CT Health Care Reform Advisory Board

Health Care System Reform Subcommittee

Summary of April 22, 2010 Meeting

Members Present: James Cox-Chapman, MD, ProHealth Physicians (Co-Chair); Christopher Dadlez, Saint Francis Hospital and Medical Center (Co-Chair); Deputy Commissioner Cristine Vogel, Department of Public Health (DPH); Paul Lombardo, CT Insurance Department (CID).

Others Present: Alexis Fedorjaczenko, DPH; Joe Mendyka, DPH; and Barbara Parks Wolf, Office of Policy and Management (OPM).

The meeting began at 11:00 am.

Deputy Commissioner Cristine Vogel suggested to the group that in addition to sending Advisory Board recommendations to the Governor and General Assembly, it would be beneficial to have recommendations that can be used by the Health Care Reform Cabinet recently established by Governor Rell by Executive Order. The Cabinet is charged with implementing federal health care reform requirements in Connecticut and is working now to meet some immediate deadlines. To provide timely recommendations, it was agreed that subcommittee would develop recommendations by May 20th and sent them to the Advisory Board for consideration at the June meeting.

Several handouts were distributed to support development and discussion of potential recommendations:

1. The American Hospital Association's (AHA) Framework for Medical Liability Reform (Dadlez)
2. Suggestion for State Policies that Need to be Changed in Order to Prepare for Federal Healthcare Reform Implementation (Cox-Chapman)
3. State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation (Fedorjaczenko)
4. Proposed Cost-Saving Legislation for Nursing Homes (Cox-Chapman)

Tort Reform

Dr. James Cox-Chapman and Christopher Dadlez provided draft recommendations addressing tort reform and efficiencies for subcommittee consideration.

The following recommendations were put forward by the subcommittee:

Recommendation #1: As proposed by the AHA, replace the current court based medical liability system with an administrative compensation system that would compensate patients for injuries that could have been avoided during medical care. Intentional and criminal acts would remain under the jurisdiction of the courts. (See handout #1). Or, at minimum, require a review of medical malpractice complaints before they get to the courts.

Discussion: This recommendation is based on the proposal put forward by the AHA. If implemented nationally, it is estimated that an administrative compensation system could reduce expenditures by 0.5 percent, a percentage that sounds small but is actually a significant amount of money. In Connecticut, the issue is not the frequency of claims but the severity of claims. For more data on medical malpractice claims in Connecticut, Paul Lombardo suggested staff contact George Bradner at CID.

Recommendation #2: Allow introduction of collateral sources of compensation. Currently, introduction of collateral sources of compensation for the plaintiff is not allowed. This change would allow for a fairer process, result in awards that were more commensurate with damages incurred, and would address the problem of settlement severity in Connecticut. (See handout #2)

Discussion: The question was asked whether this issue is addressed via statute or regulation.

Recommendation #3: Allow bifurcation of medical malpractice cases into liability and damages sections to be at the request of either counsel. Currently, bifurcation is at the discretion of the judge. Reasons for the change include: fairer process, combining liability and damages implies the assumption of wrong doing, and this will shorten the trial process. (See handout #2)

Recommendation #4: Cap damages for pain and suffering in medical malpractice cases. This action can be applied under current law or under an administrative compensation system.

Discussion: Currently there are only one or two medical malpractice insurers in Connecticut. Tort reform could encourage more insurers to offer policies in the state.

Recommendation #5: The State should pursue a planning grant under section 10607 of the Patient Protection and Affordable Care Act (PL 111-148) to explore alternatives to tort reform. The focus of this effort could include development of an administrative compensation system (Recommendation #1) as well as system for encouraging the collection and analysis of patient safety data related to disputes.

Discussion: Alexis Fedorjaczenko reviewed the handout summarizing the state demonstration grants addressing medical malpractice created under the federal health care reform law (see handout #3). This grant program supports the development, implementation and evaluation of alternatives to current tort litigation.

Efficiencies – Health Care Delivery Reform

Recommendation #6: Re-examine the limitations of each type of medical licensure to ensure that practitioners are able to maximize their ability to practice at the top of their training and licensure.

Discussion: The way to thrive in health care reform is to have everyone working to the top of their licensure. Joe Mendyka pointed out that in 2009, the Legislative Program Review and Investigations Committee develop a study entitled: Scope of Practice Determination for Health Care Professions (http://www.cga.ct.gov/pri/2009_PDHCP.asp). Information on this study will be shared with the subcommittee to see if this recommendation is addressed. [See House Bill 5258: http://www.cga.ct.gov/asp/cgabillstatus/cgabillstatus.asp?selBillType=Bill&bill_num=5258&which_year=2010]

Recommendation #6a: License medical assistants (MAs) in Connecticut by developing a scope of practice consistent with national certification. Currently, there is no licensure for MAs and their scope of practice is severely limited. This action is necessary for development of medical homes as they are a key member of the primary care team.

Discussion: Since medical assistants are not licensed in Connecticut, their scope of practice is very limited. Allowing medical assistants to do more will free up other practitioners to focus on tasks that require their special training.

Recommendation #6b: Increase access to physician assistants (PAs) by maintaining the current requirements for physician supervision but eliminate the onsite requirement. Currently, PAs require onsite supervision weekly in the office setting and at all times in the hospital.

Recommendation #7: Create a Health Care Operations Commission that would make recommendations on changing health care regulations (Public Health Code) to increase efficiency and improve quality of care in health care facilities. The Commission would be composed of experts in the health care field and would serve as a venue for end users to improve the health care delivery system. (See handout #4)

Discussion: This recommendation is designed to allow practitioners and administrators (end users/ content experts) to address regulations that impede providing quality care at the lowest cost.

Next Meeting

Thursday, April 29th at 11:00 AM at a location TBD.

The topic for the next meeting will be understanding drivers of health care costs. Dr. Cox-Chapman and Mr. Dadlez will present information from the Dartmouth Atlas. At minimum, the group will work to identify what tools the State needs to identify cost drivers. Since the Dartmouth Atlas only looks at Medicare data, the subcommittee will look into other data sources as well.

The meeting was adjourned at 12:10 PM.