SustiNet Health Partnership

Medical Home Advisory Committee

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Patient Centered Medical Home Advisory Committee Meeting
May 10, 2010
Meeting Minutes

Committee Attendees: *Ellen Andrews, Co-chair; Tory Westbrook, Co-chair; Maureen Smith; Les Holcomb; Sylvia Kelly; Jim Augur; Dominique Thornton; Jody Terranova; Rick Duenas; Ken Lalime; Jennifer Jaff; Tom Woodruff; Leslie Swiderski; Keith vom Eigen; Judith Meyers*

SustiNet Consultant: *Anya Rader Wallack*

Excused: *Evelyn Barnum; Sandi Carbonari; Amy Casavina Hall; James Cox-Chapman; Joanna Douglass; Margherita Giuliano; Bruce Gould; Joseph McDonagh; Drew Morten; Deborah Poerio; Rose Stamilio; James Stirling; Sheldon Toubman; Scott Wolf*

Ellen Andrews opened the meeting by welcoming all Committee members, adding that today's meeting is being broadcast live on CT-N. She said that this meeting will focus on support for practice transformation for the patient centered medical home (PCMH). Ellen read from the SustiNet law, saying: *Part of this Committee's charge is to develop recommended internal procedures and propose regulations governing the administration of PCMH. If a provider does not wish to perform within his or her office certain functions outside of core medical home functions, such providers shall make arrangements for other qualified entities or individuals to perform such functions in a manner that integrates such functions into the medical home's clinical practice. Such qualified entities/individuals shall be certified by the SustiNet Board of Directors based on factors that include the quality, safety and efficiency of the services provided. At the request of a core medical home provider, the Board of Directors shall make all necessary arrangements required for a qualified entity/individual to perform any medical home function not assumed by the core provider. Something that can be considered is the offering of reduced price consultants that shall assist providers in structuring their practices/offices so as to function more effectively and efficiently in response to changes in healthcare insurance coverage and the healthcare service delivery system that are attributable to the implementation of the SustiNet plan and the offering of continuing medical education courses for clinicians in order to provide better care consistent with the objectives of the SustiNet plan, including training in the delivery of linguistically and culturally competent healthcare services.*

Ellen pointed out some key issues to keep in mind while structuring a PCMH, including: offering various options for varying needs; the need to show fairness to various practices that have already invested in care coordination; offering a menu of services from a set of approved providers; for small practices that cannot hire a care manager, they can share some of their fees with a service to deliver parts of the care; allow specialization and flexibility for practices requiring contracting with one network for a defined set of services; develop approved referral networks; create a learning collaborative; using on site coaches and mentors; using patient education programs; using an approved list of consultants to assist with NCQA accreditation; engaging patients in the design of the new system; surveying consumers about their experiences and incorporating their input into solutions; using feedback from providers; what should be required of practices as far as a learning collaborative; how to develop a virtual team; how to incorporate and link to other professions; how to receive information from other providers; how to share decision making with patients; state oversight and support; coordinating the administrative burden; public education about patient responsibilities and benefits of medical homes; coordinating training on HIE with the PCCM learning collaborative; using communication systems to disseminate notices and collect feedback from practices.

Maureen Smith mentioned price consultants, saying that their role is to provide more efficiency to the practice. She pointed out that there is much greater employee satisfaction within practices that utilize price consultants. Jennifer Jaff said this Committee hasn't yet discussed patient education, but it's a crucial piece of this. There could be learning collaboratives for large groups of patients who share a health problem. She said that incentives are a good idea, but that they need to be done carefully so as not to punish people who are sick and have no control over their illness. Jennifer also said that she supports incentives for medication compliance, regardless of the outcome, suggesting the elimination of copayments for medications.

Les Holcomb said that no matter what is decided, the cost of primary care will increase. This Committee needs to ensure that the majority of the dollars that are invested in primary care are spent on the recruitment, development and retention of primary care practitioners and direct patient care support staff. This needs to be stated explicitly in recommendations made. Sylvia Kelly said the HIT component will be the most costly item. There is another SustiNet group that is working specifically on HIT development, but this Committee can discuss how to centralize HIT, particularly when working with small practices to help with keeping their expenses down. Jody Terranova said that there will need to be a huge educational effort for providers. Leslie Swiderski from Waterbury Health Access said that her organization is participating in a pilot program working with the Department of Social Services and Connecticut Primary Care Association. This program has required communication between hospitals and physicians, often needing prompt responses, and has proven to work very well. She praised the use of HIT, saying it made the entire process very efficient. Keith vom Eigen noted that technology is important; however, many of his clients are hard to track down by telephone, and often patients who are referred from emergency rooms don't follow up with physician visits. He also spoke of group visits, saying that his practice is having difficulty getting reimbursed for group visits. He pointed out that some patients have problems in getting transportation to group visits. He said that it is necessary to be open-minded and creative when making recommendations.

Leslie said that her organization has existed for five years, and they have been able to show that having access to care coordinators leads to a definite reduction in non-emergency ED visits. Her organization has bilingual employees, which is also important. It has been found that patients attach to certain employees, and this has led to patients assuming more responsibility for their own health care. Judith Meyers agreed that care coordination is vital, and said that small practices could share care coordinators. She said that CCMC has developed a Family Advisory Council to engage families with practices in an advisory capacity.

Ken Lalime said what works in one area may not work in another area. He said if care coordination is to be delivered as part of a collaborative, it's very important that it be delivered locally. Sylvia said that criteria need to be set based on function and need when making choices such as which HIT vendors to utilize. Ellen pointed out that some of the key areas are difficult to set criteria for, and suggested identifying general guidelines around patient safety and other issues that would help in making recommendations to the Board as far as defining qualified entities. Sylvia said that there are best practices in areas such as cultural competency, so she suggested the Committee look at best practices for fuzzy areas. Jennifer said that there are many more referrals from pediatric practices and hospitals than from adult practices and hospitals, and asked what drives pediatric practices to look for external resources and come up with creative solutions that aren't happening in the area of adult care. Jody said that perhaps this is attributable to the fact that pediatricians deal with entire families who can be strong advocates for children, whereas adults are responsible only for themselves. This is a tough question to answer. Ellen said this shows the importance of building a network for everyone and the need for a learning collaborative.

Rick Duenas said this Committee needs to establish standards that must be met for entities wishing to participate in SustiNet. Perhaps the standards can be broken down into clinical or basic administrative categories with a requirement that clinical entities be licensed. Keith mentioned that he was familiar with a program in Baltimore that had community and family resources to support sick, disabled, elderly, or incapacitated people, allowing them to stay out of nursing homes and helping them to function in a comfortable environment. This is invaluable, yet insurance systems are not set up to support this type of assistance. Keith suggested that perhaps SustiNet could take advantage of family and community resources and leverage them, investing a small amount and supporting them, which would provide major cost-savings. He suggested the Committee recommend some sort of home services as part of the SustiNet plan. Ellen said that home care could be part of the medical home team. Keith said that from what he had observed, there was a care coordinator who tracked patients at home, communicated with physicians, and coordinated between nurses and other home services that were being provided by the network.

Tory Westbrook asked the group for comments on what should be expected from an after-hours provider, especially whether this should be a core function or something that's contracted out. Ellen said survey responses from Committee members were mixed about this. Rick said that he would be comfortable with patients discussing health problems with a 24 hour phone service, as

long as the service had access to the patient's medical records. Les said that he felt that after-hours care meant healthcare delivery, for example, a practice with extended hours. Tom Woodruff said this wouldn't mean that every practice had to be open for extended hours every day, but rather could be part of a network that had at least one facility open for extended hours each day. This would be especially important for smaller practices, allowing them to be part of a network. Ellen said that capacity issues and geographic access should be criteria for determining locations for extended hours. Maureen suggested that the treating/advising care provider should have access to the EHR in order to make a note of the contact. Ellen clarified that after-hours providers should be used primarily for urgent care, rather than for scheduled appointments. Tom said that he felt extended hour providers should offer both routine and urgent care. Ken said that EHR's won't be put into place until after the establishment of a regional extension center. Maureen said that without HIT, she would recommend the completion of an after care report that would allow each practice to see which patients received care after-hours. Les said that pharmacy systems have the capability to receive such a report, but perhaps they should also have the capability to access referrals and provide feedback. Ken said that care received after-hours without appointments is considered to be urgent care according to billing codes, and existing providers who provide such care are licensed as urgent care facilities. He suggested making a recommendation that medical homes need to have access to urgent care or walk in facilities (that are not hospital ERs) that are currently licensed in CT and are within a 10 mile radius.

Tory brought up another area for discussion, risk assessment tool administration, and whether this should be a core or contracted function. Ellen said that survey results indicated that assessments should be a core function. Keith said that online assessments can save time for busy practitioners. There should also be consideration of periodic follow-up and updating. There was some discussion on how the risk assessment should be done and which entity should complete it. Judith said that a tool like this has to be a first level screening. She mentioned a tool called Ages and Stages that is used by the Child Health and Development Institute to monitor children's development. These are filled out every six months by parents, and the information is shared with the child's primary care provider. Maureen suggested that whatever assessment is recommended by the Committee should be accessible online as an option but for those without computer access the tool should be available to be completed in providers' waiting rooms. By doing this, any questions patients might have could be answered by clinicians. This data could be used aggregately in addition to being used for individual care planning. Leslie said that she agreed with having the assessments done at the medical home where medical assistants can help with completion of the forms and answer any questions patients may have. This would help immensely with required compliance in order to keep funds flowing. Les said that hierarchical care codes, which are used in Medicare advantage plans, need to be part of the discussion of the risk assessment tool. Jim Augur said that Anthem and other health plans have used risk assessments for years, yet haven't seen large numbers of them being completed. Anthem has tried incentives at the member level without seeing good results. Jim said that if SustiNet considers this to be important, the assessments should be mandated, and he feels this should be done at the medical home in addition to being offered online. Keith suggested offering assessments at kiosks and online stations at practices. He said that the advantage to offering

them online is that branching logic could be employed, expanding categories to be filled in only when applicable. The online version could be easily incorporated into the client's EMR, yet could be aggregated anonymously for statistical purposes. There would be a cost to this, but it's something to think about, if not within SustiNet than as part of aggregating multiple insurers to institute this. Dominique Thornton said the American Red Cross uses kiosks to accomplish this and it has proven to be quick and effective.

Tory opened the discussion for patient educational materials, programs and best practices. Les suggested the learning collaborative should provide the over-arching framework for this. He also suggested that this should be one of the first steps taken within SustiNet. Jim said that he thought the HIT Committee should be addressing the provision of educational materials to SustiNet consumers. Jennifer said that in addition to medical information, there are many other areas that are crucial for patient education, such as legal issues surrounding healthcare. She said that many of these issues shouldn't be addressed by the medical home, adding that one of the things that will occur as a result of federal healthcare reform is that there will be consumer assistance programs to help people with insurance appeals and other legal processes. Jim said there should be standardization of literature and educational materials in the medical home. Rick suggested that all provider groups have the same standards as far as certifications, professional associations, clinical care and educational materials for patients. Keith said that he's uncomfortable with mandating centrally approved materials for patients, preferring to offer a variety of resources from various organizations including online material. He suggested regional reading rooms could be set up, or perhaps case managers could provide patients with educational materials. Keith also said there could be a review board comprised of physicians, patients, subspecialists, and patient educators among others for recommending materials. There would need to be disclosure rules and freedom from financial influences, particularly drug companies. Judith said that she felt it best to recommend websites or organizations for patients and remain apart from the process of reviewing materials. Ellen said this part of the process is not to censor materials but rather to endorse certain materials. Jennifer said she felt it was important for SustiNet to compile a library or set of accessible links for educational materials, adding that there is much valuable material already available for every disease.

The meeting was adjourned.

The next meeting will be May 19 at 10:00 a.m.