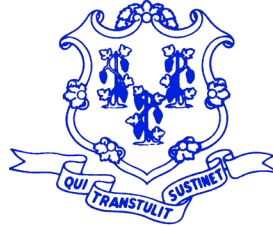


State-Wide Primary Care Access Authority

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Meeting Summary
Wednesday, May 27, 2009
7:30 A.M. Room 1D

Members Present: Dr. Daren Anderson, Evelyn Barnum, JoAnn Eaccarino, Margaret Flinter, Dr. Robert McLean, Lynn Price, Tom Swan, Dr. Sandra Carbonari and Jody Rowell

Also present were: Todd Staub

Members Absent: Comptroller Nancy Wyman, Commissioner Robert Galvin, Commissioner Michael Starkowski, Teresa Younger, Dr. Bob Schreiber and Glenn Cassis

Margaret Flinter convened the meeting and stated that a letter was sent to Department of Public Health (DPH) regarding the re-licensure project and that the Co-chairs met with Karen Buckley-Bates and Jen Phillipone and they have accepted all of the recommendations that the PCAA made. DPH confirmed in a follow-up message that they were fine with the different points in the letter and would be adopting all of them. A few things are in the physician profile and not in the re-licensure itself but apparently the databases are structured so that they can link. Therefore if the information is already in the profile, DPH will not include it in the survey. DPH has moved the date of implementation back from July 1, 2009 to July 15, 2009. Margaret stated she inquired of DPH if there would be a campaign to get a lot of physicians to use the system and DPH stated that there will not be a campaign, until they get the kinks worked out of the new system. They promised that in September they will look to get the Physician Society and Medical groups to do some campaigns for using the new system.

Dr. Sandra Carbonari asked if DPH is going to do re-licensure on a rotating schedule like they currently do.

Margaret Flinter answered that it will continue to be on the birth date of the physician.

Margaret Flinter stated there are a number of discrete pieces of legislation that are continuing to move forward, and that some were from recommendations from the HealthFirst Connecticut Authority and others that have been around for a while. A short listing is:

Never-Events, the ban on pharmaceutical gift-giving, chronic disease management coordination, and the Sustinet Plan.

The Sustinet legislation established a group to oversee the development of the Sustinet plan. It does everything this group would agree needs to be done. It creates universal care through a couple of different mechanisms, focuses on prevention and the attributes of a medical home. This will happen for a while. Between now and then there is whatever the federal government is going to do as a kind of intermediary. The question that comes back as the final report is put together is what is our highest aspirations for primary care and what can we do as soon as we can do it in the context that there will be no funding for anything we do. Now it is clear that the state is philosophically onboard with a plan that creates universal coverage, but there is no money for the plan. What can we do around coverage? Are there issues like workforce development and scope of practice that really increase access, get people more services and set things in place for the future? That is where we are at this point. Also, this is a good time to decide if there are other people that we would like to recommend to be a part of PCAA. Todd is still not officially appointed as a member, and it would be useful to formally invite him.

Dr. Todd Staub stated that the final report is important. Even if there is no funding at least it gets our thoughts on paper about where primary care really needs to go. When funding is available it will at least give us direction about where those funds ought to go and how they should be allocated to support primary care.

Margaret Flinter asked to take time to dig into the final report. I was talking coverage strategies. Between the HealthFirst and Sustinet recommendations, there is really nothing more to be added. The one short term or intermediate piece that I would like to put on the table for discussion is whether we ought to push for a strategy to at least cover primary preventive services for people in advance of the development of universal coverage. That can be done through something like a “smart card”, where you are basically able to get your flu shot, pap smear, mammogram, colon screening, and whatever the U.S. preventive services taskforce recommends. A second way to do that would be to bring in someone to talk to us about a new idea that is being put forth nationally by social venture capitalists. It is to have an interest-free credit card that is underwritten by a philanthropist, social venture group, where you could charge your cash healthcare expenses and the credit card would have a zero interest rate.

Margaret Flinter stated that Daren and Todd are going to tackle the transformation of primary care, the content, quality and delivery system. Lynn and JoAnn are working on the workforce issues and development of the pipeline. Sandra is working on the medical home and care coordination. Rob is going to help Daren edit the workforce report.

Margaret Flinter stated that the main agenda items are recommendations for additional names for appointment to the PCAA, any interim strategies between now and when Sustinet or the federal government finally gets funded and up and running and make universal coverage a reality, and the third is driving towards this final report for the end of June.

Lynn Price stated that she and JoAnn put together five recommendations, one of which may need to be removed in light of the news from DPH. We recommended that they accept our recommendations regarding re-licensure, which they have already done. This is sort of an arbitrary delineation to say that there is workforce and transformation and so on. What I realized is that some of this does bleed into

transformation because things like rapid access, better efficient use of what we currently have are delivery issues. Our first recommendation is to recognize that meaningful primary care requires an integrated team approach by a variety of health professionals. By that we mean not only the proscribing providers but also RN's, physical therapists, OT's, social workers, behavioral health providers, etc. We need to make a clear statement that is how we see primary care best practice. Our second recommendation is to continue ongoing efforts to collect timely data about workforce. The third recommendation is to invest in sustained strategies to improve recruitment and retention. Tuition reimbursement, loan repayment, and other kinds of models that other states are using are helpful. The fourth is to eliminate existing barriers to full utilization of clinician capacity. Number five is to address infrastructure barriers to efficient use of current capacity.

Dr. Todd Staub asked what is meant by the barriers to those last two recommendations.

Lynn Price answered the barriers for full practice of physicians has to do with some of the business constraints. One of the examples is that all of a sudden physicians will get word from an insurance carrier that they are unilaterally renegotiating their rates. That needs to be addressed because it makes a business plan totally unsustainable. Other health professionals also contend with practice restraints that are sometimes characterized by scope of practice but which not always have to do with scope. Sometimes they have to do with perceived economic competition or some other kind of threat to a profession. We need to talk about this to reach some type of an agreement. One part of that is what we discussed already in this committee. Nurse practitioners and other APRN's are currently mandated to have a collaborative agreement with a physician before they can practice at all. The second piece that is not as big of a barrier in Connecticut as it is in other states is that APRN's are not recognized in statute as primary care providers makes approaching insurance companies to negotiate rates much more difficult than it needs to be. There are 27 or 28 states that have done this for the exact reason we are trying to do it as well. Regarding infrastructure, the PCAA recommends that the delivery and infrastructure environment be strengthened to support and augment the primary care emphasis. For instance, community outreach is necessary, which means rebuilding your public health structure, which has something to do with public health nursing and other staff that could be embedded in primary care sites and in communities. We also need to look here about where we deliver. The medical home is a big model, Sustinet is looking at that, as well as nurse managed centers and school based health centers. The last thing is that there are a number of places where primary care occurs in nursing homes, group homes, correctional facilities, that are often not seen as the usual medical homes. We need to deliberately list these as well.

Jody Rowell stated that she volunteered to look at the workforce development for the mental health field around the medical home model. She stated she would love the opportunity to take the report and add workforce development in the mental health field, particularly as we move towards a medical home.

Dr. Darren Anderson stated that the topics that bear discussion and coverage in our section on primary care in reforming the primary care office include access. This includes mechanisms to provide greater access to primary care for those who don't currently get it and also once you get it, more about office based systems like advanced access and minute clinics, to make sure that when you actually need access to primary care you can get in. We will need to discuss the scope of primary care, really touching on the advanced medical home and the type of services offered. People need a definition of primary care and what it is that we do as our role as primary care providers. There should be a separate section touching

on preventive services that are recommended and encompassed within our task as primary care providers. I was also going to take the section on teamwork and have some of that as well, and include the potential role of pharmacists, nurse practitioners, nurses, dentists and all the other people who comprise our idealized primary care team in the role that they play in delivering primary care. We definitely need to touch on electronic health records and/or registries, the need for the ability to track outcomes, monitor panels and alternate strategies and performance. One of the topics I want to spend the most time on is on performance measures, and laying out the types of things that we are tracking now that we will be able to track in the future. These are the type of performance measures that primary care needs to be held accountable for. We need to talk about how that could be incorporated into a payment mechanism, pay-for-performance and things like that. I think that in addition, a section on mechanisms for providing non-face-to-face care should be included. This is unfunded and not reimbursed. The primary care system on the future is going to have much more emphasis on telephone care, home-based care, text message care, email care, and all the other mechanisms we have to use to keep people out of the office but to keep them healthy without the face-to-face encounter. Payment reform is obviously a big chunk, we cannot discuss reforming primary care if we don't talk about the misalignment of incentives that we currently have that emphasize this face to face contact. We need to really discuss capitation, bundled payments, value-based insurance. These are eight topics that I have had in my mind to cover on this and we can see where they all fall.

Margaret Flinter stated that it is a great list. There has been an enormous amount of information coming out from the commonwealth fund and others about payment reform and this misalignment we have in our incentives. We certainly see it even in the world of health centers. It is all visit-based. It is neither performance based nor is it management based in a way that makes the process more convenient. One of the things we have never really talked about is the role of the retail clinics, in terms of the business model. The role they play of allowing the primary care provider to go home at a reasonable time, take calls, and respond to people's needs on nights and weekends. How do they fit into primary care?

Dr. Robert McLean stated that these clinics are here to stay and the issue comes up where what has been heard from the pediatricians is that it siphons off the quick visits and the margin of profit with the other time consuming issues. It's more for the pediatricians because adults will take time off from work. For pediatricians the parents don't want to take time off of work, they want to take the kid to get the care and will use the service when they are out shopping with a slightly sick kid. The sense I have gotten is that it is a risk for pediatricians because it siphons off easy cases, which is kind of their profit. At the same time I think they do serve a role and going forward, the role will evolve. The sense I have gotten is that at one point there was concern that they were overreaching what their care was but I think that a bunch of them, specifically Minute Clinics, have very strict protocol driven care. The Minute clinics have pretty good data that they are not delivering "bad care" because if you have anything more than the list of 8 diagnoses, they will not see you. It is very discrete and very well defined and on the basis of this it probably does a pretty good job. If we are talking about the access issue it plays a positive role. If we are talking about the impact on physician practices, it may play a negative role. That doesn't mean that we shouldn't address it, but we should engage it as a discussion point. It needs appropriate monitoring and/or regulation.

Dr. Darren Anderson stated that if we are going to talk about this topic then we need to talk about linkages and the way that data is exchanged. It is perfectly fine if my patient goes to a Minute Clinic on a Saturday if I hear about it on Monday. Currently I think that they are operating in a vacuum. We are

talking about the old way of thinking. The notion of losing revenue because a sore throat goes to see an appropriate person is not the way I think we need to focus on primary care being set up. Primary care providers need as a scarce entity need to focus on what they are appropriate for doing. I don't think it is a good use of time to be treating a sore throat if someone else can do it. It brings us back to the whole notion of payment reform. If we have a model that means I lose money when a sore throat goes to see somebody else that can appropriately treat them, that's a bad model. We need to keep our mind on that larger price. If it were capitated it would make total sense. If you were paid in any other way other than fee-for-service, you would want to incorporate Minute Clinics.

Jody Rowell commented on telemedicine and the future of medical practice. Sometime ago there was the mental health transformation grant, and one of the committees made a strong recommendations, particularly in the rural areas, for telemedicine for mental health. Is there any way to piggyback on that and bring it out in the report? The other thing in the mental health area is there has had to be a shift in the Medicaid for kids in mental health. There have been grants to provide help mobile crisis in the evenings and on the weekends. The state has had a big push in that, in the way that they have saved millions of dollars in ED visits, by having someone available. What can be done in that area, because these families do utilize the emergency departments because they are available. That is what they did in mental health. When there are other mental health options available, when they are not at work, they will go wherever they can to get the care that they need when they have the opportunity not to be fired from their job.

Dr. Sandra Carbonari commented on the Minute clinics. Without that coordination and communication, it really totally disrupts the whole concept of medical home, especially in pediatrics. This is because if the primary care physician doesn't know that a child has had six diagnosis, it leads to duplication of services and possible either use or inappropriate use of subspecialists, etc. It is more than the child with a sore throat. Also, they don't really cover a lot of the hours. What parents really need is over-night, when those clinics are not open. There certainly is attraction for the use of these clinics for busy parents, but we have to be careful in looking at the quality of who is seeing kids and what is being done for follow-up. If a child is seen in a Minute Clinic on a Monday and the parents are told to be seen by a doctor in 2 days that is inappropriate, services are being duplicated.

Lynn Price stated that there was an informational hearing by the previous co-chairs of the Public Health Committee on Minute clinic directly, last summer. That may be of use, they went into great detail. In Rhode Island, it has not been legislated that they do this, but they have a much more integrated model with primary care offices to address exactly some of the issues that are being brought up. It might be worth looking at.

Margaret Flinter stated that she did watch all the hearings. It was very good. The larger issue is access coverage and making sure that primary care doesn't happen in the emergency room, to the greatest extent we can do it, and that it happens in a safe and high-quality environment. Minute clinics have very impressive quality outcomes, especially for things like, not treating with antibiotics when you shouldn't be treating with antibiotics. The goal of any primary care organization ought to be that we should have access at such a level that the Minute clinic is the one that is begging for patients because the primary care patients can all get in to see the doctor. That has to be our focus. The infrastructure have all been challenged with staying open on Saturdays and the evenings. That is just one piece of the health care system. To the extent most primary practices have some evening hours, I don't know what that is.

Dr. Todd Staub stated that his organization ran a retail clinic for a year. It is a marginal business like all the primary care. It is pretty much a loss leader for CVS and other places. It is just a way to get traffic in the store, they are not making a lot of money. It is not a very profitable business, as primary care is not. It is a challenge to all of us in primary care to deliver services to people at times when they need them. When we surveyed our own pediatricians who claimed that they had all these hours on nights and weekends, on paper it worked out to be 30%, really have coverage at those times. We have shut it down and re-group and our plan is to build it in to our existing offices. It is a challenge to deliver better service and access to the people who are our patients.

Dr. Darren Anderson stated that retail clinics are not the ideal model of what we would want to incorporate, they are there to fill a business need and provide something that our patients want. That is the point that we need to cover here. Patients want easy access, when it is convenient for them when they are sick. We in primary care have struggled to provide that. If we could provide the same thing, people would much prefer to see someone they know in their own health care setting, if they can get through on the phone and be told to come in. The retail clinics are showing a big gap in what we need to address.

Evelyn Barnum asked about the performance measures that were mentioned. It might be useful to inventory what we all already measure because it is such an easily accessed chunk of information. I am hoping that aligns with what we were thinking in terms of the performance measures.

Dr. Darren Anderson stated what we are currently measuring is probably a fairly short list in most settings. Perhaps the VA and the CHC's are separate from that. Is ProHealth currently tracking performance measures in diabetes and lipids? We could come up with a quick list. It is the preventive services and disease management for cardiovascular and diabetes, and you've got 90% of your performance measures. There are fairly well established measures out there, it is not something we will need to invent.

Dr. Robert McLean stated that without an EMR nothing is being measured.

Dr. Todd Staub stated that he would dispute that because if we don't have an EHR, we have these registries and use them proactively and there are ways to garner data for these data points that don't need an HER hemoglobin A1C's, LDL's, last visit, there's claims data, lab data. A lot of these performance measures are not dependent on an HER, and the data exists pretty often in a useable form if you could just aggregate it and create work flows around that.

Dr. Darren Anderson stated that Dr. Todd Staub is right about that. Having an EHR does not in any way guarantee that you can direct those things.

JoAnne Eaccarino stated that for school-based health centers we are really looking to the time when we will all have that electronic health record to be able to collaborate with whoever that child's primary care home is. School based health centers will also be able to not only treat things like sore throats and earaches, but also collaborate along with the primary care physicians around chronic conditions like asthma. We are looking statewide, taking just a few of those performance measures to be able to highlight the goodness of school-based health centers and why they are important.

Margaret Flinter stated that in the HealthFirst Report another one of the recommendations, that has not found its way into a bill, was around trying to get at least the major primary care organizations to agree on a set of performance measures so that we can begin to look at the state from that perspective. We are not sure how realistic this is. The Uniform Data System, for the first time this year, started mandating the reporting of clinical outcome data, hypertension, diabetes, prenatal care, immunizations, low birth rate, and selective dental and mental health. The speed of adoption of electronic health records definitely is not an “if”, but a “when”. Are the state results compiled and posted federally on all of the outcome measures? Are the UDS measures for the health centers aggregated at the state level?

Evelyn Barnum stated not yet. They are still cleaning up the data. The more interesting thing would be for us to get the databases, and there are many more interesting analyses that can be done. There’s new software called UAD where you can really look at some of the more interesting indicators in terms of how it is relational. It is great information now that it is there because 2008 was the first year that it was collected. It would be interesting to manipulate and the Feds could supply us. The second point about the inventory is that we should look at what everyone is already required to report because there are 3 levels. There are the UDS, and what is reported quarterly to the state of Connecticut Department of Public Health, and then each of the 3 managed care organizations thinks that they are doing monitoring and how their measures really overlap is another question.

Margaret Flinter stated that is why she suggested looking at the UDS which would be good for the state of Connecticut to know, at least for those millions of people to know what is going on.

Dr. Robert McLean stated that he would warn strongly, to not get into the performance measures too far, our charge is not to determine performance measures, it is to provide primary care access. If you really want to scare doctors away, you get another agency to find performance measures. There are so many organizations out there that are putting out their own measurements that are crossing over and slightly different, and it is a hodge-podge mess. It might be interesting to make some comments about it, but making recommendations that it should be required is not something we should do because other organizations do it, and Medicare does it. It is a complicated controversial thing and we could spend a lot of time on it.

Evelyn Barnum stated that she did want to address those that do pertain to access. Point of entry into prenatal care and immunizations, frequency of dental visits, do speak directly to the access issue.

Dr. Robert McLean stated that measuring access is one thing, but for the true performance stuff is a mess.

Evelyn Barnum stated that the first thought the she and Teresa had for their section was essentially a story in pictures. A couple of years ago the Feds considered changing methodology for designating health professional shortage areas. We did a lot of work that I think is still useful on that because what we did was look at what the Medicaid program said its access is to providers and then dig down and find out how many FTE’s or hours per week those providers were really making available to low-income patients and how many had a sliding fee scale. Is that the concept of our piece, that we are really talking about the lack of access is?

Margaret Flinter stated that she was hoping more for recommendations on what to do to ensure that the mission of the Authority to devise a system that means there will be universal access to primary care for people living in the state of Connecticut. It seems to me that relative to the work that we know that you were taking on the safety net setting, that it is under capacity for the needs of the population. So if we look at certain areas, like Waterbury, the size of the safety net relative to the size of the population living in poverty or members of vulnerable groups, it's a real mismatch. So how do you address that? We look at Torrington where our own report that we commissioned shows that there is a shortage of primary care and you look at the poverty population and the size of the safety net provider which is just the Torrington Health Center and there is a mismatch there. Two years from now, if Sustinet is fully funded, there's one big pool for everyone, the rates are set at commercial which is the vision that Sustinet has laid out, well then maybe you don't have the same demands on the safety net. You are always going to need the community health centers with their focus on special populations, people's whose primary language is other than English have complex social needs as well as healthcare needs, but you may not have the same demand as in all uninsured and all Medicaid people are using it because nobody else accepts that payment. So things may change but I think we have a mismatch between need and capacity in our safety net setting.

Evelyn Barnum agreed and stated that is easily represented with mapping. But our definition of safety net would be anyone that accepts a sliding fee.

Margaret Flinter stated that her definition of a sliding fee would be people who have a commitment to serving vulnerable populations which includes the publicly insured, the uninsured and also the people with special needs. I think of Planned Parenthood as a safety net provider. We could argue if that belongs in primary care and I would say it does. I would argue that for young, healthy women that may be the only medical home they need. They can get their needs met.

Evelyn Barnum stated that she just learned that ProHealth Physicians have a sliding fee scale.

Margaret Flinter stated that is a fascinating thing to include. In theory the hospital out-patient clinics have a sliding fee scales. Those are all things for us to look at. Are they being used, deployed, organized in the best way? Maybe it is more of an issue of the electronic communication.

Dr. Todd Staub stated that with the recession they formalized what doctors have always done. That is that you give people breaks because you live in the community and you know these people. We created a protocol to reduce amounts or write-off balances so that people felt empowered at the provider level to get that done. It was kind of rolling up what we have always done with doctors in the state have always done. I don't think I would say that really qualifies as a safety net though, because when you do that you can't always get lab work or specialists for free. I can give it away for nothing, but that is not really a good safety net.

Dr. Darren Anderson commented about performance measures and their implications. If we are going to make a recommendation for expanded funding of primary care, for guaranteeing access to all people for primary care, we cannot get away from the issue of what people are getting for their money. If we want people to throw more money at primary care I think our obligation is to demonstrate that you are getting some benefits for it.

Dr. Robert McLean stated that is reasonable. If you look at the actual definition of the patient-centered medical home, within that framework it includes performance measurements and an idea that there would be enhanced reimbursement based upon reaching certain targets. I think that a vague reference within that context is appropriate. I don't know that we want to state explicitly that there needs to be a new state agency that is monitoring that, or doing what other people are doing. I think that will really scare people if they think there is another board that is going to put their stamp of requirements. But I agree with you, I think it is inherent to some of what is progressing and I think it is fair to state that, I would just couch it carefully.

Dr. Darren Anderson stated that we don't need a new organization and a new set of performance measures because they are already out there. So perhaps more of what we would do is speak to the existence of current performance measures. I think there has to be some sort of accountability built into our recommendations.

Dr. Robert McLean stated that part of the idea behind patient-centered medical home is that if primary care doctors are going to be paid more, we need to hold them up to a certain standard that they are in fact performing. That is a fair trade-off.

Dr. Sandra Carbonari asked if immunization is the only pediatric performance standard measurement.

Dr. Darren Anderson answered that there are no children at the VA hospital.

Dr. Sandra Carbonari stated that it is different for different places so we need to think about if we are going to get specific. I agree that we shouldn't start to make rules in this recommendation.

Dr. Darren Anderson stated that we can certainly point to the existence of pediatric performance measures that exist as well. CHC has a good number of them, as do the community health centers.

Margaret Flinter stated when you go through the application for medical home, NCQA has further physician recognition medical home program, patient satisfaction is a measure and one of the key indicators on patient satisfaction is access.

Dr. Todd Staub stated that we can't walk away from this, even though it is complex and it generates a lot of arguments, if you don't take ownership of it then you are basically seeding it to other people who will say "here are the measures we are going to grade you on". Then it becomes 20 different agencies or commercial payors. What we should be arguing for in this report is that there should be principles of performance measurement. One of them is to try to aggregate them in a rational way so that we don't have 20 different sets. This idea of looking at what is there and what is required, I think you would see that there is 80% alignment in a lot of those things. I can tell you that in our organization, you take one disease, and there are about 50 pages in the ADA guidelines. What are you going to pick out from that as the two or three things you are going to focus on? The trick is with a population, is what are the 20% of things that drive 80% of the morbidity and mortality, and then you have to be mindful to say that those are the critical measures that we are going to follow that drive most of the disease in our population. We have to take this challenge on, we cannot leave it to insurance companies and to government agencies. I think that providers have to say: here is what we think is important for our patients. Maybe the report should outline some of those principles if aggregating the different

requirements that we have and thinking more carefully about how it affects the population and their health.

Dr. Robert McLean agreed with a warning on being careful with the words that we used. Measures and guidelines are 2 separate things. Clinical guidelines are evidence-based guidelines of what works, which are potentially different from performance measures on hitting certain targets. We need to make sure that we are always talking very specifically about each one. Some of them are evidence-based and some of them are not. The ACP is very concerned that some of the performances measures are getting out ahead of where we really know that something is the best thing to do. There are various examples in the past couple of years where an organization had a post MI performance measure, and then a big study came out that said that wasn't the best thing to do. So after something has gotten put into various documents as a performance measure they have to back track. We have to be careful of that. Earlier we were talking about retention strategies and while we talk about loan forgiveness, I learned recently that it is probably not as big of a factor as we always think. The reason for this that people pointed to the uniformed health services medical school, where people go and they graduate with no debt. They theoretically are able to go into whatever field they want after doing their service, but they go into the higher reimbursement fields like everyone else does, not primary care. So while medical school debt is clearly an issue, the income stream that people are looking at over the next 20 or 30 years is a bigger one. I don't know that there is real data and surveys showing that, but if you look at where people go, who has debt and who doesn't, they follow the same paths to the same specialties.

Jody Rowell stated that it is different for MD's than for loan forgiveness than for people who are in the mental health field or APRN's. There will not be as large of a salary increase as there would be for an MD. I think loan forgiveness for people that want to remain within their community population is their drive is a really important way to increase workforce development.

Margaret Flinter asked what Evelyn Barnum and Teresa Younger need from the rest of the group to complete a draft.

Evelyn Barnum answered that it is a story in pictures and what we would look at is mapping some of the need indicators to some of the data that we do already have about where the access is. We need to have a more thorough discussion on how we are going to define safety nets.

Margaret Flinter stated that the group really speaks to what the safety net providers need to be able to deliver effective primary care. Is that more financial investment, changes in other parts of the system like the ability to use the delegated rate for specialists? Is it more support for electronic health records? I think that it is not just geographic, because health centers today, with the millions of people they care for in Connecticut, many simply cannot access providers.

Evelyn Barnum stated that it leans a little more what she would call infrastructure than she thought the assignment was, so that is helpful. I think I am influenced by the fact that we are running this grant about emergency room utilization and I don't want to open that can of worms about the fact that primary care is being delivered in the ED's.

Margaret Flinter stated when we all have a chance to look at drafts we can help with this. The HealthFirst Connecticut Authority Report did a lot on looking at the data at who is in the ER and

looking at the payment mechanisms and looking at who can't get care any place else, fix that and you are likely to fix things else where. When we can get a draft we can look and see whether there are other references or linkages that we need. I would say go with what you and Teresa think is important to do and then we will take a look at the draft.

Dr. Robert McLean added that the ACB put out a big policy paper in February or March called "Solutions to the challenges facing primary care". It is a worth while lead that may be worth lifting passages from. I will email it to everyone.

Dr. Sandra Carbonari stated that she wanted to agree with the comment about the importance of infrastructure. Even though we are dealing with primary care access, the patients can have access to primary care providers, but the providers do not necessarily have access to all the other things they need such as pediatric neurologist, or mental health services. So infrastructure is part of what are need is too. It is all connected. This goes into my piece of the medical home care coordination part of it. I think we may have to start with some basic definitions because there are lots and lots of definitions and use of the term "medical home" that do not necessarily agree with each other. I think that was the way I am going to approach it. I suspect we will have some discussion because there are different views. The pediatric model has been around for a long time so there has been a lot of thought and writing about it. Margaret mentioned Planned Parenthood as a primary care provider. That is really not a medical home because it sort of takes care of one organ system. From the pediatric view, looking at the 15 or 16 year old who uses Planned Parenthood, they cannot really take care of all their pediatric needs including the developmental, the psychosocial and other kinds of health needs.

Margaret Flinter stated that it was a provocative statement. I look at where medical home came from, with chronically ill children. Part of the value of the authority is the breadth of perspective and if we can avoid getting rigid and say what works for most of the people most of the time, here is what works, around the edges, it will advance our cause.

Margaret Flinter asked if Dr. Sandra Carbonari is working with anyone.

Dr. Sandra Carbonari answered that she is not working with anyone else, but she would be happy to do so.

Margaret Flinter stated that she would be happy to review her draft and maybe get some other people to help. Ellen Andrews may want to help with the PCCM piece.

Dr. Sandra Carbonari stated that she is the chair of the care coordination sub-committee for the provider advisory group for PCCM. I have been working on it in that capacity so I may duplicate some of the work.

Margaret Flinter stated the Lynn and Joann are pretty far down the road but when everyone's drafts are together we will have theirs as well. Todd is working with Daren and Tom and I are working on the overview of the coverage piece. There are copies of the Massachusetts "Learning Contract", which is a well-established program. I emailed them for data, and they said they will try to get it to me and then I will forward it to the group. I thought it was actually quite good and I think we would want to expand the definition of who it covered to include nurse practitioners, certainly maybe the PA's, behavioral

health, dental, as well as medicine. I thought it laid out a pretty decent set. I also left a copy of the letter that I sent to DPH in advance of our meeting on re-licensure, they have agreed to adopt all of them. Last but not least, we need to approve the minutes. Would we like to make a motion to approve?

Lynn Price made a motion to wait to approve the minutes. She would like to be able to read them.

Margaret Flinter stated that is alright with her. For the next meeting, which is the last Wednesday in June, can we ask to have at least a draft of each section, maybe 5 days beforehand so that we can some prepared to have a discussion about them.

Lynn Price stated that it would be Friday the 19th that everything would need to be in.

Margaret Flinter stated that by Friday the 19th of June, or the very latest, Monday the 22nd of June would be the date. At least a rough first draft that we can all look at is needed. It is your best thinking in primary care.

Dr. Robert McLean stated that the ACP paper will highlight a lot of what we want to say. You can highlight sections and personalize it.

Margaret Flinter stated that imitation is flattery, and plagiarism is perfectly acceptable when used for the common good.

Tom Swan stated that it is a PDF so it is harder to copy from
Margaret stated that she wanted to ask people to submit requests of members to be added she will collect names and get them to Senator Williams. It is people who are committed to the IOM principles, understand and are an expert in primary care.

Dr. Robert McLean stated that the statute lists a specific group of 10 or 12 that the legislature set out to represent different interest groups.

Margaret Flinter stated that we can request additions if we feel that we would like to add. If everyone thinks that we have all the people we need around the table, which is fine. I wanted to allow for that possibility because I was thinking the end of session is coming up.

Dr. Robert McLean stated the he formally asks to add Todd to the list.

Margaret Flinter stated that they suggested that before he came in anyway. She would like to get to the next meeting the person who is getting together this project around the publicly supported credit card for health care expenses without interest as a way of doing things in the interim before universal health care. It is an interesting perspective.

Margaret Flinter adjourned the meeting.