

**Strategic Planning Committee****November 4, 2011****4 p.m.****Scott Heyman Conference Room**

## Present:

Don Barber, Chair, Greater Tompkins County Municipal Health Insurance Consortium  
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  
Ken Harris, Administrator, Guthrie Clinic, Hanshaw Road  
Joe Mareane, Tompkins County Administrator  
Steve Thayer, City of Ithaca Controller  
Paul Bursic, Cornell University Human Resources  
Jackie Kippola, Tompkins County Administration  
Beverly Chin, Health Planning Council  
Steve Locey, Locey and Cahill and Consultant to the Greater Tompkins County Municipal Health Insurance Consortium  
Elizabeth Karns, Village of Cayuga Heights Trustee

**Call to Order**

Mr. Barber called the meeting to order at 4:00 p.m.

Mr. Locey said at the last meeting the Committee decided to begin looking at data relative to the Greater Tompkins County Municipal Health Insurance Consortium and the TST school Cooperative. He distributed a document showing demographics to demonstrate the similarities and differences between the two groups. He pointed out the biggest difference is in the number of individuals over age 65. The TST Cooperative has over 16% of its total population over age 65 and the County's group is at 12%. He noted another difference was in the spouses – the County has a higher percentage of female spouses where the TST Cooperative group has a higher percentage of male spouses. Other than that, both groups are very similar. Mr. Barber said he would be interested in finding out whether Tompkins County is similar to other larger pools, such as Cornell's. In response to a question about premiums paid by retirees, Mr. Locey said most retirees are paying between 10-15% of their premium on the school side; on the municipality side it is typically 25% or higher. Tompkins County retirees pay 50%.

Mr. Locey said retirees receive the same coverage as the active employees; the only difference is that Medicare becomes primary once they retiree. It works much like a supplement policy; the biggest difference is there are some benefits that are provided under a carve-out that wouldn't be provided under a Medicare supplement. He said they have found that the real cost with the Medicare-age population is in the prescription drug costs since Medicare picks up the majority of the medical cost.

The next document Mr. Locey distributed was 2008-2011 Claims Utilization Data that showed which area claims data related to as well as paid claims per covered life per month in the following areas: physician, inpatient, outpatient, and other. The pharmacy data was not yet included in the Consortium data; however, he expects it will be close, with each spending approximately \$400 per life per month in terms of overall medical expenses.

In response to a question by Mr. Bursic, Mr. Locey said the Consortium typically looks at paid claims versus incurred; Mr. Bursic said Cornell looks at incurred data. This shows what actually happened during a period of time regardless of when it gets paid. He said there have been some instances in the last few years where people were billed 12-18 months later. Mr. Locey said this is something that could be provided, particularly if Cornell data is going to be used in an analysis with the Consortium data.

Mr. Locey distributed claims data broken down by diagnostic category for the purpose of seeing if there are areas through discussion that this Committee would like to target. This Committee can look at the data to see if there is additional information that can be drawn out and also whether there are additional strategies that can be put together to impact those areas. The document showed Consortium and TST Cooperative utilization in each of the categories. Mr. Locey noted how close the two groups are in terms of similar results and totals paid. He said if this Committee would like to take a closer look at the data and at a particular diagnosis they have the ability to draw out and isolate the data. Mr. Bursic said depression and anxiety are big areas but didn't notice them on the list; these areas are characteristically high at the University and areas they look at often. Mr. Locey said these kinds of areas are likely included in the Mental Health and Substance Abuse category. *He said they can ask Blue Cross/Blue Shield to see if additional information can be attained; he believes this may be possible and will look into it further.*

Mr. Turner spoke of their system and the ability to draw further down into levels of the data. Dr. Darlow said the data belongs to the employer and has to be released to whomever is analyzing it.

Mr. Locey said one area he thought may be an area to target in terms of potential impact is emergency room (ER) data. He suggested looking at this to see whether there are opportunities to alleviate the cost of an ER visit by going to a physician's office or urgent care center. He distributed ER data for both the Consortium and the TST Cooperative broken down by the top 25 diagnostic categories and noted many were the top 25 for both. He also distributed data on ER visits for minor visits. It was noted Convenient Care is not considered an ER visit and the data did not include work-related claims.

Mr. Turner said what would be useful would be having cumulative data and being able to determine if these are individual costs and symptoms or whether they roll into other chronic conditions. Mr. Barber asked if the current cost codes will allow the ability to drill down into them; Mr. Locey believes it will, as long he can find out what the final form would look like in terms of the data sets they would need. He sees this as being three parts to what this Committee is trying to do:

- 1) looking at strategies for future plan design so it is most effective in delivering the care in the most cost-effective manner;
- 2) changing people's behaviors in terms of how they access the care and become better consumers; and
- 3) provide better data to the provider community so they can better manage the care for the members.

Mr. Locey said the hardest part might be finding areas to target first. The total number of covered lives that could be impacted between the Consortium, the TST Cooperative, and Cornell is approximately 28,000.

Mr. Turner spoke of improving quality of care and the importance of involving the providers. Mr. Locey spoke of emergency room data and what other options are available to people during off-hours if they can't get to their primary care doctor. Dr. Darlow said Urgent

Care is open from 7 a.m. to 10 p.m. Mr. Harris said Guthrie now sees patients until 7 p.m. every evening and all day on Saturdays and this has proven to be very popular. Mr. Locey suggested a one-page list of resources could be made available to people showing local options that are available in addition to their primary care physicians during off-hours to avoid ER visit costs.

Dr. Darlow said his office is open until 9 p.m. four days a week and also on Saturdays. He said it is very common that someone will wait until right after closing and then contact the office. He believes the reason for this is psychological. As long as people know someone is there they believe they can wait and until they are aware no one is available at the office, anxiety sets in and the minor symptom all of the sudden becomes major and it results in an ER visit. They try to educate people about the need to call as soon as they have a problem and to not wait until it results in an ER visit. He thinks there are many people who visit an ER who do not have a primary care provider or the provider is not doing the type of research and education to minimize the ER visits. He believes education can have a major impact in reducing the number of ER visits.

Mr. Turner said through clinical integration they are proposing tying systems together and getting all data-sets so an ER doctor can access all of a patient's information, regardless of where they have been seen. This is where improved quality comes in and there begins to be actionable data. Dr. Darlow said one way they have been able to minimize ER visits for some is that there are things physicians can directly refer to hospital services that bypass the Hospital ER. These types of things include x-rays or laboratory tests. He asked if there is a way to go into the data to see if patients have a primary care provider.

Mr. Turner clarified that the data being looked at today is from a financial perspective and they are interested in data from a clinical perspective. This includes all of the data that comes in on a claims form, including pharmacy data and not only which scripts were written and by who, but also which were filled.

Mr. Locey said there are so many sources that are trying to manage an individual's care and this can lead to a patient being pushed in a lot of different directions and being confused and overwhelmed. He said in addition to education, if there could be a way of pushing this down into one source it may produce a very good outcome.

Mr. Turner said what is different about clinical integration is that when there is a visit to the ER a physician would have access to where a patient has been for care. It is like a virtual health record that would follow a patient wherever they go that would also include all medications.

Dr. Darlow provided an example of a patient who had gone to the ER. When the nurse asked the patient what medications she was taking the patient said only two. The ER physician followed up with a phone call to Dr. Darlow who was able to access the medical record and access information showing the patient was, in fact, on several different medications. He said with the system being proposed the ER physicians would have had access to Dr. Darlow's information and would have had the ability to see all medication information.

Mr. Bursic asked if a patient wasn't compliant and didn't fill a prescription, how a physician would know it had not been filled. He said this is part of the sharing of information and why having current claims information available is important. Dr. Darlow said there would be a way within the proposed system to access that information.

Mr. Turner said the program would not only be sharing the data but also following evidence-based medicine guidelines. There would also be a patient portal where the patient would have access to a care management team.

Dr. Darlow said one problem in Tompkins County is that there are no 24-hour pharmacies and this leads to increased ER visits.

Mr. Turner said they would like to use the data and create subsets that are meaningful to the employer based on their high-cost claimants as well as their chronic care conditions. Once they are prioritized, a care-management team can be put in place to act on those.

There was a brief discussion of what steps employers are taking to control things within the workplace. Mr. Bursic said Cornell has a wellness program and also has an ergonomist on staff who looks at workstations to make sure people are doing things properly. He said the physicians need to know what the employers are capable of doing and the employers need to know what the physicians are doing in terms of a cooperative arrangement.

Mr. Locey said if the Affordable Care Act stays as it currently is, on January 1, 2014 there will be a little more of an ability to motivate people to be more compliant and to do things that the physicians want them to do that are in their best interest. At that time there will be an ability to provide different premium equivalent rates that are based on people's involvement or non-involvement in wellness.

Dr. Darlow spoke of the issue of non-compliance and one of the things he is most excited about with CAP's plan. He said he doesn't believe that most people are non-compliant because they don't care about their health. He said care management nurses have much more time than physicians do and a care management team will have all of the information necessary to focus on a patient's life and understand where the barrier is to compliance and make a difference.

At this time Mr. Locey distributed Emergency Room visit data showing the top 25 diagnostic categories for the Consortium and the TST Cooperative.

Mr. Barber questioned where the Committee would like to go from this point. Mr. Locey asked which format the data would need to be in to get it to Mr. Travis and his group so that they can start to look at it and ultimately what is involved in that from a time and cost perspective. Mr. Travis said in order to share data a confidentiality agreement would need be in place that shows the employers are allowing the data to flow through CAP and Active Health. Within that agreement it would state how the data would be drilled down. Mr. Turner said they want to see data as far back as possible (up to three years) and he thinks it would be possible to run what kinds of cost savings there could be through the analysis.

Dr. Darlow said he thinks clinical integration is social reform and the more members of the lay public, the intellectual community, and the business community begin to get that message out to their neighbors, friends, and peers, the quicker this will catch on the less there will be public disbelief.

Mr. Bursic said these reports can get very sophisticated, however, there is a need to talk to providers. Cornell has taken the step to talk to providers but is still missing the ability to have actionable reasons come out of the study of the data about what can be done next. The only predictive modeling tool is where money is going to be spent. Mr. Bursic said what is compelling in what is being discussed is that data is going to be shared that will have an analysis that they are accustomed to, as well as analysis from the providers. Those providers are who can bring to the table what the right way of doing this is, in addition to what are the evidence-based standards that should be followed. Mr. Bursic said Cornell is interested in top quality care and having a healthy population and they try to promote a healthy campus. The costs are going to fall out where they do but he believes in the long run they are going be lower.

However, if they are not, he thinks they will have a much better way of dealing with costs that may rise over time or with extra-market conditions that can't possibly be controlled.

At the next meeting Dr. Darlow said he would like to show information about what he and Mr. Travis saw at a kick-off meeting that was recently held with Active Health. For the first time he was able to see what he, as a provider, what he can and will have to look at. Mr. Bursic said he would like to have an understanding of how providers will be addressing the new resources that are available.

Ms. Karns suggested looking at one condition, such as diabetes and seeing how it is treated in all of the different forums (provider, employer, and the Consortium). Dr. Darlow said they're focusing their attention on 5 –7 conditions of which diabetes is number one on the list they will be focussing on. He said physicians would like to hear from employers on what areas they would like them to focus on. Mr. Travis said it is a 3-4 month process to get agreements and data in place.

The next meeting will be scheduled through Meeting Wizard.

### **Adjournment**

The meeting adjourned at 5:35 p.m.

Respectfully submitted by Michelle Pottorff, Administrative Clerk