



December 4, 2013

Commentary regarding the Connecticut Healthcare Innovation Plan Draft 1.1

Submitted to the Core Planning Team and Work Group Members

Via email: SIM@ct.gov

The National Physicians Alliance (NPA), Connecticut Chapter, is optimistic about the goals and objectives outlined in the Connecticut Healthcare Innovation Plan, and we appreciate the opportunity to provide commentary on the Draft 1.1 version of the document. We look forward to ongoing, engaged discussions about the future direction of healthcare in the state, and are ardently committed to thoughtful and achievable healthcare reform built upon the Core Values of the Medical Profession.

We broadly support the general themes and goals already outlined in this current draft version. We do have several suggestions and considerations, and submit them for review. We have organized our comments generally based upon the contents as they are outlined in the draft, and not in order of importance. We overall agree that primary care practice transformation, community health improvement, and consumer empowerment are three primary drivers of healthcare transformation.

1. Governance Structure

The State Innovation Model has the potential to transform and improve the way care is delivered and reimbursed throughout the state, effectively impacting all providers and patients. The governance structure currently includes many thought leaders throughout the state at many levels. Because of the potential impact the SIM can have, we strongly urge you to consider including more practicing clinicians, which includes all members of the healthcare team, as this will better inform the Patient-Centered Medical Home aims that the grant supports. We ideally would like to see practicing pharmacists, nurses, physicians, physician assistants, nurse practitioners and mental health professionals included in the governance structure for future drafts of the current version and ultimate inclusion as well. We suggest that these all be people with appropriate portions of their time devoted to clinical care activities so that insight will have clinical relevance. We would also strongly urge you to include more consumer and patient representation in all levels of the governance and team structure.

2. Population health management

The SIM plan overall is heavily data dependent and data driven. We agree that objective measurements and evidence-based practice are often times foundations of good clinical practice. Indeed, active patient panel management from a team based care perspective has the potential to improve disease control and metrics for many patients. We strongly urge the committee to base the data on evidence. As an example, what are the levels of evidence that yearly foot checks, yearly microalbumin checks, biannual hemoglobin A1C measurements and LDL goals of less than 100mg/dL to improve morbidity and mortality? What (groups of) guidelines will be followed to achieve population health goals? What levels of evidence will be utilized?

A second important point to consider is what guidelines are followed: those from the United States Preventive Services Task Force, or those from advocacy or specialty societies? As an example, if a practitioner relies on evidence to offer women mammograms starting at age 50, they are practicing evidence based medicine, decreasing cost, and likely engaging and educating patients much more than a practitioner who routinely offers these same tests to women over the age of 40 without appropriate family history. This was an example cited in the SIM proposal, and has the potential to inappropriately reflect on this high quality of care that may be delivered by some practitioners. Will quality be derived from claims data? If so, how quickly will these data be available to guide practice changes? What is the process for physicians in Connecticut to individually or collectively participate in the initial development of these advanced analytics, and their ongoing review and applicability? Given the emphasis on advanced medical homes and the multiple necessities to fully deliver true biopsychosocial care to patients, will providers be evaluated somehow based on the differing levels of psychosocial needs in relation to quality? Will the SIM proposal address any social determinants of health?

We have significant concerns that many advanced analytics have the potential to both improve care while also misrepresenting the care that is actually being provided. As recently mentioned in the *New England Journal of Medicine*: “rewarding professionals on the basis of a particular performance measure has the potential to crowd out the intrinsic motivation to perform well across the board, not just on the few activities being measured.” (Berenson RA and Kaye DR Grading a Physician's Value — The Misapplication of Performance Measurement — *N Engl J Med* 2013; 369:2079-2081.)

As a group we have heard anecdotal reports of some safety net providers refusing patients with uncontrolled diseases or discharging them for “refusing to participate fully in their care.” We do not want this to happen throughout the state if inappropriate quality measures are broadly instituted, as it could have unintended consequences on the primary and specialty care landscape. One need only look to New York state’s experience in the 1990s to see that cardiothoracic surgeons refused to operate on high risk patients after public reporting of CT surgery outcomes were made public (*Ann Thorac Surg* 1999;68:1195-1200). A similar reaction by even a small percentage of providers for a condition such as diabetes or hypertension could have significant consequences. The topic of adverse selection must be addressed, and the opportunity to develop something like a clinician and consumer-centric equity and access group may be prudent.

A second critical point under this category is that the SIM plan should ideally be designed to potentially incentivize, or at least include, more patients with Medicaid or lack of insurance into the private practice community. If private practitioners who do not practice in the heavily subsidized FQHC setting, with a markedly different payment structure, are to assume the care of patients who classically have more barriers to optimal care, then the SIM has an opportunity to impact this. From the viewpoint of a private practitioner, who already is paid less for providing care to these patients, a new set of quality metrics has a potential to dis-incentivize providing care to this population even further. Our concern is that the SIM has the potential to further entrench the two-tiered system of care already in place rather than transform and eliminate it.

We’d suggest the potential creation of an ombudsman-like position for advanced analytics, someone to whom providers can turn to dispute quality measures; and to whom patients can turn to regarding concerns about potential under-treatment or mistreatment. Should the system function well, this position will have the potential to prove itself not necessary, though safeguards should be in place to begin.

3. Enhanced access and team based coordinated care

We agree that enhanced access improves care opportunities, improves provider/practice continuity, improves patient satisfaction and may decrease emergency room care visits. All of these are important goals and many have been shown to be desired outcomes, as illustrated by many publications (eg: National Quality Forum document, www.qualityforum.org/NPP/docs/Reducing_ED_Overuse_CAB.aspx) What will incentivize providers and groups to implement enhanced access beyond Accountable Care Organization shared savings models? Does the SIM have provisions or methods to more broadly implement this?

For team-based coordinated care, has there been a cost analysis to project the additional staff that will need to be hired in each setting, additional clinician time needed to coordinate care, appropriate financial incentives for performing this coordinated care and potential to increase quality metrics and receive quality incentives? In essence, can clinicians provide high quality, coordinated care (which likely means additional staff and possibly less patient visits) and still “break even” financially? This is especially important in the many smaller practices throughout the state that are not part of large health systems.

Regarding team-based care we would suggest being as specific as possible in defining an ideal vision for operationalizing this system of care. What partnerships must this include, and what partnerships are suggested? How formalized should these partnerships be?

4. Financial accountability and high value

What provisions are anticipated to be in the SIM plan that remove potential gain for cost savings? That is, in a system with shared savings, where there has yet to be a clearly elucidated plan for who will serve as a patients “primary” clinician, what safeguards can be implemented that essentially force clinicians to reinvest shared savings in improved patient care and not as profit? This may be thought of as a “medical loss ratio” for shared savings at the individual provider or health system level. We urge the SIM to consider this: that at least a specified percentage of savings be reinvested in healthcare services and not administrative overhead or non-clinical care services. Further, how will conflicts of interest be addressed in the ACO model?

Finally, as reported quality measures make care more transparent, we propose that the SIM plan may also consider that cost be reported. This is an effort to report both quality and cost, in essence, making the value of care that providers and health systems deliver be a transparent factor for care. Value is a key tenet of the current draft of the SIM plan and both pieces of information are necessary for full value transparency.

5. Evidence-informed clinical decision making

What levels of evidence will clinicians be expected to follow? Primary care and emergency department clinicians are concerned that, since many guidelines exist that guide the delivery of ideal primary or emergency care, and perhaps not as many exist to guide the care of neurosurgeons or dermatologists, for example, that additional administrative burden will be placed on primary care clinicians, the group that already suffers from the highest rates of burnout in the healthcare system. This also has direct effects on the healthcare workforce, another key component of the SIM proposal.

The SIM presently references the successes of providing high value care via the Choosing Wisely campaign. The Good Stewardship Project, developed by the National Physicians Alliance led by Dr. Stephen Smith here in Connecticut, was the harbinger of the Choosing Wisely Campaign. We would strongly urge the SIM to include HIT-based clinical decision support tools that align with the Choosing Wisely principles, e.g. inform a provider that what he/she is doing is perhaps not best practice. Examples might be not doing annual EKGs, not doing imaging early in acute back pain, not prescribing antibiotics for mild-to-moderate sinusitis, etc. These should be both point-of-care reminders and reported quality metrics just as the population health management metrics are intended to be reported publicly.

6. Health Workforce Development

We agree with expanding programs at the undergraduate medical education level that promote inter-professional education, and support funding to improve and expand this. The Connecticut Service Track is a model program and the concept should be expanded. Residency programs should be evaluated based on the number of graduating residents entering primary care who provide clinical primary care services. A resident who graduates and becomes a hospitalist provides different clinical services than a primary care doctor, but both are reported by residencies to provide “general internal medicine” services. Additionally, increased funding should be provided to training program that train trainees to deliver care in patient centered medical homes, and that produce residents who can be shown to work in primary care settings after training.

We would also like to see more detail and rationale regarding the training and certification programs for Community Health Workers.

In summary, the National Physicians Alliance agrees with the overarching goals as proposed by the SIM. We would specifically ask the Core Planning Team and Work Group Members to consider our broad and specific comments. We believe that further clinician and patient engagement at the level of the SIM plan development is essential for a successful state transformation. We look forward to continuing to work on these important topics.

Signed,

Douglas Olson, MD, NPA-CT Steering Committee Chair
Submitted on behalf of the National Physicians Alliance Connecticut Chapter