

**Greater Tompkins County Municipal Health Insurance Consortium
Strategic Planning Committee
June 28, 2011
4 p.m.
Scott Heyman Conference Room**

Present:

Don Barber, Chair, Greater Tompkins County Municipal Health Insurance Consortium
Betty Conger, Village Trustee, Village of Groton
David Parson, Systems Superintendent for Administrative Services at BOCES and Finance
Director for the Consortium for the schools
Ken Harris, Administrator, Guthrie Clinic, Hanshaw Road
Joe Mareane, Tompkins County Administrator
Steve Thayer, City of Ithaca Controller
Jackie Kippola, Tompkins County Administration
Betty Falcao, Director, Health Planning Council
Beverly Chin, Health Planning Council
Paul Bursic, Cornell University Human Resources
Herb Masser, Town of Enfield and GTCMIC Board Member
Chantalise DeMarco, CSEA and GTCMIC Board Member and Chair of the Joint Committee
on Plan Structure and Design
Karen Gonta, Tompkins County Mental Health
Beth McKinney, Cornell Wellness Program
Travis Turner, Executive Director, Physicians Hospital Organization
Dr. Lloyd Darlow, President, Cayuga Area Physicians Alliance and Vice President of Clinical
Integration at Cayuga Medical Center

Call to Order

Mr. Barber called the meeting to order at 4:05 p.m. He said minutes of the previous meeting are attached to the agenda; no changes were suggested.

Health Planning Council

Betty Falcao distributed a packet of information on programs offered by the Health Planning Council. The mission of the Health Planning Council is to improve the health of Tompkins County residents through collaborative planning, identifying gaps in services, increasing access to health care, promoting the development of needed health care services, and encouraging the integration of the various private and public health care providers into a well-organized system. Key partners include Cayuga Medical Center, Cornell, the Cancer Resource Center, Cayuga Ridge Health and Residential community, Office for the Aging, Excellus, Finger Lakes Independence Center, Ithaca City School District, Ithaca Free Clinic, Kendal at Ithaca, Lifelong, Longer Term Care Services at DSS, and the Health Department.

The Health Planning Council does a variety of things for access for people who do not have health insurance. Although this may not apply directly to employees of those in attendance, all of those employees are likely to know someone who can be helped by their services. The Council also works on prescription access by helping people get free medications from pharmaceutical companies and other ways such as the Tompkins RX program and Urgent Rx (uninsured receiving care at Cayuga Medical Center and the Ithaca Free Clinic).

Other initiatives of the Health Planning Council include: empowering individuals and helping to manage health care costs and increase productivity: better choices - better health, helping people manage chronic diseases and diabetes, asthma resources, falls prevention and

Sharing Your Wishes (advanced health care planning and health care proxy), and Worksite Wellness – Creating Healthy Places.

Ms. Falcao spoke of funding and said the Council receives base core funding from the County and also applies for grant funding.

Ms. Chin spoke of the Creating Healthy Places that is funded by New York State to address the rising rates of obesity and increased prevalence of chronic disease. In Tompkins County 55% of residents are overweight or obese and approximately 6,000 people are diagnosed with diabetes. Funding received is for a multi-year period and is to allow the Health Planning Council to collaborate with other health planning organizations and public sector entities to enhance opportunities for physical activity and increase access to more nutritious food. They are one of five organizations to receive funding for worksite wellness; over the next four years they expect to work with 20 employers in the area with 50 to 1,000 employees. The focus will be on assisting worksites in establishing policies over a 12-month period that helps increase physical activity and healthier eating. The idea is that over time these multiple practices will accumulate and shift the worksite culture to where eating healthy is the norm and not the exception. As part of the grant they will also work on creating a network of resources and providers in the community.

Ms. Falcao reminded everyone that the 211 number is available for people to call for information on what resources are available.

Mr. Bursic said the State is beginning to pull together a study group to form insurance exchanges and asked if this would be well represented. Ms. Chin said there have been forums in the area (Syracuse and Rochester) to solicit input on how to form those exchanges. On the New York State website there is a health reform website that includes a comment section. This will change the nature of some of the work the Council does; Ms. Chin and Ms. Falcao said there will be opportunities for additional input and encouraged everyone to provide comments.

Presentation on Clinical Integration

Dr. Darlow said Clinical Integration was defined by the federal government in 1996 and it has to be an active and constantly evolving program. It requires physicians within the network to modify their practice patterns and to work together in an interdependent way to control costs and ensure quality. It should, can, or must be able to utilize new advanced information technologies such as an EHR (Electronic Health Record) or EMR (Electronic Medical Record), or an RHIO (Regional Health Information Organization/Exchange), or any other advanced information technology. There can be local and regional standards versus just national standards; however, there has to be some kind of uniform standard within the network. Dr. Darlow said all of these together should be able to reduce the use of resources. He said some say overuse of resources is a problem; however, he believes it has to be viewed as proper use of resources, and noted underuse can sometimes end up being more costly than overuse. The intent is to improve quality of care and lower the cost of care.

Dr. Darlow spoke of defining value in a medical sense and the consensus focuses on clinical outcomes, has to be led by physicians, there has to be demonstration of efficacy, ongoing improvement, and there must be a stable and cohesive network. He said for many reasons it is very difficult to recruit and retain physicians in this area.

Dr. Darlow said value based purchasing is the framework upon which clinical integration is built. The buyers of healthcare should hold the providers of healthcare accountable for both quality of service and cost of care. The current systems in place do nothing to address quality and are only about cost. Dr. Darlow said value based purchasing combines information on the

quality of care (patient outcomes and status) with data on the cost of care. Providers in the network who are practicing the most appropriate care are rewarded by better patient volume.

The AHRQ (Association for Health Care and Quality) have determined that very few employers are actually doing this. They have identified three groups:

Pioneers – smallest group that is collecting data and are developing incentives for employees to enroll with the plans that are doing the best; and

Dabblers – moderate size group that is asking for information but are doing nothing with it; and

Do Nothings – this group is doing nothing about quality but are telling insurance companies not to pay doctors as much so that premiums go down.

Dr. Darlow explained an accountable care organization is a health care organization that says they will be held accountable for the cost and quality of care for a defined population. The only ACO's that exist now that are recognized by the federal government deal with the Medicare population. He said although they have been created there is no guarantee they are going to happen because of the volume and cumbersome guidelines that must be followed.

Dr. Darlow said by establishing specific cost and quality metrics an integrated network can function as an ACO and be granted some of the same privileges as ACO's. He said the current system of a fee for services is not working.

The PHO's (Physician Hospital Organization) goal is to drive the change and try to be in control of how things happen in this County rather than forced into change. Their strategy is to show commitment with an organizational structure that is led by physicians. A lot of work has been done in a short time putting the network together and this could not have been done without having a phenomenal core of committed physicians. To run this Dr. Darlow stated there needs to be approximately 40 physicians, which have already been brought on board who want to be involved with the changes that are coming. He noted the following points:

- They are looking to build a repository for claims data and payers have been very cooperative in sharing data;
- They want to develop initiatives to reduce costs;
- There has to be accountability and noted a physician can be asked to leave the network if he/she does not comply with the performance improvement and with guideline processes;
- Physicians will be reviewed and graded by their peers;

Dr. Darlow said they would like to engage both the employers and payers and noted that all of the networks in the country that have done well has done it with great relationships with the payers. They have engaged the best and most familiar legal firm on clinical integration who are actively involved and are on site at least once per month.

Mr. Turner presented the Clinical Integration organization structure. There are seven committees that meet on a regular basis:

1. Bylaws and Nominating
2. Credentialing
3. Contracts and Finance
4. Clinical Guidelines
5. Information Technologies
6. Performance Improvement
7. Care Management

Mr. Turner said CAP (Cayuga Area Plan) discusses contracts with payers and is the avenue for building the clinical integration network. He said for this community to get all of these administrators together to discuss meaningful topics is unique because many of the other clinical integration networks do not have this type of forum. There are 200+ provider members and 12 CAP contracts. There is also a Managed Care Council which is an avenue where they sit down with the major five payers and discuss quality measures and decrease costs. He spoke of a timeline for clinical integration and said they are in their 16th month with plans to approach the FTC in November.

Mr. Turner spoke of sharing of information and managing high-risk patients, noting that 20% are incurring the health expenditures. He spoke of the obligations of the physicians to participate in the network and said participation by the committee is part of their obligation. One of the things different about clinical integration versus the current messenger model is that rates are currently received from the payers with no discussion about them. If a physician chooses not to participate they are out of network. Participation in all contracts CAP enters into is a single signature; therefore, the physicians are putting their entire power over finances of their practices with the leadership of CAP.

Dr. Darlow stressed that unless patients can be kept within a network there is no way to ensure quality. There are many times when patients request to go elsewhere for care and when they come back there are no health records; he noted physicians have no control over what happens outside the network. Unless patients can be kept within a network there is no way to ensure quality. He said if membership is offered to high quality physicians who are willing to work within the requirements they are addressing quality as best as they can. This is not meant to take choice away from a patient but believes there are extremely high qualified physicians here who can provide the quality of care that patients look for elsewhere. He said there are less than 40 clinically integrated networks in the United States and having one here will attract high quality physicians. Dr. Darlow said they are confident that if physicians are willing to work within the requirements quality being addressed to best extent possible. This is not meant to take personal choice away from a patient or the physician; personal choice will always be an important part of this.

Dr. Darlow displayed a diagram of the system they will likely be choosing and said there are multiple entry points with the patient and the physician being in the center. There is a care plan that gets doctors working closely together. There is care management which involves identifying the unhealthiest patients within the employer's sector and who are the highest utilizers of health care. A team would then be established of care managers that would include a nurse and customer service individual to be healthier. The physician would immediately have information that would identify those patients scheduled to be seen in a particular day who have fallen out of their guidelines that were established. Physicians would also be able to communicate via a system similar to an instant messaging system that will improve communication and share information.

Ms. Falcao said employers are trying to look at their population as a whole and how to analyze claims data to identify ways to improve the health of employees as a whole. Mr. Turner said there are ways they can help employers analyze this information and to suggest ways to get better results.

Mr. Bursic said Cornell has discovered from years of looking and refining data that it's very difficult to get actionable data. They have involved physicians to help them understand claims data. He said by combining the various levels of data from the electronic medical record; one suggestion he thinks would be helpful would be for physicians to know if patients are filling prescriptions that are written. He said it is key for everyone to be able to work together.

Mr. Masser asked if this program would alert physicians if a patient were having different medications prescribed by different doctors; Dr. Darlow said it would but noted it is based on claims data. Mr. Turner said if a patient paid for a prescription out of pocket the claim for the prescription would not show up but the record would show the interactions with providers.

Dr. Darlow said there is always room for improvement and said since he saw data related to his generic prescribing he has made a meaningful change in his own prescribing practices over the last three months. He thinks this is a very important step for the community to know the physicians are behind improving safety, limit waste, and bringing everyone onto the same page.

Dr. Darlow said they expect to go live by the end of the year and will be offering better value, better quality, and better cost. They are willing to work with employers in areas that are identified with a need for improvement. This presents a unique opportunity for employers to work with CAP, to partner with a network that wants to improve quality, spending and more efficient care.

Ms. Kippola asked if this includes alternative medicine. Dr. Darlow said this is something that has been given great consideration and stated the FTC (Federal Trade Commission) requires that every specialty has a minimum of five things to be measured and they cannot be things that are already being done so that improvement can be measured. When getting out of the mainstream allopathic medicine the metrics do not exist and they have to be able to credential them without that. He said there will still be a role for providers of alternative medicine but it will not get in the way of what the guideline tells a physician are appropriate measures. All guidelines put in place are based on evidence-based practice and physicians will not get in the way with alternative medicine.

Mr. Barber suggested it may be appropriate in the future to have Cayuga Medical Center and Cornell, as an employer, share information about what they are doing with the Consortium.

Ms. Falcao said clinical integration is a great model but asked how an employer begins to look at its own claims data to get a handle on what's happening within a population in terms of health care. Dr. Darlow said one way to begin is to review the last couple of years of claims data. Mr. Travis said for self-insured employers Excellus provides a data cube, which is a workstation that sits at an employer's office where they would have access. Mr. Barber noted the Consortium does not have a significant amount of data at this time. Mr. Turner said the key is to looking at meaningful reports and then determining if they are actionable. He said they can share the reports that Cayuga Medical Center (CMC) looked at and look at the high risk areas. The same tools and functionality are available because both the Consortium and CMC use Excellus.

Dr. Darlow and Mr. Turner were thanked for providing the presentation. A Meeting Wizard request will be sent to establish the next meeting date in September.

Adjournment

The meeting adjourned at 5:53 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk