PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, March 15, 2006

Members in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregg Allen, DO; Andrea Arena, MD; Munawar Azam, MD; Solmaz Behtash, MD; Stanley Block, MD; Sandra Boehlert, MD; Mark Braun, MD; L. Anthony Cirillo, MD; Fadya ElRayess, MD; Sarah Fessler, MD; Michael Fine, MD; Paul George, MD; David Gifford, MD, MPH; Luke Hansen, MD; Sharon Marable, MD, MPH; Raymond Maxim, MD; Renee Rulin, MD, MPH; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. *Guests*: Susanne Campbell, NP; Emily Garber; Celia Gomes-McGillivray, RN, MPH, CHES; Anbrit Long; Amy McIntyre; Robert Trachtenberg, MS. *HEALTH*: Deborah Fuller, DMD, MS; Stephanie Kissam. *PCPAC Staff*: Carla Lundquist; Mary Anne Miller, RN, MPH, CHES.

Unable to Attend: Charles Eaton, MD; Arnold Goldberg, MD; Ellen Gurney, MD; William Hollinshead, MD, MPH; Victor Lerish, MD; Omar Meer, MD; John Murphy, MD; Donya Powers, MD; Mark Schwager, MD; John Young.

Dr. Borkan called the meeting to order at 7:33 AM. Minutes of the February 15, 2006 meeting were approved as written (motion by Dr. Cirillo, second by Dr. Maxim, all in favor). Dr. Borkan asked members to review the draft letter regarding Medicare Pt. D, and submit any comments by the end of the meeting. The final letter will be sent to Mark McClellan, CMS Administrator and other officials at CMS, Sen. Charles Grassley, the RI Congressional Delegation, and the RI Primary Care Academies.

Dr. Rulin, a member of the Governor's health care agenda task force, described the work done to date on Primary Care (PC) Innovation. PC Innovation goals, to create a stronger PC system and to increase the capacity of PCPs to deliver high quality care, will be achieved through coordinated state efforts to emphasize PC and changes in policies, benefits, and payment standards that reflect the involvement of all key stakeholders, including consumers, providers, health insurers, & health care purchasers.

Change and innovation in PC will be encouraged two ways: (1) Piloting of a "new model" practice, which will be created and managed by key stakeholders, use a public-private partnership model to obtain grant funding, demonstrate the clinical/economic value of the future PC practice, and serve to evaluate various aspects of practice design. (2) Development of a series of incremental practice innovations that can be implemented by existing practices, supported by changes in health insurance reimbursement and based on the expected value that enhanced primary care will bring. Both of these will be based on the attributes of patient-centered PC, including superb access, patient engagement in care, clinical information systems, care coordination, integrated care across teams of providers, routine patient feedback to a practice, and publicly available information.

The features, characteristics, and principles of a different model of PC must be defined before work can begin on realignment of payment and malpractice. Trying to begin with raising reimbursement schedules will not be supported by the state. Re-framing the issues/concepts as a more effective utilization of current healthcare funding in RI would support the concept that a better PC system will improve health in RI. Insurer support is essential to making reimbursement structure changes that will benefit PC innovation. The Health Insurance Commissioner supports this effort, and early talks with the state's major insurers have shown them to be receptive to the idea of a new model. The RI Area Health Education Center (AHEC) has been engaged to help define the services/access that consumers are seeking through the use of focus groups.

The steps to establish PC Innovations are: 1) With stakeholder input, select and prioritize the attributes of excellence in PC for incorporation into existing practices; 2) Create practice/contract standards and measurement mechanisms for practice innovations that implement the attributes; 3) Convene all stakeholders, including health insurers and health care purchasers, to implement standards and incorporate payment for practice innovations into reimbursement schedules; and 4) Monitor and report practice process and outcome data.

DISCUSSION: PCPAC discussion centered on financing the proposed changes and issues of trust between the PC community and the state. In view of the history of RIte Care, the PC community tends to regard the state as an unreliable negotiating partner responsible for the under-funding of PC, and perceives the state as a barrier to the implementation of PC innovation. The reputation and past actions of the state may impact primary care physician (PCP) interest in participating in this endeavor. A dichotomy exists between the state's current initiatives to both improve PC and reduce RIte Care spending. Dr. Rulin declared that this is an opportunity for the state to demonstrate its commitment to strengthening primary care by being the first to adopt the PC innovations and incorporating them into the Medicaid reimbursement structure.

Members noted that if the basic economic underpinning supporting primary care is inadequate, adding new performance requirements, even for enhanced reimbursement, could have a reverse effect on physician participation (as seen in tertiary specialists who refuse to accept Medicaid fee-for-service). Dr. Rulin explained that establishing the elements of PC Innovation will give payors a good reason to raise reimbursement for real value, and demonstrate that this is an investment worth making. Convincing payors that PC Innovation is better and different could provide the impetus for reimbursement structure change. Further conversations regarding reimbursement may confirm that this kind of transformation cannot be paid for on the back end, that up-front investment is needed. Dr. Rulin also acknowledged that in terms of reimbursement, primary care is starting from a low position and likely will need a capital infusion to make this expansion possible.

Individual practices may not be able to bear the burden of necessary investments, even if payment mechanisms for the PC innovations were rapidly established. A practice development bank must be identified/established, which would provide facilitation/design assistance and economic development funds to enable small business PCPs to invest in the infrastructure,

personnel, and information technology equipment needed to pursue PC innovations. Another model of compensation to consider is the bonus method used by Neighborhood Health Plan/RIte Care for community health centers (CHCs) engaging in quality initiatives. The CHC is paid half of a bonus up front to implement the measure, and receives the remainder when they can demonstrate that it has been put into practice. The PC Innovation initiative must be sustainable, not just for the pioneers but also for the broader PC community.

Strengthening primary care will not be financed by more state revenues; therefore, a reallocation of current health care funds is necessary. Primary care funds must come from money spent on ancillary services and/or specialty services and/or hospital care. The expectation that good PC usually decreases overall expenditures caused some concern; sometime the reverse is true and practicing good primary care according to guidelines may increase expenditures and tertiary consults. Unless society is willing to accept this, the state may find itself with satisfied patients and unsustainable increased costs. Dr. Rulin noted the literature demonstrates that problem management by PCPs will result in the same outcomes as by specialist management, but the PCPs will do so more efficiently. Nationally, states with higher proportions of PCPs per population have lower health costs and better outcomes, which aids in improving the economic health and viability of neighborhoods. However, Dr. Fine remarked that it is impossible to predict with certainty; it must be recognized that there are risks to change and a need to beware of unintended consequences.

Other key discussion points included:

CONSUMERS/ACCESS: As it exists, primary care is not meeting consumer needs. Society has changed; in the past people were willing and able to use/access services during the workday; however, today's two-working-parent families want convenient access off-hours because they cannot take time from job obligations. There is a societal mismatch that is challenging for primary care. PC Innovation must be consumer-access based, or the ability to access care will continue to be the denial point, and quality will be achieved only by denying care to a large proportion of the population. The successes of RIte Care in terms of reducing health disparities, including less fragmentation and establishment of medical homes and ongoing patient/physician relationships, should not be ignored.

COORDINATION: Dr. Borkan described a "Transform Medicine" initiative within Family Medicine, which is funding 20 practices to create business plans for the future of Family Medicine. This effort and similar initiatives from other PC disciplines should be coordinated with the PC Innovation initiative.

HIT: It is important that the Health Information Technology (HIT) products chosen for the PC innovations be transparent across platforms, have secure communications compatibility, and be HIPAA compliant. Legal experts have been reviewing electronic data transfer, and agree that it can be accomplished with no violations of patient data confidentiality.

EMAIL: Notes regarding email communications with patients: 1) Many physicians would not want to deal with technical complexity and/or HIPAA compliance risk; 2) Risk managers (especially for OBs) are not in favor of email communications with patients and doing so can impact eligibility for malpractice coverage; 3) Initiating use of email consults for a few conditions may lead to a reliance on it that might be detrimental to the patient/physician relationship; and 4) How would payors verify that the MD has given legitimate advice to the patient to qualify for reimbursement. Dr. Rulin responded that several companies, including RelayHealth (www.relayhealth.com), provide secure, online, HIPAA-compliant communications between patients and physicians. Studies of this type of system show that when implemented fully, as has been done in some western states, productivity goes up because each email consult is reimbursed.

Dr. Borkan asked PCPAC members to forward any comments on the elements/attributes of PC Innovation. Dr. Rulin asked that the group be willing to continue this conversation and work; any members interested in participating in a sub-group on this topic should contact Dr. Rulin.

NEXT PCPAC MEETING WEDNESDAY, MAY 17, 2006