

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, December 20, 2006

Members in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregory Allen, DO; Stanley Block, MD; Robert Crausman, MD, MMS; Fadya El Rayess, MD, MPH; Sarah Fessler, MD; David Gifford, MD, MPH; Sharon Marable, MD, MPH; Raymond Maxim, MD; Patrick Sweeney, MD, PhD, MPH. *Associates/Guests:* Matthew Burke, MD; Susanne Campbell, RNC; Steven DeToy; Celia Gomes-McGillivray, RN, MPH, CHES; Christopher Koller. *HEALTH:* Dona Goldman, RN, MPH; Stephanie Kissam; Ana Novais, MA; Susan Shepardson. *PCPAC Staff:* Carla Lundquist; Mary Anne Miller, RN, MPH.

Unable to Attend: Gowri Anandarajah, MD; Andrea Arena, MD; Munawar Azam, MD; Solmaz Behtash, MD; Mark Braun, MD; L. Anthony Cirillo, MD; Charles Eaton, MD; Michael Fine, MD; Paul George, MD; Arnold Goldberg, MD; Ellen Gurney, MD; William Hollinshead, MD, MPH; Victor Lerish, MD; Donya Powers, MD; Renee Rulin, MD, MPH; Mark Schwager, MD; Richard Wagner, MD.

Dr. Borkan called the meeting to order at 7:43 AM. Minutes of the November 15, 2006 meeting and the advisory letters on pandemic flu and on HPV vaccine were approved as written (motion by Dr. Block, second by Dr. Fessler, all in favor).

Dr. Gifford outlined plans for state provision of adult flu vaccine for the 2007-2008 flu season. HEALTH will purchase adult flu vaccine from multiple vendors, billing insurers, and will provide vaccine to PCPs as needed at no cost. This will assist in preventing issues of mal-distribution and will relieve PCPs from having to project need and purchase vaccine upfront. Insurers, including Medicare, will no longer reimburse providers for the cost of vaccine, only for administration, so PCPs who have placed flu vaccine orders for 2007-2008 should cancel them. A letter to all providers detailing the plan will be sent in January. Employers who provide vaccine to their workforce will be able to buy it through HEALTH. This adult flu vaccine program is a pilot for both Medicare and the state, which may consider providing other adult vaccines in the future. There have been proposals to regulate that all health care workers with direct patient contact get flu vaccine annually to help prevent spread of disease. PCPAC members noted that it makes sense epidemiologically, although there is resistance among workers, and vaccine costs become a factor for sites with high staff turnover.

Christopher Koller, RI Health Insurance Commissioner, described the development of the Governor's health policy agenda, and noted that the health care delivery system is treatment/procedurally oriented versus prevention-focused. It has been recognized that the only avenue to increasing health care supply and decreasing costs is via primary care, so the Office of the Health Insurance Commissioner (OHIC) is looking at ways to support primary care. The strategy around developing an advantage for primary care is to focus on the ability of primary care practices to deliver care to chronically ill patients. The Primary Care Stakeholders Group (PCSG) was convened to bring together health insurance plans, purchasers, and providers with a view to urging purchasers to require health plans to pay more for primary care. Primary care is a small part (~10%) of overall health care spending, but there is unwillingness to increase spending without targeted changes and systematic accountability. When polled, health plans indicated interest in expanding primary care access in order to decrease ER usage, and the PCSG has been trying to negotiate an agreement acceptable to providers, health plans, and purchasers for this with little success; providers want to be paid more for what they are doing now while health plans and purchasers want to get more before they pay more.

To build the primary care infrastructure without an infusion of public money, a political redistribution of funds from elsewhere in the health care system, or a willingness of PCPs to take on additional financial risk, the PCSG has focused on improvements in chronic care, since chronic disease represents a large percentage of health care expenditures. This will require: 1) identification of the conditions/performance measures of interest, and 2) persuading purchasers to require health plans to pay for improvement on these measures. The PCSG is developing a set of 4-5 conditions and performance measures and linked financial incentives basic yet varied enough to interest providers in pursuing the Chronic Care Model (CCM). The process is slow due to the need for uniformity among payors. A few practices will be selected to pilot an extensive set of fundamental practice changes. Mr. Koller emphasized the importance of selecting and defining the performance measures, which may include structural and outcome pieces, so improvement can be accurately gauged. A collective definition of quality and a consistency of measures and standards will be key to moving from a system that pays for procedural volume to a system that pays for quality of care.

Dr. Borkan expressed concern that this project may add to the current crisis in primary care. The CCM pulls resources away from already stretched PC systems and it is not sustainable; PCPs deal with hundreds of interacting conditions, not 4-5 isolated chronic diseases. Drs. El Rayess and Block related experiences with disease collaboratives and the CCM at their respective community health centers (CHCs) noting the difficulty in sustaining the projects both fiscally, once the implementation and training funding is gone, and in terms of staff enthusiasm for the time and tracking effort required. For financially strained CHCs, sustaining CCM becomes a question of concentrating scarce resources on a small percentage of patients or providing more access to health care for patients with a wider variety of problems. Mr. Koller observed that salaried multi-physician practices such as health centers or university groups are likely to have more infrastructure for sustaining CCM than small practices and fee-for-service settings. Dr. Block argued that the project should be first implemented in private practices where most patients are insured vs. CHCs with 30% of patients uninsured.

Dr. Borkan noted that the committee was hoping the OHIC would address major issues of primary care infrastructure including Electronic Health Records (EHR), issues of access, reimbursement rates 20% lower than surrounding areas, the increasing numbers of physicians leaving primary care, and the small number of new graduates entering the field. RI does not have the basic building blocks for primary care infrastructure, which needs to encompass quality, access, reimbursement, and EHR. He suggested priorities of establishing off-hours coverage systems and implementation of linked EHR between healthcare access points. Mr. Koller noted that EHR is essential for the CCM, and the priority for EHR is getting it into PC practices, but the health insurance plans and purchasers have declared their unwillingness to increase funding for primary care, so PCPs must advocate for themselves, making the case for the value of the work they do and for where the best investments in PC with greatest return can be made, whether it is in the Loan Repayment Program, in CHCs, or in EHR. The PCSG has focused on chronic care because that is the health care sector in which 3% of the patients use 50% of the funds; PCPs need to demonstrate how they can save money on those patients. If the PC community cannot make its case in a negotiation setting, they will have to compete for funds politically against hospitals and radiologists, who have mastered the political advocacy process. Dr. Maxim asked how primary care could negotiate with insurers, as no PCP negotiating body exists. Mr. Koller pointed out that opportunities exist to negotiate with Medicaid/Rite Care, conceding that structure is an important part of negotiating ability and larger practices have more leverage. PCPs need to look to professional societies for political representation.

Ms. Miller reminded the group that care for the uninsured, and for those cycling on and off insurance, is not being factored into this equation. Mr. Koller noted that care for the uninsured is a different battle than trying to increase financing for primary care. Dr. Gifford related that multiple parallel discussions on expanding access to health care in the state have even the staunchest advocates for universal coverage conceding that rising healthcare costs must be addressed before attempting to implement universal health insurance.

Dr. Borkan asked if the ideal practice from a patient-centered point of view, one that is about integrated care throughout the life cycle, in both inpatient and outpatient settings, for both chronic and acute issues, would be rewarded. Studies have shown that patients want access to care, quality care, and someone who knows them. It has been demonstrated that increased primary care results in lower health care costs, but in this time of decreasing resources primary care practices are unable to take financial risks to support CCM. The message PCPs are hearing is that what they do is not of sufficient value to the system to warrant appropriate reimbursement, yet if they stopped providing primary care, health care costs in other areas would soar. Mr. Koller reminded PCPAC that persuasion efforts must be targeted to the large purchasers who can make requirements of the payors. This is a zero-sum game; for primary care to get more funding, the money has to come from the rest of the health care delivery system, or from outside the system. He pointed out that there is some ability to move funds at the margins, which can result in a multiplier effect because PC is such a small portion of health care spending. But even if a ¼-½ % increase in overall spending were negotiated for primary care, it would have to be targeted and accountable; PCPs must advocate whether such an increase should go into fees for all primary care providers, or for expanded access incentives for some.

Dr. Maxim asked about patient/consumer responsibility as part of the equation, such as requiring or rewarding participation in health initiatives. Mr. Koller remarked that resentment expressed by some physicians about patients who call at all hours for reasons of convenience, and try to “game the system” to avoid paying for an office visit gave rise to speculations: Should patients pay for their care? If so, by provider time consumed or by a capitation model? How would patients react to such a change? Would they be more engaged in their care? Dr. Maxim remarked that a third of people will not come in if they have to pay, they will just get sicker until they end up in the hospital; similarly, physicians have to keep giving out pharmaceutical samples, or patients will not take their medications because they won't pay for them.

Dr. Block suggested that a strategy mutually advantageous to all stakeholders would be to increase payment to PCPs for off-hours care; health plans & purchasers would get reduced ER usage resulting in lower cost of care, patients would get better and convenient care at the PCP, and providers would better be able to afford extended hours with the additional revenue. Hospitals around the state have expanded ERs and advertise how fast they are to entice patients. Unless patients have a disincentive for using ERs when not appropriate, and are redirected to primary care, they will continue to do so. Once in the ER, patients must be seen by law, and hospitals want the reimbursement insured patients represent, especially to offset their uninsured populations. The health care system needs to look at ways to cooperatively manage patients between hospitals and primary care, to encourage patients to use PCPs available in off-hours, and to provide funding for that access. Mr. Koller noted that the state is very much hampered when there is no incentive other than convenience for uninsured and Medicaid patients to go to a PCP vs. the ER, and that it may be fitting for Medicaid enrollees to have a disincentive for inappropriate ER usage.

Dr. Borkan thanked Mr. Koller for coming and opening this dialog with the committee.

NEXT PCPAC MEETING: WEDNESDAY, JANUARY 17, 2007