

# State-Wide Primary Care Access Authority

Co-Chairs  
Margaret Flinter  
Tom Swan



## MEETING SUMMARY

**Wednesday, November 21, 2007**

**8:00 AM in Room 1C of the LOB**

The Following Members Were Present: Margaret Flinter, Tom Swan, Robert Galvin, Daren Anderson, Evelyn Barnum, JoAnn Eaccarino, Margaret Flinter, Robert McLean, Lynn Price,

Also Present Were: Fernando Betancourt, Teresa Younger

The Following Members Were Absent: Nancy Wyman, Michael Starkowski, Sandra Carbonari

Margaret Flinter convened the meeting at 8:08 AM and asked members to introduce themselves. She then reminded the members of their charge as a member of the Primary Care Access Authority:

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.

Margaret Flinter explained that the best way to learn about the infrastructure of the health care system is to hear presentations from members around the table. She introduced Evelyn Barnum as the first presenter.

Evelyn Barnum reported working with all 13 Federally Qualified Health Centers (FQHC's) as well as providing services at about 350 sites. She stated that services always include medical, dental and mental health.

Evelyn Barnum stated that there is an effort by the Primary Care Association to increase the hours of operation to enhance availability of care. She reported that 232,000 patients were served in the last calendar year with over one million visits.

Evelyn stated that the goal of the health centers is to double the number of visits and that there were a large percentage of women and children that were patients of these centers in 2006. She reported that there were also disproportionately large percentages of Hispanics and African Americans. She stated that health centers are located and modeled to serve patients who need low cost care, FQHC's employ thousands of providers across the state.

Evelyn reported that:

- 17,154 homeless residents and 2,530 migrant workers receive services.
- 40% of patients are better served in a language other than English.
- 24,534 SAGA patients receive their care at FQHC's.

Evelyn Barnum highlighted the following as challenges that the FQHC's face.

- Access to specialty services.
- Workforce development and recruitment.
- The addition of an online system to better serve patients in terms of getting appointments and streamlining the care system has also been a challenge.
- Similar to the hospitals, there are structural and maintenance needs for the facility.

Robert McClean asked about the high percentage of people who have no insurance at all and how the FQHC's deals with that issue.

Evelyn Barnum stated that 10 of the 13 FQHC's are grant funded. Funding is shared between government funding, grant funding, and charging patients based on the sliding scale.

Commissioner Galvin reported 16,000 migrants receive inadequate care, large pockets of our population speak very diverse languages and there are large groups of uninsured in population. He stated that a town could, with sufficient funding, create a system of community and school based health care, that, when working with a hospital could serve everyone in that town.

Evelyn Barnum stated that health centers have sprung up in communities where the community has identified the need and they are established by the community for the community and of the community. She added that their role is to encourage and support that growth and that there are models across the country that suggests that health centers have the ability to provide primary care access.

Commissioner Galvin stated that school based healthcare is a separate system from community health which in turn is separate from the hospital emergency department.

Evelyn Barnum noted that the separation between those health care systems creates frustration when it comes to information exchange and this is a problem that new technology will need to address.

Daren Anderson presented the following information about Community Health Center Inc. (CHC). Community Health Center Inc.

- It is a federally qualified health center with multiple cities facilities across Connecticut.
- It's a place where primary care is delivered.
- It has a model that works.
- Provides primary care in medicine, dentistry, and behavioral health wherever the patients are.
- Expanded hours of operation to the evening and Saturdays.
- Specialty care is offered.
- Primary care starts with an access to care worker and every new patient is given a comprehensive needs assessment.
- About 70,000 patients call CHC their primary care provider.
- A significant number of our patients are pediatric and adolescent.
- Advanced access scheduling is one reform CHC has made to better serve their patients.
- Community Health Center will offer you a visit within a week of your call. This decreases waits, delays, and "no-shows."

- Working closely with Walgreens Pharmacy, a system has been developed for uninsured patients to get discounts which in many cases represent a 50% discount in the wholesale cost.
- In the past year, CHC's health centers have gone fully electronic using wireless tablets that integrate all the different people in the CHC network. The electronic health tablets have been very successful.
- Community Health Center Inc. is mission driven and takes care of the most vulnerable patients in a way that's innovative, cost effective, and dynamic.
- Community Health Center Inc. is a model that is worth looking at.
- In Connecticut, over 70% of revenue comes from insurance reimbursements and reimbursements for the uninsured.
- About 30% is grant funded and generally that money is focused on specific populations.
- CHC has a very definite methodology for going to a fictional town for analyzing their healthcare needs, looking at the population and the mix of insurance and looking at a formula for what the needs would be to treat the homeless and migrants, and to be in the schools, to work with the hospitals and to integrate with the specialists.

Robert McClean asked what the cost of implementing electronic health records would be per provider.

Daren Anderson answered that he did not have that information yet and that the largest cost is the reduced productivity while you are training people to use the system.

Commissioner Galvin asked why there were two separate community healthcare systems in such a densely packed state and is that the best way for us to move forward to provide healthcare for those in need, and how do we get these two separate systems to work together?

Daren Anderson suggested that the two systems are not entirely separate, and he viewed the two systems as part of the state's network of federally qualified health centers. He stated that collectively, with the Connecticut Primary Care Association, we service almost the entire state of Connecticut. He added that since 1999, the FQHC's have worked fairly well together sharing data and ideas and have met on a regular basis.

Commissioner Galvin asked if there was a way to make their systems function better together than they do now.

Daren Anderson stated that the E-Health Connecticut project is a part of that strategy and would facilitate the sharing of more data.

Margaret Flinter commented that only 5% of the individuals served in the health centers are over age 65. When that percentage increased we will be faced with a bigger challenge.

JoAnn Eaccarino stated the following on School Based Health Centers (SBHC's):

- Provides comprehensive primary health care on the grounds or in the school.
- Staffed by a multidisciplinary team of professionals with a particular expertise in child or adolescent health.
- Connecticut model includes at least a health care provider and mental health care provider.
- SBHC's are all licensed as outpatient clinics.
- Services provided in these centers are similar to those provided in a primary care physician office.
- There is individual, group, and family counseling, patient education, case management, psycho educational groups, support groups, smoking cessation and substance abuse, nutrition, and pregnancy prevention.
- There are 1,700 school based health centers in 43 states in the U.S.
- There are 68 SBHC's in 19 communities in Connecticut.
- The major reason for SBHC visits are medical followed by behavioral health and dental.
- Reproductive health accounts for 8.1% of the medical visits.
- SBHC's remove barriers to care such as transportation, taking time off from school or work, and also canceled appointments. There are fewer "no-shows," in school based health.
- Efficiency is increased in SBHC's because if one person misses an appointment another person will probably be available to fill that otherwise empty time slot.
- SBHC's serve as a safety net for the uninsured and underinsured.
- SBHC's are also cost effective, and often the same care at a school based health center will be far more expensive at an emergency room.
- SBHC's have had a significant impact in oral health prevention and infectious disease control.
- SBHC's perform several non-reimbursable services such as classroom presentations, seeing kids in groups, self esteem, nutrition calculation etc.
- SBHC's provides a great way to reach adolescents that might not otherwise seek care.
- SBHC's can help enroll a child on an insurance plan and get them enrolled in classes more quickly.

JoAnn Eaccarino stated that the outcomes of the SBHC system are increased access to utilization of primary and preventative health care and other essential health services to improve the health of school-age children. She added that this will hopefully help these children maintain a healthy lifestyle and help them understand how to access the health care system.

JoAnn stated that additional funding is needed for SBHC's and that there is legislation that was recently introduced in Washington that may provide federal funding for SBHC's and added that there is a challenge for SBHC's in recruiting and maintaining bilingual or multilingual staff.

Robert McClean asked if there was a sense of how many students get primary care through the school based clinics.

JoAnn Eaccarino responded that she didn't have that information but strong efforts have been made to connect to a community provider.

Robert McClean asked if many vaccinations were provided through the School Based Health Centers.

JoAnn Eaccarino responded that there were many, especially to students coming from other countries without immunization records.

Commissioner Galvin used Norwich as an example of a town with 8,500 kids with the average family income at \$17,000 lower than the average state income, 75% or more students have both parents working, one out of two kids gets free lunch or lunch assistance and 35% of the children are living under 200% of the federal family poverty level. Commissioner Galvin stated this is a place where school based health is seriously needed. He also expressed concern that the system doesn't make an effort to collect money from private insurers.

Robert McClean stated that doctors often refuse to see patients because of the low reimbursement rates offered by Medicaid. He reported that the American Academy of Family Physicians has released proposals for the patient centered medical home model that will look at ways to reimburse previously non-reimbursable procedures, and addresses case management fees.

Robert McClean stated that some states are looking into the option of loan forgiveness as a way of keeping medical students in the state if they are willing to practice primary care. He stated that the tremendous debt coming out of residency prevents medical students from going into primary care practice.

Robert McClean stated that a relatively small percentage of primary care doctors have adopted electronic medical records because of the financial downfalls in the first year, the lack of productivity, and concern over whether a particular vendor's product would still be adequately functional in a few year. He stressed the need for a universal electronic medical records system.

Robert McClean added that providing health insurance for employees is a major overhead for private practices and that malpractice insurance is another large expense. He added that if Medicare fee cuts go through as expected it will create an even greater problem.

Fernando Betancourt asked about the Medicaid reimbursement schedule.

Robert McClean responded that he had stopped accepting Medicaid patients and did not know what Medicaid pays.

Commissioner Galvin added that Medicaid pays approximately half the bill and that the cost of running a primary care operation is very high. He stated that for a primary care doctor with just one additional year of education, it is possible to earn three, four, or five times as much money with a more compact workweek.

Commissioner Galvin added that when 65 cents out of every dollar goes to overhead, state income tax and licensing fees it becomes very difficult for physicians to take on patients knowing that they will not be paid at least the cost of providing care for them.

Fernando Betancourt asked Commissioner Galvin what the average salary of a doctor in the situation described would be.

Commissioner Galvin responded that the average primary care family physician may make about \$125,000 annually.

Robert McClean confirmed Commissioner Galvin's assessment and added that nationally the average tends to be between \$125,000 and \$150,000 annually. He added that Connecticut's average pay for primary care doctors tends to be slightly lower than the national average.

Daren Anderson asked Robert McClean for his view on how realistic it is, in the current setting, to provide the aforementioned additional types of services in a fee-for-service type of system.

Robert McClean responded that it would not be possible and that Community Health Center Inc. is operating the advanced medical home efficiency and grant money may be one of the major factors which make that feasible now.

Daren Anderson suggested that insurers need to be involved in some way in the final decision that the committee reaches.

Tom Swan commented that one challenge to creating a system of universal health care is figuring out what it would take to build the medical home. Tom asked what the average student loan for a medical student is and if the State has any incentives to help encourage people to stay in the state or go into primary care practice.

Robert McClean suggested that routinely medical students are graduating with \$120,000 to \$200,000 loans for medical school alone and that figure does not include any potential college loans.

Daren Anderson stated that there are three main ways to get assistance with the burden of medical school loans: 1) The National Health Service Core Scholarship Program that pays for your college if you are selected. 2) The National Health Service Core Loan Forgiveness Program that is awarded after residency is completed. 3) The State of Connecticut offers a similar loan forgiveness program in exchange for service in an underserved area.

Robert McClean asked how many people working in Community Health Centers Inc. clinics are using the programs he identified.

Daren Anderson estimated that 10 to 15 practitioners probably used those programs.

Margaret Flinter agreed with that estimate, and added there are probably hundreds throughout the state utilizing these programs. She added that School Based Health Centers and dental hygienists are now eligible for loan repayment and that federal loan repayment is also available for people working in underserved areas without working in a community health center.

Lynn Price stated that currently there are eight Advanced Practice Registered Nurse (APRN) programs in Connecticut and they are all at the Masters level. She added that the training most people are given is in primary care with some concentrations in areas such as HIV, diabetes and chronic disease management.

Lynn Price stated there are approximately 3,000 practicing APRN's in Connecticut, 2,500 nurse practitioners and clinical nurse specialists and the vast majority of those are nurse practitioners. She stated that many nurse practitioners and clinical nurse specialists work in Federally Qualified Community Health Centers, as well as outpatient clinics, private offices, hospital settings, school based health centers, other school health settings, and long term care settings.

Lynn added that APRN's are working on the issue of electronic licensure and renewal and this process should provide good data on APRN's.

Robert McClean stated that a lot of the advanced medical homes relied on team building and that APRN's are becoming more of a presence and that going forward APRN's will need to be active participants.

Margaret Flinter asked for the numbers of new APRN's on an annual basis and if they are staying in Connecticut if they are taught here.

Lynn Price stated there were approximately 200 APRN graduates annually in Connecticut.

Ellen Andrews stated the following:

- In 2004 Connecticut's health care system spent \$6,344 per person, the New England state average is \$6,409 and the United States spent little over \$5283 on average.
- Connecticut spent twelve cents out of every dollar on health care, New England average is fourteen cents and the United States is a little over thirteen cents.
- Between 2001 and 2006, almost 45,000 Connecticut residents lost employer sponsored insurance and the percentage of Connecticut employers who offered insurance dropped by 5% and HUSKY enrollment grew by 30%.



- Connecticut is fifth in the country in terms of residents that are in managed care, first in the nation in the percent of health care spent on nursing homes, and Connecticut hospitals have the second worst nursing shortage in the country.
- Administrative costs including profit have grown 65% faster than the rest of healthcare overall and it consumes 31 cents out of every dollar.
- Approximately 325,530 residents are on HUSKY which covers one in five Connecticut children and one out of every four births.
- HUSKY is the largest insurance purchasing pool in the state, therefore they have lower administrative cost relative to smaller insurance pools.
- Two out of three uninsured Connecticut adults are workers with family incomes between \$12,000 and \$45,000 a year, and they tend to be single, young adults between 19 and 29 years old. Most don't have a college degree, and Hispanics are more than three times as likely to be uninsured.
- Income is the most closely correlated demographic associated with a lack of insurance and most uninsured workers are employed in small firms, and 95% of Connecticut firms employ less than 15 employees.
- Connecticut's uninsured are ten times less likely to get care for an injury, and seven times less likely to get care for a medical emergency.
- While the uninsured receive half as much medical care as everyone else, they pay far more out of pocket and half of bankruptcies are due to medical bills with three quarters of those people having insurance when they became ill.
- There are more uninsured in Connecticut than the combined population of Bridgeport, New Haven, Middletown and Norwich.
- The HUSKY provider rates were increased up to 50%.
- Parent eligibility for HUSKY was raised to 185% of the federal poverty level (FPL), pregnant women are eligible up to 250% of the FPL and children can stay on their parent's policies until age 26.

Robert McClean asked what amount of money was given to hospitals out of the uninsured pool from the state.

Ellen Andrews responded that it was hundreds of millions of dollars and that more federal money could potentially be accessed.

Robert McClean asked what percent of Medicaid funding is going to nursing home care as opposed to direct medical care.

Ellen Andrews told the Authority that it is much higher than it is in other states.

Robert McClean asked if there should be a way to have a separate source of funding for long term care as opposed to acute medical care.

Margaret Flinter advised the committee that they will need to begin to look at what defines primary care.

Margret Flinter stated that there is the potential for a contract to be awarded to a research group at UConn to conduct an inventory of the primary care infrastructure and that to do so a definition for “primary care,” must be established.

Robert McClean described primary care as the first stop for a health problem.

Margret Flinter suggested we look at services and settings, people, and the populations and geography when looking at the health care problem in Connecticut.

Tom Swan suggested that in the time before the next HealthFirst Connecticut Authority that the definition of primary care should be discussed so that the Authority begins to look and think about how far it wants to delve into scope of practice issues and other healthcare issues.

The meeting was adjourned at 10:20 AM.