

Testimony to the Joint Committee on Health Care Financing
H 01849
An Act Improving Quality of Health Care and Controlling Costs by Reforming
Health Systems and Payments

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Mr. Chairmen and Members of the Committee:

I come before you today as an interested citizen of this Commonwealth who has also served in the MA House, as Vice-Chair of this Committee, as a member of the Executive Branch Long Term Care Financing Committee and as a provider of clinical services for over 30 years, including a period of personally doing my own billing of insurance companies for services rendered. These experiences have given me a unique perspective on these issues and the issue of health care was one of the motivations for me to run for office.

I am including for the committee, detailed testimony, which I had submitted to the Health Care Quality and Cost Containment Council in December 2010 as they were preparing to write this bill. In addition, I am delivering testimony from Mass Home Care as a board member of North Shore Elder Services.

I will comment in general on aspects and areas that are addressed in this very important health care bill. I will hand in the specifics.

This is the 4th health care reform bill in the past 6 years, but this bill is where the “rubber meets the road” and it is a thoughtful and progressive move to adjust the flow of money in our health care system to contain costs and improve quality outcomes.

Strengths:

1) **ACOs must be tried aggressively** as they lead providers to coordination of care which greatly benefits patients, allows clinicians to share their work and to be closer to the decisions of what our dollars will pay for. The parameters, risk adjustment factors and concerns about how savings and money will be handled, reflect thorough consideration of all input and is a great place to start.

2) **A strong process is laid out to base changes in the delivery system on assessing best practices** by reviewing data, providing reports and make adjustments based on findings. The use of nurse practitioners for primary care is very important, as is the use of nursing providers in the management of chronic disease.

3) For one of the first times since we have passed health care legislation in MA in 2006, **clinical practitioners have a clear place in decision-making** by serving on the advisory committee to the Health Care Coordinating Council. The presence of those who understand the science in health care is critical to determining what to pay for as we work to contain cost.

The decision-making regarding health care must always include clinical people at the table. We have made decisions for years on business models alone, which have not stood the test of time. This bill includes those providers. They have the greatest responsibility, but have had very little involvement in deciding changes. If something goes wrong, clinical people have the greatest risk, including their livelihood, while hospital exposure is limited and insurance companies are not sued when something goes wrong.

4) **Tort reform** necessary to stay focused on good clinical work. Tort reform based on a model used in Michigan with rights to sue retained, but by creating a cooling off period with an alternative. It has been very successful where employed; it is very humane; it will generally help in a healing process and should allow for more direct communication between provider and patient.

5) **The Division of Health Care Planning** is a very important component of controlling cost, with the intention of strengthening what is now our DON process which has been weakened in the last 20 years, with the idea that a free market will contain costs naturally. This is clearly not the case.

6) **The key inclusion of attention to behavioral health services**, which are everyday issues in delivering health care in any clinical area, is a very important element to cost containment. This bill has important recognition of behavioral health.

Suggestions:

Need a Long Term Care Support and Services Task Force to address how these services are included in payment reform. The lack of these services regularly sends people into crisis and causes there to be more utilization of expensive health care services. Long-term care services are medically indicated for optimal functioning of those with impairments and chronic illness. Long term and chronic illness are one of the greatest expenses in our system. These services must be considered part of the overall system of health care. We have already recognized the importance by supporting SCOs(Senior Care Organizations) in MA. We have a natural system in place through our ASAPs. We cannot ignore these services in this bill. It is part and parcel of the well-being and stability of our more vulnerable and expensive population.

Included in the written testimony on the subject are all the necessary data points to show why this is a critical issue in cost containment.

Other Issues:

It has recently come to my attention that only physicians write in **electronic medical records** in some of our largest health care institutions. All service providers should be writing in these records, not just physicians. Often other providers spend much more time with the patient and have important information to share. As well, other providers must have the information that physicians are sharing.

Comprehensive Health Education in K-12 must become a required part of our education requirements. If the idea is to educate youth to function in society, they have to start by knowing how to care for themselves and their own children. It can be part of basic science curriculum.

Thank you for your attention.