

**To: The Obama-Biden Transition Team and HHS Secretary-elect Tom Daschle**

**From: Arizona Health-e Connection, on behalf of the Arizona Health Care Community Discussion**

**Re: Arizona Health Care Community Discussion, held on December 30, 2008**

**Date: January 4, 2009**

In response to the Obama-Biden Transition Team and Secretary-elect Daschle's request for community health care meetings, Arizona Health-e Connection and Arizona State University's Center for Advancing Business through Information Technology (CABIT), along with a group of 18 Health Care Community partners, hosted such a meeting at Arizona State University on December 30, 2008. A list of the Health Care Community partners can be found at the end of this meeting summary document.

Ninety participants representing a variety of disciplines including, but not limited to, physicians, clinicians, pharmacists, insurance industry representatives, state medical agencies, state and local medical professional associations, non-profits and academia attended. A series of discussions on various aspects of health care reform were held, and a summary of each discussion follows.

### **Community Discussion #1 - Health Information Technology**

This section was broken into three groups of approximately 30 members each, which were led by the following individuals:

**Group 1:**

Brad Tittle, Executive Director, Arizona Health-e Connection

**Group 2:**

Kim Snyder, Project Director, HISPC/GITA

**Group 3:**

Jon Melling, Managing Director, Health Systems Group\Arizona HIMSS

**Question 1: What is the biggest single problem to tackle as we seek to establish a Health Information Infrastructure for the United States?**

**Group 1.**

A lively discussion ensued among the approximately 30 participants. There were several key points and concerns that included:

Privacy/Security of the data collected; standardization and interoperability; provider process integration; real time access; funding; case management; ability for specialists to share information; the lack of trust among the public as to how their information will be used; and the elderly limited by their ability to embrace technology.

There was no consensus among the group to identify and single out one main problem that would need to be tackled.

### Group 2.

- Cost
- Privacy
- Data security
- Interconnectivity, interoperability, no integration, compatibility
- IT support in practices
- Resistance to use of technology & change management
- Lack of access to high speed Internet bandwidth
- Inconsistent regulations
- Lack of consumer awareness
- Lack of data presentation in the same format
- For small practices – difficulty and downtime during the implementation transition
- Intelligent use of systems and data contained therein – clinical decision support
- Goal: establish system with 100% access to US citizens
  - i. Improve standards for persons and communities
  - ii. Standard for improving systemic quality
  - iii. Support education systems to support providers
- Concern with inappropriate use of clinical data (shared confidentially with providers by patients) by payers, employers, others

### Group 3.

- Move from capitalistic to socialist model/funding & access universal and choice
- Bridge gap to improve care – move to a Veteran’s Administration model of access to personal health information available from anywhere
- Standards value out of existing systems (policy & IT)
- Lack of interoperability between various Health Information Systems

**Question 2: What is the biggest single obstacle to the adoption of electronic medical records by clinicians?**

Group 1.

Three issues were quickly identified; Interoperability, funding, and refusal to change whether due to concerns about the impact of workflow or dislike of computerized records. The group was able to single out funding as the largest obstacle. While the importance of having standardization is a key factor, in order for the medical community to embrace HIT the need for funding will remain the largest obstacle.

Group 2.

- Cost (vs. benefits)
- Learned competency
- No single solution for provider community (nor should there be)
- Investment in existing systems
- Trust
- Benefits of systems largely to others, not clinicians
- Difficult to distill “important” information from some EMR printouts
- Medical malpractice, defensive medicine, lack of tort reform. Three needs:
  - i. How to tell how delivery “system” at large is doing?
  - ii. How to tell how well provider (or clinic or hospital) is doing?
  - iii. Who is needed to assess performance?
- Clinician relationship to the patients is important in clinical decision-making
- Need the utility of the EMR system to support day-to-day functions and customize for practice
- Current EMR systems do not serve physicians

Group 3.

- Money – how to pay for it (new system)
- How to bridge digital divide
- Lack of common standards/clinical & electronic
- Health info/education around wellness
- Manage access to coverage & benefits (home pharmacy)
- Electronic communication
- Overcome proprietary issues for EHR’s/reinvest electronic medical record ownership & confidentiality with rights & access

**Question 3: What role can the consumer play in establishing the health information infrastructure or how can the health information infrastructure facilitate better self management of health (or diseases) for consumers?**

Group 1.

The group had many thoughts on this question; making sure that patients receive accurate information; access to unbiased information (to include the underprivileged), early education that will take into account any cultural or language barriers as well as setting up a system for case management that the patient can maneuver.

A consensus was reached with the group that the consumer would have a much easier time navigating through the health information infrastructure if they receive early and consistent education.

Group 2.

- Educated
- Financial incentive to stay healthy
- Affordable Personal Health Records (PHR)
- Consumers assured access to information

Group 3.

- Each person take responsibility or authority to create (own/family) record
- Liability is issue for provider – consumers must be willing to share. Consumers want to work with docs electronically, but that's not supported by reimbursement
- Drs. Always at risk of info sharing between consumers/onus on docs to verify but easier to check and verify.
- Quality of information in medical records
- Consumer health education awareness plan on basis of HIT/early education“Dumping” all responsibility to consumer needs to be reviewed and discussed about how to support consumers in a system at a point of care
- Consumers are most difficult for safety and efficiency
- Generational/process to move on to online
- Don't make assumptions that poor, rural areas/populations would not be able to participate
- Potential use of Kiosks/ATM's to reach this population – public/private partnership for info. sharing and increased access to health information from non-traditional sources
- ***Need for cultural education & sensitivity on health care education and HIT education***

**Question 4: Arizona clinicians have stated that what they desire is delivery of an integrated (information from multiple points of care) patient health summary at the point of care. What is the best way to achieve this?**

Group 1.

The group quickly decided providing continuity of care by having records available patients and specialists alike would be the best way to achieve this.

Group 3.

- Secure centralized database.
- Possible use of regional networks vs. one national one due to complexity/size of USA
- Systems can/should be developed for safety
- Focus on basics first; minimize scale and show benefit; key element is sharing first: tests, Rx, hospitalizations
- Workable proven system
- Need to review models of payment to ensure greater flexibility cost models (consumer ownership)
- Fear of docs of interoperability to take on cost – is what they have purchased going to be the answer?
- Change management for other docs; they don't want to lose practice –health care skills
- Understand cost benefit trade-off Drs. are demanding access/connectivity & need to support the movement
- Tri-system to support exchange
- How much history is valuable to make the system useable?
- ***Need for cultural education & sensitivity on health care education and HIT education***

**Question 5: What role should the Federal government play as we seek to establish the Health Information Infrastructure?**

Group 1.

The group quickly identified two areas that the Federal government would have the most significant impact which is; funding and Interoperability with funding being the most important.

Group 2.

- \$\$\$ (funding)
- Provide national health standards
- Provide technical standards
- Promote sharing of “best practices”
- No penalties to providers if data is misused by others downstream

Group 3.

- **Design it right first**
- Time line & standards
- Public education/awareness
- Government pays for base system and designs standards for all vendors to comply
- Mandate legislation for e-records
- New reimbursement to cover getting anyone/codes up on records
- Cost of systems: install & learn misaligned with payment- philosophical – what do you want people to do?
- ***Need for cultural education & sensitivity on health care education and HIT education***
- What are priorities to introduce – value judgments
- Systems to support should be malleable to docs
- Mechanism for payment to support implementation
- Transparently deal with privacy, security issues and consumers
- Analysis of current grant-making system

**Question 5: If we were to choose one area on which to focus, to make the greatest impact in the shortest period of time (in establishing health information infrastructure), what would it be?**

Group 1.

No consensus reached on a single issue.

Group 2.

Goal establishment – **6 months**

e-prescribing

Group 3.

- Minimum standards & interoperability – set by government
- Details with timeline to demonstrate progress/maintain accountability
- Put patients in center & groups work
- Connect with state rural/urban/HIT efforts already underway
- Foster regional development to demonstrate success
- Nat'l plan and regional operational application
- Keep competition in the field
- Focus on consumer engagement

## **Community Discussion #2 - Patient Centered Medical Home Discussion**

This discussion was led by the following individuals, and organized by the Arizona chapters of both the American Academy of Family Physicians and the American College of Physicians:

Jim Dearing, DO  
AAFP Board Member, AzAFP past president & current board member

Anita Murcko, MD, FACP  
Medical Director, Clinical Informatics & Provider Adoption, AHCCCS

There was a good mix of providers present during the discussion. Most of the audience was made up of allied health providers such as nurse practitioners, pharmacists and physicians' assistants. Once the presentation was over, there was majority consensus that the Patient Centered Medical Home (PCMH) should be recommended to the Obama/Biden transition team.

### **Background:**

Pilots are different all around the country. Most include per member per month, quality measures hit as well as fee for service. Some pilots even include an extra staff person in the office to coordinate the PCMH. There is a PCMH pilot here in Arizona that is being sponsored by United Healthcare and IBM.

Every Medicaid health plan (in Arizona) has a PCMH proposal that will be ready to launch soon. The Arizona Health Care Cost Containment System (AHCCCS, Arizona's Medicaid agency) plans have to have enough providers in a geographic region to service the patients. A legislative change would have to happen in order to be able to have AHCCCS mandate physician rates (currently, the statute requires that each individual contract with AHCCCS and that AHCCCS doesn't have control over minimum standards).

### **Group Questions:**

#### **Is there a personal responsibility that an EHR helps patients with?**

Perhaps there should be a national repository for physicians and patients to go to where there is peer reviewed material for everyone's knowledge.

#### **Is there a possibility that we are moving towards a single payer system?**

Most likely not in the short term because there are too many mixed feelings, lack of trust by providers that the existing Medicare plans are sufficient enough to be the only vehicle to pay for care.

#### **How many people have primary care physicians and see them?**

Not many. The use of a PCMH would help pharmacists by making only one person the contact. Should the physician have one pharmacist that could help coordinate/manage care of chronic disease patients regarding providing drug therapy?

**Obstacles:**

Coordination of care between hospitalists and primary care physicians (PCPs) suffer as there is little to no communication between the two groups. It is especially hard to track and follow-up with patients who have no PCP. It's hard for patients to find physicians to follow them when they need an IV at home. Hospitalists don't give the report to the PCP after the patient is discharged. In addition, many physicians no longer have privileges at the hospitals because the hospitalists are on site.

Patient compliance could be a problem with the quality indicators. We need to prevent incentives to providers to discharge non-compliant patients.

Patients don't always understand what PCP means, nor do they value the care provided by a primary care physician. Patients need to be steered away from the former "gatekeeper" identity assigned to PCPs, and understand that PCPs in the PCMH model ensure and coordinate appropriate care.

One potential barrier to PCMH is the employer based insurance system. PCMH must have a payment mechanism whereby patients don't lose their PCMH when they change or lose employers.

**Crux Issues:**

Patients and the public must be educated on the meaning of both PCP and PCMH.

Making sure all payers buy in to the PCMH model and pay for it.

**RECOMMENDATIONS TO OBAMA-BIDEN TRANSITION TEAM:**

- Proceed with development, funding, and trials of PCMH concept.
- Consider moving away from employer based system.
- Educate public on fundamentals of primary care and PCMH.
- Require payers to use minimum standards for reimbursement.

## **Community Discussion #3 - Healthcare Cost Reduction for Employers and Other Purchasers**

This discussion was led by the following individuals:

Marilyn Teplitz,  
President, MGT Associates, LLC

James Garnett,  
Executive Director, AeA Arizona-New Mexico

There were about 75 attendees. Most were involved in healthcare; either healthcare providers, educators, or involved in healthcare in some other way.

### **Question 1: What is the biggest single issue contributing to the high cost of healthcare today?**

There was no single issue but the discussion focused on malpractice costs, defensive medicine due to fear of malpractice litigation, and an aging, longer-lived American population. Compounding the issue is the lack of access or awareness of preventive medicine. The global issues involve the wide dichotomy between patients who receive what they perceive as “free” healthcare and those that are under- or un-insured and facing exorbitant healthcare fees.

The uninsured and underinsured often cannot afford to go to the doctor. So, they wait until they are more critical; end up in the emergency room, straining the system even further.

Healthcare costs are rising at a rate faster than the Consumer Price Index (CPI). We should focus on reducing the rate of increase of healthcare costs, not just reducing costs in general. We may need to consider “effective control” (or rationing) of healthcare services.

### **Question 2: Have attendees or their family members experienced difficulty paying medical bills? How can policy makers address this problem?**

Medicare Part D is confusing and prescription drugs are so expensive that patients are skipping their doses to save money. There is a lack of efficiency and consistency in how patients access Medicare and its treatment. One of the participants cites an example: “It took the healthcare system so long to diagnose and treat my brother that he needed a leg amputation after an unnecessary (due to treatment delays) and costly knee replacement on the same leg.”

Health Information Technology can offer broader provider access to medical records and help provide consistent care instead of the current gaps in care due to “silos” of healthcare services. Health providers understand the system but patients do not, making it difficult for patients to navigate the system.

Public policy should facilitate consumer health needs assessments to fill in the gaps of health coverage. Should the federal government develop an agency to finance healthcare?

One participant told of her patient's prescription drug costs of \$1,400 a month for a single drug. Patient's healthcare costs should be more transparent with estimates provided BEFORE treatment. As an example, a participant claimed to have incurred more than \$1,000 of unexpected costs for unnecessary allergy testing, most of which was not included in her health plan. Had she known before she agreed to testing that it was not covered, she would not have agreed to the testing.

Section 125 health plans are more transparent and there is more flexibility in the plan. However, it does NOT pay for preventive health. A more holistic approach should be applied to healthcare including mental, environmental, nutritional, social health, dental, etc. Prevention efforts should be reimbursable.

**Question 3: As employers, what is your biggest problem with regards to providing healthcare coverage to your employees? What should employer's role be in a reformed health care system?**

The cost of and the increase in premiums is the number one issue. A small to mid-sized employer offering health insurance when its competitors do not, may put them at a disadvantage because of a higher cost of doing business. Individual employees may be covered in the plan but family members may not, escalating a financial hardship on American families. For national employers, there is varied coverage from state to state, making it difficult to offer consistent coverage for all its employees. It was the consensus of the group that employers should not play a role in health insurance. Consumers should be able to shop around like they do for other products or services for a more competitive price. Employers should take a role in their employee's preventive healthcare needs and foster healthy work environments. A dissenting opinion was that employers should NOT be involved in employee health—"too much like Big Brother". One participant makes the statement that, "the American car companies are healthcare companies with car issues."

**Question 4: In addition to employer-based coverage, would the group like the option to purchase a private plan through an insurance-exchange or a public plan like Medicare?**

The group concurs that they would be willing to pay into a healthcare plan with a safety net for catastrophic health issues or healthcare coverage in later years when health fails. Employees often stay with an employer even when they don't want to because they want to keep their health benefits. It was acknowledged that healthcare benefits are an important aspect in recruiting and retaining qualified and skilled employees. In order for employers to reduce their healthcare costs, they should encourage healthy lifestyles and pay for preventive medicine in their plans.

There is a great abundance of healthcare research and models, including NICE (National Institute for Clinical Excellence, in the UK) and AHRQ which should be put to use to establish effective healthcare public policy, or "evidence-based" healthcare public policy.

**Question 5: Do you know how much you or your employer pays for health insurance?**

Yes, most companies are providing their employees with an employee/employer breakdown of healthcare costs. The employer usually incurs all or some of the price increase differential. Without cost transparencies, individuals put off treatment because of a fear of non-affordability. Employers should enjoy additional tax/saving benefits for providing healthcare to their employees.

**Question 6: Are you familiar with the types of preventive services Americans should receive? Have you gotten the recommended prevention? If not, how can public policy help?**

Approximately 75% of the participants practice recommended preventive medicine most of the time but the group is biased because of their healthcare orientation. They believe that the general public is not anywhere near that compliant. Bring back health classes and physical education to the schools. Teachers should teach students health issues they're not learning at home. The holistic and preventive approach to medicine is agreed upon by the group.

**Question 7: How can public policy promote healthier lifestyles?**

There should be a wide variety of healthcare plans offered to employees including incentives for preventive medicine. 100% of the costs of preventive medicine should be covered under the plan with co-pays for sick care. The group consensus is to provide individuals with a more expansive menu of customizable health plans.

## **Community Discussion #4 - Provider Payment Presentation**

This discussion was led by the following individuals, and organized by the Arizona chapters of both the American Academy of Family Physicians and the American College of Physicians::

Paul F. Howard, MD, FACP, FACR  
Governor, ACP Arizona Chapter  
Director, Arthritis Health

Doug Spegman, MD, FACP  
CEO, Carondelet Health Network

Jim Dearing, DO  
AAFP Board Member, AzAFP past president & current board member

The presentation was led by introducing the Obama-Biden Transition Team vision statement for healthcare reform, and briefly examined the impact on access due to the declining number of practicing primary care physicians in the U.S. Also outlined were the main components of the current health care crisis: Collapse of Primary Care, Dysfunctional Reimbursement, Inadequate Access, and Rising Costs. Statistics regarding cost, quality, and access were reviewed.

The group discussed and explored the advantages and disadvantages for the four most common payment methods currently used: *Fee For Service; Capitation; Bundled (DRGs), Global, or Case Rate; and Salary.*

The floor was opened for questions and ideas related to the most important aspects of changing the system, including improving access to care, quality measures, and reimbursement structure.

The university system was applauded, whereby students pay a single semester fee and receive access to all care. Clinicians are employees of the system, and work efficiently. It was recommended that this type of system be explored and developed for the general population. Dr. Dearing noted that because the students in the University system are a generally healthy population, costs can be kept at a reasonable rate. While the process is good, it does not account for chronic, high-risk patients, who would increase the cost. This would cause either disproportional payments for healthy vs. sick populations, or resentment on the part of the healthy population who would subsidize the chronically ill population.

The cost-effectiveness of the VA system was discussed. The VA system is similar to the University system, both of which are “socialized” systems. The VA provides quality care to chronically ill, high-risk patients. Many veterans leave the VA system for regular care until cost

becomes an issue. It was also noted that utilization in socialist systems is not higher than utilization in the US.

The discussion moved toward Fee For Service, and the need to re-evaluate what is considered “work”. Procedures are more highly recognized and paid for but cognitive care is undervalued and is underpaid. The system must recognize that coordination of care is a high level of work and should be reimbursed at a higher more valued level. Evaluation and management (E/M) codes are grossly undervalued. Primary care physicians need to be recognized and rewarded for their breadth of knowledge and experience. In addition, relative value units (RVUs) need to be re-evaluated.

Currently the system allows for inappropriate use of subspecialists. Many patients who do not have a primary care physician use a specialist or subspecialist to act as the primary care physician.

This led to a discussion regarding the decreasing number of medical students and residents seeking careers in primary care medicine. Unless the system recognizes and rewards the primary care physician’s experience and expertise, students and residents will continue to choose specialties. In some cases this leads to a talented individual choosing a specialty instead of their first choice of primary care, just because of the income potential. Support and incentives at the educational & training level must also be developed.

It was noted that AHCCCS (Arizona’s unique system of covering Medicaid clients) could sit down with providers to establish quality measures and objectives, establish and recognize the importance of primary care, and ask the specialists to agree to lower reimbursement in order to increase reimbursement to primary care physicians. This seems unlikely on the part of the specialists.

As conditions continue to worsen, physicians are looking for a “new book of business”, or elective procedures that pay cash. More primary care physicians are turning to concierge medicine, or not accepting insurance.

It was also noted that the US should better use the public health system to screen and pick up on activity early, bringing patients into the hospital environment only when absolutely necessary. The US needs to refocus on creating and rewarding healthy behavior.

Public Health measures were emphasized. A system where only the “illness” aspect of medicine is addressed is not balanced and is more expensive financially and otherwise. We need to focus on public health measures to promote and ensure great health.

**Recommendations to the Obama-Biden Transition Team:**

<u><b>ACCESS TO CARE</b></u>	<u><b>QUALITY MEASURES</b></u>	<u><b>STRUCTURE OF PAYMENT SYSTEM</b></u>
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<ul style="list-style-type: none"> <li>• Drastic shortage of PCPs, and is getting worse</li> <li>• Financial support at the education and training level to increase number of PCPs</li> <li>• Use public health system to screen and track early, bringing patients to hospitals only when necessary</li> <li>• Real access, not just 8 – 5 access to physician care</li> <li>• “University” or “VA” system, paying one fee for complete coverage</li> </ul>	<ul style="list-style-type: none"> <li>• Incentives for coordinated care with PCPs and subspecialists (the right care for the right patient at the right time)</li> <li>• Incentives for PCPs to work toward positive patient outcomes</li> <li>• Incentives for patients to work toward wellness outcomes</li> </ul>	<ul style="list-style-type: none"> <li>• Recognize and reward PCPs for breadth of knowledge and experience</li> <li>• Reimburse for cognitive care</li> <li>• Reimburse for coordination of care</li> <li>• Re-evaluation of RVU system</li> <li>• Reevaluate reimbursement of E/M codes</li> <li>• Establish base reimbursement for codes</li> <li>• Risk adjusted payments</li> <li>• Salaried physicians with built in incentives</li> <li>• Put Medicare under one umbrella, and not use Part A, B, C, D</li> <li>• Establish “social contracts” among all involved in delivery and payment of care</li> <li>• Change to fundamental payment in system to encourage primary care training</li> </ul>
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## **Community Discussion #5 - Improving Medication Access & Use**

This discussion was led by the following individuals:

Harry Hagel, RPh, MS  
Sr. VP Government and Professional Affairs,  
American Pharmacists Association

Mindy Rasmussen, RPh  
Chief Executive Officer, AZ Pharmacy Alliance

### **Question #1: What is the biggest single medication-related issue that should be addressed within the larger healthcare reform agenda?**

No single issue stood alone among the following issues that were discussed:

- Pharma industry
- Direct to consumer advertising in print and on television – no other countries allow this
- Compliance – patient ownership
- Medication – focused care coordination
- Cost, insurance coverage, coordination with providers
- Economic considerations: price discrimination, ability to pay
- Payer driven cost containment strategies; formularies
- Cost disparities between countries e.g. USA/Canada
- Provider education
- Equal access to meds by all patients – remove barriers

### **Question #2: What is the biggest obstacle to solving the identified medication related issues?**

No single issue stood alone among the following issues that were discussed.

- Pharma industry itself
- Special interest stake holders
- Capitalism-based healthcare system
- Incentivize drug manufacturers to drive price down
- Competition & innovation
- Politics
- Core, philosophical positioning
- Health care – right or privilege?
- Under utilization of pharmacy services
- Personal/Patient responsibility & accountability

### **Question #3: What should the federal government's role/responsibility be?**

- Setting of standards/removal of disparity
- Enforcement
- Public education/awareness – promotion of healthy lifestyles (prevention)
- Citizenship
- Un- and Under-insured
- Funding for pilot programs
- Public goal – similar to national polio vaccine effort
- Create incentives for public & private interests

**Question #4: What should the role/responsibility of the consumer?**

- Be engaged!
- Accountability & responsibility
- Expectations of care from providers; medication histories

**Question #5: What should be the role/responsibility of the prescriber?**

- Developing a system for addressing patients
- Education of, and follow up with, patients
- Practice quality
- Never prescribe anything that is not in the patient's best interest

**Question #6: What should the role/responsibility of the pharmacist?**

- Educate public and care providers
- Continuing professional education
- Medication safety, prescription coordination
- Patient relationships

**Arizona Health Care Community Discussion Partners**

Arizona Association of Family Physicians (AzAFP)

AARP Arizona

Arizona Chapter of the American College of Physicians (AzACP)

Arizona Chamber of Commerce & Industry

American Electronics Association, Arizona-New Mexico Chapter (AeA)

Arizona Health Care Association (AHCA)

Arizona Health Information & Management Systems Society (AzHIMSS)

Arizona Health Information Management Association (AzHIMA)

Arizona Medical Association (ArMA)

Arizona Medical Group Management Association (AzMGMA)

Arizona Nurses Association (AzNA)

Arizona Nurse Practitioner Council (AzNPC)

Arizona Osteopathic Medical Association (AOMA)

Arizona Pharmacy Alliance (AzPA)

American Pharmacists Association (APhA)

Arizona Public Health Association (AzPHA)

Arizona State Association of Physician Assistants (ASAPA)

Health Guide America (HGA)

**Thank you for your attention to the summary of our meeting.  
Photos and video of the discussion are available upon request.  
Please feel free to contact Brad Tritle, Executive Director, Arizona Health-e Connection  
should you have any questions or concerns.**

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