hartford of creating a single entity, perhaps using an 800 number that anyone in Hartford can call for medical advice. This entity would communicate with all practices. He said that there was discussion about having a practice remain open after hours so that patients can avoid ER visits. An unidentified speaker said that hospitals are considering building urgent care centers. There was discussion about HMOs and the location of acute care providers in easily accessible places such as Wal Mart. An unidentified speaker said providers shouldn't be told how to do this, but rather told what they have to do and asked to prove it. The criteria should be: This is what must be provided and this is the proof that must be provided on whatever is scheduled in order to be qualified. Ellen said that providers don't like being told what to do, and this was a problem providers had with HMOs. An unidentified speaker said there will need to be much more quantifiable, statistically reliable continuous measurement in order to evaluate this process. Ellen said standards will need to be set. An unidentified speaker said that transforming to medical homes and converting to HIT will not be easy. Bruce Gould said that the National Standards Institute is the body charged with measuring technologies to see if they do what they say they do. The Office of the National Coordinator (ONC) actually creates the metrics and then local extension centers help put these systems into place. The ONC will be checking the metrics and posting findings on their website, making it easier for providers to choose vendors.

Ellen said that she thinks a state list of providers is a good idea. Patients could request and obtain approval for seeing providers who aren't on the list. The list wouldn't be about licensing but rather about certification. The state criteria for being on the list should be easy for providers to comply with.

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The Committee looked at section 2703 of the federal plan. Ellen said that the federal planning grant would be matched 50% by the state. This would qualify CT for a 90% Medicaid match for health home services for the first eight quarters of the program. This process is still in the planning stage, so perhaps CT could meet the deadline of 1/11. Ellen said the charge to this Committee contains language that if resources aren't available for medical homes for everyone, the initial focus should be on people the state would be most likely to save money on, i.e. people with chronic conditions. Ellen continued by saying that in VT and PA, medical homes originated with providers who showed the most interest in starting them. This is how the populations were defined to start with. An unidentified speaker said there will need to be champions and geographic concentrations in order for medical homes to work. Another unidentified speaker asked if the fee schedule would be adjusted for physicians who take on these populations. Ellen said that Medicaid rates for primary care will rise to Medicare levels in 2013 and 2014.

Ellen said CT Health Policy Project is concluding a study of physicians and their participation in Medicaid. This was done by randomly surveying CT physicians to see whether they participate in Medicaid, Husky or SAGA. There was a rate increase two years ago, geared more at specialists than primary care, but it didn't improve Medicaid participation at all. CT has lower participation than most states, even states with much lower rates. Medicaid and DSS are known as being very difficult to deal with. Ellen said there are people at DSS who are receptive to suggestions and would be willing to make changes. An unidentified speaker said that many physicians are apprehensive about serving Medicaid patients because their healthcare needs can be complicated. On the other hand, there are physicians going after the less sick patients in order to get extra funding. Ellen said that there was risk adjustment in the past, but it was done badly and was not popular. She said the science of risk adjusting has gotten better. Other states are risk adjusted for medical homes; this doesn't appear to be controversial and is trusted by physicians. The methodology for risk assessment was developed with primary care providers, and it is evaluated on a regular basis. An unidentified speaker said the better the care a provider gives, the more patients that are incredibly complex will seek out that provider. An unidentified speaker said HCC is a standard used by many physicians. Some providers use a risk adjusted percentage of premium as the HCC score changes. Ellen said that there are also risk corridors, so if there is a very complicated patient who's taking much of a provider's time, when costs go over a certain amount it bumps to a different rate. An unidentified speaker asked how SustiNet would integrate with the existing payors in CT. Ellen said this will be a problem for all the Committees and Task Forces and presents a broader issue for the Board.

An unidentified speaker commented that the state will develop a planning grant for this function that will be half state and half federally funded. Ellen said that this conversation should be at a later date. She feels the design should happen first and then funding details should be figured out. There was some discussion about goals and priorities of this Committee. Ellen asked which core functions need to be provided at the medical home team level and which ones could potentially be contracted out. She suggested 24/7 voice-to-voice phone coverage for patient concerns and referral tracking to ensure that appointments are kept and follow-up occurs. An unidentified speaker said this is a gray area. This tracking may be done within a practice very poorly creating a need for it to be contracted out, or done very well in a practice and then contracted out and done poorly. Ellen said the big question is whether to allow contracting out. Tory Westbrook said that EHRs will have some tracking embedded. If a patient misses a referral appointment, at the next visit there will be a pop-up alerting the provider of this. An unidentified speaker said that small practices would benefit from contracting out referral tracking. Ellen said standards are needed for this. An unidentified speaker said the locus of responsibility will still be the provider in spite of what things are contracted out. Much discussion was held about responsibility, accountability and contracting out. Rick Duenas said some of these

functions are administrative and some are clinical. Clinical functions are clearly part of the provider's responsibility and should remain as such. This Committee needs to think about a system that provides better care for everyone, and the medical home needs to be clearly defined. An unidentified speaker said some things are clearly defined by licensure. Ellen said licensures are set up for scope of practice, and now this Committee needs to set up a sort of licensure for medical homes.

An unidentified speaker said in providing medical home status, this Committee needs to say: Here are the functions you need to perform as a medical home. How will you do this? You must document that you can do it and continue documenting in order to keep accreditation. The same speaker said there need to be reporting standards on data function and management. An unidentified speaker said a simple way to draw the line is to only allow NCQA accredited practitioners to participate, but if this is done there may be a large number of practices that are unable to participate. This must be weighed out and SustiNet could be flexible. Ellen said NCQA is flexible about contracting out. She said she has concerns about core issues being taken out of the system. An unidentified speaker said the more things are contracted out the less control there is over quality. There was much lively discussion here. An unidentified speaker said it's important that consumers have only one point of contact. To access a checklist of core vs. potentially contractual functions that was handed out, click here.

Jamie ____ said this Committee could use NCQA standards or determine its own standards, which will be difficult. Using NCQA standards would be simpler and quicker. He said this Committee could look at outcome measures, determine the metrics to do this, and set it up for what is going to be measured. This could be used for continuity of care, referral management, multiple admissions, etc. Ellen said the outcomes just mentioned are not within the scope of the Committee to decide but would be a Board decision. Maureen Smith suggested this Committee could make recommendations to the Board. Ellen said standards are very important and need to be kept in mind. There could be a list of preferred providers to be used for contracting out.

An unidentified speaker said patients should have a choice of medical homes. There could be a website describing medical homes and how they function, allowing patients to choose the ones that work best for them. Tory Westbrook said the patients' needs are the most important part of this, so the medical home should be planned around simplifying the process for patients.

In summary, Ellen said there seems to be consensus that all services can be contracted out, although she disagrees with this. There will be strong evaluations and responses to consumers who will call one phone number that will be answered by a live person, not a voice system. An unidentified speaker said that in his practice, he'd prefer to do it all but that's unrealistic. The same speaker said VNA shares the responsibility of managing patients' care with him and it is working well. An unidentified speaker said measurement is key to this effort, using standards. This would drive accountability and create a metric which could be published for patients, showing participating providers and criteria, and allowing them to choose what's best suited for them.

Meeting was adjourned.

Next meeting will be May 10, 2010.

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