STATE-WIDE PRIMARY CARE ACCESS AUTHORITY

Interim Report to the General Assembly

February 17, 2010

Submitted by
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Co-Chairs

Preface: History of the Authority and its proceedings

The State-Wide Primary Care Access Authority (SPCAA) was established by the Connecticut General Assembly under Public Act 07-185 for a four-year term to begin in August 2007.[1] Its charge was to inventory the state's existing primary care infrastructure and to develop a system that could serve the primary care needs of the state. It was also charged with elaborating an implementation and evaluation plan for the new system.

The SPCAA was specifically instructed to consider a broad range of providers of both somatic and behavioral health services but was to define "primary care" for the purposes of its work. It chose the definition proposed by the Institute of Medicine:

> *"the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community."*[2]

This report addresses the first part of the SPCAA's charge—conducting an inventory of existing primary care capacity in the state and making recommendations for improving the system. The SPCAA's work on the implementation and evaluation plans is still to come.

Public Act 07-185 specified that the Connecticut Primary Care Association, the Connecticut State Medical Society, the Connecticut Chapter of the American Academy of Pediatrics, the Connecticut Nurses Association, the Connecticut Association of School Based Health Centers, and the Weitzman Center for Innovation in Community Health and Primary Care were each to appoint one member of the Authority. The co-chairs of the concurrently authorized HealthFirst Connecticut Authority were designated as co-chairs of the SPCAA. The members are

- Margaret Flinter, APRN, co-chair
- Tom Swan, co-chair
- Daren Anderson, MD
- Evelyn Barnum, JD
- Sandra Carbonari, MD
- Glenn Cassis
- JoAnn Eaccarino, APRN
- Robert Galvin, MD, Commissioner, Department of Public Health
- Robert McLean, MD
- Lynn Price, JD, APRN
- Jody Rowell, LCSW
- Bob Schreibman, DDS
- Michael Starkowski, Commissioner, Department of Social Services
- Nancy Wyman, Comptroller, State of Connecticut
- Teresa Younger

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[1] http://www.cga.ct.gov/2007/ACT/PA/2007PA-00185-R00SB-01484-PA.htm.

[2] Molla Donaldson, Karl Yordy, and Neal Vanselow (eds.), Defining Primary Care: An Interim Report, Committee on the Future of Primary Care, Division of Health Care Services, Institute of Medicine, Washington, DC: National Academy Press, 1994

A full list of the SPCAA members and their affiliations is provided in appendix 1.

The HealthFirst Connecticut Authority was created at the same time as the SPCAA. Its charge was to study, evaluate, and make recommendations for ways to provide health insurance for uninsured and underinsured state residents.[3] The two Authorities had no formal relationship, but where the concerns of the two Authorities overlapped, they held joint meetings. Both groups recognized that coverage expansion and primary care capacity logically needed to be considered together to insure that the newly covered persons had adequate access to needed services and that the expanded demand associated with expanded coverage could be met as efficiently as possible.

The SPCAA met twenty times between October 2007 and February 2010. The key issues identified and discussed in these meetings are summarized in this report. The proceedings are documented in meeting minutes on the Authority's website.[4]

SPCAA's interim recommendations

Access to meaningful primary care services is paramount for a healthy and productive state population. Good primary care is also key for improved utilization of limited fiscal, infrastructure, and personnel resources. New models of delivery must be implemented. At the midpoint of its term, the Statewide Primary Care Access Authority makes the following eight interim recommendations to improve and sustain a vital primary care clinical workforce and primary care system in the state:

- Recognize that effective primary care requires an integrated team approach by a variety of health professionals supported by an electronic health record, such as found in the patient-centered medical home model, and institute the necessary changes to support such care, including resources to support and train staff, logistical and infrastructure support, as well as payment reforms that align incentives for quality and efficiency.
- Continue and expand existing efforts to collect and analyze ongoing, timely data about workforce capacity, trends, and issues
- Invest in sustained strategies to improve recruitment and retention of primary care clinicians
- Eliminate existing barriers to full utilization of clinician capacity
- Address infrastructure barriers to efficient use of current capacity
- Where these reforms are not sufficient to achieve optimal access, expand primary care capacity through investment in additional delivery sites, particularly in underserved areas
- Promote the greater integration of primary care and mental/behavioral health care
- Identify and track key indicators of primary care access, quality, and acceptability

[3] http://www.cga.ct.gov/ph/HealthFirst/Docs/Health%20First%20CT%20Authority%20-%20Report%20to%20Legislature.pdf
[4] http://www.cga.ct.gov/ph/PrimaryCare/default.asp

Introduction

The current report represents an interim rather than a final report of the Authority's work. The SPCAA's work was envisioned to cover four years; it is now about the midpoint of that term. More importantly, substantial changes have occurred in the health care landscape at both the state and national levels that were not anticipated at the time of the Authority's appointment. National health reform is under vigorous debate as of the writing of this report. Passage is not yet certain and the details are yet to be decided. Nonetheless, it seems prudent to plan for the possibility of change in both private and public insurance.

Closer to home, the passage of SustiNet legislation in 2009 represents a substantial shift in the state's approach to health care.[5] This new program envisions change in both insurance and the delivery system. The Sustinet legislation was based on a proposal developed by the Universal Health Care Foundation.[6] Sustinet would combine HUSKY and SAGA beneficiaries and state employees and retirees into a single, self-insured health plan named "Sustinet" after the state motto. It is intended to implement nationally accepted best practices for improving quality while controlling health care costs. At the time of this report, a Board of Directors along with a number of committees and task forces are developing recommendations and standards. The tasks of these groups overlap to some extent with the work of the SPCAA, and coordination will be important.

The passage of SustiNet and the possibility of major changes in health policy and insurance at the national level make the work of the SPCAA extremely timely. The Authority has endeavored to insure that its interim recommendations are consistent with the work taking place under SustiNet and flexible enough to address any changes that might be advisable under a national health insurance reform initiative. The recommendations of the SPCAA reported here provide a foundation on which both the SPCAA and the SustiNet workgroups can build to strengthen the state's primary care infrastructure to provide access to high quality and efficient care for all Connecticut residents regardless of their geographic location, health status, socioeconomic status, or their insurance status.

Overview of primary care in Connecticut

In setting out its charge to the SPCAA, the legislature recognized that a clear understanding of current primary care capacity and its strengths and weaknesses would be critical to charting the course for improvement. One of the SPCAA's key tasks was to inventory primary care capacity, looking at the number of providers and the number of places that services are offered. The Authority consulted with the Center for Public Health and Health Policy at the University of Connecticut (the "Center") to obtain an estimate of the current capacity of primary care clinicians in the state. The Center issued its report, "Assessment of Primary Care Capacity in Connecticut," in December 2008.[7] The absence of systematic data collection at the state level on health care workforce at anything beyond the level of absolute numbers of licensed heath professionals meant that only indirect assessment of capacity could be

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[5] PA 09-148, available at http://www.cga.ct.gov/2009/ACT/PA/2009PA-00148-R00HB-06600-PA.htm

[6] Universal Health Care Foundation of Connecticut, SustiNet: Health Care We Can Count On, January 15, 2009

[7] The full report, "Assessment of Primary Care Capacity in Connecticut," is available at http://publichealth.uconn.edu/images/reports/PrimaryCare_Report_02_17_09.pdf

analyzed. The Authority recognizes the significant limitations of this data and anticipates the availability of more robust data in the future due to the recent DPH initiative on electronic re-licensure and surveying. The SPCAA worked with the Department of Public Health to provide guidance on critical data sets that will now be obtained on an annual basis as part of health professionals re-licensure process.

Primary care inventory and workforce monitoring

Methods, strengths, and limitations of the study

The Center's researchers used both national and Connecticut-specific data in assessing the state's primary care capacity, applying national norms of productivity and access to the Connecticut primary care workforce. The workforce it evaluated included primary care physician specialties (family practice, internal medicine, obstetrics and gynecology, and homeopathic medicine), homeopathic physicians, naturopathic physicians, nurse practitioners, licensed nurse midwives, and physician assistants. The national norms for productivity and patient capacity were combined with data on providers from the Department of Public Health licensure data base and the Connecticut State Medical Society, supplemented as needed with national sources of data on Connecticut providers.[8]

Each of these data sets has inherent weaknesses. The wide variety of data sources used allowed the researchers to refine their estimates and compensate for many of data limitations. However, there remain several limitations to their estimates as identified by the SPCAA. First, the percentage of primary care practice conducted by the physician cohort cannot be established, as primary care physicians often also practice a specialty. Second, unexpired licenses do not in themselves indicate active practice. Finally, there is no mechanism at present to assess whether or not active practices in Connecticut currently accept new patients.

Key findings

The Center's report concluded that, although overall supply of primary care based on the available data currently appears to be adequate at the state level, the distribution of providers is uneven leaving some populations—particularly those in rural areas, central cities, and the coastal areas—with inadequate access. National projections forecast an impending shortage of provider care providers, and the aging of Connecticut's healthcare workforce further portends the likelihood of future shortages.[9] Furthermore, some of these disadvantaged populations rely more often on costly hospital outpatient departments and emergency rooms.[10] Federally qualified health centers and other safety net providers are a significant source of primary care for these state residents. The report noted that an expansion of insurance coverage, while welcome, will likely lead to more challenges in these relatively underserved areas since there is little capacity to absorb additional demand.

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[8] National data sources included the National Ambulatory Medical Care Survey (NAMCS), National Hospital Ambulatory Medical Care Survey-Outpatient Department (NHAMCS-OPD), Physician Compensation and Production Survey data from the Medical Group Management Association, the Bureau of Primary Health Care-Section 330 Grantees Uniform Data System (Community Health Centers data), American Academy of Nurse Practitioners, and American Academy of Physician Assistants. Local data was obtained from the Department of Public Health licensure database.

[9] http://www.bls.gov/news.release/ecopro.nr0.htm

[10] American Hospital Association, Trendwatch Chartbook, Chart 3.7, January 2010

The Center reported the following numbers of available primary care clinicians, based on unexpired licenses with a Connecticut address for either home or work:

Figure 1: Primary care providers in Connecticut, by type (2008)

Physicians *	6271
Advanced practice nurses **	1667
Certified nurse midwives	177
Physician assistants ***	268
Total current capacity	**8313**

Source: University of Connecticut Center for Public Health and Health Policy, Assessment of Primary Care Capacity in Connecticut, December 2008.
*The "physician" category includes physician specialties (family practice, internal medicine, obstetrics and gynecology, and homeopathic medicine), homeopathic physicians, and naturopathic physicians. **DPH listed 2526 licensed APRNs at the time the Center collected data. National norms indicate 66% of advanced practice nurses practice in at least one primary care setting; the Center applied this norm to the Connecticut data. ***DPH listed 1248 licensed physician assistants at the time of data collection. Responses collected from licensed Connecticut physician assistants to a survey issued by the American Academy of Physician Assistants indicate that 21.6% practice in primary care settings.

The report summarized the capacity issues as follows:

> *"Based on the current population, estimated productivity norms, and estimated primary care provider capacity, it appears that Connecticut, like much of the Northeast, currently has an adequate supply of licensed primary care providers. However . . . the ratio of population-to-primary care provider is much higher in Connecticut's rural areas. Additionally, families in central cities are likely to continue to experience access problems . . . due to their lower income and lack of health insurance coverage. . . .The geographic distribution of providers will pose some challenges and may be exacerbated by expanded insurance coverage." (p. i-ii.)*

The report is less sanguine about future capacity given current trends in primary care. The researchers cite an impending shortage of all types of physicians and note that population growth and the aging of the population are likely to increase demand for medical care generally and primary care specifically at a time when the share of medical students choosing primary care is decreasing.

The report cautions that the estimate of current capacity "most certainly overestimates the current supply of practicing primary care providers in Connecticut" (p. ii), due to retirements and non-residence in the state. The identified regional and population-specific shortages and likely future overall shortages of primary care providers in the state should be addressed as soon as possible to avoid further deterioration in access.

The Universal Health Care Foundation of Connecticut also supported a study of primary care capacity by the Connecticut State Medical Society. The findings from the report, "Connecticut Physician Workforce Survey 2008: Final Report on Physician Perceptions and Potential Impact on Access to Medical Care,"[11] captures the changing demographics of physicians, including primary care providers, the satisfactions and dissatisfactions with practice in Connecticut, and attitudes of the survey respondents to health reform.

The survey results revealed several challenges that affect health care access in Connecticut. Doctors said making health insurance more affordable, reducing the administrative burden on physicians, regulating health insurance practices, and covering the uninsured are the health care reforms they consider most important. It is notable that the three counties of the state where physicians reported the greatest difficulty in recruitment of new physicians included the two counties, Litchfield and Windham, identified as relative physician shortage areas in the primary care capacity commissioned by the Authority. The report also confirms relatively low adoption of electronic health records and the persistent dominance of small practices of self-employed physicians in Connecticut.

The Center's report represents an excellent start to defining the problem of primary care capacity in the state. Going forward, additional information will be needed to fully assess primary care capacity. Specifically, although the report looked at a broad range of primary care providers, including both physicians and non-physicians, the SPCAA recognizes that there are other types of providers that are essential to the provision of a full range of primary care services. Most notably, a full inventory of capacity would include providers of dental care and behavioral health services, which are not considered in the Center's report. Other providers offer valuable additional access to primary care services and should also be recognized, including those who provide targeted services, such as Planned Parenthood, and those that offer non-traditional services, such as alternative providers.

Furthermore, the Center's report provides a static picture of capacity in the state. Addressing the problems of primary care in Connecticut will require mechanisms to monitor capacity on an ongoing basis rather than through periodic inventories.

Work has begun on one such mechanism. The SPCAA worked with the Department of Public Health (DPH) on a pilot of electronic re-licensure and annual survey for all health professionals, offering specific recommendations on the potential data points to be collected in this new licensure renewal process. The Department has successfully incorporated the suggestions from the SPCAA. While not yet fully implemented, physician renewals were made available with an online option as of summer 2009, and expansion to other provider licensure renewals was completed in fall 2009. The SPCAA expresses appreciation and gratitude to Department staff for the cooperation and expediency in implementing the suggestions. The SPCAA respectfully request that the legislature direct the Department of Public Health to develop an annual report detailing healthcare professional workforce data and, as longitudinal data becomes available, trend data relative to the population that can be used to accurately monitor and forecast workforce needs and trends and develop responsive strategies.

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[11] Robert H. Aseltine, Jr, PhD, Matthew C. Katz, MS, Audrey Honig Geragosian, September 2008, The full survey is available online at https://www.csms.org/upload/files/Workforce%20Survey/2008%20CSMS%20WF%20survey%2009-16-08.pdf .

Issues identified by the Authority

Authority members were appointed based on their expertise in primary care. The following discussion represents the views of these experts on the most important issues in primary care in the state based on their 18 months of deliberation.

Overview

The SPCAA notes that evidence is growing that primary care is in crisis with barely adequate numbers of providers currently and a likelihood of a diminishing number of new providers. Furthermore, the structure of reimbursement and the costs of practice innovation frequently hinder changes at the practice level that would improve efficiency, quality, and cost.

At the level of the primary care system, the problems involve the number of practices and providers, the connections among them, and the connections between them and other primary and non-primary care providers, as well as their distribution geographically and their availability by payer. At the practice level, the problems relate to workforce utilization, care coordination, and efficiency. Some of the issues can be addressed through interventions and support at the practice level. However, most will require both system-level and practice-level interventions. The recommendations that flow from the issues identified by the SPCAA reflect the fact that system and practice issues overlap and can be best addressed together.

Number of providers

Fewer than four percent of graduating medical students nationally list primary care as their desired specialty, and primary care providers express low job satisfaction compared to their peers in other specialties.[12] Low compensation in comparison to other medical fields may contribute to this dissatisfaction, but evidence suggests that there are structural explanations as well. The burdens on primary care providers have been well documented, and include increasing paperwork, limited technological infrastructure, and increasing demands for uncompensated work activities such as care coordination.[13]

The likely number of primary care providers available in the future will be a function of the size of the current workforce, the number of new entrants to the workforce, and the number of current workers leaving the workforce. The SPCAA is concerned that the number of new entrants will be insufficient to make up for the loss of workers through retirement or other causes and through out-migration from the state. Most primary care physicians have the strong sense that their numbers are diminishing. They cite the fact that new practices fill up quickly and the sense that many of the primary care physicians in the state are within ten years of retirement age. Practices report struggling to find new physicians to fill vacancies in their practices.

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[12] Sarah E. Brotherton; Paul H. Rockey; and Sylvia I. Etzel, US Graduate Medical Education, 2004-2005: Trends in Primary Care Specialties, JAMA. 2005;294:1075-1082

[13] David Mechanic, Physician Discontent: Challenges and Opportunities, JAMA, Aug 2003; 290: 941 - 946.

Nationally, fewer medical students are choosing primary care. Furthermore, many who do choose to become primary care physicians later add a non-primary care specialty and reduce the share of their time devoted to primary care, as they strive to match their aspirations with the reality of practice. Medical students perceive inequities in the system between primary and other types of care. Almost all medical students graduate with substantial debt. With the expectation of low earnings from primary care relative to other specialties, students see the choice of primary care as making this debt harder to repay.

At the other end of the career spectrum, older physicians are expressing increasing dissatisfaction with practice. The health care system has changed substantially over the past several decades so that their current practices are often very different from their original practices. The insurance industry has increased its influence over health care through, for example, restriction on participation on panels. Many see additional changes on the horizon that they fear may further threaten their autonomy or their standard of living.

Non-physician providers are also affected by the structure of the health care system. In particular, scope of practice regulations impose limits on practice that many feel are not warranted given their education and training. Expansion of scopes of practices has the potential to increase the number of primary care providers and to improve the quality of care, patient satisfaction, and provider retention in the field.

The SPCAA's experience supports the Center's report on the distribution of providers across the state. In addition to the problem of access in rural, central city, and the coasts, members report access issues related to insurance coverage. Not only do residents without insurance have difficulty finding primary care, residents often find that providers are not accepting new patients with public coverage. The result is that access is uneven across the state and across coverage groups even within areas that are otherwise well-supplied.

System barriers to practice innovation and care coordination

The rules of reimbursement currently dominant in Connecticut mean that only face-to-face encounters between licensed independent providers and patients are reimbursed. This restriction undervalues other important aspects of good primary care such as care coordination and non-face-to-face care or virtual visits and promotes unnecessary, time-consuming in-person visits when other modes of contact would be clinically effective. As a result, the development of potentially desirable and effective alternate care delivery modalities, such as the internet, telemedicine, email, electronic consults, and telephone consultation, has been significantly impeded. In the absence of any payment mechanism or clear short-term return on investment primary care has been slow to adopt new technologies such as electronic health records (EHRs). The advent of federal stimulus funding for the development of EHRs records and health information technology (HIT) that extends beyond the level of the practice at the "meaningful use" level, along with gradual progress in adopting EHRs, may position Connecticut to move towards more rapid adoption of such innovations. However, Connecticut should seek all possible means to speed the uptake of EHRs and HIT in primary care and, indeed, in all of health care in the state.

Many other innovations in practice design that have been shown to improve primary care have also been slow to be adopted. Extended hours and Advanced Access Scheduling can both improve patient's

access to care and reduce emergency room and urgent care use.[14] The Chronic Care Model lays out a conceptual framework for improving chronic illness care.[15] The Patient-Centered Medical Home model, particularly as described in the document "Joint Principles of the Patient-Centered Medical Home" lays out essential elements for the provision of high quality primary care.[16]

Each of these innovations requires substantial investment of resources as well as a culture and infrastructure to support quality improvement efforts. Primary care must innovate and adopt some of these models in order to remain viable, but it will need significant resources and support to do so. In addition to improving quality and efficiency, such support would provide a foundation for attracting and retaining primary care providers in Connecticut.

The SPCAA also identified lack of access to and coordination of care between primary care providers and specialists, as well as between primary care and in-patient care as a significant source of inefficiency and reduced quality, as well as a threat to patient safety. Inadequate coordination is frequently the result of insufficient resources at the practice level. There are few incentives in the existing payment system for devoting the necessary resources to coordinating care across disciplines. Coordination of care across disciplines requires dedicated support staff to take on important tasks such as information gathering, medication reconciliation, and cross-disciplinary communication. The lack of resources to support care coordination within the practice, or between the practice and other providers leads at the practice level to issues of quality of care and efficiency of care provision, with the result that costs are higher than necessary. Lack of reimbursement for care coordination often leads to duplication of services with repercussions for cost, quality, and safety. Connecticut's primary care case management (PCCM) program is one promising model of care coordination in the state's HUSKY program and is scheduled to be expanded to statewide in July 2010.

Lack of adequate insurance coverage poses added barriers to obtaining specialty care. In addition to the uninsured, patients with state-funded coverage face severe restrictions in access to many types of specialty services. The SPCAA recommends eliminating the disparities in fee schedules between Medicaid and Medicare as one strategy to encourage greater participation by specialists in public programs. In addition, the SPCAA recommends that payors, including public payers, implement reimbursement strategies for electronic consults and telemedicine. Other states, notably California, have detailed specific policies and procedures for guiding quality, reimbursement, and billing procedures for telemedicine and eConsults.[17] Several of the state's federally qualified health centers are working to establish "embedded" specialists for high volume specialty service needs.

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[14] For information on Advanced Access Scheduling , see http://www.cahps.ahrq.gov/qiguide/content/interventions/OpenAccessScheduling.aspx.

[15] For a description of the model, see http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

[16] Available at http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

[17] Carlton A. Doty, Delivering Care Anytime, Anywhere: Telehealth Alters the Medical Ecosystem, Forrester Consulting, November 2008

SPCAA interim recommendations

Introduction

This set of recommendations sets a path toward a more efficient and higher quality primary care system for Connecticut. Even in the best of times and in a stable policy environment, full implementation would take time. Some of the recommendations do not require new funding while others do. The uncertainty associated with national health and the importance of coordinating with the new SustiNet workgroups will similarly require additional time to implement such changes. However, the SPCAA believes that implementation of its recommendations is necessary to create a strong primary care system with beneficial future effects on both health and state finances. The current economic difficulties might affect the timing of reform but should not determine the shape that the reform takes.

Vision

The SPCAA recognizes that access to meaningful primary care services is paramount for a healthy and productive state population and for improved utilization of the state's limited fiscal, infrastructure, and personnel resources. Its recommendations are designed to improve and sustain a vital primary care clinical workforce. The recommendations take as a general approach that policy should first address how residents get care, that is, the providers and their practice sites. The critical groups to address are those that form the backbone of primary care in the state—small independent practices, group practices, independent practice associations (IPAs) or IPA-like arrangements, federally qualified health centers (FQHCs), hospital primary care centers, school based health centers, hospital out-patient clinics and other hospital affiliated practice models, including the Veterans Health Administration (VHA), which has played a pioneering role in using electronic health records and the staff-model system to provide high -quality care to a substantial portion of the state's veterans.

The SPCAA recommendations are first stated as general goals focusing in eight critical areas—workforce composition and practice, data on workforce issues, recruitment and retention, barriers to effective practice, barriers to efficient practice, needed additional capacity, greater integration of primary care and mental/behavioral health care, and tracking primary care quality and access.

Specific recommendations are also made within each of these areas, using a variety of mechanisms. The specific recommendations focus on improving the quality and quantity of inputs available to primary care, changing processes through regulation and incentives, and changing financing. Some of the recommendations require public financing, either one-time funding to support investment in new capacity, to develop a new mechanism, or for pilot programs; or continuing funding such as changes in reimbursement or ongoing support for workforce training. Either type of funding may be targeted or untargeted, such as for providers meeting certain standards, for all providers, for safety net providers, or other qualification. Others envision new or changed regulation or legislation, such as scope of practice changes, certification of providers, or submission of federal waivers for public programs. All presuppose coordination with SustiNet implementation and with any national health care reform

initiative. Finally, the specific recommendations recognize the need to collect data in order to monitor progress in both capacity and quality.

Recommendations and their rationales

The SPCAA's eight general recommendations are presented here as goals. Each goal includes a brief overview of the rationale for its inclusion. Each goal also includes specific recommendations designed to support progress toward achieving the goal. The SPCAA recognizes that these specific recommendations should be coordinated with the work of the SustiNet workgroups.

1. Recognize that effective primary care requires an integrated team approach by a variety of health professionals supported by an electronic health record, such as found in the patient-centered medical home model, and institute the necessary changes to support such care, including resources to support and train staff, logistical and infrastructure support, as well as payment reforms that align incentives for quality and efficiency.

The successful implementation of an effective primary care delivery model requires a team approach. Optimal care can best be delivered when clinicians and support staff of various specialties and disciplines are involved with patients across a variety of settings. The SPCAA recommends that policy makers recognize the need for fostering the development of such teams through supportive payment structures, workforce development initiatives, and promotion of cross-disciplinary communication. Effective communication and collaboration among the various groups is paramount.

This task is especially challenging in Connecticut where, as the Connecticut State Medical Survey reports, the majority of physicians are still in self-employed small practices, which are unlikely to employ the kind of broad-based team described here. Federally qualified health centers already practice in a team-based model, and there is evidence to suggest that large practice groups are adopting a team-based approach as well. The work of other states in New England and around the country to support private practices in making these changes provides important lessons and models that Connecticut would do well to consider in advancing primary care practice in the state.

Primary care patients benefit from health promotion and disease prevention in addition to attention to illness and disease management; indeed, this approach is the foundation of primary care. Similarly, primary care requires recognition of the complex interplay between behavioral health and physical health, and the necessity of securing access to both, when needed. Oral health presents another challenge to primary care. Outside of the federally qualified health centers and the school based health centers, oral health is not generally integrated with primary medical care but access to both preventive and restorative services is essential to optimal primary care and good outcomes. Nutritionists, social workers, diabetes educators, health educators, and outreach workers are all potential members of the primary care team depending on the setting, site, and needs of the patient population.

Primary care delivery often requires helping patients navigate between a complex array of unconnected care delivery sites. A patient may receive acute and sub-acute care in a hospital or emergency room

setting. Care can be provided in rehabilitation and skilled nursing facilities as well as at home, school, or in ambulatory settings. Care is also delivered in settings that are not easily "connected" to the usual source of care, such as nursing homes, group homes, and correctional facilities. On-site employee health services are enjoying resurgence as companies pioneer delivering preventive care, such as flu shots and hypertension and hyperlipidemia screening, chronic disease management services, and treatment of minor episodic illness in the workplace. It is important to remember that patients in rural areas, patients who face transportation constraints and other barriers, and patients who speak languages other than English require additional efforts on the part of the primary care team to render care accessible. Where care is delivered may ultimately be less important than how that care is coordinated among and between the primary care team.

The Patient-Centered Medical Home (PCMH) is a primary care-based model currently receiving significant interested nationally and in Connecticut. This model, first developed by pediatrics, is now endorsed by multiple professional societies representing each of the primary care disciplines, including internal medicine, family practice, pediatrics, and osteopathic medicine. In Connecticut, the Veterans Health Administration has recently adopted this model and has begun implementing it across its national primary care delivery system. To date, the NCQA website does not list a single Connecticut practice as having secured designation as a patient-centered medical home. This may reflect both the degree of "stretch" required by most practices to demonstrate that they have met the criteria as well as the limitations on types of primary care providers who can be recognized. The PCMH does appear to represent a strong, positive step forward, and the SPCAA recommends that policymakers support and provide resources for its adoption. Several pieces of proposed federal and Connecticut legislation seek to promote the PCMH as a starting place for integrated primary care. In fact, Connecticut has already taken a promising step through its pediatric medical home initiative that was led by the Department of Public Health and is currently in place in Connecticut for children with significant health problems.

The SPCAA recommends consideration of the following actions in support of this recommendation:

- Design and implement a major, all-payor primary care transformation program for both individual and large group practices modeled after successful PCMH efforts in other states such as Vermont's BluePrint for Health and Pennsylvania's Prescription for Pennsylvania. The executive branches of both states have strongly supported the development of the patient-centered medical home concept, provided resources to help patients transform and meet the criteria, and brought the major payers, both commercial and public, to the table to support those efforts through enhanced reimbursements
- Support the development of alternative, non fee-for-service payment mechanisms that recognize the value and importance of the full spectrum of primary care activities, including team based care, care coordination, and non face-to-face encounters and care
- Encourage the incorporation of communication strategies in primary care practices that promote patient centered care, emphasizing prevention, wellness, and self-management
- Provide incentives and support for primary care practices to improve quality of care.
- Endorse and support the development and expansion of the PCMH model and take concrete steps towards actualization in concert with the work of the SustiNet medical home committee

- Support primary care practices in securing National Committee for Quality Assurance (NCQA) medical home status
- Establish criteria for certification of new and existing capacity, such as EMRs, the medical home model, expanded access and coverage off-hours, and connection to the patient's medical home via electronic health record or health information exchange (HIE) for school-based health centers
- Develop Regional Extension Centers, similar to those proposed for HIEs development in each state using federal stimulus dollars, to support progress of the four major types of practices towards meeting the standards of medical home. Provide loans and/or grants to help practices meet transition costs
- Provide better payment for providers meeting medical home certification under public programs. Endorse better payment for certified providers under private insurance

- Support development of patient-centered medical/healthcare home-based curricula at public schools and universities of medicine, nursing, and other health professionals
- Provide financial, technical, and logistical support for practices to acquire and implement electronic health records, including leveraging all possible federal financial resources for this purpose.
  - Help providers obtain and use available federal grants for HIT
  - Monitor progress of both eHealthCt and the state HIT Planning group
- Support selected pilot programs to explore innovations for both private and public sector with strong evaluation components in coordination with SustiNet
- Provide financial support and technical assistance for quality improvements at existing facilities. Support could take the form of one-time grants and/or loans or ongoing support through enhanced reimbursement
- Develop other pilot programs as needed to support development and expansion of the medical home model in the state, building on successful models from other states, such as North Carolina, Pennsylvania, and Vermont where appropriate
- Support the work of the Primary Care Coalition of Connecticut and other entities with a key focus on advancing and supporting primary care in Connecticut
- Support pilot alternative reimbursement strategies that assign value to PCMH care activities beyond the face to face encounter.

2. Continue ongoing efforts to collect timely data about workforce issues and support collection of clinical indicators to monitor quality

Optimal use of the clinical workforce resources requires accurate, integrated, timely, and multi-level data collection and analysis, which yields strong benefits in allocating patient care resources. The SPCAA recommends that the policymakers take steps to create and facilitate timely collection and analysis of workforce data and quality of care indicators and that these data be collected in a format readily incorporated into one database for state aggregate analysis.

Electronic licensure/re-licensure has been implemented and has the potential to provide valuable workforce data when the intended survey data collection is fully implemented, but only if resources are consistently dedicated to encouraging providers to change from paper to electronic licensure and for the data analysis and reporting functions to make the data useful for workforce planning.

Additionally, Connecticut must begin to harness valuable health data through the systematic collection of patient data not just from insurance claim data, but directly from EMRs as their penetration in Connecticut increases. Currently, EMRs are developed, produced, and implemented supported through various proprietary systems and thus not designed to a common purpose. However, the usefulness of the data gained by such systems is greatly enhanced when the EMRs generally collect the same type of data in the same way. The requirement that all new systems utilize a single, common communication standard, HL7,[18] is a significant step in the right direction that should facilitate aggregate data collection across different systems.

EMR vendors have the capability of designing systems for client needs. The SPCAA urges the state to leverage its purchasing power toward this end. Pertinent data points in an aggregate database include markers for health promotion (vaccinations, childhood developmental screening, tobacco cessation, weight counseling, domestic violence screening, firearm safety, and the like); disease prevention and management (for example, in diabetes, retinal and foot screening, as well as lipid and A1C monitoring, and the like); and clinician data (comparing any given clinician against the aggregate data for clinicians on the same indicator.) The usefulness of such aggregate data has been demonstrated at the federal level in recent years for management of diabetes, HIV, and cardiac disease, and for several wellness markers.

The SPCAA recommends consideration of the following actions in support of this recommendation:

- Publish access and quality data annually. Annual reporting will allow the development of trend lines for important indicators of workforce, access, and quality
    - Subsequent to the roll-out of electronic re-licensure and survey of providers, provide funding for a formal annual report annually on true primary care capacity per population in Connecticut
    - Review and report on the Uniform Data Set (UDS) annually for all Connecticut FQHCs, individually and in aggregate, including trends in access to care and in the ratio of FQHC providers to underserved population
    - Develop performance-reporting measures for all primary care facilities. Reporting should be mandatory for licensed facilities and for those certified under DPH. Provide assistance in reporting for all facilities, including those seeking to report voluntarily
    - Establish formal criteria for monitoring the quality of primary care, using EPSDT (with possible later expansion to "Bright Futures")[19] for pediatric care and the Veteran's

[18] http://www.hl7.org

[19] EPSDT refers to the Early and Periodic Screening, Diagnosis, and Treatment protocol used to monitor child health and development under Medicaid. Bright Futures is a national health promotion and disease prevention initiative, based at the American Academy of Pediatrics, that addresses children's health needs in the context of family and community.

Administration model of multiple indicators of clinical processes and outcomes, adherence to prevention guidelines,[20] patient satisfaction, and access for adult care

- Using data already reported by the Office of the Health Care Access (OHCA) on a periodic basis to track ambulatory sensitive admissions to hospitals

- Charge the SPCAA with review, comment, and response to all monitoring data

3. Invest in sustained strategies to improve recruitment and retention of primary care providers

There are documented problems, both currently and predicted for the future, in the primary care workforce. The SPCAA recommends that the state develop policies that will improve the recruitment and retention of primary care workers in the state to enhance current workforce capacity and invest in strategies to increase the pipeline of primary care workers to head off the looming future shortage.

The Center for Public Health and Health Policy at the University of Connecticut report indicated a downward trend in physician recruitment and retention both nationally and in the state. The Connecticut State Medical Society report of December 2008 reports variability across the state in the degree of physician satisfaction, their plans to continue practicing in the state, and the challenges of recruiting new physicians to replace retiring or relocating physicians.[21]

The nursing shortage is well-documented. Recent data from the federal Department of Labor (March 2009) indicate that health care sector jobs demonstrate growth well above that of the other employment sectors.[22] Nursing is expected to continue experiencing shortfalls. Registered nurses (RNs) are a key piece of any model of primary care delivery. RN case-management programs for asthma, depression, diabetes, and other chronic diseases are a hallmark of integrated care systems, such as the patient-centered medical home and chronic disease management models that the SPCAA recommends be encouraged in the state. Furthermore, RNs represent to a large extent the pipeline for advanced practice nurses.

NPs and PAs practice in virtually every primary healthcare setting, but formal data is available only for the federally qualified health centers through the Unified Data System (UDS) reports.[23] The federal 2008 UDS report documents a total of 72 NPs and PAs who collectively were responsible for 187,913 visits in Connecticut's FQHCs in 2008. Virtually all payors reimburse services provided by nurse practitioners and physician assistants. Medicaid recognizes both as primary care providers but there is variability among commercial payors in this area.

Virtually all health professionals in primary care, including physicians, advanced practice nurses, physician assistants and other health care providers necessary for a vigorous primary care system face significant debt upon entering the workforce. Strategies built on loan-repayment, tuition-forgiveness, or combined programs exist at the federal level. These programs are generally focused on addressing

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[20] For example, US Preventive Services Task Force guidelines, which can be found at http://www.ahrq.gov/clinic/cpgsix.htm.
[21] Aseltine et al., 2008. See footnote 11 for full citation.
[22] Available at http://www.bls.gov/news.release/pdf/empsit.pdf
[23] Available at http://bphc.hrsa.gov/uds/2007data/region/default.htm

extreme provider shortages and are not confined to primary care. Successful implementation of robust primary care in Connecticut must consider adapting such strategies to leverage resources toward primary care settings and providers.

Retention of workers remains a challenge as well. One main theme discouraging retention in primary care and healthcare generally is the negative business climate for sustaining a practice. Historically low reimbursement rates and increasing costs of professional liability insurance are often cited. Other factors contribute to the difficulties of maintaining a practice, such as the practice of insurance payers unilaterally changing the terms of contract with providers with severe consequences for provider business plans. A practice cannot and should not be wholly insulated from market conditions; however, policies that favor stable and predictable practice parameters are more supportive of primary care practices.

Workforce pipeline issues need also be addressed through student recruitment to the health professions and providing the necessary resources to support faculty and other educational system components in their provision of a solid educational experience for the variety of primary care professions care in Connecticut. A summary of efforts made in other states can be found in a recent report issued by the Office of Legislative Research.[24]

The SPCAA recommends consideration of the following actions in support of this recommendation:

- Invest in primary care workforce development
    - Develop a robust loan repayment mechanism that supports health care providers across all disciplines both in choosing primary care specialties and in choosing to remain in Connecticut at completion of training. Such a program should complement and augment the National Health Service Corps federal program. Any state program should be structured to take advantage of federal matching funds to allow a more robust loan repayment program in Connecticut.
    - Provide funding for students, faculty, and traineeships/internships
- Annual report to the legislature's workforce committee on the number and percentage of graduates of Connecticut's schools of medicine, nursing, and dentistry, the number of graduates of Connecticut-based residency training programs in medicine, nursing, and dentistry, the number of such graduates remaining in the state of Connecticut, and the number of graduates of residencies in family practice, pediatrics, and internal medicine who are entering sub-specialty training post-residency.
- Invest in Connecticut's state university system, in coordination with the Department of Education, to educate and train primary care providers who will serve the state's population
    - Support University of Connecticut residency programs in family medicine, internal medicine, and pediatric medicine
    - Support University of Connecticut School of Nursing primary care nurse practitioner specialties

[24] Saul Spigel, Dec. 10, 2008, Backgrounder: Recruiting and Retaining a Primary Healthcare Workforce, 2008-R-0679, available at http://www.cga.ct.gov/2008/rpt/2008-R-0679.htm

- Add a family nurse practitioner certification track to the University of Connecticut School of Nursing program
- Support the development of training, residency, or fellowship programs at FQHCs or other entities that can demonstrate ability to support the transition of new nurse practitioners into primary care practice in complex settings
- Support the development of the "teaching health center" model, with the potential for developing FQHC-based physician residencies, as proposed in federal legislation[25]
- Expand existing programs at Southern and Western Connecticut State Universities programs through support for faculty expansion, new laboratories, and student scholarships
- Support curriculum development and educational models such as the Urban Services Track at the University of Connecticut that promotes interdisciplinary learning models between and among health professions students interested in primary care careers
- Support curriculum development and programs to improve cultural competence among primary care providers
- Current federal health reform proposed legislation includes significant funds for the development of nurse managed health centers, teaching federally qualified health centers, FQHC based post graduate residency training for nurse practitioners, community-based primary care medicine residencies, physician assistant residencies and other innovative approach to increasing Connecticut's capacity for primary care. The SPCAA encourages eligible and capable Connecticut entities and organizations to pursue funding for development of these new models.

- Improve provider participation in public programs through the institution of auto-enrollment for providers, seeking Connecticut licensure in their respective disciplines, with opt-out provisions

4. Address existing barriers to efficient primary care practice

The current primary care business model is characterized by a fee-for-service, transactional reimbursement system and is generally thought to under-reimburse patient evaluation, management and prevention services as compared with volume-based, procedure-based services. The current model is widely recognized to pose a significant barrier to the development of new, more effective primary care practice. Inadequate reimbursement and outmoded payment models in primary care lead to under-resourced offices without staff trained and able to provide critical but unreimbursed activities such as maintaining disease registries, helping patients with self-management goals, behavioral health consultations, patient education, and care coordination.

Other states have looked at legal scope-of-practice definitions as an area that may place unwarranted restraints on access to care and have identified where increased access might result from revised definitions. Scope-of-practice debates are state-based, centering on the statutory or regulatory language defining practice. These debates occur within and between professional disciplines, and frequently leave both the public and policy makers confused as to the issues. The SPCAA has focused its

[25] For an overview of the THC model see http://www.medicaleducationfutures.org/uploads/THCSummary.pdf

efforts on strategies to increase access to meaningful and effective primary care. Not surprisingly, given the diversity of its membership, there is not unanimity among members on the issue of scope of practice. The SPCAA recognizes that resolution of issues of scope of practice is critical to forward progress in primary care in Connecticut.

Scope of practice issues are not limited to any one profession. Professional scope is no longer clearly delineated by professional credential. In 2006, a panel of six national regulatory boards, representing medicine, nursing, physical therapy, pharmacology, social work, and occupational therapy found that actual scope of practice changes frequently in the rapidly evolving healthcare environment, and that no profession "owns" any particular activity or skill.[26] Similarly, other states recognize via registration or credentialing categories of personnel such as community health workers that Connecticut does not today recognize.

The SPCAA recommends that the focus remain on access, quality, and safety and that scope of practice decisions be evidence-based rather than historically bound.

5. Address delivery and infrastructure issues to support enhanced and integrated primary care in Connecticut

Addressing delivery issues will likely yield large benefits in provider satisfaction, resource efficiency, patient satisfaction, and fiscal prudence underlying such delivery redesign. In short, the SPCAA believes that Connecticut can develop meaningful access to primary care and, at the same time, with the same strategies, enhance provider satisfaction in delivering primary care. The SPCAA recommends that the delivery and infrastructure environment be strengthened to support and augment an emphasis on primary care within the health care system. Of particular importance are (1) an emphasis on community-based primary care, (2) improvements in the efficiency of delivery, and (3) changes to the reimbursement system to recognize the contribution of primary care to individual and community health.

Community outreach itself is germane to good primary care, particularly with populations that have not enjoyed ready access to care. Enhanced public health support, including public health nurses , community health workers, and staff embedded in the primary care sites and communities is vital, as are incentives to develop community-based primary care through medical homes, nurse managed centers, school-based health centers, and similar models. Care should be taken to include settings not generally in the usual information flow, such as school-based health centers, nursing homes, group homes, and correctional facilities.

Policies that encourage and support increased efficiency of extant resources are recommended, such as expanding the implementation of rapid "same day" access designs; increasing transparency and communication in continuity of care between acute and community settings; and aggregate data collection and regular outcomes analysis to provide individual providers, practices, communities, patients, and policymakers regular feedback on performance. Several of these practices have been

[26] Changes in Healthcare Professions' Scope of Practice: Legislative Considerations, available at https://www.ncsbn.org/ScopeofPractice.pdf

implemented in the state through individual entities and practices, and many have been in place for years in other states. The SPCAA recommends that Connecticut adopt these approaches as part of the initiative to enhance provider satisfaction in delivering primary care by making the work more efficient and more directly related to individual patient care.

Reimbursement discrepancies between primary care and specialty practices contribute to primary care provider dissatisfaction. Achieving equity in reimbursement and enhancing efficiency of care provision through changes in delivery can contribute both to provider retention and to quality of care.

The SPCAA recommends consideration of the following actions in support of this recommendation:

- Implement payment reform for primary care providers. This recommendation should be put in place as soon as possible and should not wait for the implementation of SustiNet
    - Increase Medicaid payment rates to defined percentage of Medicare[27]
    - Consider alternative payment methodology models. The Sustinet provider advisory committee has been tasked with considering specific recommendations in this area that support quality of care , continuity of care, maximum provider participation in primary care
    - Implement a program focused on practice coaching and transformation with bonus payment and differential fee schedules for participating practices , modeled on the Pennsylvania experience, "Prescription for Pennsylvania"[28]
- Emphasize the importance of improving access to primary care with extended hours and timely availability of appointments
- Explore development of nurse-managed health centers
- Improve access to dental care
    - Maintain current benefits under the state's Medicaid dental plan
    - Ensure that oral health care is covered under SustiNet
- Support selected pilot programs to explore innovations both for private and public sector with strong evaluation components in coordination with SustiNet

6. Expand primary care capacity through investment in additional delivery sites, particularly in underserved areas

The SPCAA believes that the above recommendations will contribute substantially to enhancing primary care capacity in the state. Even when fully implemented, however, they may not be sufficient to meet future demand as identified in the University of Connecticut report. The SPCAA recommends that, should other measures prove insufficient, the state undertake investment in additional primary care capacity, particularly in the areas of identified current shortage.

The SPCAA recommends consideration of the following actions in support of this recommendation:

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[27] This recommendation was also made by the HealthFirst Connecticut Authority but has not yet been implemented.
[28] See http://www.rxforpa.com/ for a description of the Pennsylvania program.

- Invest in new primary care capacity and access in identified underserved and rural areas, areas of northeast and northwest where capacity is a documented problem
    - Access to care should reflect both availability (geographic proximity and by service) and affordability (coverage, costs)
    - New capacity may take the form of new FQHCs, school-based health centers, mobile clinics, nurse managed health centers as well as increased recruitment of private practice primary care providers
    - Financing should be sought from foundations to supplement state resources
- Invest in dental care capacity at new and existing primary care sites
    - Support mobile portable and mobile dental services serving schools in low income areas
    - Support expansion of dental services in FQHCs
- Invest in school-based health centers and community health clinics centers in communities where access to primary care is limited or where the economics of the community have adversely affected employment and transportation
- Harness technology in pursuit of improved access, streamlined access to specialists, and cost effectiveness. Develop standards for electronic (virtual) consults between primary care providers and specialists, starting with linking practices with a significant percentage of publicly insured patients with the University of Connecticut Health Center specialty departments

7. Promote the greater integration of primary care and mental/behavioral health

The Patient Centered Medical Home has highlighted the importance of primary care and provided a model for improving the quality of healthcare in America. However, this model has not sufficiently emphasized and articulated the importance of integrating behavioral health care with primary medical care. The SPCAA recommends that the state put in place policies to support the integration of behavioral health with primary care. Studies have shown that inadequate response to early childhood stress often leads to health problems later in life including alcoholism, depression, eating disorders, heart disease, cancer, and other chronic diseases.[29] Adults living with serious mental illness die 25 years earlier than the general population in large part due to treatable conditions such as diabetes, heart disease, alcohol and substance use, smoking and infections diseases.[30] High quality outcomes are likely to be more difficult and more costly to achieve without a holistic approach to health. Several models of integration have been shown to be effective.[31]

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[29] Centers for Disease Control and Prevention. Atlanta: CDC; 2006 [cited 2007 April 9]. Adverse Childhood Experiences Study Available from: http://www.cdc.gov/nccdphp/ace/index.htm.

[30] National Association of State Mental Health Program Directors (NASMHPD) Medical Directors Council: Alexandria, VA; October 2006. Morbidity and Mortality in People with Serious Mental Illness Available from: http://www.nasmd.org/medicaid_mental/docs/NASMHPD_Morbidity_and_Mortality_Report.pdf

[31] There are several evolving models of integration which have some proven success, most notably The Four Quadrant Clinical Integration Model and Impact Model (http://www.integratedprimarycare.com/NCCBH%20Four%20Quadrants-EBP%20cr.htm). There are other medical home models which have also proven successful that focus on the chronic disease side of care and are less clear about how behavioral health issues are integrated, including the Chronic Care and Primary Care Case Management Models. Clearly the emphasis in moving forward should be a holistic approach in both primary care and behavioral health settings regardless of the model of care adopted.

Key to successful integration is the removal of numerous and complex barriers that have long plagued both the medical and mental health arenas. They include financing methods, policy and regulation, information technology, and workforce stability. Current financing mechanisms discourage the efficient provision of behavioral health services together with somatic services. Proposals for EMRs often leave aside incorporation of data on behavioral health treatment, despite the fact that people with serious mental illness more often than not also have serious co-morbid medical issues. While there has been no study specifically addressing the workforce issues of behavioral health in Connecticut, the growing shortage of professionals has been documented nationally. Particular attention needs to be paid to cultural competence and language capacity in behavioral health services as behavioral health sessions require a strong comprehension of the language and culture of the client that cannot be filled by translators. Finally, there are differences between behavioral and somatic health workers in funding to support workforce development that hinder expansion of behavioral health capacity.

The SPCAA recommends consideration of the following actions in support of this recommendation:

- Identify and address barriers to billing for medical and psychiatric services on the same day at the same facility
- Identify and address barriers to information sharing across providers of somatic and behavioral health services. Support development of HIT systems to facilitate information sharing
- Coordinate with the Department of Public Health as it rolls out changes to workforce data collection. It is imperative to collect data on behavioral health providers, including type of practice, degree, bilingual capacity, and location of practice
- Provide financial support for the expansion of the behavioral health care workforce
    - Invest as needed in training of the behavioral healthcare workforce such as licensed clinical social workers and clinical psychologists as well as psychiatrists and psychiatric APRNs
    - Develop new programs for loan forgiveness, working income, financing for internships, and work study opportunities for behavioral health care workers, and streamline administrative requirements for existing programs
    - Develop programs to increase cultural competence and diversity among behavioral health care workers
    - Create internships, fellowships, and residencies for behavioral health/psychiatric clinicians (social workers, nurses, psychiatrists) in settings that have successfully integrated primary physical care and behavioral health care
- Enhance capacity within the existing workforce through support of behavioral health telemedicine service for rural and other vulnerable populations

8. Identify and track key indicators of primary care access, quality, and acceptability

The SPCAA is confident that implementation of the first seven recommendations will result in a primary care system that is more accessible, more efficient, and provides higher quality care to all residents. It recognizes that its proposed changes cannot be accomplished overnight. Careful implementation requires monitoring to ensure continued progress toward stated goals and to allow for mid-course

corrections as circumstances change or as experience dictates. Ongoing monitoring will obviate the need for additional static analyses or mandated task forces or authorities. The SPCAA recommends that the state put in place mechanisms to track key indicators in primary care.

The SPCAA recommends consideration of the following actions in support of this recommendation:

- Publish annual summary data and trends over time on utilization, staffing, payor mix, and clinical outcomes for primary care providers, beginning with data already reported annually by the FQHCs and expanding to other providers over time
- Assign responsibility for analysis of the summary data to an existing or new entity and use the results of the analysis to monitor implementation of the SPCAA's recommendations and to guide further primary care policy development

Summary and conclusion

The overarching goal of the SPCAA's recommendations is a primary care system that meets the needs of all state residents regardless of their insurance status, geographic location, health status, or demographic characteristics. The SPCAA believes strongly that the changes proposed here, if implemented, will lead to a greatly improved primary care system in the state, one that is not only more efficient but also more equitable. Greater efficiency in care provision can promote better quality of care in the near term which should improve provider recruitment and retention over the longer term. Thus, investment in primary care capacity now will provide the foundation for sustaining capacity for the future.

The SPCAA recognizes that the state is currently facing a difficult economic outlook. In addition, the state system of health insurance is poised for change under SustiNet, and the national system may also change if Congress is able to achieve national insurance reform. Coordination of the various efforts is critical particularly given current tight budgets.

The work of the SPCAA will continue. Over the next two years, it will meet to outline a plan for implementing its recommendations and for evaluating their effect on primary care access, efficiency, and quality, drawing on successful efforts in other states and working in coordination with the SustiNet workgroups. In this sense, the recommendations reported here represent the beginning rather than the end of the SPCAA's work.

Appendix 1: State-Wide Primary Care Access Authority members and affiliations

Margaret Flinter, Co-Chair, SPCAA

Tom Swan, Co-Chair, SPCAA

J. Robert Galvin, Commissioner of Public Health

Michael P. Starkowski, Commissioner of Social Services

Nancy Wyman, Comptroller

Dr. Daren Anderson, Weitzman Center for Innovation

Evelyn Barnum, CT Primary Care Association

Dr. Sandra Carbonari, American Academy of Pediatrics, CT Chapter

Glenn Cassis, Connecticut African-American Affairs Commission

JoAnn Eaccarino, CT Association of School Based Health Centers

Dr. Robert McLean, CT State Medical Society

Lynn Price, CT Nurses Association

Jody Rowell, LCSW, Child and Family Therapist

Dr. Bob Schreibman, CT State Dental Association

Teresa Younger, CT Permanent Commission on the Status of Women

Appendix 2: Useful Links

Public Act 07-185 establishing the State-Wide Primary Care Access Authority
http://www.cga.ct.gov/2007/ACT/PA/2007PA-00185-R00SB-01484-PA.htm

Report of the HealthFirst CT Authority
http://www.cga.ct.gov/ph/HealthFirst/Docs/Health%20First%20CT%20Authority%20-%20Report%20to%20Legislature.pdf

Minutes of the SPCAA meetings
http://www.cga.ct.gov/ph/PrimaryCare/default.asp

Public Act 09-148 establishing SustiNet
http://www.cga.ct.gov/2009/ACT/PA/2009PA-00148-R00HB-06600-PA.htm

SustiNet: Health Care We Can Count On
http://www.healthcare4every1.org/site/DocServer/sustinet_proposal.pdf?docID=541

Assessment of Primary Care Capacity in CT
http://publichealth.uconn.edu/images/reports/PrimaryCare_Report_02_17_09.pdf

Bureau of Labor Statistics Employment Projections, 2008-2018
http://www.bls.gov/news.release/ecopro.nr0.htm

American Hospital Association, Trendwatch Chartbook
http://www.aha.org/aha/research-and-trends/chartbook/ch3.html

CT Physician Workforce Survey 2008
https://www.csms.org/upload/files/Workforce%20Survey/2008%20CSMS%20WF%20survey%2009-16-08.pdf

Advanced Access Scheduling
http://www.cahps.ahrq.gov/qiguide/content/interventions/OpenAccessScheduling.aspx.

Chronic Care Model
http://www.improvingchroniccare.org/index.php?p=The_Chronic_Care_Model&s=2

Essential elements of the patient-centered medical home
http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home

US Preventive Services Task Force guidelines
http://www.ahrq.gov/clinic/cpgsix.htm

Bureau of Labor Statistics unemployment report
http://www.bls.gov/news.release/pdf/empsit.pdf

Federally Qualified Health Centers Unified Data System
http://bphc.hrsa.gov/uds/2007data/region/default.htm

OLR Backgrounder: Recruiting and Retaining a Primary Healthcare Workforce
http://www.cga.ct.gov/2008/rpt/2008-R-0679.htm

Teaching Health Center Model
http://www.medicaleducationfutures.org/uploads/THCSummary.pdf

Changes in Healthcare Professions' Scope of Practice: Legislative Considerations

https://www.ncsbn.org/ScopeofPractice.pdf

Prescription for Pennsylvania
http://www.rxforpa.com

Morbidity and Mortality in People with Serious Mental Illness
http://www.nasmd.org/medicaid_mental/docs/NASMHPD_Morbidity_and_Mortality_Report.pdf

Four Quadrant Clinical Integration Model and Impact Model
http://www.integratedprimarycare.com/NCCBH%20Four%20Quadrants-EBP%20cr.htm