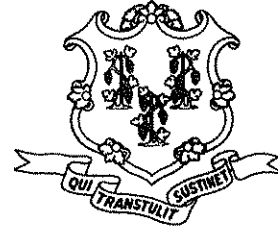


State-Wide Primary Care Access Authority

Co-Chairs
Margaret Flinter
Tom Swan



Legislative Office Building
Room 3000
Hartford, CT 06106

Phone
(860) 240-5254

Fax
(860) 240-5306

E-Mail
statewidePCAA@cga.ct.gov

Meeting Summary

2-4-09

Members present: Dr. Daren Anderson, Tom Swan, Margaret Flinter, Dr. Robert McLean, Joan Eaccarino and ODr. Sandra Carbonari

Members Absent: Nancy Wyman, Robert Galvin, Michael Starkowski, Evelyn Barnum and Lynn Price

Others Present: Mary Eberle, Brian Benson and Robert Trestman

Margaret Flinter convened the meeting and explained that the previously scheduled meeting was rescheduled due to bad weather. The key business of this morning is to review and accept the report we commissioned to assess primary care capacity in Connecticut. Dr. Robert Trestman, Mary Eberle, and Brian Benson are here to present it and to answer questions from the Authority. In addition, we need to focus on what we are doing over the next couple of months in terms of zeroing in on the critical aspect of how we fulfill the charge to come up with a set of recommendations for universal primary care, which might be consistent with the other projects that are moving forward or may have some specific variations based on this committee.

Margaret Flinter asked Tom Swan to give an update on the HealthFirst Connecticut authority.

Tom Swan stated that the HealthFirst Authority postponed the vote on the final report at the January meeting and scheduled it instead for the February 24th meeting.

Margaret Flinter thanked everyone who came to the December HealthFirst meeting where the draft report was presented. After the meeting we made some changes and have put in some additional

language for the next meeting for people to consider. Some of it is clarifying what “value-based design health insurance” really means. We heard from advocates in the dental community that although we always knew when we were talking about primary care and comprehensive services that we were including dental, they did not feel that we have done an adequate job of making that clear. We have gone back and tried to incorporate some of that language. We will probably discuss more of the pros and cons for individual mandates but make it clear that without a set of regulatory protections and benefit design protections which we don’t currently have a mechanism for, we couldn’t put the cart before the horse but that might be a direction to go in the future.

Margaret added that she and Tom are now working with Dr. Jon Gruber, an economist from MIT, to develop some cost estimates for the HealthFirst proposals.

Margaret reviewed the national recommendations for health reform while preliminarily seem to put emphasis on electronic technology, primary care, strengthening Medicaid, prevention, and chronic disease management. All these things really dovetail very nicely with a lot of things that we are trying to do in the HealthFirst Report, in particular that nobody is out there on their own trying to find their own insurance and being in that category of people who simply can’t get to it. She noted that there should be more information coming out on increased support for health professions training.

Margaret asked Dr. Sandra Carbonari for an update on the PCCM project. She stated that it started February 1st and it is being rolled out in Waterbury and in the Willimantic area. One of the difficulties was that there was a lot of pediatrics interest but getting internal medicine and primary care people interested was a challenge. Saint Mary’s, Stay Well (FQHC) and two pediatrics practices in Waterbury have started out with it.

Robert McLean asked what’s the per-member per-month that is given to the primary care providers and whether it was the same for pediatrics and internal medicine? He noted that many internists don’t participate in Medicaid because of reimbursement, and that \$7.50a month is not going to be enough for them to even enter it. Unfortunately it will not be given the appropriate test because you are not going to get enough doctors involved at the internists level.

Sandra Carbonari explained she wasn’t implying that the internists didn’t want to do it because they didn’t think it was a good idea economically. We are already a medical home so it is a little bit easier for us to incorporate some of the major changes whereas it is a new concept to internal medicine so it is going to be a lot more difficult for them to change things. If you first start out with a hundred patient, that is not going to support a major change in your practice.

Margaret Flinter stated that there is a lot at play with healthcare right now. The Universal Healthcare Foundation has rolled out their Sustinet Plan, the Governor is giving her budget address at noon, and the federal government is preparing the stimulus package and has health care reform as a priority. We have a charge of how to make primary care available to every resident of Connecticut within the next four years. She then asked Dr Trestman and his team from the University of Connecticut Health Center to present their assessment primary care capacity in Connecticut.

Dr. Robert Trestman thanked the Authority for the opportunity to present the information today, and noted that the main presentation will be done primarily by Brian Benson. Brian Benson and Mary Eberle were the primary authors of the documents. The estimates are very difficult to make. There are many parameters that will influence what the real capacity is. This in context is a first pass, making use of national data to inform our best guess, giving very limited data for Connecticut itself.

Brian Benson stated that he will be providing an overview of our research on primary care capacity in Connecticut. This overview will include background information, a summary of findings, some of the data sources we used, and some results in detail.

Brian reminded the Authority that the State-Wide Primary Care Access Authority, through the Department of Public Health, contracted with the University of Connecticut Center for Public Health and Health Policy to estimate the current capacity of the primary care provider workforce in Connecticut and to project the workforce required to meet increases in the demand for primary care services based on demographic changes and changes in insurance status.

The Center conducted its research project from September to December 2008 and delivered the results of the research in this paper entitled "Assessment of Primary Care Capacity in Connecticut" on December 31, 2009.

Summarizing some of some of the main findings of the report:

- There is an appearance of an adequate supply of licensed primary care providers in Connecticut at present. This is on the current population, estimated productivity norms and the number of licensed primary care providers.
- Geographic distribution is unequal. There are disparities in Connecticut geographical distribution of primary care resources. There are fewer resources in rural areas and most health professional shortage areas designated by the Health Resources and Services Administration are located in Connecticut's larger cities.
- Unexpired provider licenses vs. practicing providers. One of our main sources of information was the DPH licensure database and what we found was that the count of unexpired primary care provider licenses issued by DPH almost certainly overestimated the current supply of practicing primary care providers in Connecticut, but by an unknown percentage. There may be a large number of currently licensed primary care providers who are retired, who reside in other states or are not practicing in their respective fields. There may also be a large number of physicians licensed in primary care specialties that do not currently provide primary care services or they split their clinical time between primary care and specialty care.
- More existing data about physicians than other primary care providers. There several questions that cannot be answered by using the current DPH licensure database or national survey data and might be best answered through a survey of providers. However for this research project, time and resource limitation did not allow the use of a survey.
- Existing research:
 - impending and future shortage

 - Selection of non-primary care careers by medical students.

There is far more existing information about primary care physicians than other types of primary care providers. We think that a survey of providers would help shrink this information gap.

- There is a growing concern about an impending shortage of physicians and particularly primary care physicians. Existing research shows that several factors contribute to these concerns, including population growth, that is estimated to exceed growth in physician supply, and aging population who's care is best coordinated by a primary care provider, increasing rates of chronic diseases in the population and the decrease in medical students pursuing primary care careers.

It is likely that Connecticut will not be able to absorb increases in primary care services demand in the future without improvement in primary care workforce capacity.

- Massachusetts experience
-primary care access problems with individual insurance mandate

We looked at the experience in Massachusetts following health reform that was passed there in 2006 and found that they have experience some problems in their health care system, including difficulties with accessing primary care by the newly insured. Thus if Connecticut were to implement plans for universal or near universal health insurance coverage or a mandate requiring coverage it would be beneficial to plan to increase primary care capacity system as well.

The following is the data that we used. As mentioned before, one of the primary source of the DPH licensure database. We received licensure data for:

- MDs, Osteopaths, Homeopaths, Naturopaths
- Nurse Practitioners
- Physicians Assistants
- Licensed Nurse Midwives
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What we found on the DPH licensure database at the time it was given to us is that there were approximately 8300 primary care providers in Connecticut with unexpired licenses. And by percentage of primary care provider with unexpired licenses, physicians make up the largest portion at 75%, nurse practitioners at 20% and physician assistants and licensed nurse midwives make up 5%.

In addition to DPH licensure data, we acquired data from National Ambulatory Medical Care Survey (NAMCS), National Hospital Ambulatory Medical Care Survey-Outpatient Departments (NHAMCS-OPD), Medical Group Management Association (MGMA), and other sources (existing surveys, Bureau of Primary Health Care, Health Resources and Services Administration, US Census).

These national and Connecticut specific data were used to estimate the number of primary care providers in Connecticut and to develop national and regional norms on the productivity and patient capacity of primary care physicians. So using these various data sources and the DPH licensure database we calculated some measures to estimate primary care productivity in Connecticut. However

there was limited data for all types of providers. We found that there is far more existing information about primary care physicians than other primary care providers.

Therefore the only measure we reported for all provider types is population per primary care provider and for primary care physicians we reported several measures including:

- Primary Care Physicians per 100,000 persons
- Encounters and visit data
- Geographic distribution of primary care physicians and lack of health insurance

We found that statewide there are 421 people for every one primary care provider with an unexpired license. By County, we found that there is a relative shortage of providers in the more rural Counties in Connecticut (Windham, Tolland and Litchfield County).

The following measures discussed will include data for primary care physicians only and for most of these measures, Connecticut appears to have an adequate current supply of primary care physicians. But the starting point for these estimates is the number of unexpired licenses in the DPH licensure database. We are sure this overestimate the supply but it is impossible to say precisely to what degree.

Dr. Robert McLean asked Brian Benson to give an approximate degree.

Brian Benson responded yes. When the State of New York sends out a re-licensure form they include a survey. What New York found was that when licenses are renewed by primary care physicians, the equivalent of 72% are full-time primary care physicians. So what we can do is take the 6200 times 72%. That's the closest measure we could find.

Dr. Robert McLean stated that when he looked at the internists number, which are a large set I would probably estimate that 50%, if not more of the people who are listed as internists in Connecticut, are subspecialists. Some of those maybe doing primary care and some may not, but that will drop your numbers significantly. There is no way to know that.

Brian Benson stated that he saw on the DPH database that about 30% of internists listed a subspecialist on their license but that is voluntary information.

Dr. Daren Anderson asked if that information from New York was available.

Brian Benson responded that the survey did not get that specific.

Dr. Robert McLean stated that when he conducted the 2008 survey the residency program in the state he found that 50-60% were going into a medical subspecialty fellowship, another 40% were becoming hospitalists, and a handful were planning on going into primary care. Hospitalists are general internists, but they are not seeing ambulatory primary care. That is an increasingly large number and we have no idea what that number is.

Dr. Daren Anderson asked if ACP has data on the percentage of its internist members who are actually practicing primary care?

Dr. Robert McLean responded that he couldn't say for sure but that the ACP quotes that about 50% are subspecialty trained.

Brian Benson stated that they had the same findings.

Dr. Sandra Carbonari stated that a lot of pediatricians in Hartford and New Haven are specialists. She stated that on the license a practitioner can either put their practice address or their residence. That can really slant the data.

Brian Benson stated that using the New York survey they found 106 primary care physicians per 100,000 of their population. Applying those survey results to the Connecticut DPH licensure database and our population, we found that our results were better. We tried to get a handle on a measure of encounters and visits to primary care physicians and we took the DPH licensure data and we coupled it with FQHC and Medical Group Management Association, the National Surveys, Ambulatory Care Surveys. At first this showed an adequate supply of primary care physicians. We think that this may not be an accurate reflection of what is occurring in practice.

We also reported on the geographic distribution of primary care physicians and lack of insurance by county. The pattern remains the same and the report will be revised to reflect these numbers. We found that it is fairly consistent across the board but a little higher in Fairfield and a range of 10-12% in the other counties. If we add primary care physician per 100,000 in the population it is clear that the more urban counties have more primary care physicians per population.

Combining the percent uninsured and primary care physician per 100,000 in the population by county in a ratio and we thought this might show areas where increased health insurance coverage might further strain local primary care physician capacity and counties that might be in a better position to absorb these increased numbers of persons with health insurance. Higher ratios indicated those counties where increases in health care coverage might further stress existing primary care structures due to the combination of increased health care coverage among the local population.

The situation in Massachusetts prior to their health reform appeared similar to that in Connecticut currently.

In summary, what we found was that there is the appearance that there is adequate supply of primary care providers based on available data sources. We believe the data is accurate but it is not reflecting precisely what is occurring on the ground. We found fewer providers in rural areas. It is clear that the analyses based on the number of unexpired licenses over estimates supply. We also found a future shortage of primary care providers is highly likely.

Some of the things that we were unable to determine were the number of providers with unexpired licenses that are not currently practicing and the percentage of time spent providing primary care vs. specialty care. We found that there is quite a lack of existing Connecticut specific information about Nurse Practitioners and licensed Nurse Midwives.

A survey of providers, similar to the one New York does might be the most efficient way to get these types of data.

Tom Swan asked if UConn was monitoring or participating in the implementation of the DPH electronic licensure system and did they know the types of data that would be derived from this.

Mary Eberle stated that one of the things the report does and the surveys we found and the difficulty we found in getting specific information on the things that we needed. One of the things that does is provide a template for what their electronic licensing system could do. Something like what New York does when you are renewing your license you have to go through twenty or thirty question questionnaire might be a very effective way to gather a lot of information that we could not get at.

Margaret Flinter stated that she read the RFP that DPH released for the electronic relicensure project, and did not see the type of questions we would want to have for workforce planning. She suggested that this Authority is the group that should compile the list of questions and submit to DPH with our recommendations. She also suggested that we need to work with the licensed behavioral health and dental people around the same issues. The online licensure starts with physicians and nurses. If New York State has a good model then it would be helpful to get their questions.

Brian Benson answered that he has a copy of the New York survey.

Robert Trestman commented that they would certainly send an electronic copy of the survey for the committee's use.

Tom Swan stated that he thinks we should forward the report to the folks doing the data. We have all shared in the frustration in the lack of quality data that we have to be doing for the state of Connecticut.

Joan Eaccarino stated that if DPH does it then it will be at least a year to get the data. She asked if there is any other way to get the data, through the medical society or the APRN group.

Robert McLean answered that the State Medical Society has some data from their survey.

Brian Benson commented that he was told that it is about 70% of licensed physicians are members of the society.

Robert McLean stated that only about 1500 or 1700 received the survey and the response rate was of that was about 24 or 25%. It got at a lot of issues, but not as many primary care access issues as we would have liked.

Margaret Flinter added that our Authority does not have funding at this time for further survey activity. Adding more data is something we can look at but our real focus for the future is getting the online survey up and running with the right questions.

Mary Eberle stated that one of the things a report like this can do is create a sense of urgency around the data issue. We need better data. It presents us an opportunity to do a very good job for the future.

Dr. Sandra Carbonari asked if we have any official connection to DPH and stated a concern that DPH may finalize the electronic relicensure before we have real input. The things that seem that we have to tackle are the pipeline issue of primary care providers, the coverage for the patients, the content of care, the payment mechanism, how to incent primary care providers, the geographic distribution, and retention issues. These are the core issues

Robert Trestman commented that if funding were to be available, his team would be delighted to pursue this and to improve upon the data in the phase two and actually do a survey. Brian Benson stated that he can ask Massachusetts what their re-licensure process is, and see if they do a survey. Maybe that would be another thing to add.

Margaret Flinter asked for a motion to accept the report as presented.

A motion was made by Sandra Carbonari and seconded by Daren Anderson. The report was unanimously accepted.

Margaret Flinter added that she didn't know if there would be funding for part 2 according to DPH. Over the next couple of meetings we have to tackle the issue of recommendation around the pipeline of providers, and recommendations for the contact and care of the patients.

Margaret Flinter added that the next meeting will be on Wednesday, February 25, 2009.

The meeting adjourned at 8:45 am.