

# State-Wide Primary Care Access Authority

Co-Chairs  
Margaret Flinter  
Tom Swan



## MEETING SUMMARY

**Wednesday, December 19, 2007**

**7:30 AM in Room 1C of the LOB**

The following members were present: Margaret Flinter, Tom Swan, Robert McLean, Daren Anderson, Evelyn Barnum, Joann Eaccarino, Commissioner J. Robert Galvin, Lynn Price, Sandra Carbonari.

Also present were: Teresa Younger, Fernando Betancourt and Meg Hooper.

Absent were: Comptroller Nancy Wyman, Commissioner Michael Starkowski.

Also absent were: Frank Sykes.

Margaret Flinter convened the meeting at 7:42 AM and asked members to introduce themselves.

Lynn Price asked that the November Meeting Summary reflects the following change, overall there are about 200 APRN graduates in the state, half of which are from Yale.

Joann Eaccarino requested the following statement, "care provided in School Based Health Centers (SBHC's) are considered preventative", on page five of the November Meeting Summary be changed to, in the early days of SBHC's that was the intent but as things have evolved there are many more children being seen for minor and acute illnesses and certainly in the mental health world many children are being seen with actual DSM4 diagnosis.

Robert McLean stated he would like to clarify a couple comments that he had made at the November meeting. 1) At the bottom of the second page, I had stated that I had asked about the high percentage of people who have no insurance at all and how their insurance deals with that issue, instead of "their insurance", I was referring to the FQHC's. 2) About two pages later, under community health center, I asked "what was the cost per provider" and actually what my question should be is, what was the cost of implementing the Electronic Health Record (HER) per provider. 3) About two pages later, under my own comments, I had stated that "there is a relatively small percentage of primary care doctors that have adopted electronic health records" and if you go another sentence later, it talks about the concern over whether this is really the future of medical records, and that was not my intent because there is clearly a future for electronic medical records, and so what I would rather that to say is I'm concern over whether a particular vendors product would still be adequately functional in the future.

Meg Hooper stated that she was at the meeting but she was sitting in the back.

Tom Swan asked for a motion to approve the November Meeting Summary.

Lynn Price offered the motion and Daren Anderson seconded.

Meeting summary was approved on voice vote.

Tom Swan stated that one of the really big task is analyzing what's really out there and if we are going to ensure that everybody has access to primary care, what's needed in terms of where we are and where we are not.

Margaret Flinter stated that the point of today's discussion is for this group to really lay out how we want to approach the inventory, what is the meaningful data that we need to get about the primary care infrastructure in the state and the larger vision of universal access to primary care.

Margaret Flinter reminded members that the Department of Public Health holds some funding and has the ability to contract with experts to conduct the inventory. She stated that members should think in terms of current technology relative to what we might want to know about geographic locations, ratios of people to population and distributions.

Robert McLean asked if counting the number of buildings is a way to count federally funded clinics, trying to look at hospitals or truly looking at where health care is being delivered.

Margaret Flinter stated that it might be a marker for location.

Meg Hooper stated that it addresses access in the geographic areas that do not have facilities that provide services for primary care, particularly in the Northeast and Northwest corners of the state. She added that it could help determine what kinds of primary care services are being provided and where.

Fernando Betancourt stated that there are a number of other important issues such as an analysis in terms of concentration, how far it is for our transit routes and what is driven by the market. He added that it will provide the Department of Public Health with an assessment of where they have to locate their resources versus what the market is driving.

Teresa Younger stated she is concerned about the hours of operation, because when we talk about access we can't talk about it in terms of nine to five or eight to four thirty. She added that when we talk about what those hours of access truly are, they are not necessarily always forty hour a week, fully functioning, they may be three hours a week or six hours a week or twelve hours a week and that would be informative for the same reasons Fernando is talking about, particularly where mass transit has limited service hours.

Robert McLean stated that clearly classifying this based upon zip codes makes a lot of sense and that he can see us spending a lot of time getting a lot of data that we really don't need or will use. He stated that we know that we don't have enough primary care doctors and we know that they need to have more hours. He suggested the inclusion of the definition of the advanced medical homes in increasing access and hours.

Margaret Flinter stated that part of this is to get our global wish list and then turn it into the reality of what can we do within the confines of the budget that we have.

Lynn Price agreed with the statements of Meg, Fernando and Teresa on the issue of addressing access. She stated that you can look at the zip code in New Haven for instance and it takes you from the Quinnipiac River all the way up to Yale, and there is a wide variety of patients who don't really have meaningful access either because of transportation issues or they might be elderly.

Sandra Carbonari asked if the inventorying of buildings is by services provided. She stated that although there is a primary care provider in the building there may not be dental services, mental health services, and all the other types of services. She added that if there is one provider that's there three afternoons per week, providing say pediatric care, then that leaves out a whole bunch of other services that are not available in that building.

Meg Hooper stated that she will go back to the data that the Department of Public Health collects to identify types of services, hours of that service, number of providers providing that service as that can address capacity even better than square footage. She added that the Medical Society will be of great assistance in providing information on the primary care doctors and the six thousands offices that are out there.

Robert McLean stated he was not exactly sure of the details and the demographics that the State Medical Society has and if they have more than the State Department of Public Health. He added that asking primary care doctors if they are open from six to nine may or may not be relevant because if they are available by phone they are on call. He added that for some facilities, hours and availability is crucial but for the vast majority of people in the state who are getting their care not through those facilities but from doctors in the community they probably do have access if they have a primary care doctor.

Robert McLean added that looking at some of the sub-specialties may not be accurate because a number of people do primary care but also have a sub-specialty that may or may not become evident in the demographic that the State Medical Society has as oppose to directly surveying them. He stated that going forward the Department of Public Health should include as part of the paperwork for re-licensure questions that clearly asked, what's your specialty, and do you perform primary care, since these very simple basic answers could be easily codified.

Meg Hooper stated that hours of service, getting at the sub-specialties and who actually provides primary care would require that the survey or phone call clearly defines primary care.

Robert McLean asked how many physicians are currently licensed in Connecticut ?

Commissioner Galvin stated about sixteen thousand but added that only about thirteen thousand five hundred are actually practicing medicine in Connecticut. He added that some are administrators and some are from other states with dual licenses.

Robert McLean stated that the State Medical Society has between eight and ten thousand members and that their data is based on an America Medical Association data base.

Commissioner Galvin said if primary care is not carefully defined and measured properly the result will show there are plenty of primary care providers. Commissioner Galvin added that the big problem is they are all in the big cities and the nice suburbs and nobody is out in the Northwest, and the Southeast corners of the state.

Commissioner Galvin defined primary care as pediatrics medicine and general internal medicine of family practice. Commissioner Galvin stated that if primary care providers don't do seventy five percent of their practice on people who call up and ask to see them, then probably they are not providing real primary care. He added that if you are a primary care provider and you are not taking new patients, or you do not see Medicare patients that it will not do new patients any good.

Lynnn Price said she wanted to state for the record that we will be looking at special populations, many of whom are treated with mobile services and we will keep this focus on them as well.

Daren Anderson stated that ultimately we are going to treat this as a study, we are going to make assumptions, test with the strictest assumptions, and we are going to look first, if we use the strictest definition of primary care, what do we have, and if we loosen that to include other areas we are going to have a slightly wider assumption. He added that we are going to need to collect more data up front and then analyzing it in different ways is ultimately the best we are going to do on this because there is no perfect answer to the question of how many specialists are seeing primary care patients or not.

Margaret Flinter stated that the issues around availability to special populations, to minority populations and to the more urban densely concentrated populations are all really critical things and the clinicians around the table have such different practice and service arenas that they approach it from different ways. She added that we can actually take a first pass look to get the data to then ask the question a couple of different ways based on the data not the respondents. She reminded members that the conversation right now is pretty centric to primary care physicians but the charge is much broader. She stated that the charge is to look at APRN's, dentists and the behavioral health world.

Meg Hooper stated that Commissioner Kirk at the Department of Mental Health and Addiction Services (DMHAS) and the Department of Public Health has the best inventory that is obtain from that statewide perspective based on the information submitted to them and they would have to reach out to their community providers to assess that full services. She added that the Department of Public Health can talk with DMHAS and that the Authority could invite them to be a member of the Authority.

Margaret Flinter stated that inviting both the Commissioner of Mental Health and Addiction Services and representatives from the State Dental Society are probably a good idea since we have representatives from the State Medical Society and the Connecticut Nursing Association.

Tom Swan acknowledged David Krause, who is representing Comptroller Nancy Wyman's office.

Margaret Flinter stated that Mr. Rollins, President, Middletown NAACP, presented his report and one of the recommendations of their report on health disparities was to also try and get a look at representation in the primary care workforce by ethnic racial background. She added that this would be a way of knowing how well we are doing at getting a health care workforce that reflects the patient population we are serving.

Meg Hooper stated that the above is a little bit more difficult right now because we have a voluntary check off box in our licensure data system for all of the folks that we license, where it is optional to indicate your race and ethnicity. She added that ethnicity is presently defined as Hispanic and Non-Hispanic.

Meg Hooper stated that the Connecticut Health Disparity Project is housed in the Department of Public Health and they are working with our licensure folks to see if we can formulate a more encouraging statement. She added that the data is self reported but it is not consistent and that any information particularly from State Medical Society and other folks through the associations would be helpful.

Meg Hooper stated that the Department of Public Health is working on it across both the reporting mechanisms and the interpreters themselves. She added that it can be an additional variable for the survey since our goal is to identify if there is a primary care shortage. She stated that the survey might not provide the justification to say there is a primary care shortage, but we might then get into insurance, access to types of services, special populations, including those that need transit services and the broad statement is, do we need more primary care.

Margaret Flinter stated that she did not think that is the charge and if you take a literal interpretation of the charge to our group, shortage isn't referenced, it's really inventory. She thought the question to ask

is, “*how do we achieve the outcomes we seek and what is our goal for a healthier society?*” She added that elimination of health disparities and access are all built into the charge.

Meg Hooper stated that she will work with the Office of Primary Care, in the Public Health Initiatives Branch to determine what other surveys and assessments have been done. She added that she did not want to repeat work that was already done and asked members to forward material that they thought relevant to her at [meg.hooper@ct.gov](mailto:meg.hooper@ct.gov)

Robert McLean stated that Dr. Galvin’s comment regarding asking people if they are actually actively taking new patients is crucial because we may have enough primary care doctors or providers but the practices are not open and they are not in the right place. He added that if they are in fact actively practicing, the question to ask is, *are they going to be practicing in five years?* He reported that some surveys in other states asked, 1) *how many providers are over the age of fifty or fifty-five;* 2) *how many are approaching retirement;* and, 3) *how many are going into second careers because of frustration with the system.*

Robert McLean suggested that a survey of fourth year medical students be conducted to assess the field of practice and residencies that they are entering into. He added that this would give a snap shot of what’s happening within the state in the next couple years. Robert McLean stated that a lot of people are afraid of Connecticut because the malpractice premiums are too high, Connecticut is an insurance state, insurance isn’t friendly and the fee schedules are not high enough.

Commissioner Galvin stated that the information regarding where residents went is available right after graduation.

Bob Scalettar stated that while a licensure may be the common universal for a data base of physicians in the state the breadth of it you are describing is limited. He questioned whether or not the insurers would capture all this information on their credentialing applications and through an effort in the last couple of years through a national organization called the Council for Affordable Quality Healthcare (CAQH) where there is a common application form that physicians fill out. He added that while it won’t be one hundred percent of participating physicians, it will give the vast majority of the kinds of information the Authority is looking for.

Meg Hooper asked if the above is something that the Co-Chairs will be willing to inquire about.

Margaret Flinter responded they are pretty open to speaking with everybody who has something of value to offer.

Robert McLean stated that the CAQH is a central organization therefore we may be able to get the information directly from them and not go through the insurers.

Lynn Price stated that similar questions to those asked of physicians should be asked of APRN’s because the licensure data is not by specialty. She added that a number of insurance companies still do not recognize APRN’s as providers and that we need to be careful not to leave out dentists, psychologists and other types of providers who may not be a part of that data.

Margaret Flinter stated that we have to determine what constitutes primary care services for the purposes of conducting the inventory.

Robert McLean stated he had forwarded a report from the American College of Physicians which stated how the Councils of State Governments had recently passed a resolution endorsing what’s called the “Patients Centered Medical Home”. He added that this is also endorsed by the family physicians,

pediatricians and internists at a large national level. He outlined the definition for “*primary care*” as *each patient has an ongoing relationship with a personal physician trained to provide first contact, continuous and comprehensive care.*

Sandra Carbonari stated that in pediatrics the concept of medical home is being ongoing for over a decade and while she agreed with those points she would offer the definition of a “*medical home*” as *accessible, continuous, comprehensive, family centered, coordinated, compassionate and culturally effective*

Daren Anderson stated that the Advanced Medical Home is a road map for where we want primary care to go and not what exists today. He added that he was at a conference last week about Advanced Medical Homes and it is a wonderful concept of exactly what we think primary care should be delivering in the twenty first century but as many participants noted, what’s described in the entirety of the documents really doesn’t exist in many places today outside of some specific really high performing organizations.

Lynn Price reported that there is an ongoing project in Waterbury as well as a community access project some years passed with the community health clinics in New Haven, Saint Raphael and Yale primary care clinics and what we discovered is that we perceived people to have somewhat of a medical home while they do not perceived that. She added that even though they would name the clinic as their primary care provider they still went to the emergency room because it was convenient to them because of transit hours and work hours.

Daren Anderson discussed the idea of whether or not to include urgent care walk-in centers and minute clinics since they claim to be providing primary care. He added that on some level some of them may do so but he believed that question needs wider discussion as we start looking at the numbers that we are getting back.

Sandra Carbonari stated that trying to change the behavior of patient population is not going to happen easily because if the patient sees the most accessible source of care as the emergency room they will utilize it. She reported that people don’t go to the emergency room because they have a sore throat at night but because in the morning they need to go to work, to school and lots of other things, so to the patient that’s a very acceptable alternative to waiting until in the morning. She added that by definition places like minute clinics do not provide primary care and based on our most basic definition it doesn’t fit the criteria of the first contact and continuous care.

Margaret Flinter stated that based on her and Daren’s experience on educational and behavioral change at the health center we should always look close to home, at ourselves and the systems, because we are the last to change our behaviors and educate ourselves about what our patients and our consumers are often saying they really need from us. She added that on the retail clinics and the minute clinics, it would be awfully useful to know where patients are actually going.

Lyn Price agreed with Margaret’s comments and added that we needs to look at what it is that the consumers are doing and ask them.

Joann Eaccarino stated the SBHC’s makes an effort to connect the family and child with medical home in the community and the reality has somewhat to do with behavior but also it has to do with the reality of people’s lives if they are going to loose their jobs because they took a couple hours off in the morning to go to their primary care provider in the community. She added that SBHC’s do have continuity with the children in that population.

Evelyn Barnum asked how we are going to combine consumer representation and input into the work we do. She added that she is well acquainted with most systems of care and that it amazes her how anyone can navigate that system if they are not familiar with the health care system.

Teresa Younger added that we may want to create a parking lot of questions that counter what we find out regarding the information of primary care with how consumers and the public are actually using those services.

Daren Anderson proposed a consensus that we at least take a first stab at developing an inventory of what we would define as strict primary care, which are people that are specifically engaged in family practice, internal medicine and pediatrics, and then define a broader category of primary care, which might include people doing urgent care and OBGYN. He suggested that ultimately we will have to match-up the population and look at what it is doing, match-up pediatric, geriatric and the middle-age population and look at how the system is providing for those different age groups.

Fernando Betancourt asked if that is to start a definition of what primary care is or was it for the purpose of the inventory.

Robert Mclean responded that primary care is, a relationship with a provider trained to provide first contact, continuous and comprehensive care.

Fernando Betancourt asked if that would include mental health services.

Margaret Flinter stated that it's going to have to include mental health.

Robert McLean stated that primary care provider is someone who is trained to treat medical conditions and that person generally has some mental health training as part of their medical school and residency, and they are the appropriate person to triage that person into the mental health system. He added that it will be very difficult and if we start counting mental health providers as primary care providers because they are not, they are part of that medical home or part of that system.

Margaret Flinter stated that the charge is around primary care and not just primary care providers and she thought there is a distinction between the two. She added that if we refer to primary care, oppose to primary care provider, it will be first contact, continuous and primary works as a objective criteria. She stated that the issues relates to the medical home and that the world's health definition would add, *socially acceptable, close to where people live and work based on sound scientific principles.*

Margaret Flinter stated that it gets trickier with behavioral health because everyone needs a level of primary care in medicine and dentistry. She added that in behavioral health there is a sifting that goes on and generally that's not something we looked at as a primary preventative service.

Lynn Price asked for clarification regarding the definition of, "comprehensive and accessible" and suggested that it be a part of the decision.

Margaret Flinter stated it is challenging on the accessible part and that she was unsure that it would work as a screener of what primary care is.

Fernando Betancourt stated he was close to supporting the consensus that is building, but the meeting summary of 11-24-07 is quoting Margaret as saying "*primary care providers are any physician, dentist, nurse provider of service for the mentally ill or person with mental retardation or anyone else providing primary, medical, nursing, counseling or other health care, substance abuse or mental health service*

*including such service associated with or under contract to HMO or medical service plan”, and he thought this is much broader category and is almost contrary to the suggested consensus.*

Robert McLean agreed with Fernando’s comments and added that the legislative charge required the inclusion of those people as a part of the primary care system.

Fernando Betancourt stated that he understood the comment but saw it in the context of Commissioner Galvin’s comment that we have to start with a clear definition. He added that the definition in different ways would yield different results at the end and it is better to do it now, whether we decide it is a broader category and narrow it afterwards.

Commissioner Galvin stated there is simply no primary accessibility to psychiatrics, and clinical psychologists and that the vast majority of psychotherapy is done by primary care physicians and specialists physicians

Sandra Carbonari stated that first contact doesn’t necessarily means accessible because the contact the patient is making is, I need a doctor, and they are hearing that the practice is not taking new patients and they do not participate with their insurance. She added that the other part of accessible is twenty four hours a day and on call.

Margaret Flinter stated that a provider who is serving two thousand patients and is unable take one more patient is still accessible.

Margaret Finter asked if the group was ok with going forward with the definition as “first contact, continuous and comprehensive”.

Margaret Flinter informed the meeting that she had invited Senator Williams to discuss his decisions and focus in establishing this Authority but due to scheduling conflict he was unable to attend but promised to attend another meeting. She added that the question to be asked is, *“could Connecticut be the first state in the country to say we are so committed to making sure that access to comprehensive primary care is 100% available and is accessible on a regular basis to everybody in the state of Connecticut”*.

Margaret Flinter stated that the Authority will ask Commissioner Cristine Vogel from the Office of Health Care Access and Commissioner Michael Starkowski and David Parrella from the Department of Social Services do presentations at the next meeting.

Tom Swan announced January, 23, 2008, at 7:30 AM, for the next meeting. \_\_\_\_\_

The meeting adjourned at 9:17 AM.