

# **PRIMARY CARE PROVIDER ADVISORY COMMITTEE**

## **Meeting Minutes, December 21, 2005**

*Members in Attendance:* Jeffrey Borkan, MD, PhD, PCPAC Chair; Munawar Azam, MD; Stanley Block, MD; Mark Braun, MD; L. Anthony Cirillo, MD; Robert Crausman, MD, MMS; Sarah Fessler, MD; David Gifford, MD, MPH; Arnold Goldberg, MD; William Hollinshead, MD, MPH; Victor Lerish, MD; Sharon Marable, MD, MPH; Richard Wagner, MD. *Guests:* Andrew Arntstein, MD; Solmaz Behtash, MD; Emily Garber; Paul George, MD; Celia Gomes McGillivray, RN, MPH, CHES; Ellen Mauro, RN, MPH; Amy McIntyre; Chris Tanguay; Robert Trachtenberg. *HEALTH:* Becky Bessette; John Fulton, PhD; Bill Waters, PhD. *PCPAC Staff:* Carla Lundquist; Mary Anne Miller, RN, MPH; Rebecca Stokes.

*Unable to Attend:* Sandra Boehlert, MD; Herbert Brennan, DO; Charles Eaton, MD; Michael Fine, MD; Ellen Gurney, MD; Ray Maxim, MD; Omar Meer, MD; John Murphy, MD; Donya Powers, MD; Mark Schwager, MD; John Young.

### **Key Points**

- *The involvement of primary care providers in the pandemic response plan is critical to its success.*
- *Primary care providers need to be provided with details of the obligation implied by volunteering to participate and the structure of the pandemic response plan. Such essential information is necessary to promote participation and ranges from a delineation of personal risk, to how they will be compensated for participating at hospitals, alternative care sites, or other practices, to what equipment will be available. Few providers will be able to volunteer for any length of time, given the various constraints.*
- *Two-way communication with providers and coordination of open/closed primary care practices will be key to deciding how to staff Alternative Care Sites and how to best match the geographic need to available resources. The infrastructure/staffing/equipment needs to fulfill this function must be defined.*

Dr. Borkan opened the meeting at 7:36 AM, welcomed Dr. Paul George and Dr. Solmaz Behtash, Family Practice residents joining the Committee, and noted that the Chief Resident in Internal Medicine/Primary Care at RI Hospital has also been invited and will be attending in the future. PCPAC is still seeking ACOG representation, as well as a resident from Pediatrics, interested in primary care. The minutes were briefly reviewed and accepted as written (motion by Dr. Block, second by Dr. Braun, all in favor).

**RI Pandemic Influenza Plan (Draft):** Following up from the November meeting discussions of the organization of health care in response to a pandemic, the committee sought to address specific questions regarding PCP participation, mobilization, and the educational and training efforts needed. Dr. Gifford commented on the need for input from the PC community and noted the key efforts of Dr. Cirillo in putting the report together, along with Dr. Waters, Dr. Fulton, and many other HEALTH staff members. Dr. Cirillo provided an overview of the plan.

### **Pandemic Response Strategy Overview**

HEALTH/EMA will work together to provide overall direction of pandemic response activities. The goal will be to slow down disease spread and to manage those who become ill. Hospitals have been assigned as coordinating field offices for defined regions. Hospital beds will be reserved for Influenza-Like Illness (ILI) patients in need of ICU-level care and those with other illnesses. ILI patients not in need of ICU-level care will be redirected to other sites, including:

- Primary care practices –as many practices as possible will be kept open for as long as possible, by hospital-coordinated redistribution of personnel and supplies
- Alternative care sites (ACS) – solely for treatment of ILI patients, to be located at closed public schools, coordinated by the assigned hospital for the catchment area, staffed by PCPs whose practices have closed, as directed by the coordinating hospital

### **Plan Structure**

The state is divided into 10 regions assigned to coordinating hospitals. Each region will have its own Emergency Operations Center (EOC) staffed by EMA and HEALTH personnel, to provide communications and mobilization of resources across the regions, since the impact may not be uniform across the state. State agencies will track disease spread statewide to inform redistribution of resources. The hospitals will work directly with HEALTH to fulfill public health functions and keep primary care sites open for as long as possible.

Current planning directs all inpatient pediatrics to Hasbro/RI Hospital. RI Hospital is assigned a proportionately smaller bed to population ratio so some adult beds can be used for pediatric inpatients. Negotiations with Hasbro/RI Hospital to finalize this plan are ongoing. Women & Infants, Butler, and Bradley Hospitals will not have regional assignments due to their specialty nature.

It will be essential to maintain open pharmacies and pharmaceutical supply chains for chronically ill non-ILI patients. Pharmacy safeguarding has been earmarked for a special planning process involving HEALTH, the Pharmacy Board, major chains, and independent pharmacy representatives.

Discussions with insurance companies are ongoing to discuss how their beneficiaries will be receiving care in a pandemic response scenario. Because the alternate care sites will be coordinated under hospital auspices, care provided at ACS should be billable through the hospital and reimbursed to volunteer providers, as long as adequate documentation and tracking are implemented. Even when a payment system is fully defined, a major cash flow problem is anticipated, since it is estimated that \$450 million will be needed to pay for the care provided over 12 weeks of pandemic. Insurance Commissioner Chris Koller is meeting with insurers to figure out how to establish a reserve fund, and if payments may be spread out over time.

Next steps in regional planning: Newport Hospital, St. Joseph Hospital, and Miriam Hospital will begin coordination of health care delivery systems in their regions for the next three to six months, and will communicate barriers encountered, unique issues, and lessons learned to assist the other seven regions in developing their coordination mechanisms.

It is important to recognize that each decision made has cascading consequences:

- School closure and use as ACSs will displace the students who rely on school programs for meals; adequate nutrition for these children during the emergency period must be addressed.
- Provisions will need to be made to keep health care workers with school-age children available; hospitals may need to establish daycare for children of health care workers.

HEALTH/EMA need to establish communications mechanisms with “non-traditional” emergency response sectors such as primary care providers, news media decision makers, grocery stores, or banks to enable involvement of a variety of stakeholders that may be impacted by the pandemic response structure. When licensure moves to a web-based system, HEALTH will be able to require data fields for contact information from licensed health care providers and will be able to move beyond the fax blast method of communication, which is the best method that is currently available but not adequate for the future. Email communication is not yet feasible due to lack of email addresses.

The goal of the planning effort is to minimize the overall impact of a pandemic infection. It is not currently possible to prevent a pandemic or rapidly create a vaccine in response, and the accustomed level of care and services will not be available, but concerted preparation will result in less chaos when the plan must be executed.

### **Coordinating Hospital Functions & Responsibilities**

Building on the strength of each hospital's knowledge of its region, the 10 designated hospitals will be the coordinating points for the resources with which they interact, as well as the primary care practices in the area, to identify available resources (e.g. personnel from offices which have closed) and redistribute resources to sites of need (offices which could remain open with one additional staff person, or an alternative care site (ACS)). Two-way communication with and coordination of open/closed practices will be key to deciding how to staff ACS and how to best match the geographic need to available resources. The infrastructure/staffing/equipment needs to fulfill this function (databases, GIS mapping, phone and/or email communications) must be defined.

Hospitals and primary care providers must take advantage of the planning process to establish mutual understanding to assure smooth response operations regarding familiarity with hospital chain of command, assurance of admitting privileges, and definition of emergency credentialing processes. Hospital operating procedures need to be established for providers working at ACSs under hospital auspices/billing, admission of pediatric patients to Hasbro/RI Hospital, and documentation and reimbursement of PCP services

In most cases, hospitals will postpone elective surgeries for infection control. The plan must address (provide guidelines) on deferring elective/semi-elective/routine medical care during the pandemic period and mobilize the providers of such care. Other staffing resources to consider enrolling/mobilizing include medical and nursing students (although they may be needed to staff campus health centers) and licensed nurses not currently working in direct patient care.

Hospitals will be responsible for coordinating Alternative Care Sites (ACS) and will assign licensed health care providers whose office practices are closed to staff the ACS.

- Need to define the anticipated coverage that will be needed to sufficiently staff each ACS, including licensed health professionals and support staff
- Identify the patient documentation, tracking, and billing procedures for ACSs
- ACSs must have emergency supply sources and delivery mechanisms
- Transportation between hospitals and ACSs should be addressed

### **Primary Care Provider Participation**

Recruiting/Enrollment: Licensure renewal could be used to identify those willing to participate and update key contact information, but optional pages on renewal forms are rarely filled out and contact information questions (such as emails) tends not to be regarded as mandatory. Adding one yes/no question on interest in volunteering to licensure forms could provide a pool of potential volunteers. The state could make follow-up calls to gather the necessary details (including data for rapid emergency credentialing) and start building the contact information databases now, then use licensure questions to move forward/update over time, especially when web-based licensure renewal is implemented. Web-based renewal can include required fields for contact information that is needed for a variety of emergencies. Optional windows can open to register volunteers and note emergency qualifications.

Licensure similarly could be used to collect contact information and create a database for other licensed health care professionals, particularly for nursing personnel. Nurses not currently working in clinical settings constitute a large pool of trained individuals who could help in a flu pandemic if recruited/enrolled.

Another option in development under a federal grant program for hospitals is the Emergency System for Advance Registration of Volunteer Health Professionals (ESARVHP). It will use the licensure database to pre-register health professionals, and could add information for emergency credentialing to medical licenses.

Financing: It is essential to delineate how primary care providers will be compensated for participating at hospitals, alternative care sites, or other practices in order to promote participation. Few providers will be able to volunteer for any length of time unless financial compensation and/or financial obligation relief are offered.

PCP Commitment: Primary care providers need to have an understanding of the obligation implied by volunteering to participate and the structure of the pandemic response plan, including:

- Anticipated length of emergency operations and PCP commitment
- Obligation to report availability, go when called and where directed
- Insurance/tort claims coverage (particularly for CHC MDs under federal coverage)
- Reimbursement
- Coordinating hospitals, catchment areas, and ACS locations
- Training requirements
- Communications mechanisms
- Availability of supplies, Personal Protective Equipment (PPE), and N95 mask fit-testing

Management of Volunteers: The Medical Reserve Corps (MRC) has been proposed to register, train, and coordinate volunteer primary care providers during a pandemic. There are presently a few hundred members of the MRC, but the challenge in RI is that many MRC members also are involved with the Disaster Medical Assistance Team (DMAT), as well as their own practices. Additionally, PCPs may perceive joining the MRC as a more extensive commitment than they are comfortable with.

None of the PCPAC members present were part of the MRC, and could not speak to the appropriateness of the MRC for this purpose. The functions/capabilities required of a system for volunteer provider coordination during a pandemic should be defined, and the pandemic workgroup should meet with MRC to evaluate if they can/should fulfill these requirements, or if a dedicated alternate system should be established.

In the future hospitals will be installing a software-based emergency notification system that uses extensive databases to send blanket or targeted messages by specialty and geography, with questions, replies, and follow up based on prioritized contact list. Within minutes coordinators could get a sense of who could respond to an emergency and how quickly. Hospitals may choose to use the system internally or they may broaden it to cover all physicians with privileges. This system has had a successful small-scale demonstration in RI.

### Personal Protective Equipment (PPE)/Stockpiles/Supply Chains

The primary care community is eager to have guidelines on stockpiling PPE, but there are important factors to be considered before guidelines are released:

- The level of protection required/recommended is unclear regarding masks. All masks are predicated on bacterial spread and may not be effective against viruses. Splashguards may provide the most protection for providers as flu is spread via droplets.
- Ideally, the federal government should make stockpile recommendations, but they do not seem to be forthcoming. Dr. Gifford is one of ten State Health Directors who formed an advisory group attempting to address this issue. He recommended that RI medical academies and professional organizations send messages to the CDC requesting federal government guidance.
- The recommendations need to be consistent with border and regional states; if there are contradictory recommendations, people may overreact and refuse to work without extreme measures of protection.
- N95 masks must be fit-tested, not all providers can use them, and alternatives may not be available. They are already in short supply and quantities for stockpiling will be insufficient for the next three to five years.
- If N95 PPE is recommended, the state should consider including N95 fit-testing (and possibly one or two masks) as part of enrollment and education of PCPs for pandemic response.

Primary care practices and Community Health Centers (CHCs) do not normally stockpile PPE, IV fluids, etc. and will rapidly exhaust their supplies on hand. It is unlikely that the usual supply chains will deliver in a pandemic. ACSs will need to be supplied as well. Assumptions in draft plan of very minimal basic equipment (masks, gloves, splash guards, IV, fluids, oxygen, antibiotics, antivirals, antipyretics) to outfit the ACSs would cost approximately \$70 million.

- Hospitals should coordinate emergency supply chains for ACSs, CHCs, and primary care practices remaining open.
- The response plan should address management of a central stockpile, should funds be available to purchase supplies in quantity.

PCPAC members made specific recommendations on the Draft Pandemic Influenza Plan (PCPAC Advisory dated January 6, 2006, attached). Dr. Marable suggested that a recent report from the Trust for America's Health be reviewed for validity of deficiencies noted in RI's health emergency preparedness efforts, and possible incorporation of such as preparedness planning focus areas.

***NEXT PCPAC MEETING WEDNESDAY, JANUARY 18, 2006***