State-Wide Primary Care Access Authority

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Meeting Summary

October 28, 2009 7:30 A.M. in Room 1C

Members present: Co-chair Margaret Flinter, Dr. Daren Anderson, Lynn Price, JoAnn Eaccarino, Dr. Sandra Carbonari, Dr. Robert McLean

Also present: Rep. Elizabeth Ritter, Sen. Jonathan Harris and Kevin Lembo

Margaret Flinter convened the meeting. She noted that co-chair Tom Swan is absent due to business in Washington D.C. Margaret Flinter stated that co-chairs of the Public Health Committee, Rep. Elizabeth Ritter and Sen. Jonathan Harris, as well as state of Connecticut Health Care Advocate Kevin Lembo would be attending the meeting today.

Margaret Flinter asked for a motion to approve the July and September minutes.

Lynn Price made the motion to approve both minutes.

Dr. Sandra Carbonari seconded the motion.

The minutes were approved.

Margaret Flinter asked the Authority to consider issuing an interim vs. a final report. She stated that it does not make sense to do a final report when everything is so up in the air both on the national level, and with SustiNet. The members agreed to issue an interim vs. final report.

Margaret said that our consultant, Barbara Ormond, has all of our materials and is working through our minutes, presentations, outline and recommendations.

Margaret Flinter asked that the members review the recommendations developed to date and ask questions or comment.

Dr. Daren Anderson pointed out that there is nothing in here about payment reform. Margaret Flinter noted that the Provider Advisory Committee of SustiNet is charged with looking at payment reform too, but that would be good to look at for our report and asked Daren to flesh out that recommendation, which he agreed to do. He added that it is almost impossible to talk about serious primary care reform if we don't talk about payment reform because the payment structure, fee for service, low reimbursement rates is driving the behavior that we see, which is 5 to 10 minute visits, productivity focused, poor quality and we can't ignore the topic. He also pointed out that the outline does not include anything on monitoring or performance measuring.

Margaret Flinter pointed out that we had included reporting measures, and had previously suggested using the VA scorecard for quality reporting in primary care. Daren said we need a number of quality measures, including patient satisfaction with quality and access, and outcomes in chronic disease. He also pointed out that the VA is adult specific, though many can be used for pediatrics.

Daren Anderson also recommended that we look at more broad indices such as ambulatory sensitive admissions and readmission rates, and we should at least set a goal. While these current measures have been effective, they are at best, intermediate outcome measures and ultimately we should be looking at broader measures like hospitalizations, ambulatory sensitive hospitalizations, 30-day readmission rates, and at some point looking at morbidity and mortality.

Margaret Flinter agreed and said that the ambulatory sensitive admissions has been reported on by OHCA in the past, and we can ask that this be done annually, at least. She reminded the group that the results are largely what we would predict: that if you are uninsured, Medicaid or a member of a minority group it is way up over the other populations. A recommendation might be for there to be an annual report card published where we are tracking that as a measure of whether we are getting the quality and the outcomes.

Dr. Sandra Carbonari recommended that we specific pediatric measures. She suggested that we might add into the performance measures, EPSDT or bright futures. She stated that the chronic disease model does not work for pediatrics. There are certainly some children with special health care needs and chronic diseases, but what really drives pediatric primary care is EPSDT.

Margaret Flinter asked if there was a pediatric EPSDT equivalent to CIRTS (immunization registry and tracking). Dr. Carbonari said that there is not, but those measures would be very good ones to report one. Although EPSDT is most associated with Medicaid, these measures have become standard in pediatrics and she would recommend we use it for all children. She also thought that "Bright Futures", which she described as "EPSDT plus" and focuses on developmental issues, prevention, and anticipatory guidance, might be a good basis for pediatric reporting. Dr. Carbonari agreed to follow up and see if any states are doing this level of reporting.

JoAnn Eaccarino commented that the report should include school based health centers" under "financial support for quality improvement in critical groups. She stated that we need to look at all statewide initiatives that address quality. Margaret asked her how the SBHCs might report as a group and whether they had a mechanism for reporting utilization and quality data. JoAnn noted that a lot of it is in the software systems that the SBHCs use.

Lynn Price commented on the medical home elements of the interim report. She stated that we need to be very clear in our language. Do we really want to say, when we are setting up criteria for a medical home that we are going to use all of the existing and onerous criteria to be certified as a medical home. She stated this might be very inhibiting and added that we should discuss it and decide how detailed we want to be in that description. Lynn also asked for clarification about the medical home vs. the PCCM model. How do they fit together? How has the PCCM rolled out, and how will this work with SustiNet, Charter Oak, and other initiatives.

Margaret Flinter responded that this is a great question, and we probably need to have a discussion again about medical home because there is a whole group in SustiNet devoted to medical home. Margaret added that she dropped into the outline of recommendations one that we pick some region of Connecticut, and while not often a fan of pilots, consider a medical home project. We have PCCM pilots, let us try a non-Medicaid focused medical home pilot of private practices coming together trying to share those resources that make you a medical home. It seems like that would be a worthwhile thing to do to see what the experience is. She suggested that in reading the SustiNet legislation, it seems that PCCM would be subsumed into medical home if that payment methodology advances, but probably Ellen Andrews or somebody could tell us better.

Dr. Daren Anderson commented that the medical home is a concept that pulls together the chronic care model, planned primary care case management, and think all of the primary care reform that we have been talking about. The VA has just contracted with the ACP to implement medical home across the VA. Nation-wide they administered the practice assessment and what we are finding is that it also includes the VA model because it talks about performance measurement and use of clinical reminders etc. He stated that "medical home" has to be a centerpiece of what we are describing because it really does include almost all of the different elements that we have been talking about, access, payment reform, case management, performance measurement, is all a part of the medical home. Part of what the medical home has done is that it is sort of taxonomy, and what it does is that it embraces all the things that we have been working towards. He said that this needs to be a cornerstone of what we are writing about.

Dr. Sandra Carbonari said that there are two medical home and primary care Medicaid practices in her region that are robust medical homes, and these are general pediatric practices, not specialty practices. They have existed for five years. She added that by definition, the medical home is not in the specialty practice in pediatrics, because the hub of the medical home is the PCP and the family.

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Lynn Price stated that she endorsed exactly what Daren has said and added that she is trying to get at whether or not we are going to adopt whatever the overarching certification requirements are. Her understanding is from past discussions that it can be difficult for practices, particularly smaller practices, to sustain this.

Margaret Flinter summarized and said the question becomes, and this Authority is as good a place as any to flesh this out, how do we move people down that path? How we support people and incent people/practices, and how do we treat them differently once they get there. If there is really, evidence that medical home demonstrates better outcomes which there seems to be then we have to do something in the recommendation area. It also goes back to payment reform, and assignment. We have not yet said within this health reform piece that everybody has to pick a medical home. Unless we can begin to measure outcomes by panel, It will be hard to gauge results. She added that this is complex, but we can't just say that "SPCAA supports support medical homes" and leave it at that."

Dr. Sandra Carbonari said that one of the challenges with medical homes is that you really need some up front support to do it. So to say that you have to prove that you are a medical home and then you will get support for it, is really going the wrong way around. She does not think it can happen this way. She also pointed out that while this process is evolving, the patients with the most complex needs may tend to gravitate to those practices that are medical homes, so they then may become overwhelmed and not have adequate support.

Margaret Flinter returned to the recommendations: Precisely how do we support it? The regional extension centers that Connecticut will apply for is all about helping practices plan for, choose, implement, learn to use and get over the hump of the electronic health records. The same process is probably true for medical home, but who is going to do that? She commented that she thinks the regional extension centers are a brilliant idea for HIT; can it be done for medical home? That is what we are trying to get into for these final recommendations.

Lynn Price added one last thought for the record, to get back to the discussion around payment reform and accountability with outcomes: We can help people get to a point where they are a recognized medical home practice, but if you are not rewarding them for doing it then I don't think it will continue.

Dr. Robert McLean commented that in the actual description of medical home, one of the formulas proposed for reimbursement is to pay for performance outcomes. He suggested that if you accept that, then it needs to be part of any medical home initiative.

Margaret Flinter next welcomed Public Health Committee co-chairs Rep. Betsy Ritter and Sen. Jonathan Harris and Connecticut Health Care Advocate and SustiNet Board Chair, Kevin Lembo. She introduced them saying that the Authority had asked for them to come to ensure that you are aware of what the Authority has been doing, and so that the Authority is aware of what you are doing both with SustiNet, and also in terms of the priorities in the Public Health Committee around primary care are for the upcoming legislative session.

Margaret gave a brief summary of the SPCAA to date: SPCAA was convened just about two years ago, just as a lot of change began to happen: the economy began to tank, a new administration came in a 7 year later and health reform became a central part of the national agenda; in Connecticut, the HealthFirst Authority completed its work, the SustiNet legislation passed, and we are on the brink of a lot of potential change---but more uninsured people than ever, and still many concerns about both coverage and primary care access, cost, and quality.

When the legislature created the PCAA there was some thought at that time that maybe we should look at some form of coverage that is just for primary care and left the rest of the issues to be addressed separately. As things developed, and as the state reform and national reform began to take place, that never looked like a viable way to go. We on the Authority worry about people getting to primary care, but uninsured people worry about going bankrupt because of catastrophic hospital and diagnostic care.

We are charged with trying to figure out the current capacity for primary care in the state of Connecticut, very hard to do because we have no data that can help you do that. Our colleagues at the University Of Connecticut Center for Public Health did a methodologically very sound and good report using something national medical expenditure data and produced a report that we will include with our interim report. It showed that generally in Connecticut, by the numbers we have adequate capacity in primary care, except in northeast and northwest Connecticut.

The Authority also worked closely with the Department of Public Health on the electronic re-licensure project to make sure that we began to collect data that allowed us to predict future needs based on current trends and to get an accurate picture of the primary care capacity for the population on an annual basis. We recommended, and they substantially adopted, the survey data used by New York State. That will now be collected electronically at the time of relicensure. We will need to support DPH in making sure they have the technical resources to analyze and report on that data every year. It asks not just the standard questions (date of birth, address) but questions of training, specialty, locations, hours in direct care vs. research or administration, availability of electronic health records, anticipated retirement date, years in practice, openness to Medicaid patients, new patients, etc.: are you practicing primary care, and not just certified for primary care? are you really available to the population for primary care. It includes much more data than previously. As this rolls out we expect the state to have, and make use of, that data.

We have moved on now to recommendations for the interim report. We want to be aware of what SustiNet is doing. And we are trying to be as specific as we can, to give you something to sink your teeth into. Looking at primary care performance reporting measures, what should those measures be? How can we get everybody to do it? Expanding the safety net, but with criteria for where do school-based health centers and FQHC's get started? What kind of support? What should they have to prove they have as capabilities before we will put additional support in? These are questions we are trying to

move towards recommendations. We have some scope of practice recommendations that we will probably be making, and of course we will including dental and behavioral health in that.

Lynn Price added that in terms of the capacity issue, she wanted to clarify that, as you will see, the capacity report, really just addresses people who have current access now and does not look forward to the time when under any particular system, we might have better coverage. It is by utilization, not workforce availability. It does not tell you who tried to get care and could not.

Dr. Robert McLean described the Ct. State Medical Society efforts to address workforce capacity and availability. He pointed out that there was a lot of press about a year ago that the State Medical Society put out a survey looking at workforce, and it looked at general medical workforce. They are in the midst of putting together a survey that is going to go out to the primary care workforce in the state, which will hopefully answer many of the questions that we are trying to get at. That is going to give us a lot better data on some of the access issues, and practice issues, whether they are actually taking new patients, and how many hours they are working, whether they are full time, etc. So a lot of those pieces of data that we have not been able to actually get accurately, hopefully this will give us the most accurate picture that we can get. They anticipate that survey will go out in the next month, with a goal is to have something tangible by January or March.

The Authority members then asked for Representative Ritter, Senator Harris, and Kevin Lembo to address them.

Rep. Ritter thanked the Authority for their work and said that many of the questions and the information she is seeking are ones just touched on. This is precisely the kind of information we have been seeking, and we will be looking forward as this unfolds, to seeing further information. Most of interest is the primary care capacity in the system now. She stated: Looking ahead, from a policy standpoint, I think it is really incumbent upon us that we establish a methodology for some kind of prediction for access to primary care and practice patterns, and also, as our population begins to change, the workforce that will be needed to go along to support that care system. I believe that will be critical, and that is something that will be of interest to us. I will tell you frankly that one of my frustrations, as a legislator in these times is that we do not have a lot of money. Most often, the first response when we start talking about the workforce issues is “pay for me to get educated and I will join the workforce”. There is perhaps some resistance to the explanation that that cannot be the answer. We need to look further at our workforce and how it grows and matures and the career path that is there for many people that brings people into the healthcare workforce, and keeps them there. We bring many people in, but we do not keep them all. Those are some of the immediate concerns.

Sen. Harris thanked the Authority for the invitation. To start out, our priorities are now just being formed, so that is why this interaction now is important. He spoke to the difficult position of the State. The first is the budget crisis, which is most likely going to have a deficit, in the current fiscal year, somewhere towards a billion dollars by the time we get back in February. Between revenue that is not coming in and savings that might not have been realized the way we anticipated, a minimum of half a

billion, but probably closer to a billion dollars deficit is expected. In the next biennium, we could have a $6b deficit. We do not have the rainy day fund, we probably will not have stimulus dollars, and to the extent that we have achieved savings that we have targeted, those are gone, and our bonding is high. This is the backdrop that we are trying to plan against. We want to try to get things done, and be realistic, not plan for something that can't happen. We also have a timing issue. We have a holistic planning model. It is important that when we figure out what we can do, that it is as consistent as possible and not in conflict with the holistic plan that hopefully we will be able to implement. That is the context within which we are planning.

One of the things that I think we can do some work on, and exploration on, is workforce development. One way is taking away the approach of loan forgiveness in exchange for work, to some other ways of thinking about it. One of the options that I have read about is giving incentives or disincentives to out state medical school to produce primary care doctors. There is a model that I believe is being used in Minnesota, where they can profile, those that are more likely than not to go into primary care. Across all of our professions, we should try to give incentives to all of our institutions that receive state dollars to produce more primary care professionals so that they either will receive more funding or less, depending on their outcome measures going forward.

The other thing that I think we need to do**,** and haven't figure out how to yet, is to look at the array of other professionals and services that may provide some aspects of the medical home so that we can try to squeeze at much out of existing assets that we already have in Connecticut. That would help to deal with the fiscal crunch, because we already have some of the existing infrastructure on the ground.

Dr. Robert McLean commented in response: I think you identified the problems very well, especially with the workforce. Whether we like it or not, pay and reimbursement is the key. If you are going to get people into primary care, then they have to get paid more. There is nothing you are going to do to the medical school that is going to make them change the incentives for medical students, Medical students are going to change where they want to go, and they are going to choose based upon, maybe loan burden, but more than that, how much they are going to be earning in 10 or 20 years. That is clearly demonstrable when you look at people in the military medical schools who graduate with no debt burden. They go into dermatology, ophthalmology, anesthesia and radiology at the same rate as everyone else. Therefore, it is a huge system problem of how to essentially redistribute income from specialists and the system. Dr. McLean noted that big challenge is to figure out where all the money is going now. He offered the argument that there is plenty of money out there, if you redistribute it not among doctors, but among insurance companies, pharmaceuticals, DME. He also pointed to that generous state employee benefits and questioned why the state should offer "Cadillac" plans to employees. He suggested that at a micro level, perhaps the state should spend less per month on each employee and squeeze the insurance companies. He concluded that the State could squeeze down on some of these areas and do amazing things with the savings.

Sen. Harris acknowledged Dr. McLean's comments and said that big change in this area likely would not happen in this session. Those changes are more likely part of the larger holistic SustiNet discussion, payment reform and switching away from fee for service to some more of flat-funding type of a system that redistributes some of the money and narrows the gap between different kinds of providers. He noted that one of his concerns with the whole health care debate is that it has become an insurance reform debate, and it is all about coverage, when we need to deal with cost. If we do not control, and make the cost structure fairer, then we will not have the dollars to cover people or to do as you say. He also said: With respect to the medical students, I believe that the idea is not incentives or disincentives to become a primary care doctor, but literally, by looking at someone's application and their background, you can raise the percentage and the probability of creating primary care physicians by selecting certain people from the pool of applicants that would be more apt to do so. I was told by my doctor, of all the students in medical school, only 20% are contemplating going into primary care. Of course, we know because of what you laid out, how that drops off as they go through their education and their debts go up with their knowledge base. However, apparently, you can take that 20%, and by selecting in a different way, maybe build that up to 40% are contemplating, and then increase your numbers. That is what we want to explore.

Dr. Sandra Carbonari added that it is not only loan repayment and income, but also quality of life issues. Primary care providers have always been whom the burden is shifted onto, without necessarily any support. The whole structure of the way the health industry looks at things is that procedures and gadgets and hands on stuff is much more valued than the more cognitive kinds of things, particularly in pediatrics. All of the screening and prevention is valued relatively low, compared to what the value is in the long-term, over the life of the child.

Sen. Harris agreed, and commented that it is difficult to be a generalist these days. He also said primary care practice needs to change. The offices cannot close at lunch and at 5:00 pm when people work and need to be seen in the evening, or to call at lunchtime. This has to be part of the evolution.

Dr. Daren Anderson quoted the CEO of Sony who said "We have to stop paying for crap We pay more than any other country in the world for health care, probably significantly more percent of our GNP than anybody else, and our outcomes are worse, not just our disease outcomes, but the service outcomes as well. Not being able to get an appointment when you want it, that's crap. Not being able to get through on the phone, that's crap." Dr. Anderson said that we need to think about not throwing more money into the system, but finding where the money is being spent inappropriately, or being spent for bad services. At Dartmouth they have demonstrated that probably about a third of all the things we spend money on in healthcare are useless, unnecessary, and potentially harmful. Potentially as much as half have questionable benefit at best. There is plenty of money in the system; the question is how to redirect that money to things that we know work.

Dr. Anderson stated that one thing that we know that works is primary care. Primary saves money and improves outcomes, and I think that is where we need to focus our efforts. I do not believe it is all about finance. I recently moved to the VA and am in charge of recruiting primary care doctors, and my email inbox is overflowing with people who want to come to the VA and work. It is not because I pay them a lot more, but we provide them with a model that works. The VA reformed its system about 10 years ago, and the first thing they did was they built a very strong primary care infrastructure and electronic health records system with an integrated system emphasizing case management, patient satisfaction, and access, and we provide support for the primary care doctors when they come there. We give a reasonable lifestyle, we do not shut the phones off at 12:01, but we also are not crushing them with 10-minute visits. We are doing pretty well recruiting because we have a place where people can practice in a model that makes sense, they feel like they are taking good care of their patients and we emphasize quality.

Dr. Anderson also praised the Urban Services Track at UConn Health Center. A few years ago, Dr. Bruce Gould and a few other people at UConn set out to do exactly what Sen. Harris suggested. They wanted to identify people early; they went back to even high school to find people who have a predilection for primary care. Combining the training with nursing, pharmacy, dentistry, and medicine, and give them a concentrated tract all the way through medical school, hopefully leading on into residency, where they are trained in the tools that you need to practice primary care in the modern era. I think there are about 3 or 4 years into it and I think it is a model worth supporting and emulating. It is a very robust effort that is unique in the country to support primary care.

Rep. Ritter thanked Daren for his comments and added that when she started her career the VA system was not one of the systems that we brought up when talking about things that we were proud of in healthcare. This was long time ago. It is gratifying to hear the progress with the VA as well as Bruce Gould's program at UConn. She asked that help the Legislature see ways we can move pieces of our system closer to these models that work.

Margaret Flinter said we hear you loud and clear about macro restructuring and we hear you loud and clear about the budget. The flip side of that I think has to be a commitment to supporting innovation, as used in the VA. I think we will be coming back to you with specific recommendations for innovations, which, even if their budget number is neutral, we made need legislative support to get them through. Sen. Harris said that he would agree with that and we welcome the recommendations. Part of that is to make sure that it fits with SustiNet so they can be analyzed together.

Dr. Robert McLean announced that UConn is doing away with their primary care residency program next year. Most members present were not aware of that and will seek more information.

Margaret Flinter then thanked Kevin Lembo for joining the meeting and asked him to speak. She stated that he was one of the strongest members of the HealthFirst Authority. She asked for an update on SustiNet.

Kevin Lembo thanked the Authority for their work. He gave an overview of SustiNet. The committees are the HIT committee, the medical home committee, the provider advisory-quality-reimbursement reform committee, and the prevention committee. The Board has recently added, through the statutory power of the board, a diversity and equity committee as well, because one of the very glaring and obvious issues when we first sat down was the lack of diversity at the table. There are several taskforces, seated by the Leadership. These include tobacco, obesity, and workforce. Workforce has met already, and medical home is about to meet. Committee co-chairs are being assigned, and each committee will have a board liaison. The Board will seat the committees after the November 12 meeting. That is where the initial work will happen. One of their goals is to build committees that not only represent the state in all of its diversity and its ability and its knowledge, but also to make sure that they have got a group of people who are going to get this done.

SustiNet has two staff positions to help get the work done. Kevin commented that in his analysis, the work ahead is probably a $2m effort when you consider the modeling, research, writing that needs to be done. Therefore, SustiNet is seeking some funding for that. The Board is very aware of the federal progress; once the Congress acts, the SustiNet Board has 60 days to report to the legislature on how Connecticut will respond. There are immediate things that need to happen, and we need to report to them in a very tight timeline.

Margaret Flinter thanked everyone for attending. She reminded the group that SPCAA is committed to wrapping this interim report up and getting a set of recommendations to the Legislature as soon as possible. Our next meeting will be the Wednesday before Thanksgiving, November 25, 2009.