CT Health Care Reform Advisory Board

Health Care System Reform Subcommittee

Summary of May 25, 2010 Meeting

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

Others Present: Alexis Fedorjaczenko, DPH; and Joe Mendyka, DPH

The meeting began at 10:00 am.

The group gathered to develop additional recommendations for consideration by the Advisory Board on May 27, 2010. Below are draft recommendations as agreed upon by the subcommittee members.

Medical Malpractice / Tort Reform

1. Connecticut should apply for funding under the *"State Demonstration Programs to Evaluate Alternatives to Current Medical Tort Litigation"* (P.L. 111-148 section 10607) and should design a demonstration program that includes the following components:

   a. Administrative Compensation System
   Connecticut's demonstration program should utilize the American Hospital Association's "Framework for Medical Liability Reform" which proposes an administrative compensation system that would be created to compensate patients for injuries that could have been avoided during medical care.

   The AHA framework includes the following main components:
   - Claims for injury during medical care would be handled through an administrative process (intentional injuries and criminal acts would remain in the courts).
   - Compensation would be provided for injuries that could have been avoided and that meet a minimum threshold of harm.
   - Patients would submit claims to a local panel that would make decisions using explicit nationally established decision guidelines and schedules.
   - Patients who question the local panel's decision would bring their claim to other sources that might include an expert panel, administrative law judge, or the court system.

b. Bifurcation of medical malpractice cases into liability and damages sections Bifurcation should be allowed at the request of either counsel.

Health Care Reform and the Health Workforce

2. Connecticut should 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.

    a. Connecticut should license medical assistants ("MAs"), a health care professional that is a key member of the primary care team in medical homes. Currently, there is no Connecticut licensure for MAs and their scope of practice is severely limited. Connecticut should develop a scope of practice consistent with national certification in order that the state is be able to fully implement federal opportunities for medical home demonstrations.

    b. Connecticut should increase access to physician assistants ("PAs") by maintaining the current requirements for physician supervision but eliminating the onsite requirement. Currently, PAs require onsite supervision weekly in the office setting and at all times in the hospital.

3. Connecticut should enact legislation creating a procedure for administrative review by DPH for proposed changes to scope of practice laws prior to being raised in the legislature.

    a. DPH should identify and pursue grants/demonstrations available through the PPACA that would assist with funding to implement the proposed scope of practice process.

4. Connecticut should aggressively seek its share of residency slots for the training of primary care physicians.

    a. To qualify for the '*Distribution of Medicare graduate medical education (GME) positions*' (P.L. 111-148 section 5503), identify entities in Connecticut that satisfy the requirements for this program (priority goes to hospitals: in states with low resident/population ratio (70%); in states with a high number of people in health professional shortage areas and/ or located in rural area (30%)).

    b. Develop linkages between teaching hospitals and qualified hospital and physician practices in medically underserved or rural settings.

    c. Address primary care broadly, to include internal medicine, family practice, pediatrics and obstetrics.

5. Connecticut should apply for a '*Health Workforce Development Planning Grant*' (P.L. 111-148 section 5102) to analyze health care labor markets; identify current and projected needs; identify short and long-term workforce development strategies; identify existing Federal, State and private resources for health workforce recruitment, education, training and retention. (This will require a 15% state match.)

6. Connecticut should apply for a '*Health Workforce Development Implementation Grant*' (P.L. 111-148 section 5102) to encourage regional partnerships and promote innovative workforce pathway activities. (This will require a 25% match.) This grant will allow Connecticut to address the workforce needs of a reorganized health care delivery systems (i.e. accountable care organizations, medical homes) and address the need to have health care professionals function in new/changing roles.

7. DPH should work with the state's community health centers and school-based health centers to maximize the receipt of federal money for the purposes of: maintaining and expanding the number of such clinics; maintaining and expanding the number of such clinics that possess FQHC status; ensuring that these sites provide safety net coverage for the entire state population; and utilizing new methods of integrated care coordination.

Linking Service Delivery Reform to Payment Reform

8. Connecticut should join the New England Coalition for the Patient Centered Medical Home. This coalition of all New England states (except Connecticut) has applied for waiver authority from CMS to stage a combined Medicare/Medicaid patient-centered medical home demonstration project.

9. Connecticut should encourage policies for formation of Accountable Care Organizations in Connecticut linking payment reform to these new care delivery models.

10. Connecticut, through the Department of Social Services, should pursue payment reform demonstration projects included in the new federal legislation, including *'Medicaid Demonstration project to evaluate integrated care around a hospitalization'* (P.L. 111-148 section 2704) and *'Medicaid global payment system demonstration project'* (P.L. 111-148 section 2705).

Prevention and Wellness / Patient Participation

The subcommittee discussed the benefits to pursuing wellness initiatives and of developing a recommendation that Connecticut, through DPH, pursue all available initiatives in the PPACA. The subcommittee acknowledged that many areas of the system are impacted by patient behavior outside of the influence of other social forces such as government and insurance companies. We can provide public education and other

incentives but cannot force people to do anything. The subcommittee also discussed the importance of patient trust in the health care delivery system as a key factor of implementation

The meeting was adjourned at 11:10 am.