

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, September 20, 2006

Members in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregory Allen, DO; Gowri Anandarajah, MD; Stanley Block, MD; Mark Braun, MD; Fadya ElRayess, MD, MPH; Sarah Fessler, MD; Michael Fine, MD; Arnold Goldberg, MD; Ellen Gurney, MD; William Hollinshead, MD, MPH; Victor Lerish, MD; Sharon Marable, MD, MPH; Raymond Maxim, MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. *Associates/Guests:* Paul Block, PhD; Susanne Campbell, RN; Celia Gomes-McGillivray, RN, MPH, CHES; Ellen Mauro, RN, MPH; Kirsten Spalding; Robert Trachtenberg, MS. *HEALTH:* Stephanie Kissam; Ana Novais, MS. *PCPAC Staff:* Carla Lundquist; Mary Anne Miller, RN, MPH, CHES.

Unable to Attend: Andrea Arena, MD; Munawar Azam, MD; Solmaz Behtash, MD; L. Anthony Cirillo, MD; Robert Crausman, MD, MMS; Charles Eaton, MD; Paul George, MD; David Gifford, MD, MPH; Luke Hansen, MD; Donya Powers, MD; Renee Rulin, MD, MPH; Mark Schwager, MD.

Dr. Borkan called the meeting to order at 7:34 AM. Minutes of the June 21, 2006 meeting were approved as written (motion by Dr. Wagner, second by Dr. Maxim, all in favor). Several announcements were made:

- Brown Medical School student Kirsten Spalding described plans for National Primary Care Week in RI, October 15-21, 2006. This year's NPCW theme is "Addressing Health Disparities: Healing the Nation".
- Dr. Fine announced that Jack Geiger, MD, MSci, founder of the community health center movement, will be at RI Hospital on Wednesday, November 8, 2006, for hospital-wide grand rounds at 7:00 AM to discuss equal treatment.
- Dr. Paul Block announced that the Collaborative Family Healthcare Association will hold their 8th Annual Conference "Best Practices in Collaborative Healthcare" in Newport, RI, on November 2 – 4, 2006, featuring national and local speakers. For more information or to register online, visit www.informalearning.com/cfha.

Dr. Fine opened the presentation on **integration of primary care and behavioral health (BH)** with a brief history of the efforts in the state to create policy and engage stakeholders on the topic, which resulted in the founding of the Allied Advocacy Group for Integrative Care (AAG). The AAG brought together interdisciplinary PC providers, the mental health provider community, state government agencies, and psychiatrists to consider how integrated care could be achieved in RI, and has initiated various demonstration projects. The AAG now believes that the leverage to move integrated care forward in RI rests with the state government itself. When the totality of state employees, Medicaid & Rite Care beneficiaries, and municipal employees is considered, the state is by far the largest purchaser of healthcare and insurance. The AAG is proposing that the state create service delivery standards to structure the purchasing of health insurance in a way that offers incentives for primary care practices to provide first co-located, then integrated BH care. The Service Delivery Standards for Integrated Care would be incorporated into all health insurance procurements negotiated by the state, for the purpose of accessing savings, improving outcomes, and decreasing the stigma of seeking behavioral healthcare. Primary care and mental health organizations are being asked to review the AAG's Proposal (see attachment), and consider endorsing it. The proposal is a living document, still open to discussion and editing. The process of coming to agreement on this issue will be critical to improving the primary care delivery system in RI.

Dr. Wagner gave the perspective of the formal state mental health infrastructure, noting that it is important to look at what has/has not worked both nationally and locally. The separation of alcohol/substance abuse (SA) treatment into a silo of care has been particularly counter-productive, and mental health treatment still carries a stigma that impacts efforts to implement integrated electronic health records. Patients do not want their BH/SA records integrated due to the persistent stigma, which needs to be addressed. Dr. Wagner absolutely supports that incentives are needed to begin to improve the system.

Dr. Paul Block acknowledged that integrating behavioral health with primary care is an incredibly difficult process, and outlined some of the results of the AAG project for SAMHSA and the experiences of Psychological Centers in co-location and integration efforts. Co-location and integration of services has shown to be of such benefit to patients that advocates have persisted, and will persist, in implementing it in spite of the complexity and financial strain. The AAG arrived at the present proposal by considering what sector would benefit most financially by integration of care, and kept coming back to the state. The cost offsets to the state, both within healthcare (reduced hospitalization/impact of co-morbidities) and in disability, public health, the justice system, and other state expenditures, make it unlikely that insurers will take the first steps to create incentives for provision of co-located or integrated care on their own, despite the fact that they too will realize savings. The state does however have the leverage to require insurers to include incentives for co-located or integrated care in the healthcare insurance products it purchases. Although cost analyses are limited, the evidence is compelling that the savings to the state will be substantial, in terms of both dollars and human suffering.

PCPAC members discussed the proposal and voiced considerable concern about several issues, including:

- **Financial considerations** – State funding for reimbursement of health care services is finite. If incentives are implemented for co-location or integration of behavioral health services with primary care, a greater amount of the finite pool of funds will go to practices that can provide such services, and those unable to do so will receive an even smaller portion of an already small pie. Adding pay-for-performance incentives in the wake of cuts to Medicaid will not make practices “financially whole” and may be viewed negatively. PCPAC understands that the goal of the AAG proposal is to negotiate requirements for insurers to pay incentives for co-located or integrated care, not to dictate what providers must do, but feels that potential exists for such government purchasing to indirectly dictate [or eventually, directly mandate] how primary care providers are expected to practice, which eventually may result in financial disincentives for practices not providing co-located or integrated care. The limited data available indicates that the proposal would generate cost savings for the state, but currently there is no way to assure the savings would be reinvested in health care.
- **Equity of feasibility** – Economies of scale make co-location or integration of behavioral health with primary care much more practicable for larger primary care practices than smaller or solo practices, effectively eliminating small practices from competition for incentive dollars. Smaller practices may face physical site limitations that prevent the addition of behavioral healthcare providers, may find it more difficult to implement open/advanced access, and are less able to absorb the necessary startup costs and investment of time, especially if the co-location or integration implementation is not successful.
- **Provider availability** – The paucity of psychiatrists willing to participate in Medicaid or to accept any third-party insurance will limit the effectiveness of this measure to increase access to behavioral healthcare in the state through reimbursement incentives. This critical workforce issue must be addressed before primary care practices will commit to making behavioral health services available on site.

PCPAC members are in support of the general concept of co-location and integration of behavioral health services with primary care, and the Committee agreed that promoting integrated care is necessary to address the unmet behavioral health needs of the population of Rhode Island, but felt they could not at present endorse the AAG Service Delivery Procurement Proposal, due to the pragmatic reservations noted above.

Dr. Borkan asked what **topics PCPAC should address in 2006 – 2007**. Members suggested: Pre-Authorization requirements from insurers; Immunization & flu vaccine updates; Adult vaccine purchasing & distribution; Reimbursement structure/pay for performance; HPV vaccine; MinuteClinic; Medicare Part D Prior Authorization process; and Primary care workforce (including allied health professions/nursing, and loan repayment).

NEXT PCPAC MEETING WEDNESDAY, OCTOBER 18, 2006