

Health Working Group
Regional Primary Care Coalition
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Participants

Derek Barnett (Kaiser Permanente)
Danielle Cameron
Lori Jackson (Alexander and Margaret Stewart Trust)
JoAnn Knox (NoVa Scripts Central)
Phyllis E. Kaye (Regional Primary Care Coalition and Health Working Group)
Terri Langston (Public Welfare Foundation)
Patricia N. Mathews (Northern Virginia Health Foundation)
Margaret K. O'Bryon (Consumer Health Foundation)
Nancy Pallesen (Arlington Free Clinic)
Ria Pugada (Public Welfare Foundation)
Irit Rasooly (Primary Care Coalition of Montgomery County and Regional Primary Care Coalition)
Patricia Rodgers (Northern Virginia Health Foundation)
Gwen Rubinstein (Washington Area Women's Foundation)
Rachel Wick (Consumer Health Foundation)

Please note: *Organizations are listed for identification purposes only. The views expressed during the discussion and the recommendations that came from it are those of the individual participant and do not necessarily reflect the views or positions of the organization.*

Health Care Community Discussion

Some 14 leaders from philanthropic and safety net/primary care communities in Washington, DC, Northern Virginia and Suburban Maryland participated in a far reaching discussion on health care issues facing the area's uninsured and underserved and developed recommendations for addressing them through health care reform. The December 22, 2008 meeting was convened by the Health Working Group of Washington Grantmakers and Regional Primary Care Coalition in conjunction with the Obama-Biden Health Care Community Discussion Transition Project.

Participants included leaders of both regional and national foundations who fund in the health area and representatives of health services safety net providers. The discussion was organized around questions provided by the Obama-Biden Transition Project.

Health System's Biggest Problems and Overall Recommendations

There was a strong consensus that the overriding problems with the U.S. health care system are that it focuses on sickness rather than health, is not cost effective, has limited access and misaligned incentives, and, in reality, is not a system at all. Services are fragmented and operate in their own silos and with little coordination.

Specifically:

- Health care in the US is based on a medical model rather than a health or wellness model. Primary care is undervalued;
- There is a lack of service integration especially around oral health, behavioral health, and pharmaceutical access;
- Workforce and diversity issues need to be addressed – there are too few persons of color in the medical professions and insufficient use of allied health professions and community health workers;
- The real costs of care and services cannot be easily determined so it is hard to manage these costs effectively;
- There is a mindset that “more is better”, that technology/doctors can “fix” problems and that the most important healthcare is provided by specialists. Physician payment and reimbursement rates reflect these values. Incentives are generally misaligned. Most financing and reimbursement systems favor paying to treat sickness rather than to prevent illness or promote wellness and generally rewards the use of specialty care and technology rather than primary care and care coordination;
- Medical technology leads to huge investments that do not necessarily result in improved health status for individuals or population; and
- Universal health care coverage does not exist, and where there is coverage, not everyone who is eligible for it is enrolled, and not everyone can afford the associated costs. People may not be able to afford premiums and can be denied coverage for medical and other reasons.

Recommendations: The administration should develop and implement policies, financing mechanisms, and programs that bring together disparate, competing elements of the health care “system” to create a person-centered, wellness-focused system of care. This includes:

- Realign financial incentives so that they support health and wellness - make sure that primary care (broadly and clearly defined) is paid for under public and private insurance and other health coverage programs, and that people have access to these coverage programs;
- Treat oral health services, behavioral health services, preventative services, and health education, prescription drugs, as part of comprehensive and integrated systems of health care and not treated as ancillary services;
- Use health information technology to its fullest – as a means of :
 - connecting patients to appropriate care – “no wrong door” to finding access;
 - facilitating service coordination and integration;
 - improving quality;
 - identifying and measuring the effectiveness of services, prevention activities, interventions and population health;
 - educating providers, consumers and the general public; and
 - increasing efficiencies and reducing or controlling costs
- Link health reform to workforce development and job creation with a focus on communities of color.
- Look at lessons learned from state universal coverage and single payer systems with a and consider how the models might be replicated and brought to scale (e.g. Massachusetts Connector program to provide universal access and Maryland’s single payer system for hospitals to help prevent cost shifting).

As a society, we need to make a decision about whether healthcare is a commodity or a right. The system we develop will reflect our values. We hope that health care system that this nation develops regulates health in the **public** interest. Not having a comprehensive system creates significant gaps in who receives care and what care they receive.

Choosing a doctor or hospital

For the uninsured and medically underserved, the population of particular interest to those engaged in this community dialogue, there are not a lot of healthcare choices. Access to providers is limited, and often by the time under- and un-insured patients seek care they are too sick to make considered choices. To the extent that people “choose”, they do so based on:

- What’s available, i.e. clinics/doctor/hospitals willing to provide services to those who cannot afford to pay;
- Referrals from families and friends;
- Referrals from social service programs; and
- Cultural and linguistic appropriateness.

Lack of access contributes to using hospital emergency departments for non-emergency care and to hospitalizations that could have been avoided with timely primary care.

The uninsured and medically underserved have very limited access to specialty care. While there are programs to facilitate access to specialty care (including basic dental and mental health care services), the un and underinsured consumer does not have luxury picking among providers. They face similar challenges in “choosing” hospitals – not all hospitals are willing to provide necessary but non-emergency services to those who cannot afford to pay.

Even if there were good measures and useful ratings of the skills or performance of physicians, specialists and hospitals it is unlikely that they would be able to utilize that data. Assuming the data is easy for people to interpret, using it assumes people have real choice. Most people health care choices are limited by who participates in their insurance plans and coverage networks. And choice is even more limited for the uninsured and underinsured as not everyone will see patients who cannot afford to pay.

Paying Medical Bills - How can policy makers address this problem?

Data tell us that medical debt, illness, and other consequences of lack of insurance and underinsurance take a serious toll on individuals, families, communities, and our economy. Medical debt and the costs of coverage preclude asset building and are crippling forces for lower and middle income individuals trying to attain a foothold on the economic ladder. Recent bankruptcy law changes exacerbate the problem. It is difficult for the people to make financial plans for medical expenses. Debt can be caused because people fall out of coverage due to illness, employment changes, or economic hard times. We do not have a good means of identifying these individuals, connecting them to resources, or providing them with care.

Recommendations for Addressing Problem:

- Medical bills need to be transparent – consumers and third party payers need to understand the bills they receive and pay;
- Hospital policies and billing for the uninsured and charity care need to be clearly stated;
- Cost shifting from one payer to another needs to be addressed – frequently the uninsured is charged more than those with health coverage. Maryland’s all payer system addresses these issues and should be considered as a model; and

- Reduce the overall costs of health care by focusing on a wellness model, prevention, and chronic disease management.

Employer-based coverage, and option to purchase a private plan through an insurance-exchange or a public plan like Medicare: role of employer in reformed system

This implies coverage or the ability to purchase coverage which is not the case for low income or the uninsured and underinsured. The group considered creating a simplified insurance system, developing affordable plans that small employers or individuals could buy into, creating links into public programs, exploring capitated coverage programs or ones with very large risk pools, and broadening coverage of primary care as important ways to reduce the costs and expand access to health care. However, there will still be people who may not be able to enroll in or purchase insurance.

The notion of buying into publicly funded programs was appealing to the group. It would allow for more widely available options, increased negotiating power, and opportunities for regulation. The pre-requisites for success would be making enrollment and continuation of coverage easy, assuring physician participation and adequate coverage of services, and taking steps to ensure access for those who are enrolled. For example, many physicians don't accept Medicaid and clinics serving Medicaid or uninsured patients typically have long waiting lists. Expansion of public programs would need to address these concerns, perhaps by using health information technology and other tools for facilitating access to care.

The baseline of any system, of course, needs to be good quality, accessible care. Insofar as broadening public programs are a means to that end, they would be helpful.

Prevention Services: How can public policy help? How can public policy promote healthier lifestyles?

The group focused on the fact that the medical system is limited, in that its mission is primarily to provide treatment to those already ill. Policy makers play an important role in realigning system wide incentives to promote prevention and wellness through coverage programs. For example, policy makers at the federal, state and local levels and those responsible for creating benefits packages and programs, can provide incentives for prevention and wellness services which can lower healthcare costs in the long run, even if upfront costs are significant. Recommendations for addressing this issue are to:

- Make sure that primary care (broadly and clearly defined) is paid for under public and private insurance and other health coverage programs, and that people have access to these coverage programs;
- Reward physicians and patients for implementing "best practices" for prevention;
- Mandate coverage and payment for physical exams, appropriate screenings and treatments that result from diagnoses made at those screenings;
- Make sure that mental health, addiction treatment, dental care, and basic pharmaceutical access are part of basic coverage programs are important ways for policy makers to promote and facilitate healthy lifestyles; and
- Foster creation of primary care and integrated health systems that allow for meaningful provider/patient conversations about health across the spectrum of care, and medical homes in which patients can be connected to education, prevention, primary care, and specialty care services. The group strongly supports the Medical Homes model, which is operating in the District of Columbia with very good results.

Policy makers also have the ability to make health a critical part of community planning and development by reaching across sectors to look at land use and other policies and to make

sure that , schools workplaces and other institutions promote healthy lifestyles. The group also concurred that using place-based initiatives, such as Wellness Opportunity Zones, could bring to bear multiple design and development strategies to help solve the problems chronic diseases diseases such as diabetes and asthma that affect individuals throughout their lives. More holistic approaches will be needed if we are to pursue prevention and improve population health.