

## **PRIMARY CARE PROVIDER ADVISORY COMMITTEE**

### **Meeting Minutes, November 16, 2005**

*Members in Attendance:* Jeffrey Borkan, MD, PhD, PCPAC Chair; Munawar Azam, MD; Stanley Block, MD; Sandra Boehlert, MD; Mark Braun, MD; Robert Crausman, MD, MMS; Charles Eaton, MD; Sarah Fessler, MD; Michael Fine, MD; David Gifford, MD, MPH; William Hollinshead, MD, MPH; Victor Lerish, MD; Sharon Marable, MD, MPH; Mark Schwager, MD. *Guests:* Andrew Arntstein, MD; Celia Gomes McGillivray, RN, MPH, CHES; Leonard Mermel, DO; Amy McIntyre; Chris Tanguay. *HEALTH:* Deborah Fuller, DMD; John Fulton, PhD; Deborah Pearlman, PhD; Patricia Rajotte; Maureen Ross, RDH, BS; Bill Waters, PhD. *PCPAC Staff:* Carla Lundquist; Rebecca Stokes.

*Unable to Attend:* Herbert Brennan, DO; L. Anthony Cirillo, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Ray Maxim, MD; Omar Meer, MD; John Murphy, MD; Donya Powers, MD; Richard Wagner, MD; John Young.

- *The leadership and coordination of pandemic flu preparation and response efforts should be provided by HEALTH, although hospitals may be used as field offices to decentralize operations and provide additional experienced management personnel.*
- *The hospitals identified as coordinating centers for their regional catchment areas should work together with communities, health centers, urgent care centers, and primary care leadership and organizations to manage the regional pandemic response.*

Dr. Borkan opened the meeting at 7:35 AM. Minutes of the October 19, 2005 meeting were approved as written. Dr. Borkan briefly reviewed primary care academy representation on the committee (Dr. Lerish for AAP, Dr. Fessler for AFP, and Dr. Boehlert for ACP) and noted that ACOG and RIMS representation is needed. Dr. Gifford stated his goal that PCPAC function as the forum for HEALTH and other state agencies to bring issues before primary care physician leaders, to avoid formation of parallel groups. It is important that the committee have the involvement of and communications with all RI primary care academies and the RI Medical Society.

Pandemic Flu Preparation and Response Planning: Dr. Waters provided a pandemic flu background document with statistics on the expected state impact, and outlined HEALTH's internal and external partners collaborating on a draft plan for submission to Governor Carcieri by December 20<sup>th</sup>. HEALTH is working on a decentralized approach to preparation and response using hospitals as regional coordinating hubs in their catchment areas for all health care delivery, working together with community health centers and primary care practice groups. Hospitals were selected to act as local health departments since HEALTH does not have the manpower to coordinate all activities statewide and hospitals have experienced staff distributed regionally. PCPAC members voiced concern over use of hospitals to coordinate care delivery during a pandemic, since hospitals are not regarded as authorities by primary care providers and an increasing number of PCPs do not have strong ties to hospitals. The committee felt that leadership and coordination of pandemic flu preparation and response efforts should be provided by HEALTH.

Dr. Arntstein and Dr. Mermel discussed the expected impact of a pandemic on the state, the anticipated age distribution, and the rapid exhaustion of hospital surge capacity and ventilators. The numbers of expected ill in a full-blown pandemic point out the problems of providing care and maintaining operations of government, business, and society with a greatly reduced workforce. The need to coordinate with primary care physicians will be critical since the majority of those taken ill will require outpatient treatment, not hospitalization. Current models of practice will not be workable in a pandemic, necessitating radical changes in provision of health care.

Dr. Fine noted that primary care practices might have more functional surge capacity than hospitals, since they may be able to expand their hours of operation and/or defer non-urgent patients. The preparation and response plan must organize as many primary care providers as possible, provide appropriate training, and secure commitments to participate in the emergency structure prior to an emergency situation, possibly using the Medical Reserve Corps. Primary care practices with personal protective equipment (PPE) capability should be identified, and all practices should be coded to maintain separation of infected patients. Maintaining the maximum number of practices open, and utilizing licensed health professionals from closed practices at other sites is essential. A major issue in keeping practices open is staffing; many health care workers will fall ill, need to care for family members, and/or may perceive the work environment as too risky. Staff instruction in PPE use and infection control measures may help mitigate the risk perception.

Public schools closed to minimize disease spread may be used as field hospitals/clinics, with staffing pre-assigned/volunteers committed. These surge sites should be pre-designated in each community to assess equipment/supply/staffing needs at the most basic level, since a true field hospital (100-bed) would cost \$1 million. A plan for public/private funding of pandemic costs must be developed to address the significant costs of preparation for a pandemic and the major costs of an outbreak. HEALTH legal staff are working on defining the State and HEALTH emergency powers that would be invoked during a pandemic. HEALTH's emergency powers should address legal and regulatory easement of legal liability, standards of care, extent of testing, and use of recently expired medications during a pandemic.

Dr. Crausman emphasized the importance of educating the medical community in preparation for a pandemic. Education opportunities should be made widely available to health care professionals detailing: (1) the scope of a pandemic flu outbreak; (2) office practice preparation and operation during a pandemic; and (3) the state pandemic flu preparation and implementation of the response mechanism. Educational drills may enhance preparation and training for pandemic flu in addition to lectures or web-based training.

PCPAC members made specific recommendations on the organization of the statewide pandemic flu preparation and response, and the training of health professionals (PCPAC Advisory dated December 15, 2005, attached).

**NEXT PCPAC MEETING WEDNESDAY, DECEMBER 21, 2005**



## Rhode Island Primary Care Provider Advisory Committee

*“Advising the Director of Health and the Office of Primary Care on  
programmatic and policy issues that support primary care in Rhode Island.”*

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Richard Hillman, MSW  
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Victor Lerish, MD  
*Barrington Pediatrics*

Ray Maxim, MD  
*University Medical Group*

Omar Meer, MD  
*Internal Medicine*

John B. Murphy, MD  
*Rhode Island Hospital*

Donya Powers, MD  
*Partners in Family Healthcare*

Mark Schwager, MD  
*University Medical Group*

Richard Wagner, MD  
*RI MHRH*

John Young  
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December 15, 2005

David Gifford, MD, MPH  
Director  
RI Department of Health  
3 Capitol Hill  
Providence, RI 02908

Dear Dr. Gifford,

At the November 16, 2005 meeting of the Primary Care Provider Advisory Committee, members discussed Pandemic Flu Prevention and Response in RI. The Committee is pleased to provide the following response and recommendations to HEALTH in support of its efforts to create a statewide plan for pandemic readiness. The committee recognizes that these recommendations may overlap the plans currently in development, but felt it would be useful to present the conversation highlights as a whole. These comments are an attempt at a consensus statement from all PCPAC members. The major discussion areas were the organization of the statewide response and the training of health professionals.

### Organization of Health Care to Respond to Pandemic

The state has chosen to use hospitals as health department field offices to decentralize operations and provide additional experienced management personnel. While the members of PCPAC can understand the desirability of this approach, they generally feel that the leadership and coordination of pandemic flu preparation and response efforts should be provided by HEALTH. This is due to a variety of reasons, ranging from the need for central organization to the fact that an increasing number of primary care and other providers do not have strong ties to hospitals.

Should the chosen approach be that of decentralization, we suggest that the hospitals identified as coordinating centers for their regional catchment areas work together with communities, health centers, urgent care centers, and primary care leadership/ organizations to plan/coordinate/manage the regional pandemic response. For this to succeed, the roles of professional societies and organizations in this collaboration must be defined.

Primary care offices may have a greater capability than hospitals to redirect their efforts to focus specifically on pandemic flu outpatient care. The surge capacity of primary care practices should be utilized to mitigate hospital overload. Postponing well visits/preventive care/chronic disease management, and expanding office hours may expand primary care surge capacity.

Public schools closed to minimize disease spread may be used as field hospitals/clinics, with staffing pre-assigned/volunteers committed. These surge sites should be pre-designated in each community to assess equipment/supply/staffing needs.

A flu pandemic will require a fundamental shift in the organization of health care to a public health mode. To meet the surge in demand and maintain as many outpatient care sites as possible, the state must be able to utilize available licensed professional staff from office practices that have closed to staff surge sites and support practices still open. Points for consideration:



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- The preparation and response plan must organize as many primary care providers as possible, provide appropriate training, and secure commitments to participate in the emergency structure prior to an emergency situation.
- Consider using the Medical Reserve Corps to organize, train, and direct participating providers. Inclusion of incentives may encourage volunteerism. Medical, nursing, and other health professions students also may be mobilized to help staff surge sites.
- The structure must provide for off-hours coverage to avoid emergency room overuse and to keep the non-infected out of hospitals and should provide a mechanism for practices to collaborate regionally to ensure patient coverage. The plan template must be flexible to accommodate community differences and responsive to the specific cultural and linguistic needs of each community.

Designate primary care settings with personal protection equipment (PPE) stockpiles in each catchment area. Establish call groups and code practices for sick or well visits either within or between practice groups. Identify the level of care available, PPE-capable practices, and how codes will be invoked. Urgent care centers may also be coded to separate influenza-like-illness (ILI) patients from non-ILI patients.

The operational plan should address how immunization would be implemented should a vaccine become available close to the onset of a disease outbreak. Public immunization clinic sites, staffing, and protocols should be pre-established to maintain separation between sick and well patients.

A plan for public/private funding of pandemic costs must be developed to address the significant costs of preparation for a pandemic and the major costs of an outbreak.

- Basic infection control supplies/equipment and preparation may be the responsibility of individual office practices for their sites/providers, but the closed schools which may be used as hospital surge overflow sites or public clinics will need to be appropriately stocked, and will not have the physical infrastructure of physician offices.
- Unfunded educational mandates are difficult to implement and will not result in an adequately trained workforce.
- The RI Area Health Education Center is federally funded to establish infrastructure to provide continuing education to health care professionals.

HEALTH's emergency powers should address legal and regulatory easement of legal liability, standards of care, extent of testing, and use of recently expired medications during a pandemic.

### Medical Community Education

The health care community in the state will require education on the impact of a pandemic flu outbreak, preparing office practices to operate during the outbreak, and participation in the state plan for prevention and response. The availability of education opportunities should be widely publicized among health care professionals.

Education on the scope of a pandemic flu outbreak should:

- Convey the expectations of morbidity and mortality, age distribution, seasonality, rapid exhaustion of hospital surge capacity, number of outpatient visits, and the need to look beyond the existing infrastructure to meet anticipated demand.



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- Explain the necessity for a fundamentally different approach to providing care in a prolonged emergency situation, and that the models and standards of care now used will need to be adapted.

Education on office practice preparation and operation during a pandemic should include:

- Guidelines on assessing office surge capacity, maximizing available time for flu patients (possibly by expanding practice hours), deferring non-urgent patients, and separating influenza-like-illness patients from others.
- HEALTH recommendations on stockpiling personal protective equipment (PPE) including quantity per provider, office signage, preparation steps to be taken now, infection control measures, and staff orientation.
- The proper use of PPE and infection control procedures to prevent disease spread, and the necessity of following the protocols despite the associated costs.
- The effectiveness of measures to reduce risk for health care workers and the need to reduce perception of risk to personnel and their families to ensure sufficient staff will be available to operate the practice.

Education for the health care community about the state pandemic flu prevention and response plan should include instruction on the preparation and implementation of the response mechanism. Educational drills may enhance preparation and training for pandemic flu in addition to lectures/conferences/web-based training.

*Response Preparation Training* should include:

- The scope of State/HEALTH emergency powers and the plans that will be invoked during a pandemic.
- The hierarchy of authority and official channels of communication that will be in effect.
- How health care professionals will be enrolled as respondents
- How primary care practices will be coded for pandemic response
- How call groups will be identified and implemented

*Response Implementation Training* should include:

- How to get instructions & status reports, report office closings and availability status of health care professionals, and access information for the public/patients.
- How, where, when and to whom to report to staff surge sites/open practices

I trust that this advisory information will be useful in development of the state pandemic flu prevention and response plan. The Committee and I look forward to reviewing the draft document and continuing to work with you in a productive manner that will improve the health of the people of Rhode Island.

Jeffrey Borkan, MD, PhD  
PCPAC Chair