PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, March 21, 2007

Members in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregory Allen, DO; Francis Basile, Jr., MD; Thomas Bledsoe, MD; Stanley Block, MD; Mark Braun, MD; Matthew Burke, MD; Robert Crausman, MD, MMS; Sarah Fessler, MD; Michael Fine, MD; Arnold Goldberg, MD; Ellen Gurney, MD; William Hollinshead, MD, MPH; Victor Lerish, MD; Raymond Maxim, MD; Albert Puerini, Jr., MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. *Associates/Guests*: Steve DeToy; Mark Fields; Celia Gomes-McGillivray, RN, MPH, CHES; Ellen Mauro, RN, MPH; Sally Mendzela. *HEALTH*: Helen Drew; Stephanie Kissam; Patricia Raymond. *PCPAC Staff*: Carla Lundquist; Mary Anne Miller, RN, MPH.

Unable to Attend: Gowri Anandarajah, MD; Andrea Arena, MD; Munawar Azam, MD; L. Anthony Cirillo, MD; Charles Eaton, MD; Fadya El Rayess, MD, MPH; Paul George, MD; David Gifford, MD, MPH; Sharon Marable, MD, MPH; Mark Schwager, MD.

Dr. Borkan called the meeting to order at 7:37 AM. Minutes of the January 17, 2007 meeting, the draft advisory letter on emergency communications/state support of primary care, and the draft PCPAC Principles & Composition were reviewed. The January minutes were approved as written (motion by Dr. Block, second by Dr. Fessler, all in favor). Dr. Borkan requested that any comments on the advisory letter or the Principles & Composition be emailed to him by Friday, March 23, 2007. Ms Miller provided a brief update in response to the PCPAC Advisory of October 2006, regarding the cultural sensitivity and consolidation of Health data forms.

Primary Care Leadership Council: Dr. Borkan remarked that Primary Care is not currently favored by academia, commercial insurance, or public insurance, and is suffering under the weight of social changes. It is difficult to be practicing primary care in RI. Dr. Borkan noted that in parallel to the current efforts to develop PCPAC into an advisory body more representative of the entire Primary Care Community, another group, the Primary Care Leadership Council (PCLC) is evolving into a primary care advocacy body within the state. Drs. Fine, Basile, and Puerini were invited to provide an overview of the PCLC.

Dr. Fine described the historical failure of primary care advocacy in RI, particularly in regard to the establishment of low primary care reimbursement for RIte Care and payor implementation of the "all products" clause. Despite urging from DHS, the primary care community was unable to effectively fight to raise reimbursement levels and the visibility of primary care, despite the success of the RIte Care program. RIte Care reimbursement levels at 30-40% of commercial levels persist to this day. Over the past year, the interaction of the primary care community has changed. In the course of focus group meetings for an Allied Advocacy Group project, primary care leaders began conversing not as economic enemies, but as members of the same constituency with common issues. This has evolved into the PCLC, which has begun to work together to be an effective advocate for primary care in cultural, social and legislative spheres. This presents an opportunity to build a lower cost, more effective health care system for RI from the ground up.

Dr. Basile explained that one of the first tasks for the PCLC was to articulate their vision of an ideal primary care practice that transcends practice size and style. He noted the PCLC vision statement emphasis on access to care, completeness of care, and humane integrated/multi-disciplinary care. The vision statement citation of a five-to-eight physician practice is based on organizational development research and optimal efficiency/communications. The PCLC is aware of how difficult it can be to grow a small practice, especially with dearth of incentives in the current environment. The ideal practice vision is meant to be a practice model, not a statement on the composition of a patient population. The interdisciplinary staffing goal is similar to that of an appropriately staffed community health center. The vision outlines the attributes of primary care that should be accessible to all persons. The focus of the practice should be on the geographic community, allowing the needs of the practice area to dictate the specific services required and appropriate funding streams. In this way, differential community needs can be identified and addressed, whether cultural, linguistic, geographic, or economic. The PCLC has not yet specifically addressed funding streams, but is aware that federal funds are being targeted at "high poverty" counties, which RI does not have. The provision of primary care services needs to be regarded as a business problem that is different for each community, but must answer the same question: *Can you afford to be in business?* Dr. Basile referenced an article by Dr. Lynne Kirk, which visualized an ideal advanced medical home that is neither reality nor immediately practical for many patients or practices for many reasons. Nonetheless, he pointed out that there is still much to gain by building a multidisciplinary team for efficient care delivery and holding up the ideal as a goal.

Dr. Puerini enumerated the makeup of the PCLC, which includes all aspects of primary care in RI. PCLC has become a productive group with stimulating discussions on improving how primary care is delivered, not just increasing reimbursement. The group is currently working on three pieces of legislation:

- A mandate for a Primary Care Development Center to assist in primary care physician recruitment and helping practices administratively. Bill H5599 was introduced in January. The PCLC supports the establishment of a Primary Care Development Center in part to address the issues of financing/capital investment needed to introduce the additional paraprofessional and service components of the medical home.

- An action exception to antitrust laws, which would permit primary care physicians to engage in negotiation with health insurers. The exemption would be granted under the supervision of the OHIC, and would apply only to primary care physicians due to the unique reimbursement issues they face. This bill is in draft form and has not yet been introduced. PCPAC members noted an antitrust action exemption would be overwhelmingly important in RI, as insurers now can dictate pricing to Primary care physicians. The legislation would be a move toward equalizing the power balance and would motivate insurers to rethink the seriously skewed distribution of payment. Examining an entire person should not be paid less than examining a mole on an arm.
- A modification of the RI Health Professional Loan Repayment Program requesting the state to set aside funds specifically for recruitment of primary care physicians. This draft legislation has not yet been introduced.

Dr. Braun observed that the ideal advanced medical home of the PCLC vision would require the corporatization of primary care practices; the advanced medical home as described is not achievable or sustainable for solo practitioners. He noted this is not necessarily negative, but it is important to be aware of the end result. Dr. Fine replied that it is less corporatization than a change in the level of analysis of health care delivery from the physician level to the practice level, an approach necessary to provide communities what they need and allow physicians to have a life as well. Dr. Basile noted that the vision is not a rule, and that different practices can achieve the service delivery goals in various ways. Several small/solo practices may opt to work cooperatively to provide ancillary services to their patients. He emphasized that it is very important for the primary care community to engage and collaborate with sub-specialists as well. Co-locating sub-specialists provides an advantage of selection; primary care physicians can choose them based on responsible and appropriate operation. Dr. Wagner pointed out that the PCLC should be careful not to "dumb down" the language in its vision and other statements. Psychiatry and particularly child psychiatry should be represented, not just "mental health workers".

The motivation behind the Primary Care Leadership Council is to have all the primary care pieces in the state work together to alleviate the power vacuum for primary care policy by speaking out, testifying, tracking legislation, and getting the state to focus on primary care as a whole. There is a clear need for an organization to advocate for all of primary care with the legislature, the media, and the public. Dr. Basile noted this is not the first attempt to form a committee to speak for primary care, but it is the first with this level of agreement, sincerity, and willingness to focus on issues and cultivate generalism.

PCPAC brings together the primary care disciplines and practice types, but has limitations due to its role as a state policy body, especially with regard to advocacy. PCPAC cannot directly advise the Governor on creation of programs to promote primary care, but PCLC can fill that role and move the PC community agenda forward. The intent is for the PCLC to work in coordination with PCPAC due to its close relationship with the state, and have both groups operate in tandem to pull together the work being done by the various academies/societies. The collaborative relationship would be assisted by the considerable overlap in memberships of PCPAC & PCLC, and their common goals to define what is and is not primary care, and to organize around those principles.

The members present discussed the importance of communications between groups, academies, and individuals. It will be essential to establish specific reliable communication mechanisms, perhaps via academy listservs; information flow should not be left to osmosis. Dr. Fine mentioned that the PCLC recently had a volunteer to become director of communications, and these suggestions will be forwarded. Dr. Sweeney recommended that if the PCLC is going to be the voice of primary care, representation of OB/Gyn is needed, and would be best served by a practicing community OB/Gyn physician. The PCLC should contact the RI Section of ACOG for nominations. Dr. Wagner recommended that psychiatry/child psychiatry also be represented on the PCLC, in accordance with National Academy recommendations that behavioral health be integrated with primary care.

Dr. Borkan thanked the PCLC leadership for this first conversation, and noted there is clearly room for both PCPAC and PCLC in the state to work together in complementary roles.

Announcements:

- Members expressed interest in the CON process and in examining thriving practices in RI for future meetings.
- Ms. Kissam reminded the group that the deadline for comments on current CON applications is April 1, 2007.
- PCPAC is seeking representatives from the Internal Medicine and Pediatrics Residency Programs who are planning to go into primary care.

NEXT PCPAC MEETING: APRIL 25, 2007