

## **PRIMARY CARE PROVIDER ADVISORY COMMITTEE**

### **Meeting Minutes, January 18, 2006**

*Members in Attendance:* Jeffrey Borkan, MD, PhD/PCPAC Chair; Gregg Allen, DO; Stanley Block, MD; Sandra Boehlert, MD; Sarah Fessler, MD; Ellen Gurney, MD; William Hollinshead, MD, MPH; Ray Maxim, MD; Renee Rulin, MD, MPH; Richard Wagner, MD.  
*Guests:* Ellen Mauro, RN, MPH; Chris Tanguay. *HEALTH:* Dona Goldman, RN, MPH; Deborah Pearlman, PhD. *PCPAC Staff:* Carla Lundquist; Mary Anne Miller, RN, MPH; Rebecca Stokes.

*Unable to Attend:* Munawar Azam, MD; Mark Braun, MD; L. Anthony Cirillo, MD; Charles Eaton, MD; Michael Fine, MD; Arnold Goldberg, MD; Victor Lerish, MD; Omar Meer, MD; John Murphy, MD; Donya Powers, MD; Mark Schwager, MD; John Young.

Dr. Borkan opened the meeting at 7:40 AM. The comprehensive minutes of the December 21, 2005 were approved as written (motion by Dr. Block, second by Dr. Wagner, all in favor). Dr. Borkan welcomed new member Gregg Allen, Jr., DO, of Knightsville Internal Medicine, Cranston. Dr. Allen is representing the RI Association of Osteopathic Physicians and Surgeons, replacing Dr. Herbert Brennan.

**MAIN TOPIC: Design of health care delivery programs to engage primary care providers.** Several examples for discussion were presented.

Ellen Mauro, DHS: DHS is seeking to improve health care delivery to adults with disabilities enrolled in Medicaid by implementing voluntary managed health care system options. The complex target patient population (~14,000 non-dual eligible adults) accounts for much of the Medicaid budget. The system is envisioned as very patient-oriented, to ensure access to high quality, affordable health care emphasizing the preventable, primary care and establishment of a medical home. Nurse case managers will be key, but the integration/financing structure is undetermined. Its creation will shift the state from being a payor of last resort, to a purchaser of health care services. The State wants to develop a core group of primary care and specialty providers and is seeking input.

Dr. Wagner, MHRH: The Allied Advocacy Group for Integrated Care (AAG) works to promote and expand integrated primary health care and behavioral healthcare in RI. Healthcare is delivered in silos with few sites of integration, impacting the quality of care. Efforts to integrate have met barriers including patient complexity. The inherent challenge of patients with co-morbid conditions creates a treatment disincentive. If the state were to implement a system to address these patients, they would find a huge unmet need.

Universal access to care must include clinicians willing to provide in a timely way, and in the fashion required. The AAG is soliciting input from all aspects of health care to break down barriers in terms of specialties, and has developed draft documents on models of integration and standards of care that are not specialized. All health care service programs should strive for practice/treatment guidelines that are the same for Medicaid and private populations.

Dr. Hollinshead, HEALTH: A Family Health effort to extend the medical home concept to families raising children with complex medical needs has successfully utilized experienced parent consultant who partner with the primary care practice staff to help families effectively use the practice. The program has nine trained parent consultants, who attend appointments with the families and make home visits. The program is young, so their role varies. The presence of the parent consultant in the practice clusters the special-needs visits, improving quality of care and efficiency. There is a waiting list of practices requesting a consultant.

**DISCUSSION:** Member discussion focused on the barriers to PCP participation in presented initiatives, and potential approaches to overcome them.

#### **Significant Barriers and Disincentives:**

- Lower reimbursement schedules for publicly insured patients versus privately insured are disincentives for private providers.
- Complex patients require more provider time effectively lowering payment rates.
- Adding a new service measure to a primary care practice requires training for which practices may not have time. The program services may change, making it difficult to stay abreast of current offerings.
- Many managed care systems handle patient interactions via phone, fax or email, which can be ineffective, especially for non-English proficient populations.
- Health service initiatives provide patient information to primary care practices in different formats. It is challenging to avoid duplication. Practices can become overwhelmed with feedback reports, and information may be overlooked.
- Difficulty providing continuity of care to patients who move in and out of eligibility.

#### **Recommendations for program design included the following (see also PCPAC Advisory dated February 6, 2006):**

- Financing: At minimum the managed care plan fee schedule should have parity with other state plans. Medicaid should offer higher reimbursement for care of challenging patients, allowing providers economic parity. The state must not allow the deep discounting to occur as happened in RIte Care. A minimum time commitment to the program from both patients and providers may be helpful.

- Core/Expert Providers: Identify a group of core providers, such as hospital based clinics and community health centers, as preferred sites for Medicaid patients due to their expertise with Medicaid managed care programs and the given population. The core providers may include private practice PCPs with high numbers/percentage of Medicaid patients. Extensive experience with the population of interest would help assure high quality care. Making “expert providers” eligible for an enhanced fee schedule would give the state more leverage to assure standards of care and desired practice policies were being met, and would increase the provider’s understanding of the state’s goals. Patients enrolled in the managed care plan would be encouraged to use the expert providers, but would be free to choose any provider willing to participate in the program.
- Provider Interface: Design public health care service programs with heavy and light users in mind. These groups will require diverse levels of case management involvement. For the core sites with considerable Medicaid experience, provide periodic one-page reports highlighting the services the patient is receiving and their contact person/care manager.
- Design for Population: It is important to design programs to meet the needs of challenging patients, so they do not end up excluded. The program needs to address the issue of high rates of missed appointments for publicly insured patients, for which providers are not reimbursed. Behavioral health services integrated within the primary care practice will improve patient outcomes.
- Patient Interface: Provide facilitating services for patients including translation and transportation assistance for appointments. Have nurse case managers meet with patients for enrollment/medical history/case review/etc. Make patient consultants/coaches/ombudsmen available. Assure that communications with patients are effective, respectful, and culturally competent.
- Case Management: Two approaches to nurse case manager integration were proposed.
  - Use relationships/resources that PCPs already work within the community, such as Visiting Nurses Associations (VNA), to provide the case management and program interface, relieving the primary care practice staff. Request input and buy-in from these organizations during the design phase.
  - Integrate the nurse case manager within the primary care practice in a tailored role for the practice type, thereby providing immediacy, staff and patient support, and tracking of services received by an individual with patient history and treatment plan knowledge.

***NEXT PCPAC MEETING WEDNESDAY, FEBRUARY 15, 2006***