Statewide Primary Care Access Authority

A World of Change

2007 thru 2011

Our Charge

- The State-Wide Primary Care Access Authority must:

  (1) determine what constitutes primary care services;
  (2) inventory the state's existing primary care infrastructure,
  (3) by December 31, 2008, develop a universal system, which maximizes federal financial participation in Medicaid and Medicare, to provide primary care services, including prescription drugs, to state residents; and
  (4) by July 1, 2010, develop a plan for implementing the system.

  The inventory of the primary care infrastructure must include:

  (1) the number of state primary care providers,
  (2) the amount of money spent on public and private primary care services during the last fiscal year, and
  (3) the number of public and private buildings or offices used primarily for primary care services, including hospitals, mental health facilities, dental offices, school-based health clinics, community-based health centers and academic health centers.

  A "primary care provider" is any physician, dentist, nurse, provider of services for the mentally ill or persons with mental retardation, or any one else providing primary medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan.

  The Authority must:

  (1) estimate the cost of fully implementing the universal primary care services system it develops,
  (2) identify any additional infrastructure or personnel needed to implement it,
  (3) determine the role of the state, private health insurance, and third parties in the system; and
  (4) identify funding sources.

  The Authority's plan for implementing the system must include:

  (1) an implementation timetable,
  (2) benchmarks to assess the state's progress in implementing the system, and
  (3) ways to measure the system's effectiveness.
- See Sec. 31 of PA 07-185

From 2007-2009

- The SPCAA worked collaboratively with the HealthFirst Authority
- Many meetings, presentations, workgroups done in common or with strong overlap
- Final report of HealthFirst Authority issued by majority approval April 2010
- Issued a series of final recommendations with a focus on univeral coverage, strong primary care, implementation of electronic health record, and increased access in shortage areas

At the same time….

- Universal Healthcare Foundation unveiled Sustinet and a design for reform, access, coverage, and practice transformation
- A presidential campaign heated up
- November, 2009: President Obama is elected
- April, 2010: the Patient Protection and Affordable Care Act became law.
- ? (who would have imagined this in 2007)?

December, 2008

- University of Connecticut Center for Public Heath and Health Policy, on behalf of the SPCAA, released its study “Assessment of Primary Care Capacity in Connecticut”
- National and Connecticut specific data used to estimate the number of PCPs in Connecticut, norms on productivity and patient capacity, and combined this with data from DPH licensure databases to estimate current capacity of provider workforce in Ct. and levels necessary to meet the demand based on changes in insurance status.

Summary of Findings

- “Based on current population, estimated productivity norms, and estimated primary care provider capacity, it appears that Connecticut, like much of the northeast, has an adequate supply of primary care providers.”
- “However distribution problems exist, particularly in rural areas, with higher patient to PCP ratios”
- “Inner and central city families continue to rely on FQHCs and hospital based clinics due to lower incomes and lack of health insurance.”

Of note:

- “the count of unexpired primary care provider licenses issued by DPH most certainly overestimates the current supply of practicing primary care providers in Connecticut. There may be a large number of currently licensed primary care providers who are retired, reside in other states, or are not practicing in their respective fields, or are not practicing primary care.”

SPCAA Interim Report: Feb, 2010

- Recommendations
  - Support development of integrated, team approach
  - Urgent need to collect timely data about primary care workforce
  - Invest in strategies for recruitment and retention
  - Address delivery and infrastructure issues to efficient primary care practice
  - Expand primary care capacity in underserved areas

(continued)

- Implement and sustain the integration of primary care and behavioral health
- Identify and track key indicators of primary care access, quality, and acceptability
- Direct DSS to authorize pilots testing the use of virtual visits and eConsults

Recommendations to Legislature January, 2011

- Support development of patient centered medical homes
  - Financial support for non –FQHC practices seeking PCMH recognition
  - Financial support modeled after the “regional extension center” model to coach and train practices in transformation to the PCMH model

Recommendation 2

- Enhance efforts to secure timely, on-going primary care workforce data
  - Mandatory on line electronic licensure renewal for all MDs, NPs, P.A.s, Dentists
  - Implement full survey at re-licensure, using data set developed by SPCAA and approved by DPH
  - Direct DPH to devote appropriate resources to analyze submitted data and report to legislature annually
  - Mandate annual report by Dean of UCONN School of Medicine on number and percent of graduating students choosing primary care residency

Recommendation 3

- Invest in sustained strategies to improve recruitment and retention of primary care providers to practices in Connecticut
  - Designate a primary care healthcare workforce office at the state level charged with continually monitoring workforce adequacy, and primary care access across Connecticut.
  - Maximize efforts to recruit NHSC scholars and Loan Repayment providers to Ct.
  - Implement key recommendations of the Institute of Medicine's Future of Nursing report that impact primary care
  - Leverage federal funding opportunities to develop new and expanded access points for primary care in schools, public housing nurse managed health centers, and FQHCs

Recommendation 4

- Address existing barriers to efficient primary care practice
  - Remove prohibitions against non-licensed personnel administering medication in the primary care setting and allow medical assistants, under the willing supervision of a licensed health care providers, to administer routine immunizations and vaccines
  - Establish Medicaid pilot to provide transition care to enrollees admitted to hospital and monitor impact on re-hospitalization for Medicaid enrollees relative to other populations.

Recommendation 5

- Expand primary care capacity through investment in additional delivery sites, particularly in underserved areas
  - Support continued development of school based health centers and community health centers
  - Support public and private colleges and community organizations in securing grant funding for education and training at both pre-licensure and post-licensure level

Recommendation 6

- Promote greater integration of primary care and mental/behavioral health
  - Align reimbursement with primary care
  - Modify billing systems

Recommendation 7

- Establish an “all claims” database (ACDB) for Ct. and enroll Ct. in the All Claims Database Council system
- Specifically, track indicators for
  - Obesity
  - Ambulatory sensitive admission to hospital
  - ER utilization
  - Patient experience/satisfaction
  - Mandate annual report card to legislature on measures of health status of Connecticut’s population

Evidence of Progress since 2007

- PPACA
  - Medicaid has expanded
  - Health insurance exchange is being set up
  - Pre-existing conditions are phasing out
  - Coverage for Prevention is mandatory

  NEXT GENERATION

  Quinnipiac is opening a new medical school devoted to primary care

  NP residency specific to primary care in 5th year

  NHSC greatly expanded capacity

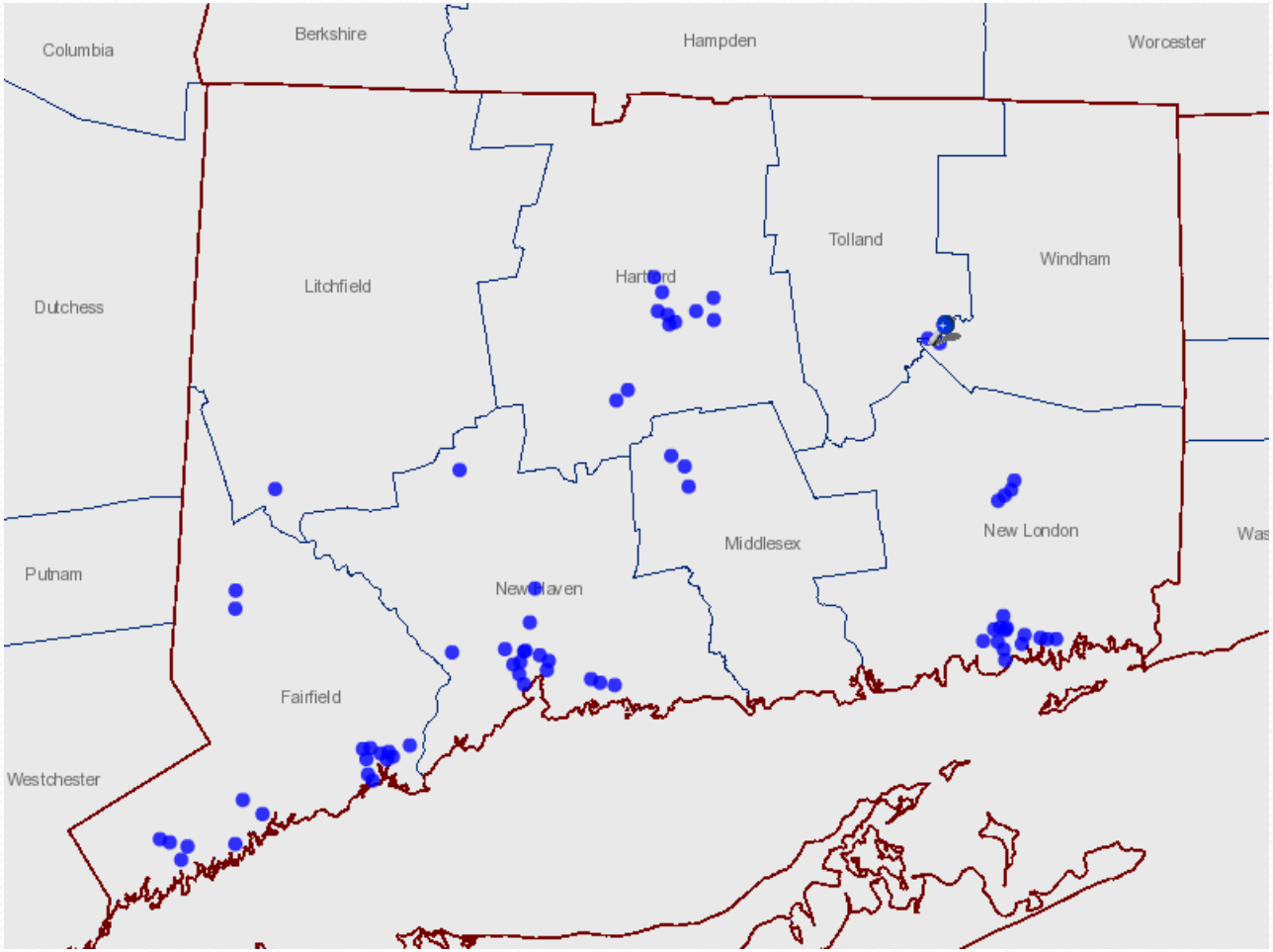
Progress

- Pace of adoption of electronic health records has vastly accelerated
- Patient Centered Medical Home primary care providers: from zero to 320 in Connecticut!
- MODEL of care is transforming, from integrated care, to support for non face to face care—but too slowly
- Still no organized, systemic system to help practices transform.

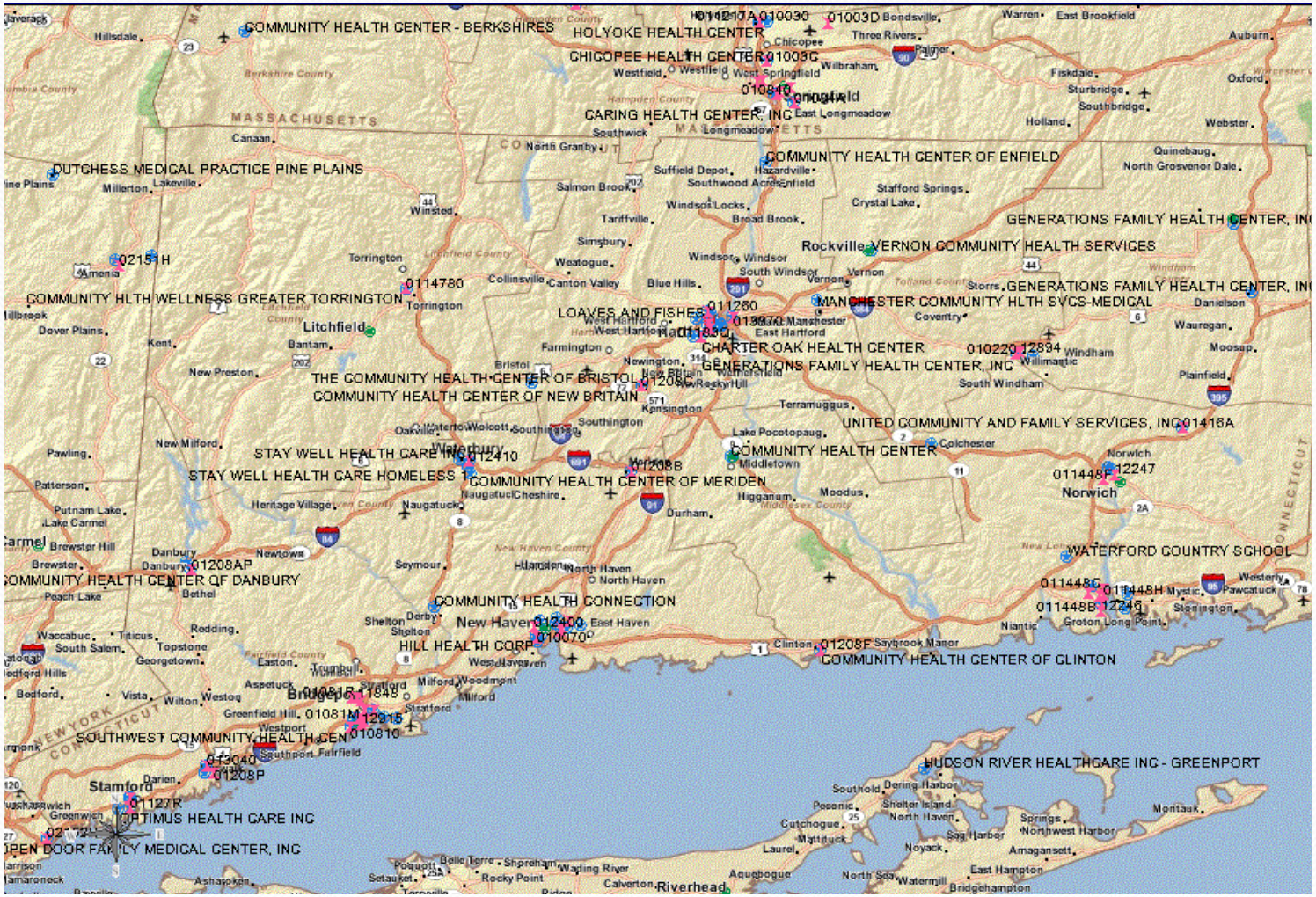
Increasing access

- Comprehensive School based health centers have grown to 78 schools, with an increase of 16.5% in enrollment; an additional 150 schools offer dental care
- FQHCs have expanded: Between2007 and 2010, a 41% increase in patients, (220k to 311k)
- FQHCs: 45% increase in MDs, 106% in NPs, 90% increase in psychiatrists, 160^ increase in LCSWs.
- (3) new FQHCs, 15 new FQHC sites, 3 to soon open
- NHSC: now 158 FTE providers in Connecticut: 98 in urban areas; 59 in rural areas.

Connecticut School Based Health Centers



FQHC's in Connecticut



Innovations

- eConsults, as described by Dr. Mitch Katz of San Francisco Health Department in his presentation to the SPCAA in 2008, now in place with University of Connecticut, but still very small
- Patient portals, as an element of electronic health records, now part of many primary care practices
- DSS is developing patient-centered health home standards and methodologies

The Work Continues

- Commissioner Mullen has convened a primary care taskforce to again try to identify the locations of each primary care facility in Ct.
- Commissioner Bremby and Medicaid Director Dr. Mark Schaeffer created an expert advisory board and are working on “person centered medical home” statewide standards
- Governor Malloy has established a healthcare cabinet
- Health Insurance Exchange Board is up and running
- We will not rest.

Private organizations continue to innovate and support primary care

- CHCACT
- Connecticut Center for Primary Care
- CSMS
- Primary Care Coalition of Connecticut
- CTAPRNS
- Weitzman Center for Innovation in Community Health and Primary Care

Conclusions

- The world of health care changed radically between 2007 and 2011
- We are closer than we have ever been to the first step: universal coverage for all people, and universal access to primary care
- Our challenge is to continue to drive transformation in the effectiveness, quality, and accessibility of that care.
- The triple aim: improved quality, better safety, decreased cost, and universal access to primary care is within our reach.