

# State-Wide Primary Care Access Authority

Co-Chairs  
Margaret Flinter  
Tom Swan



## Meeting Summary

Wednesday, October 29<sup>th</sup>, 2008

Members present: Tom Swan, Margaret Flinter, JoAnn Eaccarino, Dr. Robert McClean, Lynn Price, Dr. Sandra Carbonari, and Teresa Younger.

Also Present: Jennifer Filippone, Steve Casey, Karen Buffkin, Robert Aseltine, Dr. Todd Staub and Dr. Jim Cox-Champman.

Absent were: Comptroller Nancy Wyman, Commissioner Robert Galvin, Commissioner Michael P. Starkowski, Dr. Daren Anderson, and Evelyn Barnum.

Margaret Flinter convened the meeting at 7:44 AM and asked members to introduce themselves.

Margaret Flinter requested a motion to approve the meeting summary.

Robert McLean asked that he be added to the attendance. The meeting summary was approved.

Robert McLean:

I got feedback from a physician that attended one of the hearings was concerned that we were looking at tying medical licensure to Medicaid enrollment. I think I specifically stated that I don't think that is a good idea.

Margaret Flinter:

It was tied to the changing of reimbursement rates for Medicaid as way of changing participation and changing those indicators that The Office of Health Care Access (OHCA) gave us about who uses the emergency rooms and who is being admitted for ambulatory sensitive conditions.

The Quality Access & Safety Workgroup may still end up with that as a recommendation but it will be tied to better reimbursements.

Teresa Younger:

The Universal Health Care Foundation video taped all of the hearings and I think they are available on their website.

Margaret Flinter:

We asked Bob Aseltine, from the Center for Public Health Policy at the UConn to brief us on the work that they are doing for the Authority in terms of the assessment of primary care inventory in the state.

We had asked the Department of Public Health (DPH) through Steve Casey from the DOIT to speak on the status of online licensure. We also invited Todd Staub, and Dr. Jim Cox-Chapman, from ProHealth to talk about the work their organization is doing relative to the transformational element of primary care delivery.

### **Presentation #1**

Mary Eberle:

Since we signed the MOU with the DPH we have gathered data bases from NAMCS, NHAMCS and the DPH licensure data base, and we are in the process of getting a data base from the AMA.

Brian is trying to figure out how to compare what's in each data base with each other to ask the questions we need to ask. We are working to divide out of the national data bases the Northeast data and that's about the closest we can get to Connecticut's data.

Margaret Flinter:

How does the Connecticut State Medical Society survey factor in, if at all; are there elements that you can use?

Mary Eberle:

If it's applicable we will use it but right now my understanding is that was more about attitudes and this is about capacity.

Margaret Flinter:

I think there is probably some referencing to be made.

Mary Eberle:

To the extent it's applicable we will reference it and include the findings that apply.

Margaret Flinter:

Are we are still on track for December?

Mary Eberle:

Yes

Margaret Flinter:

Until we get to electronic licensure we are never going to have an ongoing look and unless we collect the right data we will not have a way to predict what is happening in the healthcare workforce.

### **Presentation #2**

Jennifer Filippone:

For a number of years we have been working with a variety of groups such as Allied Health Workforce Policy Boards and members of the Legislature in trying to identify a mechanism collect data for the healthcare workforce in Connecticut.

Two years ago the Legislature passed a bill that would require the DPH to initiate that process through online licensure for physicians, dentists and nurses.

Steve Casey:

The infrastructure in the state is decentralized and each agency has control of their own applications that is managed by DOIT managers. Lois BRYANT who was the DPH manager led the effort for the RFP for the consultant to write the business requirements. IT does not drive business requirements therefore we need the business community from that agency to get involved. The DPH was very strong in making that commitment and we are ready to work on the RFP. By the time we got the requirements the legislature was in budget-impasse last June and July so we had to wait until we got the green light from OPM that the money was carried over. We did get that news in August and in September we drafted the RFP which is now under architectural review.

### **Discussion**

Margaret Flinter:

I think what this group is most interesting in is, “what are the questions for the data that’s to be collected and can we engage in a discussion about that”

Jennifer Filippone:

We had worked with a variety of groups on developing a survey tool that we intend to use as a part of the online process. If you renew your license online essentially you cannot complete the process until you have answered a series of questions. We are trying to develop a process for folks who don’t utilize the online system.

Some of the questions that we are looking at are, 1)Where are people practicing, 2) Are you actively practicing, 3) Are you providing direct patient care, and if not, why not, and what would it take to get you back, 4) Get information about a particular practice location, and 5) Looking at people’s education background.

Robert McLean:

Some of the questions should be, 1) Are you practicing primary care and if so what percent of your time? and, 2) Are you doing it in a supervisory capacity or are you doing it directly?

Tom Swan:

Are you asking anything in terms of whether or not providers are taking new patients and or HUSKY?

Jennifer Filippone:

The first question is a part of the physician profile and the goal is to combine the information we are collecting as a part of the profile with the survey so we are not being redundant. We are interesting in all of your input but I would caution that there are many groups that want to participate in the development of the survey tool and we want to make sure we are not coming up with a tool that’s 30 pages long. We want to be sure we are asking the right questions and we are not asking too many questions that aren’t going to give us any real good data.

Sandra Carbonari:

Is there any question about future plans and do you plan to retire in the next 5, 10 or 15 years?

Jennifer Filippone:

Yes

Robert McLean:

Physicians love to complain about the exorbitant licensure rates and I would suggest that giving a \$50 discount for the using the online system may really increase your numbers dramatically. I don't think the cost for something like that would be huge especially since you may be saving manpower dollars doing it electronically.

Jennifer Filippone:

All of the licensing revenue that's generated from health care practitioners goes directly into the general fund. It doesn't directly support any of DPH activities in terms of license renewal or issuance of licenses. Fees are set by the Legislature so in order to waive that \$50 would require legislative approval and would have quite a fiscal note. Although it may not sound like much, any fiscal impact would be substantial especially in the time that we are in.

Four or five years ago the DOIT conducted surveys of all the states to determine what the utilization rate across the country is in terms of online licensure. The physicians, nurses and dentists utilization rate is actually much lower than other health care professionals and in fact it was less than 50% across the country. In terms of a cost savings, we actually don't do a lot of processing with the renewals right now, so there will not be as large a cost saving.

All our renewal cards are actually processed outside of the agency in terms of the payments. We ask a series of questions on the back of the renewal cards but presently that data is not been entered into the system so there is no savings.

Robert McLean:

So how many doctors with felonies are out there practicing right now?

Jennifer Filippone:

The questions are, 1) Have you ever been convicted of a felony in the pass year, 2) Have you had any action taken against you in another state, 3)Do you currently have any action pending against your license in another state? These are questions that trigger an investigation and we do initiate an investigation of any practitioner regardless of the profession.

Margaret Flinter:

Can you share with us what the process is for the remainder of the time before you settle on the final set of questions, can this committee get a copy of the draft, is there sort of an open comment section, and are you planning on having sort of a public meeting for the various health professions to comment?

Jennifer Filippone:

I can certainly give you a copy of the draft that we have and our goal is to get back to all the different groups that provided us with input in the beginning. In terms of timelines, I think we will have a better idea over the next month or so when we figure out exactly when the RFP is going to be issued or how

that process is going to work. We are hoping that this will be up and running at the beginning of fiscal year 2010.

Josh Rising:

Are providers going to have an option to do paper or online or is it all going to be online?

Jennifer Filippone:

We have not been given the authority to mandate online licensure at this point and there is issues related to accessibility that would need to be resolved before that. I think that as we roll this out and we get into it for a year or so we can start to evaluate the utilization rate and how can we make more people actually use it.

Josh Rising:

If less than half of the providers are doing it then it is going to be a limited set of information.

Jennifer Filippone:

We have made a commitment at the DPH to find a way to collect the data from those folks who do not renew online.

### **Presentaion #3:**

Bob Aseltine:

I am here to talk about the 2008 Connecticut (CT) Physician Workforce Study. This is a study that was conducted by the CT State Medical Society and funded by the Universal Health Care Foundation.

Massachusetts (MA) has done a workforce study for 15 years and this is something that has not been done consistently in Connecticut but began about two or three years ago when the Medical Society engaged a consulting firm to help them get information about the state of physicians and their perceptions about the practice environment in Connecticut. In 2007 we worked with the MA Medical Society using some survey instrument that they had developed, to create something that was unique to CT and provide some perspective on the status of physicians and their perception of the environment here in CT.

The first step was to, 1) Assess CT physician satisfaction with their careers in medicine and their lives as physicians, 2) To identify problems associated with the supply of physicians in certain specialty areas in CT, 3) Try to determine the possible causes of those problems and, 4) Assess the potential impact on access to care, 5) Concern over the professional liability environment in CT and it's relationship to practice patterns and patients access to care, 6) Examine physician opinion on healthcare reform and, 7) Examine the use of technology in CT physicians practices.

The self administered survey was mailed to 4000 physicians practicing in CT. The sample was drawn from the medical society, physician directory from RI & CT and the DPH physician profile. Using these 3 data sources it is estimated that there is roughly 6500- 7000 physicians practicing in CT with a CT business and a CT full and active license.

Approximately 1100 physicians completed this survey. Eighteen specialty areas were included. The final analysis was done with 1075 physicians. About 80% of this sample was males and most prominent age groups were in the 45-65 age range. Approximately half of the sample were considered self-employed. Among practice sizes you see that typically the practice sizes among physicians in the state are very small- approximately half or more that half (57%) are practicing in either solo practices or small groups that are under 5 physicians. They tend to provide an average of 42 hours of direct patient care.

Tolland County only had 14 respondents and therefore was omitted from some of the graphs and figures that you are going to see here. We cannot generalize on that small of a sample.

The first question is overall satisfaction with career in medicine by specialty. For the most part physicians are on average satisfied. Neurological surgery, urology and obstetrics and gynecology among certain specialty area tend to be lower in overall satisfaction. Family medicine, internal medicine and general surgery tends to be slightly less satisfied than those in the dermatology, emergency medicine and radiology.

We looked at the likelihood of them recommending to someone graduating from medical school that they practice in the state of Connecticut and we see a mirror image of what we saw with satisfaction. Specialty areas that are most satisfied are most likely to recommend practicing in CT to young graduates. Emergency medicine, radiology and oncology tend to be the highest. Neurosurgery tends to be the quite low and some of the other specialty areas are very likely to recommend their area for practicing.

We look at the overall satisfaction with practice in CT, by county, gender age and practice size and we do see some differences by county with Litchfield County the lowest. Windham is more than likely to recommend practicing in CT. This tends to vary linearly by age with older physicians more likely to recommend practicing in CT than younger physicians. Physicians in smaller practices tend to be less likely to recommend practicing in the state than those in larger practices.

Surgical subspecialties are quite likely to be contemplating a career change and pediatricians, dermatologists and emergency physicians are amongst the most stable and happy with their situation in CT.

One area of this survey that is very important from the standpoint of access is the difficulty in recruiting physicians and this was something that we looked at by specialty area, county and practice size and you can see that overall it is very difficult to recruit in their specialty area and in their geographic. Neurosurgeons, urologists and dermatology were among the highest or the most likely to say that it was very difficult to recruit physicians in the area of practice. Emergency physicians, pediatricians and radiologists were less likely to say they had difficulty recruiting physicians. Some of the rural counties had the greatest difficulty in recruitment. In Windham county 72% said it was very difficult to recruit physicians for that area.

One dimension of recruitment difficulty and satisfaction with their careers is the professional liability environment. 33% of physicians of a cross specialty say liability premiums are very burdensome.

One issue that is also very prominent is the estimate of waiting days and we are looking at roughly 17 days for new patients and almost 11 days for existing patients but in specialty areas such as

dermatology, neurology, and obstetric and gynecology these wait days were close to a month for new patients and almost 3 weeks for existing patients.

A dimension of access difficulty involves the inability to get referrals and we looked at this in terms of specialty and almost half the physicians said they had difficulty getting referrals over the last 3 years. These are quite pronounced among pediatricians and emergency physicians which is extremely problematic because these are the people that are making a tremendous amount of referral.

50% of patient care is paid for/covered by commercial insurers, almost a third by Medicare and the balance by Medicaid/Husky, self pay and free care. This vary dramatically by specialty area, cardiovascular diseases, half the patients treated under Medicare, for pediatricians commercial insurers covers about 2/3<sup>rd</sup> of their patients and 30% are covered by Medicaid/HUSKY. Amongst psychiatrist about 1/3<sup>rd</sup> of the patients that they treat are self-pay and almost 13% are free-care.

We also asked a series of questions about technologies that physicians are incorporating in their practices and found that practice management applications and billing applications are used quite frequently by physicians. However, EMR and E prescribing, two of the technologies that might have the greatest opportunity for improvement and the quality of care are used less frequently by physicians at this time.

While generally satisfied with their careers in medicine, physicians ranged between not very to some what likely to recommend a CT practice to younger physicians and this negativity was most pronounced among neurosurgeons, OBGYN and general surgeons. Nearly 20% of physicians reported contemplating a career change because of the practice environment in CT and this was most pronounced among the surgical subspecialties which were as high as a 1/3<sup>rd</sup> of the physicians in those categories. Physicians reported difficulties in recruitment and retention of physicians, 35% said it was very difficult but this was twice as high among neurosurgeons and neurologists. Difficulties in recruitment and retention were most evident in Litchfield, New London and Windham Counties and small group practices had the greatest problem with recruitment and retention.

The personal liability in CT has led many physicians to reduce their risk exposure. They are less likely to be seeing high risk patients, less likely to be doing high risk procedures and these are most common among the surgical subspecialties

Other data revealed difficulties in obtaining referrals and consultations for patients and these were most pronounced among emergency physicians and pediatricians

Physicians were very supportive of expanding current safety net programs or creating a large insurance pool to improve access to care and they were less supportive of a single payer solution to cover all CT residents

Adoption of technologies were the greatest potential to improve patient care, EMR, e- prescribing where it is limited to about 20-25% of Ct practices.

#### **Presentation #4:**

Todd Staub:

This presentation is divided into three sections: 1) general ideas about primary care and healthcare reform, 2) what we are doing at ProHealth physicians, and 3) how the things that help us be successful and those elements that this group might need to think about on how to extend that to all primary care groups across the state.



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These are the elements that have made us successful in our practice as a primary care group and they are some principles that this group should consider:

Revenue base- we have 10% of the state, 20% of the market and even more in some of the areas that we are in. We are able to bargain better and we have strong governance. We have a board of directors that is elected, we have a decision process and we have a very clear sense of what we are about. This is about primary care, aligning with the goals of the people and overall wellness.

The missing ingredient is management expertise in the small practice environment. What has made us successful is the business management partnership (we collaborate with business people that knows what they are doing around the mission of wellness)

The American Academy of Family Practice tried to implement the Medical Home Model within their practice and they had tremendous trouble with their practices and they have completely collapsed under the strain of this type of change.

Most practice don't have the basic business practice components and there is this lack of organizational skills which hamstringing primary care and make it less effective. Medical Home is good but we need to look beyond that model and we need to find ways to cultivate what that structure should be.

This is a small state but I think a frame for fostering organizational governance, and management is something we should think about.

**Discussion:**

Robert McLean:

Do you have a fully functioning EMR among all the sites?

Todd Straus:

We do not, but we have a practice management system, we own our lab, we have the other ancillaries so we have the data. We have the data warehouse where we can put these things together.

Jim Cox-Chapman:

We have attempted to see our patients as a population that needs to be managed in terms of prevention. We have a disease registry and we know how many diabetics we have, how often they have been to our offices and what their latest level of control is. We have at least 4-5 years worth of experience and data that will go into the electronic system.



We got caught up in the medical malpractice crisis and with the management expertise looking at our patients as a population we were able measure where our exposures were and then go in and have focused programs to lower the amount of risks. With that program we have been able to lower our number of cases by 47% and our failure to diagnose claims by 72% and have driven our malpractice premiums down by 34%.

Terresa Younger:

You had mentioned that you had modeled this report off the MA report and I was wondering if there is any correlation in any of the numbers or whether you didn't do a comparison on that level?

Bob Aseltine:

We didn't necessarily model the report after MA but what we did was used some of the survey instruments that have been developed in MA. The MA Workforce Report tends to collect far more data from other sources than physicians themselves. It's a bit more comprehensive in that sense and less focused exclusively on the physician's perspective. Some of the same issues that we see in Connecticut are seen in MA in terms of liability concerns, the degree to which physicians are curtailing high risk services and procedures and patients that they see.

Terresa Younger:

And were there any assumptions made in the final report about why women were more likely to recommend practice in Connecticut than some of those small disparity numbers, and, were there any conclusion made on that or were the facts just put forth?

Bob Aseltine:

There were no conclusions based on that, I don't know if the Medical Society might have some thoughts about that. One of the things that we tend to see is that women physicians tends to be younger, they tend to be more oriented towards primary care, they tend to be more invested in public health issues, so their perspectives are a little bit different.

Robert McLean:

A question for Tom and Jim- do you guys participate in Medicaid?

Todd Staub:

Yes, we do.

Jim Cox-Chapman:

I just want to foot note what Todd said.. You are absolutely right about satisfaction

Margaret Flinter:

If we were taking Bob's survey and only survey ProHealth community of physicians, Nurse Practitioner and Physicians Assistants on issues of recruitment, first of all, can you recruit new providers, retention and satisfaction with your opinion would the results be different? And is there a lesson for the State-Wide Primary Care Authority?

Todd Staub:

If you look at Bob's data, there is clearly a satisfaction rating that went from solo, to small groups to mid size, to large and the larger group groups had the highest satisfaction. We have a fulltime recruitment department and they tract people with connection to Connecticut, we do presentations and have involvement in the residency programs with students, we are funding some resident and student activities, providing stipend, and things that we are doing so we can develop a pipeline of people. And I think more importantly what we are trying to show to the primary care students and residents that are contemplating this – here is a career path in the state that is viable.

Tom Swan:  
What about turnover?

Jim Cox-Chapman:  
Turnover, since we went through our birth agonies about 10 years ago I think our basic turnover has been people leaving for the usual types of reasons, retirements, moving out of state, spouse relocating. That's not been a major issue and again attracting people to come into primary care and retaining them is a challenge.

Margaret Flinter:  
The next meeting has to be about beginning to put the report together much of which will be drawn from the previous meetings and discussions but also trying to marry that up with where the HealthFirst Authority is. At the last meeting we gave you this preliminary view of a modeling and I would like people to take another copy and really go through and think about each piece.

The HealthFirst Authority is trying to get some financial modeling on some of these proposals between now and their next meeting. They are looking at the creation of a Health Trust, Pooling, some new approaches to getting to universal coverage in terms of employer/employees, individual and government shares and there is a big chunk about transformation of the delivery system.

The next meetings will be on Wednesday, November 26, and on Wednesday, December 17, 2008, at 7:30 AM.