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Transcript

00:00:03 Speaker 1

There we go. Hi, everyone. My name is Boyd Jackson. I am the director of legislation and regulation at OHS. As such, I direct the what used to be the health systems Planning unit, which is the unit tasked with producing the.

00:00:22 Speaker 1

Statewide, the healthcare facilities and services plan, which is why we're all here today and we've been working with our consultant alterum, we have Corey Ryan here from Alterum who will be, you know, kind of shepherding us through this.

00:00:37 Speaker 1

Conversation. But you know, in my role as as director of the the unit, I want to give a very personal and deep my my appreciation, my gratitude to all of you for participating today. You know we we review.

00:00:55 Speaker 1

The the planning of the health system throughout the year. Uh, but you all live it and breathe it every day and we really appreciate your insight to inform the way that we think about it from from the government side. So thank you all for joining and being willing to to engage with us today. We.

00:01:14 Speaker 1

Have.

00:01:15 Speaker 1

A number of people on the advisory committee, so rather than doing all the introductions now, maybe I'll ask that before you share any comments you give just a brief introduction, your name and maybe the entity you represent or your your relationship to the plan.

00:01:35 Speaker 1

But I I don't. I I want us to be able to get right into the conversation.

00:01:40 Speaker 1

Just kind of logistically, uh, we're going to finish up introductions from myself and from Corey. Then we're going to turn it over to the group to offer comments. You can ask questions of Corey about

how OS and Altera, we're thinking about various parts of the plan, but really just a time for you to share your thoughts and engage with one another on.

00:02:02 Speaker 1

Any issues and thoughts that you saw in the plan then we'll take about 30 minutes.

00:02:09 Speaker 1

UM, maybe a little more if we have folks from the public who want to comment, it looks like we do have a number of public folks here listening. So folks have public comments and then we'll have some time at the end for the advisory group to either respond to issues brought up by members of the public or offer some.

00:02:28 Speaker 1

Concluding remarks.

00:02:31 Speaker 1

And just I think we'll try for order if you can use the raise hand function in the zoom window. That way we can try to alleviate, you know people interrupting or talking over each other on accident as is common to happen with these virtual meetings.

00:02:51 Speaker 1

So let's try to use that if possible, but we may dispense with that if that's not necessary. I do want to remind everyone and I'll probably remind several times throughout the the meeting.

00:03:03 Speaker 1

We are absolutely keeping track of all the comments made today and we'll consider those as we prepare to release a final version of the report, but we do ask that you consider contributing written remarks, written comments in response to the plan on any topic throughout the plan, whether it's just the physician.

00:03:23 Speaker 1

Practice or you know, any cardiac cardiac services, imaging, whatever the case.

00:03:29 Speaker 1

BUM. So please do consider submitting written comments as those will be easy to track and and really consider, but whether, whether spoken today, whether written all, all of the all of the comments that we receive will be given due consideration. So thank you again for participating and I'm very excited to have this conversation. But for now I will turn it over to.

00:03:51 Speaker 1

Corey Ryan from Altera.

00:03:54 Speaker 2

Wonderful. Thank you, Boyd, and thanks everybody for being here today. Great to see so many engaged folks and very excited to gather, begin gathering some of our feedback on the initial draft of the facility and services plan that was released. So hopefully everybody on this call has had the opportunity to review it. We're looking for very specific feedback today related to the content that was released in that and your perspectives.

00:04:14 Speaker 2

Both on the information that was provided, the way it was presented, and then also the the kind of conclusions that were drawn out of the work that was done within this work. So I am going to share my screen. Boy is there a way for you to give me permission to share if we can get away with it, if I can't, but if you can find permission for me, that would be great.

00:04:32

Yeah.

00:04:47 Speaker 1

I think you should have the ability to share now, Cory.

00:04:50 Speaker 2

Perfect. And I can and I will share the screen over.

00:04:53 Speaker 1

Here.

00:04:57 Speaker 2

You see my slides, boy.

00:05:00 Speaker 1

Yes, we can.

00:05:01 Speaker 2

Perfect. Fantastic. OK, so I'm going to do a really, really high level overview of the overall goal for the facility and services plan that's been released. This plan is a blueprint for designing and characterizing healthcare delivery within the state of Connecticut. This is kind of a dual purpose document. It serves both as a resource for policymakers and those directly involved in the certificate of need.

00:05:21 Speaker 2

Process to manage decisions around around those determinations, and also provides general information to the public and a great set of information around the current state of the healthcare delivery system within the state of Connecticut.

00:05:33 Speaker 2

And how that data and information might be used to guide further planning and targeted resources towards the improvement and quality of specific healthcare facility and services within the state. The goals of the FSP and this plan in the way that it engages with the Office of Health strategy and how it's used is to prevent excess capacity and duplication of services.

00:05:54 Speaker 2

And prevent the underutilization of existing medical facilities, identify gaps in services and unmet need where they exist, and identify strategies to help improve those those gaps and services and eliminate them.

00:06:06 Speaker 2

Providing clear guidelines for adding services for healthcare services within the state and fostering fair competition and overall better access to services through transparency and data on the way current healthcare facilities and services are distributed across the state of Connecticut and we do this in a variety of ways, one of which is providing a very robust set of data around the existing capacity of different types of healthcare facility and services.

00:06:27 Speaker 2

Within the state, our interpretation of how those available services relate to the current need, and then how we might be able to identify both gaps and existing services or potential under over utilization of existing services within the state.

00:06:40 Speaker 2

There are 10 chapters as currently laid out within the facility and services plan. We're going to talk about a few select pieces of these today given the expertise that we have on the call around physician practices and particularly primary care, I expect that we're going to spend most of our time talking about these specific chapters today. And so first and foremost, looking at the primary care chapter and any comments that you may have around Chapter 7.

00:07:00 Speaker 2

The data that are that are enabled, they're in and the way that primary care services overlay and relate to physician practices within the.

00:07:06 Speaker 2

State and also potentially some conversation around behavioral health, although there is a specific targeted conversation around behavioral health as well, but where physician workforce relates to behavioral health, there may be some relevant conversations there today and then also around Chapter 2 and some of the workforce conversations that have been overlaid in the overarching trends section of this report as well. So hopefully guide a lot of your comments towards these particular chapters today.

00:07:26 Speaker 2

There are going to be other advisor groups and other opportunities for the public to be able to submit comment related to other sections of their report. I think Boyd has hopefully alerted folks of

some of the other ongoing activities and other advisory groups that have been made available. So please try and keep your comments focused today to these specific chapters and we'll try and curate that as best we can.

00:07:44 Speaker 2

Just detailing for folks is a really quick overview of first and foremost, the primary care chapter. These are the sections that are in that chapter right now. This is first looking at the relationship of primary care to the certificate of need process within the State of Connecticut Overlaying House Certificate of need Impacts. The addition or change in primary care service availability.

00:08:04 Speaker 2

Within the state, which is somewhat limited but does have some impacts there and then specifically the way it also impacts physician practices and other types of facilities within the state.

00:08:12 Speaker 2

There then is an introduction chapter that talks about the overlay of primary care delivery system within the state of Connecticut and then some detailed sections that detail then the specific types of primary care facilities and primary care offerings that are offered within the state of Connecticut and also how those facilities might then be meeting or not.

00:08:32 Speaker 2

Meeting current need for these types of services within the state and then a detailed look at unmet needs and gaps in services for these types of care within the state. Looking at perticular gaps and access to particular types of services, availability of different provider types and and the sufficiency of the existing workforce within the within the state of.

00:08:50 Speaker 2

To get to meet these particular needs. Lastly, there's then a section that looks at primary care trends and ongoing initiatives and particular policy impacts of things that are going on within the state of Connecticut that may impact future need for primary care or the delivery of primary care within the state of Connecticut.

00:09:06 Speaker 2

I want to highlight here just because certificate of need is a really important component of this facility and services plan and of course the one of the reasons why OHSU initiates and updates this document.

00:09:16 Speaker 2

The relationship to primary care for certificate of Need is somewhat limited in this report compared to some of the other advisory committees and other chapters that are related in this document. Primary care services housed in facility settings that are licensed as outpatient clinics do not require CN approval, so that's not something that's typically required as a part of the way the current.

00:09:35 Speaker 2

Laws written that require certificate of need, other primary care settings are also exempt. There is one component of primary care and physician practice settings that may be related to.

00:09:47 Speaker 2

To the certificate of Need Process which is primary care services that are that are operated in a hospital setting and so that is where a certificate of need authorization would be required and where there is an overlap between primary care and the certificate of Need Process. But it's relatively narrow.

00:10:02 Speaker 2

So welcome to take comments or questions on that as we get into the larger discussion today, but that is one of the components just related to specifically to the certificate of Need Process where the primary care definitions are relevant.

00:10:13 Speaker 1

And Corey, before we move on to that point, if you have comments about the relationship to the certificate of need.

00:10:20 Speaker 1

Uh, program and process. Please make sure that those are forward-looking comments about how this should be implemented in the future. There are open applications and we don't want to comment on any currently pending applications which may touch on this issue. So please just.

00:10:40 Speaker 1

Keep your comments focused to the plan itself rather than to current open.

00:10:45

Notes.

00:10:46 Speaker 2

And there will be plenty of other advisory committee opportunities and public comment opportunities to talk about other components of the certificate of Need Process really highlighting this year to try and guide our discussion towards this very specific narrow case in which physician practices and primary care overlay within the certificate of Need group.

00:11:02 Speaker 2

So I have some specific discussion questions that we can go through, but I'm just going to overlay some of the categories of topics for discussion today. And given the volume of participants we have here, I think if you can try and guide your topics towards these particular components of the discussion that we have planned.

00:11:16 Speaker 2

For today, I will detail kind of what we're thinking as far as questions and opportunities for feedback that we have and then I will open it up for the advisor can be members to begin providing feedback. I would say I can certainly guide the discussion in a little bit more detail, but at the end of the day, we this is an opportunity for us and OS to listen to what your feedback is to what's been produced so far and we're very excited to hear what you might have to say so.

00:11:38 Speaker 2

I have some sections here where we can talk about the way we characterize primary care delivery and physician practices within the state of Connecticut. Feedback on both the underlying data that are used to characterize those groups and the way the definitions of those groups are defined. That would be a useful area for feedback.

00:11:53 Speaker 2

Detail on how we've described hospital operated primary care centers and the data that are provided by OHSU around those particular facilities and the way that we present and characterize that data would be useful to get feedback on.

00:12:04 Speaker 2

Information and feedback on the way that we provided data around unmet need and gaps and services for primary care and physician care within the state of Connecticut.

00:12:12 Speaker 2

Issues around consolidation in the primary care sector and consolidation of physician practices the way that we talk about policy related to those issues and the way that those potential issues might impact primary care going forward would be useful areas for feedback.

00:12:25 Speaker 2

#5 here the way that we characterize the physician workforce, the data that we include in the facility and services plan around the physician workforce and implications that that workforce has for providing adequate primary care within the state going forward. And then broader trends in policy related to primary care as the last topic section and then any other comments or feedback. So again, I have specific questions, but I think we've got a really large group here. I would love for folks just to kind of raise their hands and kick off conversations within one of these topic areas.

00:12:49 Speaker 2

We'll try and keep it organized as best you can to avoid myself if we get too off track, we might try to guide the conversation towards one or two of these topics. Particular, but for now, let's kind of see what folks interest areas are.

00:13:01 Speaker 1

Great. Thank you, Corey. And we're right on time for for the beginning of the advisory group portion. So doctor Kay?

00:13:13 Speaker 3

Mine's more of a procedural question in terms of the plan for the meetings, how many meetings we're going to have and what are we.

00:13:23 Speaker 3

I understand what we're trying to accomplish as a whole, but but I'm not getting a sense of how these meetings are going to progress and when we're going to come up with specific recommendations on this very broad on this very broad selection of topics.

00:13:39 Speaker 1

Sure. So I I think the advisory groups are working a little differently than the working groups of the the first time in in 2012 specifically because we currently we have an existing plan that we're just working to update. So the way we've thought about this is.

00:13:58 Speaker 1

Is uh.

00:14:00 Speaker 1

Providing comments similar to how one would do in a federal regulatory process and we just we want to convene these groups so that stakeholders have an opportunity to interact and share comments directly with OH S so we're not going to be taking votes on formal recommendations or anything like that.

00:14:21 Speaker 1

Or trying to ensure that everyone agrees on one thing, but we'll be taking all of the feed.

00:14:27 Speaker 1

Back in processing it and then incorporating where appropriate, into the final report. Currently all the groups are scheduled for each group is scheduled for one meeting, so we have 6 advisory groups that will each meet once. For this, this period 2 1/2 hours and then.

00:14:47 Speaker 1

We're going to have one session at the end which will be just general comments and discussion for anyone who wants to come on any part of the plan. So that'll be the 7th meeting.

00:14:57 Speaker 1

And then each.

00:14:58 Speaker 1

Individual will have an opportunity to submit written comments, which I think will largely draw on some of the discussion that comes up in these working group meetings.

00:15:08 Speaker 3

So for example, today you see you're highlighting Chapter 7. Is there a schedule of highlighted ones so that?

00:15:16 Speaker 3

We will so that we can be prepared.

00:15:17 Speaker 1

Yes.

00:15:20 Speaker 1

Yes, we can. We can put that in a slide and show that toward the end, we do have a schedule of the other advisory group meetings.

00:15:20 Speaker 3

Rugrats.

00:15:31 Speaker 1

Cardiology labor and delivery imaging services bed need and acute care inpatient methodology and.

00:15:43 Speaker 1

I've lost my behavioral health. Thank you. I I went out of order and and lost track. So we do have we do have those scheduled. We're we're working on locations and and links. So we can we can provide that schedule for everyone.

00:15:43 Speaker 2

Saver house.

00:15:49 Speaker 3

That would be helpful. Thank you.

00:16:04 Speaker 1

I think I saw another hand. Yes, go ahead.

00:16:10 Speaker 4

So thank you for putting this together. And I just wanted to like, you know, just build upon what Doctor Kay just mentioned earlier. So the idea is to share thoughts, feedback, comments and then you will drill it down and then go from there and.

00:16:27 Speaker 4

Who is the like? What's the desired outcome for whatever document, whatever advisory report we present? Is this going to the legislature or who is the directed audience who's going to utilize the work of this committee?

00:16:44 Speaker 1

Yeah. So it'll go to OHS and then we'll continue working with Alterum who.

00:16:51 Speaker 1

Has been our consultant in reviewing uh, the work of other states, reviewing our prior work and incorporating updates as appropriate. So it's coming to OHSU and we will be moving from our preliminary plan to the final report, I think by the end of October.

00:17:12 Speaker 1

So comments are due by the end of September. We'll take all of that in. We have OS staff on this call, including myself, who are taking notes on any of the comments made and we are going to consider each of those and to the extent possible, we will respond to those comments.

00:17:30 Speaker 1

And and articulate the thinking on each of those.

00:17:35 Speaker 4

And this Consulting Group, what happens between now and their feedback? Like is there like, what's the, who's the other eyes looking at it before that final product is submitted?

00:17:44 Speaker 5

Uh.

00:17:51 Speaker 1

So this is an OS product, so OS is statutorily required to issue this plan which is supposed to be updated every two years. We have the the initial plan is from 2012 which involved a lot of folks who are on this call and in these other advisory groups.

00:18:11 Speaker 1

Who are in working groups really starting from scratch to develop the plan and how it would be used this one?

00:18:20 Speaker 1

Is the largest overhaul that we've done since 2012, but it's an update of that 2012 report and that's why the working groups are formed a little differently. Rather than taking, you know, consensus votes for recommendations, we're really looking for kind of all of the comments and feedback and OS.

00:18:40 Speaker 1

Hopefully today is in more of a listening position so that we can really take in these comments and we know I think we have a very broad.

00:18:49 Speaker 1

Group here with lots of different viewpoints and so rather than try to get everyone to agree to any formal recommendations, we'll just be taking all of those comments in and weighing them against each other. We being OHS with our, with consultation from Altera.

00:19:05 Speaker 1

Based on their.

00:19:05 Speaker 4

So I'll be very curious and interested in having conversation on four or five and six as we go along and get down to the list. So that's one area where I was like gonna have some additional thoughts and comments.

00:19:21 Speaker 2

Great.

00:19:23 Speaker 1

Doctor Riddle.

00:19:25 Speaker 6

Yeah, hi. Thanks for having us all get together here. This is going to be an interesting discussion. I'm Kara Riddle. I'm a primary care internist, and I'm also the senior medical director for our primary care practices with Hartford Healthcare Medical Group. So I oversee primary care practices in pretty much all regions of our of our state.

00:19:46 Speaker 6

I mean, is it important to you that we go in order with these questions or does it really matter?

00:19:55 Speaker 1

No, I think you can start wherever and open up the discussion from where you see fit.

00:20:00 Speaker 6

OK, I wanted to make a comment on the on the number four topic here, which is consolidation for primary care physician practices. So I was able to read through the, you know, preliminary reports that was sent out as part of this and I, you know the the report highlights some of the concerns you know that arise with consolidation of primary care physician.

00:20:21 Speaker 6

Practices which you know I think are are there. You know, there's certainly data to support some.

00:20:27 Speaker 6

Some concern over costs and things like that, that come along with consolidation, but my comment is that you know, we are in an era post pandemic of AI big data, you know EPIC, which is

our electronic medical record system and is the electronic medical record system for the vast majority of the.

00:20:48 Speaker 6

You know, hospitals and healthcare systems in Connecticut at this point, not all, but a lot of them.

00:20:53 Speaker 6

You know, Epic has tons and tons of data, and so you know how that ties into our population health strategies. You know how we do billing with all of this. We have, you know, federal regulatory requirements that keep increasing. We have value based payment models. You know, I think all of these reasons are why you have consolidation.

00:21:14 Speaker 6

Because it becomes with all of that that has to be done. You know, if you're in a solo practice or in or by yourself, it becomes very challenging, you know, to try to function in a space.

00:21:25 Speaker 6

With all of those you know, with all of those needs which are not going away, you know AI is not going anywhere. We have to figure out how to make it work for the things we need to do, you know, value based payment I think is is you know what we all are hoping we're going to be moving more towards, but that requires value based payment, requires a lot of data analytics.

00:21:45 Speaker 6

Population health management, all kinds of different things. So, so that was my comment about consolidation. So you know in my view, it's kind of like a I like if you can't beat it, you have to join it. You have to figure out how to make it work for you. And so that that's really my comment related to consolidation and happy to see if others have.

00:22:04 Speaker 6

Comments about the same topic.

00:22:13 Speaker 1

Great. That seems to have gotten the the conversation going. Doctor Acosta.

00:22:19 Speaker 7

Hi, thank you for having us. I'm rod Acosta. I'm the chief assistant executive of staff for health.

00:22:25 Speaker 7

And I'm also the President of the staffer Health Medical Group.

00:22:28 Speaker 7

I'm a primary care doctor. Family medicine still see patients have very limited basis, but I've been in practice about 30-7 years.

00:22:37 Speaker 7

And one of the reasons that we joined the hospital and this was back in 2010, 2011.

00:22:45 Speaker 7

Is similar to what Doctor Riddle was saying. Basically, we could not keep up with the cost of our practice. We wanted to get our own. ER was expensive. They were clunky at first. We actually ended up getting one or two or three as time went by, but our biggest challenge was actually dealing with the insurance companies and the payers.

00:23:07 Speaker 7

By the time I joined, I was the managing partner. It was almost impossible for me to meet with anybody.

00:23:14 Speaker 7

And their answer usually wants to give me a sheet of paper giving what their fee schedule was going to be.

00:23:19 Speaker 7

And it was take or leave it. You couldn't negotiate anything with them.

00:23:23 Speaker 7

And our costs kept going up. Labor kept going up.

00:23:27 Speaker 7

And it was very, very difficult to keep a successful primary care practice. We probably could have gone out longer, but but the writing was on the wall. Then eventually you would have.

00:23:37 Speaker 7

To join a bigger.

00:23:38 Speaker 7

Group it was just not sustainable and I really admired the physicians that are able to do it.

00:23:44 Speaker 7

I'm not really sure how they're doing it, but kudos to them.

00:23:48 Speaker 7

But it's extremely difficult to stay in private practice nowadays and be able to hire more physicians.

00:23:54 Speaker 7

And I'm not sure what they're doing nowadays with the labor shortages.

00:23:58 Speaker 7

Because of the affected healthcare systems, you can imagine what it's doing to the individual providers and the cost that they have incurred that they have to incur to be able to hire people.

00:24:11 Speaker 7

Thank you.

00:24:14 Speaker 1

Thank you, doctor Gaman.

00:24:18 Speaker 4

So hi.

00:24:20 Speaker 4

So I'm the little guy in the room. I agree with my good friends and colleagues, Dr. Carson and Doctor Rill. They are accurate in their statements.

00:24:31 Speaker 4

But I would like to bring attention to another thing. So I'm still independent primary care, family medicine practice in East Granby. So it is difficult nor denying.

00:24:42 Speaker 4

But it can be done. Now my question to us ourselves. All of the physicians and everybody in this room is whose interests are we trying to protect here?

00:24:55 Speaker 4

Right. If the answer is our patients.

00:24:58 Speaker 4

The patients may not benefit from the consolidated practices.

00:25:05 Speaker 4

The choice that's available to the patients when they need to seek medical care are limited and even more limited in today's world than what it was, maybe even 10 years ago.

00:25:18 Speaker 4

#2 the cost of care, which we all worry about, we all know the cost of care goes up when it is being delivered by a large system versus a small community.

00:25:32 Speaker 4

There is the facility fees for the same service that's added onto the same service that would have been provided to this patient in a smaller community setting, which is not the case with the large system. There is no specific data suggesting the quality of care is.

00:25:52 Speaker 4

Better from a large system practice versus a small practice. Actually it's the other way around. Private practice still offers better quality of care and primary care. You know, all my colleagues in the primary Care World know what it means. It's all about relation.

00:26:07 Speaker 4

Chips. So if you're unable to maintain long term relationship with your patients for due to you know several different reasons, I don't want to go into the specific details but the long term relationship with that community that you serve with that patient population that you serve is not the same and I'm going to tie this into one other comment that I want to make.

00:26:29 Speaker 4

When it comes to the corporatization and consolidation, is.

00:26:33 Speaker 4

We lose competitive advantage.

00:26:37 Speaker 4

The fundamental principles of.

00:26:40 Speaker 4

Like the capitalism is not being provided in corporatism, so these are two separate things. The fundamental principles of choice for the consumer and the availability of competition are gone in a consolidated environment. The consumer who's the patient here.

00:27:00 Speaker 4

Does not. They don't have a choice but to use AB or C so the cost to the system is higher without a clear evidence of improved quality.

00:27:13 Speaker 4

In a consolidated world now to doctor Riddles point, she's absolutely right. But there's so much.

00:27:20 Speaker 4

Required demands from the payers onto the small practices like myself, so it is challenging to meet those requirements and I'm just going to tie this with an example that I share with my medical students and you some of you my some of my friends may have heard this previously.

00:27:40 Speaker 4

But it's the administrative burden imposed upon the physicians practices from the insurer.

00:27:47 Speaker 4

First, the pairs which leads to my good friends like Doctor Costa and Doctor Riddle to join some of these other systems because it is difficult. So we are trying to fight one problem but inadvertently creating another.

00:28:05 Speaker 4

That was not my physician friend's choice, but they had.

00:28:09 Speaker 4

Limited options to pick from and whatever they picked is now unfortunately becoming a different problem, and the end and the end of the day.

00:28:19 Speaker 4

The community the patients are suffering.

00:28:23 Speaker 4

So it's it's a complicated web and to like bring another layer of complexity into the shortages. 2 in five practicing physicians today are over 60 will be over 65 in the next 10 years.

00:28:40 Speaker 4

So you do the math right. We are short today. How bad it will be tomorrow.

00:28:47 Speaker 4

And secondly, the last thing I'll add, the incoming primary care physicians from the medical school to the residency program and keeping them in Connecticut, it's another whole big problem. So we're not getting enough people interested in taking a career in primary care or don't so many different reasons. We can talk all day.

00:29:07 Speaker 4

For those and then whoever goes into those areas, we are unable to keep them engaged in the state of.

00:29:15 Speaker 4

Take it.

00:29:16 Speaker 4

And it's it's it's like, you know, all in my mind 4-5 and six are linked.

00:29:22 Speaker 4

In one way where we need to look at the person, the process and the policy.

00:29:28 Speaker 4

And now we go which order it's. You know, it's debatable. So where we do we go from policy to person or the person process to policy that's some some of our conversation. I'm hoping to hear other thoughts in the group. So I'll stop there and.

00:29:44

Yeah.

00:29:46 Speaker 1

Thank you, doctor Kuros.

00:29:53 Speaker 8

I think I was muted. Hi, good afternoon. Please have the opportunity to comment here and I'd like to comment in a couple of different areas. With respect to to the.

00:30:07 Speaker 8

Consolidation of primary care. I don't want to conflate that with other types of consolidation. I what I want want to do is introduce the concept of minimum efficient scale in delivering a certain type of primary care, accountable care, population, health management, because I think.

00:30:28 Speaker 8

But you know, if you're going to work in a value based payment based on the total cost of care for defined populations and if you want to understand that you're, you're doing that in a payer specific way because that's the nature of the work then.

00:30:48 Speaker 8

Each of those specific payer populations that you're going to take care of in a value based payment, total cost of care model, you have to have a certain population size to have statistical validity, right. And so I think in that respect you have to, you have to recognize that if you want to do.

00:31:05 Speaker 8

Advanced primary care under total cost of care value based contracts there is a minimum efficient scale that's fairly large.

00:31:15 Speaker 8

And this is my 100th day at New Man's, by the way. I'm sorry. I'm the President of the medical practice there and the interim chair of primary care. I was my whole career and before arriving in Connecticut 100 days ago was working in Rhode Island. But there are other aspects of this.

00:31:35 Speaker 8

Notion of minimum efficient scale. Besides the payment models that are also worth thinking about and talking about, I think that when you look at an advanced team based model of primary care today that the individual offices need a portfolio of centralized clinical and administrative programs to support them to allow the frontline.

00:31:56 Speaker 8

Folks to really work at the top of their license and do the things that they do best.

00:32:00 Speaker 8

And so if you want to enable that high level of performance in a team based environment.

00:32:05 Speaker 8

Then then you need to have enough scale to be able to provide the analytics that they're going to need to provide the transitions of care kind of programming that you want to have to have different disease management programs to have systematic ways to address social determinants of health and the technology.

00:32:26 Speaker 8

The human infrastructure to do that work.

00:32:30 Speaker 8

You really have to have some scale and so I respect the.

00:32:34 Speaker 8

Small practice independent model. I was a practicing primary care doc for 20 years. I started my career in that place. I understand the relative virtues of that model. But if you want to do.

00:32:47 Speaker 8

You know these larger total cost of care value based payment models, you really and some of the administrative supports and clinical supports I was talking about you need more scale. So those are different choices.

00:33:02 Speaker 8

But to be halfway is really difficult. It doesn't have to be an ownership model, but if you you can do an IPA model. But if you want to do pop health and a CEO contracting, you need a certain amount of scale. So I wanted to point that out and it and it just becomes more true all the time because the the data and analytics are getting more complex. The introduction of AI makes it more.

00:33:24 Speaker 8

Complex the ever increasing demand on primary care providers to get through all the the preventative and screening health services as well as the acute care needs of their patients.

00:33:37 Speaker 8

It's a lot and I, I would argue that that that type of scale enables a higher level of performance overall in a system.

00:33:42

No.

00:33:46 Speaker 8

Of care context in a systematic, standardized approach that ultimately I would argue, elevates performance. The second piece I wanted to touch on was the issue of we have this numbers problem. We have an aging primary care physician workforce. We have a weak pipeline and we have population demographics.

00:34:07 Speaker 8

Where?

00:34:08 Speaker 8

More baby boomers or constantly aging into Medicare and to the ranks of of patients with chronic illnesses. I think in that context we should be talking about primary care capitation because I think what we're going to need to do is to have larger teams. I think each doc, whether we like it or not is going to have to have a.

00:34:29 Speaker 8

Larger panel of patients.

00:34:30 Speaker 8

They're going to need to have a rope, more robust team based care model, and I think in that context a fee for service volume based reimbursement model is counterproductive.

00:34:43 Speaker 8

And I think that a primary care capitation model nested within an accountable care model that that ensures quality and cost efficiency and the like is probably going to need to be the way of the future. So appreciate the chance to make those comments. Thank you.

00:35:02 Speaker 1

Thank you. Uh, doctor McGovern.

00:35:06 Speaker 9

Thank you. Margaret McGovern, I'm the chief physician executive for the aligned clinician Enterprise, which is inclusive of Northeast Medical Group, which is the employed physician group of Yellow Haven Health System and Yale Medicine. The faculty practice plan for the School of Medicine. Welcome to Connecticut.

00:35:26 Speaker 9

Cocorosie so and I've been here 2 years. I I I agree with everything you said and I just want to reiterate that message that.

00:35:36 Speaker 9

That the types of infrastructure and support that primary care physicians need is extraordinarily difficult for them to do as completely independent. So it doesn't mean that independent primary care physicians have to transition into employed models. And there's other ways to get at this issue.

00:35:57 Speaker 9

You mentioned IPAS clinically integrated network.

00:36:00 Speaker 9

Works, but to be able to bring to bear to independent primary care physicians and community, the kind of infrastructure they need to be successful in managing their patients and to lean into the investments that are needed to develop, you know the care models that first of all are.

00:36:20 Speaker 9

Attractive to graduating residents who are looking to practice in different kinds of care settings with care teams that are inclusive of.

00:36:29 Speaker 9

Mental, behavioral health, social work, pharmacy care management function that's extraordinarily difficult for independent primary care physicians in the community to pull that together on their own, but doing it as part of a relationship, remaining independent, but in a relationship with a larger entity.

00:36:49 Speaker 9

Can be incredibly powerful in in driving.

00:36:53 Speaker 9

Of being able to distribute that care model. I think you know the challenges facing primary care and they've been referenced here. I mean, everyone's raising them, you know, being able to be successful in different payment models. It's very difficult to do if you don't have scale, which someone spoke to contracting can be extraordinarily difficult.

00:37:14 Speaker 9

Figuring out a financially sustainable way to embed behavioral healthcare into primary care to free the primary care physician to do the work.

00:37:24 Speaker 9

That they were fundamentally trained to do and have others helping them to assist with those issues in their patient population. The administrative burden is huge. And so I think we're all looking for a solutions for this because it is a pain point for everybody and I do want to just take a few seconds to talk again about your #5 on this slide.

00:37:45 Speaker 9

About you know the data, it's it's a big pain point. It makes it difficult to safely discharge patients from the hospital into the care of a physician who's going to make sure their treatment plan is followed.

00:37:58 Speaker 9

It obviously drives unnecessary emergency room use, so transitions of care, even discharging someone from the Ed who needs to be seen timely for follow up care. I think these are all challenges that health systems in the state are facing and are looking for solutions for how we can do this work.

00:38:18 Speaker 9

In the most fiscally responsible way, delivering high quality product to our patients and also respecting the absolutely important role of independent physicians in the Community who we want to partner with and engage with in this work. So we can deliver what we need to to our patient.

00:38:40 Speaker 9

So also just want to put out there that frankly nothing you know would make me happier in my work than to be able to develop those partnerships with. We think we're about 200 primary care physicians short to take care of the needs in our health system and nothing would.

00:39:00 Speaker 9

Be better than to be able to do that by creating those relationships with and helping to in legally compliant ways etcetera. Support independent physicians in the community because when health system entities employ physicians.

00:39:15 Speaker 9

It requires an investment per provider for any kind of specialty, including primary care, and that MGM, a benchmark for primary care, is $180,000 a year every year, forever. That's the investment needed. So very large expense, you know, to try to do the work that way. And I just want to comment then again briefly on #5 about.

00:39:34 Speaker 9

The data which you know I have no reason to think is not accurate, but I think there are nuances to the physician workforce numbers, a couple of people have.

00:39:44 Speaker 9

Referenced that the primary care workforce is aging and you know, certainly what I've observed is that, you know, those panel sizes start to drift down as people are contemplating retirement, slowing down, et cetera. So you know, one FTE of a primary care physician.

00:40:05 Speaker 9

Is not equivalent, necessarily. And then there's the impact of how much transition to concierge medicine is happening in our markets because those panel sizes can be extraordinarily low.

00:40:16 Speaker 9

And again, you know a primary care, they're not all the same. There's not apples to apples when you're comparing physicians in the community, how they practicing, how much clinical time they're expending, what's their model for their practice. And I think these are nuances to thinking about, do we actually have enough primary care physicians in our environment?

00:40:35 Speaker 9

It certainly doesn't feel like we do because it's a huge challenge for people to get access.

00:40:42 Speaker 9

And it's a huge dissatisfier for patients when they can't get timely access and it impacts all of the other things I referenced about, you know, making sure that patients have proper care after an acute and acute stay in a hospital or some other setting. So I think this is really important to think of solutions for how we can.

00:41:03 Speaker 9

And attract newly minted primary care physicians out of their residencies. How do we keep the ones we're training in the state state of Connecticut here, how do we create creative practice environments where they can make a living and be professionally satisfied by practicing and care models that really are supporting them throughout their day?

00:41:24 Speaker 9

So that they can do what they're trying to do.

00:41:27 Speaker 9

Thank you.

00:41:29 Speaker 1

Thank you Doctor K.

00:41:35 Speaker 3

Yeah, well, amazing, amazingly good comments. I just want to rather than talk.

00:41:43 Speaker 3

With any specific proposals here, I think.

00:41:48 Speaker 3

I want to amplify some of the things that doctor Guman mentioned, but point out a couple of things.

00:41:55 Speaker 3

A few three things. One is I'm not sure if anybody's familiar with the Harvard Research study that showed that compared the quality of care among private practice employed comma employed physicians comma and those that are owned or strongly affiliated.

00:42:15 Speaker 3

But not necessarily salaried by consolidation entities, and it showed.

00:42:22 Speaker 3

Unequivocally and fairly strongly that the that the best quality of care was provided by primary care physicians. So I'm sorry by by independently private practice physicians.

00:42:36 Speaker 3

Second thing.

00:42:39 Speaker 3

I'm not going to talk that much about the consolidation or the the big picture things, the consolidation that everybody's talked about, but I want to point out a few, a few specifics that show that it's not necessarily consolidation that's bad, it's how consolidation is executed.

00:42:56 Speaker 3

So I'll give you a few examples. Doctor Gumar mentioned facility fees. Well, you know why should something cost? Why should an echocardiogram be billed at?

00:43:09 Speaker 3

$600.00 one day and the day after the closing of a of an acquisition by a hospital be billed at $2000.

00:43:18 Speaker 3

These are not. This is not a made-up number. This is made-up. This is just shown to me by patients who asked me why their bill changed when they went to their cardiologist, but it's not restricted to cardiology. It's basically across the board and primary care physician visits are generally higher now one $2000 echocardiogram.

00:43:39 Speaker 3

Can blow a hole of patient's entire years worth of.

00:43:44 Speaker 3

Portables many patients, including myself, trying to stay below the deductible. So I think you know that's one example. Another example is how it's executed. You know the epic.

00:43:58 Speaker 3

Information System has a lot of choices that are made by entities that purchase them, and one of the choices is how to whom they want to whom they want to include in their list of drop. The drop down menu of referral.

00:44:15 Speaker 3

Opportunities. So for example, also speak I'm first of all, I'm a retired radiologist. I have no skin in this game anymore. I've just been a an observer and now a participant in health policy at multiple in multiple venues, so.

00:44:32 Speaker 3

But when I was practicing, I was called by a primary care physician to ask me why they cannot get my practice on their on their drop down menu when they just want to send an electronic referral.

00:44:46 Speaker 3

And it turns out that at that point in Epic, there was a choice that you could make when you have settings like you have settings on your on your apps, on your, on your computer or your iPhone that will do. You want to include, you want to include as potential refers. So there's steerage. It's not a, it's not, it's not necessarily a mandated steerage.

00:45:07 Speaker 3

But it's all for all practical purposes, it's the equivalent of a mandate.

00:45:12 Speaker 3

So we need to think about things like that and then of course, you know the there's the mention of facilities, but this is all to prevent leakage so that there's a capture of revenue. One of the things, one of the impetuses for the health information exchange that I helped to draft in 2014 and 15.

00:45:32 Speaker 3

So the the the mandate for which I helped to draft was to prevent that from happening to to require information sharing rather than information blocking.

00:45:43 Speaker 3

So these are the kinds of things that are the.

00:45:46 Speaker 3

Downstream consequences of.

00:45:51 Speaker 3

Why don't we say recapture of the money spent to buy the practices that that there have become captain and and there's something wrong about that. And so it's not necessarily that a big group is bad, it's just how it's how it's administered. And I and it's interesting that the that.

00:46:11 Speaker 3

Today, we've already heard from medical directors of those captive groups and certainly with the best of intentions, but you don't necessarily control how the whole process works. And I I applaud the things that you've mentioned. The last thing I just want to.

00:46:30 Speaker 3

Feedback on the on the the people that are speaking so far is that.

00:46:38 Speaker 3

We've got one set of consolidators which are the hospital hospitals in the state and for the most part.

00:46:45 Speaker 3

They've got a tough job. The hospitals have a very tough job, limited funds, they've got, you know, all sorts of mandates that they've got to follow and administrative guidelines.

00:46:58 Speaker 3

On the other hand, what we have is a tsunami of private equity. I'm using private equity in a small piece, small E sense, and that is there are other types of financial investor owned entities that circumvent the laws against corporate practice of medicine by using.

00:47:18 Speaker 3

Techniques developed over the years, either legislative or regulatory, or legal machinations, and I don't think we would be we. I think we would be remiss in our responsibility to not think about those sorts of things here and talk about them and come out with some sort of solution.

00:47:34 Speaker 3

I I don't want to take up the time now to discuss some of those solutions and I'm not really prepared with documentation, but I kind of know them by heart and I I want to make sure everything I say is is.

00:47:45 Speaker 3

Well.

00:47:45 Speaker 3

Documented. So consolidation itself isn't bad.

00:47:51 Speaker 3

But it's how it's executed and that's kind of I view that as the role of this.

00:47:56 Speaker 3

Group of people, but also the state to eventually get involved in that.

00:48:01 Speaker 3

Thank you.

00:48:02 Speaker 1

Thank you, doctor Ashman.

00:48:06 Speaker 10

So I'm in private practice. I've been in Connecticut for over 30 years. I'm a dermatologist, so it's a specialty practice.

00:48:14 Speaker 10

But I'd like to say that Doctor Gurman and Dr. Kay expressed my interests as well, and I'm also the chairman of the Board of the Fairfield County Medical Association. So we hear about it a lot from private practice physicians who join our group.

00:48:35 Speaker 10

And I'd like to say.

00:48:36 Speaker 10

That.

00:48:37 Speaker 10

When you have private practice, you have more competition in the Community, which is a good thing. You have more choice for patients, which is a good thing. You have relationships that patients make with their private physicians that go on through generations. I see grandchildren and children and parents and grandparents.

00:48:58 Speaker 10

In my practice and and, it's a very rewarding feeling to have these relationships.

00:49:04 Speaker 10

And so I would say that we really do need private practice and we need to have ways to encourage people to come to the state of Connecticut and open private practices. And we had mentioned some of these things in our policy recommendations when I was on the work group.

00:49:25 Speaker 10

For uh, the office of Healthcare Strategies with uh, a lot of the people on this panel.

00:49:32 Speaker 10

And it may be something that the state should consider, such as helping new doctors with student loans, with housing, encouraging them to get into underserved areas in the state. You know, these would all be good things that would help all of us in in trying to make the state of Connecticut.

00:49:53 Speaker 10

More appealing to doctors who are coming out of their training and also doctors who have trained in.

00:50:00 Speaker 10

State and why not ask them why they're not staying in the state of Connecticut? There's they obviously have their reasons. And if we knew them, maybe we could adjust and offer them things that would be more appealing to continue their their practice in the state where they've trained.

00:50:21 Speaker 10

Also, Doctor Kay touched on these private equity groups, but I think we should also consider these larger conglomerates like CVS.

00:50:32 Speaker 10

And United Healthcare and Humana and all these big companies that are.

00:50:42 Speaker 10

Taking on things beyond what they originally were purposed to do, so you might have United Healthcare.

00:50:52 Speaker 10

Buying up pharmacies, buying up private practices of physicians and what they vertically enlarging their their info.

00:51:03 Speaker 10

Florence.

00:51:04 Speaker 10

It's something that we haven't discussed really in the state, but I think that aside looking aside from looking at private equity, we should also be cautious about these groups entering into our state and changing what we have in the state of Connecticut.

00:51:24 Speaker 10

So that's what I would like to add for this afternoon.

00:51:31 Speaker 1

Thank you.

00:51:37 Speaker 1

And we don't have any hands up currently. So Corey, I may turn to you and see if based on this conversation any any you know, FSP specific questions come to mind based on some of the conversation that we've had so far.

00:51:54 Speaker 2

Yeah, I'm happy to start to point us in One Direction here. Maybe it's there's been some good conversations here around the physician workforce.

00:52:01 Speaker 2

And and I think really what I would love to be able to do today is help elicit some feedback from this group, around the information that we presented in the facility and services plan so far in the way it represents the current physician workforce capacity within the state and where that workforce is headed as far as projections of where the workforce is, the aging of that workforce and the its ability to meet the upcoming need.

00:52:21 Speaker 2

I think Doctor McGovern to to your comments is a good question around how we've represented that workforce so far and the data that we have, any data that we're potentially missing in the way that we've characterized that work for.

00:52:32 Speaker 2

Of course, and and anything more that we can do to help describe that as a potential future upcoming problem and and how OHSU you know, within its purview, you know, should be responding to that as as future needs. Obviously, this is not really a document to talk about policy discussion. It's not really a document to talk about strategies, but it is a document where what we're trying to do is lay out a data and understanding of the existing.

00:52:53 Speaker 2

Landscape within the state. So any specific comments around what's in the FSP of what folks have seen so far and if those folks are on time to do that today, that's OK. But I would encourage folks to kind of give us response.

00:53:03 Speaker 2

Around the way that we presented the current situation, whether or not you feel it's accurate and what more we could do to describe that, so HS and the public has a good understanding of of what the needs are within the state related to the physician workforce. So that's a question I have, but I see a couple other hands going.

00:53:16 Speaker 1

Up. So I'll let you manage it from their point. Thanks. And and before we turn to Doctor Brown, I just want to check back with Doctor Riddle to see if.

00:53:23 Speaker 1

If you had something else to add before we.

00:53:26 Speaker 6

I had a comment on on one-on-one of the topics further down, but I'm happy to hold it. You know, since we, you know, wanted to.

00:53:32 Speaker 6

Talk about that. I'll. I'll just hold it for after.

00:53:34 Speaker 1

OK, thank you, Doctor Brown.

00:53:35 Speaker 11

Sorry.

00:53:37 Speaker 5

I just wanted to comment on and and just for those of you who don't know me, I'm the Chief Medical Officer, Vice president, medical affairs at at Griffin Hospital. So again, one of the the smaller hospitals in our in our state, I'm also a infectious disease doctor. I've been at the state my entire career. I trained at Yale. I'm an infectious disease doctor. I started off in private.

00:54:00 Speaker 5

Practice.

00:54:01 Speaker 5

My wife is also a physician who's currently in private practice, so together we're we've had quite a bit of experience with with the state and I could tell you that it's it's interesting because we have seen a reduction in in the private practitioners that we are seeing in the Community. And again, I've seen this now from the hospital.

00:54:21 Speaker 5

Standpoint, but I've also seen it from personal experience as well. As you know, my wife and and and I, you know, part of the the things that I don't think was necessarily addressed was is the primary care docs as well as specialists are continuing to drop Medicaid.

00:54:38 Speaker 5

As a reimbursement, so we're having our state, which we're having a discussion in this in this standpoint to talk about sort of what can we do, but yet some of our private practitioners can't afford to take Medicaid because it's just the dollars aren't there. And I think a lot of us from the beginning of starting any starting any practice or understanding the practice.

00:55:00 Speaker 5

That we know that the, you know, cost of living.

00:55:04 Speaker 5

Created the cost of living straight out in comparison to the cost of living adjustment for private practice doesn't match and that it stays. It stays dormant from a practice standpoint, yet we spend more, it costs more and there's more competition that's potentially there because honestly I find a lot of private practitioners who.

00:55:26 Speaker 5

Don't necessarily want to stop private practice.

00:55:28 Speaker 5

But kind of have to because they can't afford to do that or it's just getting too hard. So I think there's definitely some some opportunities from the state standpoint that can help with that. I think we need to look at restructuring and and revising the the Medicaid process, which is up to one in five of our individuals instead of Connecticut that are on yet.

00:55:49 Speaker 5

You know, our private practitioners private primary care as well as specialists are now no longer taking it and.

00:55:54 Speaker 5

Making it very difficult.

00:55:58 Speaker 1

Thank you. Uh, doctor mosdell.

00:56:02 Speaker 11

Thank you, Josh Mossdale, my primary care internist and the chief of primary care for attorney health in New England and Connecticut, Massachusetts and also interim medical director of our clinically integrated network.

00:56:14 Speaker 11

Just want to comment just to come back a little bit to what Corey said. I was a little bit surprised when I was looking at Table 7.7 which was mentioning that it seems that besides family medicine, we will have an adequacy of primary care providers in the state of Connecticut over the next seven years or so.

00:56:30 Speaker 11

Which I think probably everyone on this call would agree is not what everybody's currently seeing. So you know, I guess my comment back to you would be one you know, are we looking at this in the right way to ensure that we do have an adequacy in Connecticut, which I don't think is the case. And two, if we don't, is it because we're looking at things that are rurally based and we're just simply not where we need to be.

00:56:52 Speaker 11

In terms of do we need to care for people in Windham County, Tolland County, Litchfield County, and we're not in the right places at the right time. If that is the case, then I would suggest, you know, the state has a pretty vested interest and incentivizing folks to be there in the rural areas and other places where people are underserved. But in general kind of just didn't feel right to me looking through every.

00:57:12 Speaker 11

Piece of the data, I know Corey had mentioned.

00:57:26 Speaker 1

Thank you, Doctor Riddle.

00:57:29 Speaker 6

Yeah, sure. I I guess I'll and I put it in the comment, but I I totally agree with that table. I was surprised I I it's not doesn't line up with some of our own projections in terms of our future workforce. You know certainly we project a shortage of family physicians, but we also project a shortage of primary care internists and you know others as well. So I thought that was a little.

00:57:49 Speaker 6

Interesting to.

00:57:50 Speaker 6

OK, the comment that I was going.

00:57:52 Speaker 6

To make earlier.

00:57:54 Speaker 6

Was really just surrounding and and it's it's not something that I think has been identified here as sort of an overarching topic. So I guess it goes under other you know, but I think that the implications for our patient population and a lot of the changes you know that have happened and will happen in primary care I think is something that gets overlooked.

00:58:14 Speaker 6

Frequently, you know in our healthcare system, you know we have engaged in a lot of activities to try to.

00:58:22 Speaker 6

Provide additional services like telehealth and you know other partnerships and some unique arrangements to try to increase access to.

00:58:29 Speaker 6

Here, as Doctor Quiros indicated, we we have a shortage which in which means that, you know, a primary care physician, probably is going to have to have a bigger panel and work within a care team, which I think is OK, you know, there's a lot of literature to support those models, you know, providing a good quality of care. But that is very different than what our patients have been historically used to.

00:58:53 Speaker 6

You know in their primary care relationship.

00:58:55 Speaker 6

And it just is, you know, in my view it's it's that it's that thing that falls in the category of kind of it is what it is you know. But I think we.

00:59:04 Speaker 6

Know.

00:59:05 Speaker 6

This, you know, state legislators know this. Healthcare systems know this. Payers know this, but we haven't done a good job educating our patients. You know that these changes.

00:59:16 Speaker 6

Are necessary, you know, to take better care of them. And so it's just something that I think about a lot and that I don't want to lose sight of, you know, in the midst of talking about all these other super important topics. So anyway, that was just my comment that I wanted to add on here.

00:59:33 Speaker 1

Thank you, doctor Kuros.

00:59:36 Speaker 8

Well, I would agree that I I think patient expectations and and what we're versus what our care models are going to look like in 5 and 10 years there probably is something of a mismatch there. And I think that's a point well taken.

00:59:50 Speaker 8

I also share some concerns about tables 7.7. Although when I look at.

00:59:55 Speaker 8

It.

00:59:56 Speaker 8

You know, one way to look at it is to say, well, only family medicine physicians is off, but then you realize it's off by 9.

01:00:03 Speaker 8

100 and so the absolute numbers, and I don't know exactly how you parse how many family medicine physicians you need versus general internists, and that that's maybe sort of a nuanced question. But overall I think still the the shared intuition on this call is that we're not going to have enough providers.

01:00:24 Speaker 8

And I think the other piece that maybe could strengthen that argument in this section of the document is if you had any more detailed information about population demographics that you might be able to line up approximate to the physician workforce information that.

01:00:42 Speaker 8

Might be useful.

01:00:47 Speaker 2

If I can just jump jump in here, but these are great comments. Thank you for the comment. Specific to table 7.7, we will definitely take a look at that. I'll note the data coming from that are coming from from hersa you know from the government agency that's that's putting out these projections. They're obviously our limitations. I'm sure we can detail a little bit more the methodology that they use to generate those such that there may be differences in the way.

01:00:49 Speaker 1

Go ahead.

01:01:07 Speaker 2

Exactly as you're talking about. Care is going to be provided in the future. Our needs for the population may change over.

01:01:12 Speaker 2

Time I'm curious and and again folks can do that on this on this call or in in written documents. If there are other sources of information that you feel represent this problem as a workforce shortage that we're not capturing yet in the facility and services plan now would be a great time for to be able to provide that to us and and to HS, I think we would certainly welcome any other information that we have.

01:01:32 Speaker 2

Around.

01:01:33 Speaker 2

How needs might be different than what horses representing or how distribution of the needs across the state of the geographic or locality needs are are potentially different, so certainly happy to try and capture that still, there's certainly time we want to make sure we're we're accurately describing this need within the state, but doing it in in a data-driven way. So there are potentially other sources we can do that on our side to take a look for that, but if folks have.

01:01:53 Speaker 2

Data within your you know within your systems, within your facilities that represent this need or data that you know from other publicly available sources that we should be trying to capture. We would love to take that into account.

01:02:03 Speaker 2

So I'll just throw that out there.

01:02:06 Speaker 1

Yep. Thank you, Corey. Doctor guman.

01:02:10 Speaker 4

I just wanted to add a comment to what Cory just said. So there double AMC report for the projected shortages is 1 document that you may want to look and I can share that. And if you look at the statistical like the the number like you know the over the past maybe 15 years.

01:02:28 Speaker 4

We have added physicians so there are there has been like a.

01:02:32 Speaker 4

What?

01:02:34 Speaker 4

10 to 14% increase in the medical school incoming total number of medical students. So we are about close to 1,000,000 number nationally. The problem is it's not, it's not like the proportionate. So if you look at the number of medical school.

01:02:54 Speaker 4

Admissions and the number of CMS sponsored training programs they match more or less.

01:03:01 Speaker 4

Yes.

01:03:02 Speaker 4

Almost equal. However, Pediatrics, family medicine, emergency medicine, they go unmatched. So what happens is the medical students are not going in where the population needs maybe.

01:03:19 Speaker 4

And secondly, even in sub specialty world, we have tons of stroke neurologists, but you cannot find a general neurologist.

01:03:30 Speaker 4

So Connecticut, it's a very interesting state. We are like for like 400,000. So we are among the like the number I think #17 when it comes to the ratio for trainees and the 200,000 population. So we are training a lot of physicians after they finished medical school but.

01:03:50 Speaker 4

We don't need them all. We don't need as many stroke neurologists. We don't need as many of the subspecialty. But our training program. So there are the funds that are flowing towards training are not proportionately distributed to where the need is.

01:04:08 Speaker 4

So we only have limited primary care training spots where nobody goes and then we have too many of sub specialty training spots. We train and then they leave Connecticut. So I think we have to redistribute or recalibrate our needs in training. And the last comment I'll make, I don't know if she's anybody looked at the.

01:04:29 Speaker 4

JAMA, like maybe two weeks ago, where are all the pediatricians? Right. So we are very unique in Connecticut situation where we don't have as a dire needs and shortages as some of the other parts of the.

01:04:44 Speaker 4

Three hour. So it's a national problem. It's coming our way. We are not hit as hard just yet, but soon we will be in about 10 years. So I think now is the time to address this because it takes a long road for training those and practicing physicians.

01:05:04 Speaker 4

And statistically speaking, most physicians practice within a 250 mile radius of where they're trained.

01:05:15 Speaker 4

Unfortunately, our radius in that zone gets us out of the state.

01:05:20 Speaker 4

So even though they may be training and practicing within New England, but they may not be necessarily in Connecticut. So I think it's the looking at the the national AMA numbers, I'm happy to share those with you. The statistics don't match the math just doesn't add up for certain specialties and certain needs that the communities.

01:05:42 Speaker 4

Rehab.

01:05:45 Speaker 1

Thank you. And doctor Cable, before we come to you, I just want to go to a couple comments in the in the chat function, I see a a comment from Mr. Kramer about the the geographic distribution that that maybe the aggregate numbers, it's echoing some of the points that have been made by others.

01:06:05 Speaker 1

That maybe the aggregate numbers reflect that, but geographic distribution and I'll note that throughout the plan that's been a real focus for OHSU and for ALTERUM to really think about not just the statewide number or even the regional planning area number.

01:06:25 Speaker 1

But but to really look at the geographic distribution amongst those, so as as Corey emphasized, you know we have to go.

01:06:34 Speaker 1

Guess what we can see in the data. So if there are better data, we're certainly happy to incorporate those. And Doctor Kay, you you referenced a couple of the bills from the last legislative session, the governor had Senate Bill 9 and OHSU had House Bill 5316. Each of those addressed.

01:06:54 Speaker 1

Various pieces around consolidation within the certificate of Need program. So just to flag those because you raised that in a comment, but I'll turn it over to you now.

01:07:08 Speaker 3

Before I made my comment they there, there was a those two bills were in the same hearing and and were testified jointly by UH by the two people I mentioned in there. So I want to do a little preamble here. I have a little different. I'm looking around. I think I have a little bit.

01:07:24 Speaker 3

Different.

01:07:24 Speaker 3

Perspective. Not because I'm a radiologist, but because I'm.

01:07:28 Speaker 3

Senior retired perhaps more of a consumer of healthcare and definitely more consumer healthcare than I was before and also a wider network of people who look to me for advice or confide in me or ask me questions.

01:07:42 Speaker 3

So.

01:07:46 Speaker 3

When I saw when I looked first looked at table 77.

01:07:50 Speaker 3

They said to me this it appears that the projected number.

01:07:55 Speaker 3

Versus the demand may be that the projected number is just the market operating market forces operating and that is that when when I get asked questions by friends and family about how they can get to see a primary care physician and they can't because they may even have one, but they can't get through.

01:08:15 Speaker 3

And but they can get easily through to to to some of the non physician providers that they have.

01:08:22 Speaker 3

So maybe it's not really out of whack if you add up the two columns, they're pretty close. In fact, I think when I first did it, it may be higher on the projected projected numbers of positions. Not to say that one's more productive than the other, and I don't have that perspective of practice that everybody else here does. So I think that's something that that the market.

01:08:41 Speaker 3

Maybe.

01:08:43 Speaker 3

At least in Connecticut, getting ahead of where people's expectations are and where our expectations are and where the entity that did that, that did that those projections. So I'll leave that to, I think that's something should be entered into the discussions because it seems to me there already has been and there's going to continue to be a.

01:09:05 Speaker 3

A shift of provider of the letters after our providers name as to what their responsibilities are.

01:09:14 Speaker 3

That's it.

01:09:15 Speaker 1

Thank you, doctor Mosdell.

01:09:19 Speaker 11

Thank you. I would just add something that I think doctor real kind of kicked off when I was looking at the report and I looked at 761, which is primary care trends, it was discussing primary care delivery away from primary care providers, office space space to retail clinics and urgent clinics. You know, I think a lot of.

01:09:35 Speaker 11

Folks have probably not experienced that as much. I know doctor Goldman makes a point.

01:09:41 Speaker 11

Of patients coming in for relationship building with primary care and longitudinal care. However, I think to the point of Doctor Kuros probably Doctor McGovern a little bit earlier as we move more towards collaborative care teams, which is happening and as we move more towards value based care which is happening to doctor Riddles point will probably end up with larger panels. And as we do that and the patients don't really understand that.

01:10:02 Speaker 11

I think that that.

01:10:03 Speaker 11

Kind of relationship starts to go away and you may see a shift back towards those retail clinics. And I think when that happens, that's when you start to see one probably less.

01:10:14 Speaker 11

Lots. Let's just say less good care occurring for the patient. But to the insurers, probably having more control as they kind of delve into those areas. So I think just something to think about as we're looking at that portion of the report, what's going to happen longitudinally is we try to make our adjustments to the value based care to the collaborative team model and can we push patients into areas that maybe we don't really.

01:10:33 Speaker 11

Want them to go?

01:10:39 Speaker 1

Thank you. So we are just about at the time that is set aside for public comment and we have approximately half of the folks on this call our general public members. So I do want to make sure that we.

01:10:56 Speaker 1

Open the floor and I want to invite anyone who may not be a formal member of the advisory group, but who has been listening and has any thoughts about.

01:11:09 Speaker 1

The topics of conversation that we've had, if if you would like to contribute any public comment please, you know you're welcome to go ahead and raise your hand as well and we can bring you into the conversation and and hear from you. But.

01:11:25 Speaker 1

While we see while we wait to see if there are any public comments we can, we can continue with the conversation of the advisory group, I don't think we need to fully put it on hold in the hopes of public comment.

01:11:48 Speaker 2

But if it's helpful, I can point us to another kind of area potentially around some of the other chapter sections of the chapter in Chapter 7 around unmet needs and gaps and services. I think we particularly call out here some of the health provider shortage area designations that have been made across the state.

01:12:04 Speaker 2

And and some areas specific to both behavioral health, primary care and maternity.

01:12:08 Speaker 2

Care curious if folks have similar or related comments to the way we've described the workforce more broadly, it will take back obviously the comments around 7.7, but some of the other data provided in this chapter, if it seems to ring true with your perspectives of of what is going on within the state related to the number of.

01:12:24 Speaker 2

Providers.

01:12:25 Speaker 2

And the the way that the hipster definitions.

01:12:29 Speaker 2

Which are health provider shortage areas again indicate that there are different parts of the state that might have higher levels of need and and how we're presenting that data as potential shortage areas going forward. So any of the comments or questions or or feedback related to those areas I think would also be particularly useful to us.

01:12:49 Speaker 4

So I can just make a comment may not be as specific to the the question that you posed, but again, I'm going to remind us all.

01:12:59 Speaker 4

Like you know, whose interests are we trying to protect here? If the answer is our communities, our patients, then we have to look over the same lens and with all these challenges that we're talking about, I think there's one other piece that I want to bring to our attention is the changing scope of practice.

01:13:19 Speaker 4

For so many different reasons. Again, you know there's a there are challenges that, you know, some of those things that you could have done that I can still do as a practicing independent primary care physician in my office.

01:13:34 Speaker 4

A physician in a large system may have to consult.

01:13:38 Speaker 4

An orthopedic surgeon for that knee injection that you could have done in the office.

01:13:42 Speaker 4

For that skin biopsy that you could have just done, a punk in your office. Now you have to send them to the dermatologist because the system decided that your office will not be stocked or your facility will not have access to the instruments that you may need to perform those in office procedures. And now linking some of those to.

01:14:03 Speaker 4

Limitations in training, like if you haven't done this in a few years, you're not gonna wanna do it and your skill set will not be the same. So to tie those into your comment about the maternity shortage areas, and if you look at the state of Connecticut past 10 years.

01:14:20 Speaker 4

Just for different reasons. Again, there's, you know, legit reasons, but look at how many maternity care units have closed.

01:14:29 Speaker 4

And what has the impact been on the communities they used to serve?

01:14:36 Speaker 4

So I'll just.

01:14:38 Speaker 4

Like, I will encourage us or this team to look at the impact to the consumer in that Community who happens to be the patient.

01:14:48

And.

01:14:49 Speaker 4

And we heard these stories all the time. And, you know, we hear from our communities who are getting impacted. So that business decision is made by the corporate entity, which may not have been in the best interest of that community, that the Community Hospital was established to serve.

01:15:09 Speaker 4

In the corporate structure, things did not meet certain thresholds for the care delivery mechanisms, but I'm what I'm trying to say is sometimes you have to be present for the greater good for the common good.

01:15:26 Speaker 4

But not only looking at the red, green and black on an Excel spreadsheet, so there are things that we have to maintain our focus for the very reason healthcare industry is.

01:15:43 Speaker 4

You know, we I feel we are privileged that we have a skill to help someone and then get paid for.

01:15:49 Speaker 4

Right, right. But if you, if you flip the script that we only looking at one piece of it, we may not be true to our focus where we belong. So I encourage every patient, every physician to ask yourself like who do you report to? I can quickly say report to my patients.

01:16:08 Speaker 4

So what I'm trying to say is like, you know, there may or may not be any conflict of interests, but there may be some conflicts when the system is designed to do X and when your focus is shifted.

01:16:24 Speaker 4

From helping the patient or helping the community, there will be consequences. Some of the consequences we're already seeing in the rural America, it's not as bad in Connecticut just yet.

01:16:37 Speaker 4

But we are headed towards it and it's a matter of time where we will have to, you know, be very, very mindful on the choices we make. So, you know, stop there, but it's a it's a question to ask whose interests are we trying to protect?

01:17:00 Speaker 1

Thank you.

01:17:08 Speaker 1

Any follow-ups or other thoughts on areas of unmet need across the state specific to some of these categories?

01:17:22 Speaker 2

I'm happy to jump off that last comment just a little bit around.

01:17:27 Speaker 2

Issues around changes in the way care is being provided and and one kind of specific threat of that is the potential adoption of telehealth. As we've seen during the COVID-19 pandemic and the way that that will continue going forward. And the way that that may impact both the provision of care and the utilization of the existing physician workforce, both I think has some potential benefits and some potential risks to it.

01:17:48 Speaker 2

I know there's a little bit of that in the primary care chapter. There's also a whole section on telehealth and Chapter 2 around broader.

01:17:53 Speaker 2

Friends curious of the way that we've described those trends as they're occurring within the state and whether or not you think we've actually accurately portrayed what's going on and how that might potentially impact care going forward.

01:18:08 Speaker 1

Yes, doctor Riddle.

01:18:10 Speaker 6

Yeah. Thanks. I actually thought you did a pretty good job summarizing, you know, the trends as it relates to telehealth. You're right, it's it's not going anywhere, it's.

01:18:20 Speaker 6

Around a little bit pre pandemic and the pandemic escalated. Certainly our need to be able to provide those services and and they're here to stay and so I I thought the report did a pretty reasonable job, you know, summarizing where we are. I think that one of the key items with telehealth which I believe your report does call out is the need to revise.

01:18:40 Speaker 6

Some of these state by state.

01:18:41 Speaker 6

State, you know, laws slash regulations surrounding where the physical patient is, where the where the provider is. You know, a lot of states right now have laws in place or regulations such that the provider must physically be in the same state as the patient in order to provide that telehealth service, which you know, on the face of things, you know.

01:19:02 Speaker 6

Vast majority of the time, sure. Would. You know, we're we're in the same place. But you know, we have, for example, our Snowbird population. You know, folks who are flying to Florida for the winter. And why wouldn't they want to be able to continue to see their PCP in a virtual way if they could, which we can't right now with these regulations. So I would love to see.

01:19:20 Speaker 6

Some regulatory change there that sort of broadens the scope of the ability to provide these telehealth services to larger populations because they do think that that is going to be necessary under the topic of technology. I did also want to bring up the topic of artificial intelligence. So I've attended, you know, a number of lectures recently.

01:19:41 Speaker 6

About AI and and how we're going to be using it and a statement that was made in one of those really resonated with me, which is that AI is not going to ever replace us, replace physicians or healthcare providers. But healthcare providers who do not use AI may be and I think that's really the way we need to sort of think about this.

01:19:59 Speaker 6

I think this is also an area where.

01:20:02 Speaker 6

Even nationally, I think you know, federally, locally, we really have an opportunity in front of us to think about how we're going to use AI to be thoughtful about it and think about how we're going to regulate that use. You know, there are very practical and beneficial applications of AI. So for example, when we talk about administrative burden for primary care clinicians.

01:20:24 Speaker 6

And other clinicians, you know, writing notes, for example, is a is an area of great promise for AI. So can that, you know, decrease our burden of, you know, needing to type or, you know, do these things if it can help us.

01:20:36 Speaker 6

Out there are also significant risks when it comes to AI in terms of clinical decision making and you know there and I I want to get into all of that on on this meeting. But I think we really have an opportunity in front of.

01:20:49 Speaker 6

Us.

01:20:50 Speaker 6

To be at the forefront of how we choose to handle that. Like I said, it's one of those things where you can't beat it.

01:20:57 Speaker 6

So we have to join it and we have to figure out how to make it work for us and a thoughtful and reasonable way.

01:21:09 Speaker 2

Thank you. I I think that discussion is definitely relevant here. We can continue to have that. I also note there's also a a technology section of the report that's kind of added on to the in the imaging and equipment and then new technology chapter that will be a separate advisory committee meeting a separate discussion. So there may be some relevant topics that can come up related to AI and that discussion as well, but happy to talk about where it relates to practices and workforce.

01:21:29 Speaker 2

Here today.

01:21:32 Speaker 1

And I will flag just on the telehealth piece, one of the places that, OH, S has heard a lot about that has been in the behavioral health context.

01:21:45 Speaker 1

And whether and to what degree telehealth providers should fall under various certificate of need requirements. So opportunity to provide thoughts there as well. Doctor Kay.

01:22:03 Speaker 3

Start to write a comment, but then realize it's probably a little bit too long for for for chat. So I I agree with Doctor Riddle that that we're in a new era with respect to telehealth and but and we need to, we're going to need to join it because we I'm not sure we want to beat it anymore.

01:22:21 Speaker 3

The It's come up numerous times over the years I've been involved in health policy in Connecticut and early on it used to be that.

01:22:30 Speaker 3

You.

01:22:31 Speaker 3

The confounding thing was the fact that the that that we states have licensure.

01:22:37 Speaker 3

And if you're going to be licensed in a state that you're not providing this where the different from where the patient is then.

01:22:48 Speaker 3

What's what's the sense of having a state licensure, a state medical board to approve these things?

01:22:54 Speaker 3

So perhaps at least maybe for the time being, we should consider matching the state licensure to the state of residency the the, the official state of residency of the patient.

01:23:08 Speaker 3

Ah.

01:23:09 Speaker 3

Just just a way to to to to streamline what is already happening and make it available for reimbursement to the physicians who take the time to take account the Telehealth Council and don't have to do it for free.

01:23:35 Speaker 1

Thank you. And doctor Ashman.

01:23:39 Speaker 1

Ohh, you're on mute.

01:23:43 Speaker 10

Sorry.

01:23:44 Speaker 10

So I was under the impression that if the doctor and the patient are residents of the same state, the Lauren, Connecticut says that you can take care of your snowbird patients without a problem as long as they're both reside in the same state.

01:24:01 Speaker 10

So no matter where, that's what we were told at one of our meetings at the Fairfield County Medical Association, one of the the lobbyists explained.

01:24:10 Speaker 10

That to us.

01:24:11 Speaker 10

So if I'm wrong, you can check the statute, but that topic came up at one of our meetings and we were informed that as long as we.

01:24:20 Speaker 10

Were both.

01:24:21 Speaker 10

Residents of the same state, you could take a patient no matter where they are in the United States.

01:24:28 Speaker 10

And as far as telehealth goes, I think it's a, it's a good thing in some ways and it's a bad thing in some ways, just like anything else that you have to deal with. I mean, it's good that a patient can have access to a physician if they live thousands of miles away from a physician. They can't get to that facility. You know, it's great.

01:24:47 Speaker 10

They can't get an appointment to a facility. It's great that they can. They can go on telehealth if it if you need it for triage. I know. With dermatology, it was during the COVID pandemic. It was a good thing. If somebody was able to triage a Melanoma, they would get the patient.

01:25:04 Speaker 10

Then, and despite the fact that there were other patients waiting, so you know there are good, good parts to that, some of the bad parts to it or or things that we might not care to have happen is a lot of antibiotics or or issued over telehealth or a doctor may not know a patient who calls up and asks for.

01:25:26 Speaker 10

Sabbaticals that go out and you worry.

01:25:28 Speaker 10

About.

01:25:28 Speaker 10

Creating resistance to these substances because it's given out too.

01:25:32 Speaker 10

Much or I have acne patients that are getting medicine from doctors they've never seen to treat their acne and they don't. They have no idea about the background of these patients. Also you want to have the information get back to their to their original physician. So if my patient sees someone out of my practice, I would like to know.

01:25:53 Speaker 10

What was done to treat them so I could add it to their record and I know how to move forward on treating them myself, or if they had a treatment which I thought wasn't appropriate. I could get back to the patient and say.

01:26:04 Speaker 10

You know, understand this telehealth person advised you in a certain way, but I think it it would be to your benefit to take this line of treatment instead. So you know, you could make rules and regulations to try to adapt to all the good parts and bad parts of telehealth.

01:26:24 Speaker 10

As far as psychiatry goes, they have a lot of psychiatry.

01:26:26 Speaker 10

She colleagues who loved telehealth, they do a lot of their treatments through telehealth with their patients. So in in that respect, it's probably better. And if there is a shortage of psychiatrists and this expands the ability of patients to get.

01:26:46 Speaker 10

Health it would be beneficial to the patient to get a psychiatrist, to be willing to see them, so there are pluses and minuses like everything else, with anything that we deal with and you just have to work around everything to make it the best possible solution for our patients.

01:27:12 Speaker 1

Yeah, and thank you. And Doctor Kay to your uh comment in the chat, Corey and I met with the Department of Public Health regarding telehealth and licensure requirements. I will just note that.

01:27:29 Speaker 1

That uh, that is handled by the Department of Public Health through their licensure requirements rather than OHS. So we will, we will leave that for them to specify. It is complicated. There has been a lot of change.

01:27:49 Speaker 1

UM.

01:27:51 Speaker 1

Specifically, it's it's bounced back and forth with which types of providers were able to do telehealth in various contexts, and there was a statutory change. I don't know, Cory, if you have the statutory change at your fingertips, but we did go over what is.

01:28:10 Speaker 1

In the plan with the Department of Public Health to ensure that what was presented was accurate.

01:28:19 Speaker 1

But what the point of the plan here is just to describe the current trends in telehealth, highlight some of the key issues one of them being licensure and how that affects the ability of practitioners to be able to offer services and to whom they can offer those services.

01:28:38 Speaker 3

But shouldn't we know that?

01:28:40 Speaker 3

Shouldn't this body know what the answer is, what the current law is?

01:28:44 Speaker 3

And shouldn't the directors of the EMG and Hartford Healthcare Medical Group and all those things know be have that information from from us so that we they can bill appropriately when they?

01:28:57 Speaker 1

Yes, and I see a couple hands. So it looks like we may get some additional feedback back from McGovern.

01:29:06 Speaker 9

So yes, we're we are totally on top of these rules and educate our clinicians about it. But the state of Connecticut cannot dictate what the state of Florida permits and the state of Florida, you have to register to do telehealth there. You can have a license from another state and then you just have to register, but you must do that to.

01:29:26 Speaker 9

Uh be permitted to provide a telehealth service to a patient who's located in Florida. It doesn't matter if they live the rest of the year in Connecticut, and every state has different rules. So this is complicated. And as you point out, the rules are constantly changing.

01:29:40 Speaker 9

And we constantly are refreshing this guidance to our clinicians, but it's really the state the patient is physically located in, they dictate who and who cannot provide telehealth services.

01:29:54 Speaker 1

Thank you. And doctor Acosta, did you have something to add to that?

01:29:59 Speaker 7

No, I was just the same. You you do have to register in the state. We had a couple of concierge doctors that have many patients that go down to Florida for the winter and they felt that it was a very simple process.

01:30:11 Speaker 7

Not onerous at all. It's simple to do it, but you do have to register with the state.

01:30:15 Speaker 9

I put the link in the chat says it right there. How to do it?

01:30:20 Speaker 1

Thank you. And doctor Riddle.

01:30:22 Speaker 6

Yeah, it was just, I mean, it's more of the same, but you know, I doctor Mcgovern's correct, these rules are a little complex and it varies state by state. So we do keep on top of it. We have a telehealth team that does telehealth visits and we maintain clinicians on that team who are licensed in Connecticut, but also Rhode Island, mass in New York because we have a lot of patients in those border areas. So we need to make sure that.

01:30:44 Speaker 6

You know, we have the appropriate.

01:30:45 Speaker 6

Folks in place. So anyway, it it gets a little complex. But you know, I think the overarching point here is that if this could be simplified in some way, maybe there would need to be a federal regulation. I'm not really sure, but it is complicated and and unnecessarily so. And in my view.

01:31:05 Speaker 1

Thank you.

01:31:14 Speaker 2

That was all really helpful. Boyd. I'm having to jump us to maybe another topic of interest. I'll I'll point folks to because I know I didn't put this on the list today, just Section 3 point 3.4 of the facility and services plan, which is actually in the acute care section. But I'm calling it out because it's another area where we talk about.

01:31:29 Speaker 2

Primary care and the impacts of the availability of primary care and the way that there are knock on effects of potentially not having adequate primary care or physician workforce. And the way that that potentially triggers avoidable emergency department visits.

01:31:42 Speaker 2

Curious for folks that have taken a look at this section of if our treatment of that kind of topic is is valid and if that's kind of a valid topic for us to bring up in the facility and services plan. We're at large. We tried to provide as much data as we could linking the two topics. I think we talked more qualitatively about how this is a potential impact of shortages of primary care and.

01:32:01 Speaker 2

And primary care physicians within the state, we don't have a lot of direct data to then show how that may contribute to avoidable emergency department visits. But kind of show the two trends Co occurring within the state. So curious thoughts of the presentation of that data and that topic more generally.

01:32:16 Speaker 1

Thanks, Corey. And as we turn to Doctor Riddle, I will remind everyone if you're a member of the public, you are still invited to participate in the conversation. So go ahead and use the raise hand function if you'd like to join the conversation, go ahead, Doctor Riddle.

01:32:32 Speaker 6

I was. I was just curious what what criteria are you using for avoidable ER visit. That was one of the questions I wrote down when I was reading through.

01:32:42 Speaker 2

Yeah, it's it's a good question and it's based on an OS methodology and I can go back and look because I don't think it's cited there and it's a good point that we should describe that in more detail. It's based on a A claims definition that's trying to identify specific types of Ed visits that are avoidable based on the diagnosis and the and the procedures that are provided. But I don't have it off hand of what was used in that and we should include that in the report.

01:33:04 Speaker 2

So I'll make note of that and we can add that there.

01:33:27 Speaker 1

Any other thoughts on the acute care section? I know this one in particular the the physician practice group kind of spans several topics and to ask folks to have read the entirety of the plan in the shortest amount of time. I I recognize the.

01:33:46 Speaker 1

The difficulty in that so as I mentioned, we will have more opportunities to comment on the plan.

01:33:54 Speaker 1

Writ large, and I do have a slide to show as we start wrapping up. Once we start wrapping up, I have a slide to show the additional meetings that we have. So we'll make sure that folks have that on their radar.

01:34:18 Speaker 2

Yeah, we're going to open it up to to anything else that we've missed that we haven't talked about yet. Wait, I think we've covered most of the specific questions that I had in.

01:34:24 Speaker 2

These in these uh sections here. Yeah, Mr. Kramer.

01:34:28 Speaker 12

This this whole concept of avoidable emergency visit intrigues me and I think it has to do with what?

01:34:37 Speaker 12

Alternate services are available in markets.

01:34:41 Speaker 12

And it also speaks to the availability of an appropriate number of primary care physicians who actually have visits available during normal hours of operation.

01:34:52 Speaker 12

So I think it's it's difficult for me to fathom that any visit to an emergency department would be considered avoidable without looking specifically at the availability of reasonable alternatives. And if we look in particular at the availability of services in the northeast corner of the state.

01:35:15 Speaker 12

There is a paucity of.

01:35:16

Of.

01:35:17 Speaker 12

Urgent care available options. There are not enough primary care offices open during daytime hours and as a consequence there there's often times only the option that a patient who is.

01:35:34 Speaker 12

In acute distress and we can debate the term acute.

01:35:39 Speaker 12

Significantly, but.

01:35:41 Speaker 12

If there is a need to go somewhere, oftentimes the emergency department at day Kimball is the only option that they have. During times when things are reasonably available. So I think we need to be very cautious about how we couch the term avoidable.

01:35:57 Speaker 12

Because it has to do just as much with what else is available.

01:36:08 Speaker 1

Thank you. That's helpful. And we can provide some more context for that framing.

01:36:24 Speaker 1

So I I.

01:36:25 Speaker 1

I think as Corey said, we've we've hit on most of the discussion topics that we.

01:36:32 Speaker 1

Had so we, you know, #7 other comments of feedback, you know, this is really any additional thoughts or ideas that came up as you reviewed the plan, this is the forum in which to raise those doctor Kay.

01:36:52 Speaker 3

Yeah. So.

01:36:55 Speaker 3

There's a there's a there's a something of there's a void in where I think I thought we might go here and that is related to the table 7.7. You know, I made some, but I thought might be provocative comments and I really didn't get much in terms of much response in terms of.

01:37:13 Speaker 3

You know where is primary care? I don't need primary care physicians. I mean, where is the primary care patient?

01:37:20 Speaker 3

Going when we see that disconnect between the projected numbers in total versus the individual lines.

01:37:30 Speaker 3

And maybe it's just that's the way it's going to be and maybe that's not inappropriate because when our served on Governor Lamont's transition team for healthcare and brought it up back then that.

01:37:46 Speaker 3

Primary care physicians may just be the quarterback of a team or the OR the head coach of a team who has responsibilities appropriate to their training and can grow into it and thereby perhaps provide a better.

01:38:02 Speaker 3

A better.

01:38:04 Speaker 3

Better delivery of of primary care services. Now I know that's in some organized medical medicine associations. That's a third rail kind of a topic.

01:38:15 Speaker 3

But if we really want to be honest with ourselves and also as doctor Guman says, who are we serving here? I don't think we're serving patients really well when they can't get in touch with it when they have their expectations of speaking to the doctor are not met.

01:38:33 Speaker 3

And it's an extremely frustrating thing for for patients of whom I'm aware now much more than I used to be when I was a radiologist. So. So I think that that that may be an elephant in the room, something we don't talk about. So we build a Moat around, I don't know, but what is the vision for primary care in the future? And I don't read enough.

01:38:54 Speaker 3

About the.

01:38:54 Speaker 3

To to to to know what's being discussed.

01:39:01 Speaker 3

And if we don't discuss this here, what are what are we going to, you know, where is this going to be discussed?

01:39:11 Speaker 1

Doctor Riddle.

01:39:12 Speaker 6

So I think the vision, at least in my view of primary care going forward is exactly what you talked about, which is utilizing primary care.

01:39:22 Speaker 6

Clinicians, physicians in particular, but of course advanced practitioners, pharmacists, nurses, you know, I think that the the trained primary care clinicians need to be the quarterback of the team. You know, I think in utilizing all of these, you know, different technology, resources from AI to telehealth is retail clinics. I mean, you know the whole picture, I think we can build a support.

01:39:43 Speaker 6

Network around our patients, it's going to look a little different than what we have right now. But I think if we don't utilize all of those resources that are available to us, we're going to keep doing the same thing we're doing over and over right now, which is in this.

01:39:58 Speaker 6

You know, sort of race that we all find ourselves. I was going to make a comment related to preventive services. I noticed it was towards the end of the primary care chapter. I think in the report about risks to coverage. So there's a case, I think in Texas. You had mentioned that was brought, you know looking at.

01:40:07

There.

01:40:20 Speaker 6

No longer providing preventive services as outlined by the US Preventive Services Task Force.

01:40:27 Speaker 6

And you know, under the Affordable Care Act, something that, you know, our population has come to enjoy over the past number of years here. And. And I do think that's a risk because.

01:40:38 Speaker 6

You know, paying attention to preventive care, of course, you know, prevents a lot of disease down the road. It's a better way to handle things, both in terms of outcomes, but also in terms of cost. I do think that while there are a lot of pluses to maintaining coverage to those preventive services, the concept of the annual physical is something that we've really been.

01:41:01 Speaker 6

Thinking about in our healthcare system because.

01:41:03 Speaker 6

Is prior to the inception of the Affordable Care Act. You know, if you go back a number of years, many insurance plans you know would cover the annual physical based on your age. You know, if you're young and healthy, you don't need to have a physical every year. Maybe you get one every 345 years. You know, if you're over 50, probably need to get one.

01:41:24 Speaker 6

The year the Affordable Care Act, you know, sort of guarantees everybody this this annual physical every year. And I think it's a great idea. But in practicality what it has done and I think this speaks to some of our access issues and thinking about that you know how we need to think about things a little differently. You know, if my schedule as a primary care clinician.

01:41:45 Speaker 6

It's clogged up with every 25 or 35 year old who thinks they need an annual physical every year I do nothing but annual physicals every day all day. That's all I would do. And the reality is, is that my services are needed, you know, to take care of my sick patient who has congestive heart failure and COPD and kidney disease.

01:42:04 Speaker 6

And so I think, you know from a policy perspective, you know, thinking about how we handle those preventive services and what's appropriate for people and what's truly evidence based, you know, is important so that we can get the right patients to the right provider for the right kind of care and then perhaps utilize other care team members if we really want to provide some of those other.

01:42:25 Speaker 6

Types of services, so it's a long winded answer but the the topic of the preventive care you know particularly like I said, the annual physical is something that I think was highlighted in that section.

01:42:37 Speaker 6

Of the report.

01:42:43 Speaker 2

Thank you. That's good feedback. We can, we can think about that a little.

01:42:55 Speaker 1

Anyone else have thoughts, either general comments or UM?

01:43:00 Speaker 1

Responses to Doctor Kaye.

01:43:02 Speaker 1

'S.

01:43:03 Speaker 1

Question about the how we view the future of primary care and what we how we expect for that to be provided and delivered.

01:43:16 Speaker 1

Doctor kuros.

01:43:19 Speaker 8

Yeah, I'll just add in as I look at Table 7.7 and I, I didn't have this thought when I was reviewing it initially.

01:43:27 Speaker 8

To think in specific terms about the other team members that belong there. In my view, clinical pharmacists are probably on that list. That hasn't really been a topic that we've raised today. I think integrated behavioral health providers are probably on that list.

01:43:47 Speaker 8

And so.

01:43:50 Speaker 8

You know, maybe in some written comments down the road, I could develop that thinking and where maybe others would would agree or or have different ideas. But I I think that's part of how we think about this.

01:44:04 Speaker 8

This model of care in the future is having having more frequent ready immediate collaboration with team members that would include those two as examples.

01:44:21 Speaker 1

Thank you. And I and I appreciate the calling back to written comments that's going to be an important part of this process and I hope that at the very least this conversation is getting some of those.

01:44:35 Speaker 1

Creative energy flowing and and people will will reflect on this conversation and and continue to think about their comments. Doctor Ashman.

01:44:46 Speaker 10

That was going to go back to Chapter 3, where you took us in and you have the inpatient bed capacity section there and you, you give one line at the end to psychiatric maternity service lines. And I I think it's important, especially for the psychiatry admissions.

01:45:06 Speaker 10

To have the space to admit people who are in dire need of seeing a psychiatrist.

01:45:13 Speaker 10

And they're locked down units, a lot of them. So it's more difficult to expand the capacity of beds that you can have for these patients. So I think you know that something has to be done so that maybe hospitals have the ability to expand the number of beds for these particular patients.

01:45:33 Speaker 10

In in the venue that they need to be taken care of.

01:45:40 Speaker 2

Yeah. Thank you. There will be definitely opportunity to talk about the rest of chapter three. I think I called out that specific section related to the primary care workforce and the impacts on on Ed visits, but definitely opportunities both in our behavioral Health Advisory Committee to talk about behavioral health issues and and certainly the overlay of that within the acute care and and that need topics as well. So I'll pause on that for today and and we can certainly have those conversations in the in the subsequent meetings.

01:46:02 Speaker 2

Void. I'm sure you'll share those those dates.

01:46:04 Speaker 2

With folks? Yep.

01:46:06 Speaker 1

The bed need is July 29th. That one I know off the top of my head.

01:46:19 Speaker 1

Other general comments, I know everyone will have an opportunity to submit in writing, so if if that's all that we have for today, we don't have to stretch out to our full time. But we did want to make sure that we.

01:46:33 Speaker 1

Had ample time.

01:46:34 Speaker 1

For anyone who wanted to share.

01:46:38 Speaker 1

I will go ahead and share.

01:46:44 Speaker 1

I hope.

01:46:48 Speaker 1

Am can folks see this slide now? Yep. These are our additional advisory body meetings.

01:47:01 Speaker 1

First up to do.

01:47:03 Speaker 1

So we appreciate you all being willing to to step in first.

01:47:13 Speaker 1

And coming up I am getting a repeated message that says Zoom quit unexpectedly. So if I disappear, I provide my sincere apologies. We'll have our behavioral health coming up on Wednesday. Next week, we'll turn to cardiac services.

01:47:34 Speaker 1

Reproductive health, which with with a large focus on labor and delivery services, which has been a key issue in the state and imaging all three next week imaging services broadly, MRI CT scanners and the like and and then we'll wrap up in the last week of July.

01:47:55 Speaker 1

With the acute care and inpatient bed need methodology that we just discussed.

01:48:01 Speaker 1

And.

01:48:03 Speaker 1

Our last session on that Wednesday is just intended to be a general overview and comments session, largely for the public, but for any advisory group members who through the process come up with additional ideas, we welcome you back to that session to provide any other thoughts and commentary.

01:48:24 Speaker 1

The goal here comments are not due until the end of September for written comments.

01:48:30 Speaker 1

The goal was to have all of our stakeholder advisor group meetings early in the process get those done in July so that you then have time to reflect on those conversations and incorporate in your writing as you wish. So that was our thought on timing, we're.

01:48:48 Speaker 1

3rd If if anyone's participating in future meetings, we're we're trying to establish some hybrid locations so that folks can come in person if they wish, but it turns out.

01:49:00 Speaker 1

That booking booking places for people in the summer can be a challenge, so we'll we'll try to accommodate as many folks as possible to hear as many viewpoints as possible.

01:49:12 Speaker 1

So if no one has any further comments at this time, I I will note that Doctor Guman has been sending some studies in. So thank you for that. If anyone else has, along with comments, we welcome peer reviewed literature data sources, things like that as Corey kind of mentioned. So we welcome those submissions.

01:49:32 Speaker 1

As part of your comments as well.

01:49:34 Speaker 1

So thank you all very very much for coming. I have learned a lot from all of you and this has really been an important session as we look to move this forward. So thank you all very much.

01:49:47 Speaker 4

Thank you.

01:49:49 Speaker 7

Thank you.