PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, June 20, 2007

Members in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregory Allen, DO; Stanley Block, MD; Matthew Burke, MD; Sarah Fessler, MD; Michael Fine, MD; Ellen Gurney, MD; William Hollinshead, MD, MPH; Victor Lerish, MD; Raymond Maxim, MD; Anne Neuville, RNP; Richard Wagner, MD. *Associates/Guests*: Celia Gomes-McGillivray, RN, MPH, CHES. *HEALTH*: Annemarie Beardsworth; Becky Bessette; Virginia Paine. *PCPAC Staff*: Carla Lundquist.

Unable to Attend: Munawar Azam, MD; Francis Basile, Jr., MD; Thomas Bledsoe, MD; Mark Braun, MD; Denise Coppa, PhD, RNP; Robert Crausman, MD; Steven DeToy; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; David Gifford, MD, MPH; Arnold Goldberg, MD; Albert Puerini, Jr., MD; Patrick Sweeney, MD, PhD, MPH.

Dr. Borkan called the meeting to order at 7:35 AM. Minutes of the May 16, 2007 meeting were approved as written (motion by Dr. Block, second by Dr. Wagner, all in favor).

Immunization Update – Ms. Beardsworth, Coordinator, Immunize for Life Program, reported that HEALTH would have a series of meetings this week with the Medical Directors of health insurance companies, the Adult Flu Advisory group, and the Adult Immunization Coalition to resolve questions on reimbursement and insurance coverage. Providers are concerned about exceeding the 5% vaccine wastage allowance. Ms Beardsworth noted that providers will be able to adjust their orders until October 8, 2007, and HEALTH will assist in redistribution of adult flu vaccine between practices with excess and those in need. The 5% wastage limit will not apply to pediatric vaccines this year. PCPAC members voiced concern that the wastage limit would result in physicians/practices under-ordering vaccine, and that in the case of late delivery (as in the last two years) practices would not be able to get all the vaccine administered to their patients. HEALTH ordered adult vaccine from four vendors; the balance of orders should be shipped by November 1st. HEALTH is working on a statewide start date of October 15th to make sure sufficient supply is on hand and prevent over-early vaccination including a public education program. Dr. Block predicted that only about 50% of high-risk patients who have regular appointments in September/early October will return after October 15th for a flu shot. He noted that optimal vaccination time may be later in the season, but providers must be realistic about reaching their patient populations.

Family Health Plan - Dr. Hollinshead distributed copies of the 2007 plan for maternal and child health to assist PCPAC members in making recommendations for the 2008 plan, as discussed at the May PCPAC meeting. He noted that Family Health is looking for creative ways to integrate major investments already made and to adjust current programs. Dr. Wagner noted that the plan priorities are framed to be positive and promote healthy lifestyles, but he recommended that priority 2 be expanded to include "and the reduction of alcohol and drug use."

Review of Certificate of Need (CON) Applications - PCPAC was asked to provide recommendations for conditions for approval on Certificate of Need applications, in order to promote primary care infrastructure and access to services for uninsured/underinsured populations. Five CON applications were submitted for the current cycle; comments may be submitted between July 10th-August 29th.

General Comments on the Applications: The CON applicants do not truly address the integration of proposed services with primary care and prevention efforts in the answers to questions regarding Healthy People 2010 goals, coordination of care with PCPs, preventive services in the PC setting, and unmet PC needs. The answers to CON application questions regarding population to be served are based on total service area populations, and do not address how underserved patients will access services. Children are included in the population counts even though it is not clear that the health services in question will be provided to children. Each CON Application was reviewed in consideration of the following issues:

- Specific areas of prevention and primary care connected to the application subject
- Primary, secondary, and tertiary prevention measure to reduce incidence of the conditions which will be treated by this CON investment
- Ongoing, accountable process of providing specified amounts of access to services for uninsured/underinsured/Medicaid patients

Oncology-Related CON Applications - Three of the proposals (Memorial Hospital Radiation Oncology, Radiosurgery Center of RI, and Roger Williams Hospital) are for highly expensive oncology treatment equipment or facility investments. The applicants should address the needs of the surrounding community in order to reduce the future demand for these tertiary services while providing the best care for patients with malignancies. As noted in the Radiosurgery Center proposal, aggressive cancer screening per ACS guidelines and healthy behavior education efforts at the primary care level will result in the reduced incidence, morbidity, and mortality related to most cancers. There is enormous unmet need in RI for access to screening colonoscopies for uninsured, underinsured, or Medicaid patients. Even if a PCP is able to find a facility to use, they often are not able to find a gastroenterologist to perform the procedure, and vice versa. Hospitals have both facilities and physicians, but they control access and have long waiting lists for uninsured patients.

Some physicians have become reluctant to refer patients for screening colonoscopy, due to lack of access. The medical community may try to follow the best guidelines available, but if screening services are not available, prevention and early detection become impossible. Dr. Maxim urged the group to research availability vs. relying on anecdotal data. There was a statewide process to evaluate access to gastroenterology, which concluded RI had a problem with GI access. Dr. Fessler noted that RI Health Center Association (RIHCA) could do a quick poll of its member health centers for current data. Dr. Borkan asked if RIHCA could discuss the capacity needed for screening colonoscopy, and where, at their next meeting. The question of CON applicant collaboration with primary care practices/organizations was raised. Dr. Block pointed out that hospitals are adept at asking questions of community health centers and claiming that as collaboration, with no impact on access or increased services for the health center patients. Comments to the three oncology treatment CON applications:

- Require each applicant to provide a specific number of timely, free screening colonoscopies annually for uninsured/underinsured patients, accountable to the Department of Health with revocation of licensing as a consequence of non-compliance. The number of screening colonoscopies required should be proportional to the size of the associated hospital, based on either bed count or operating budget.
- Ask each applicant what procedures they will put in place for primary, secondary, and tertiary prevention in connection with the investment for which they are seeking CON approval.

Kent Hospital Primary Angioplasty - Dr. Borkan pointed out that there is considerable controversy about the need for Primary Angioplasty at Kent Hospital, since this expensive high-tech service is available in several other area hospitals in the state. In addition to charity care requirements, Dr. Block suggested requiring stress tests for patients referred from the primary care setting in need of further evaluation of chest pain. Other preventive cardiology procedures suggested include total access to free cholesterol, blood sugars, and blood pressure screenings, as well as screening stress tests. These items would not add significant costs. PCPs concerned about a pattern of chest pain have found it nearly impossible to get an uninsured patient an outpatient stress test, and have had to instruct their patients to call an ambulance when they are having chest pain in order to get a stress test. A specific number of weekly stress test slots should be dedicated to uninsured patients, to hold down the wait time. Dr. Wagner encouraged moving the prevention focus back to include not only screening services but to provide free smoking cessation clinics; earlier prevention efforts and reduction of risk behaviors will truly change the trajectory of disease incidence.

Dr. Wagner asked if setting conditions on these high-tech applications would disproportionately disadvantage the access in specific places, as opposed to promoting low-cost, low-tech solutions that could potentially be expanded to all hospitals that offer those high-tech procedures. Dr. Fine answered that requirements placed on new applications will set a standard for future CON requests. The applications for cancer treatment and invasive cardiology facilities, combined with existing services, exceed the need in the state from a population perspective. Research shows that the more high-tech services are available, the more they are used, but it is the low-tech services that have demonstrated impact on population health. Dr. Fine noted that he is uncomfortable with PCPAC being asked to concur with these initiatives that add to the high cost of health care while primary care is perennially under funded. He suggested framing a response to challenge the state to engage in a coherent planning process, so the services available would meet the needs of the population instead of being driven by competition between hospitals. Dr. Block responded that PCPAC is not endorsing any CON applications; rather the committee is trying to convey that entry into lucrative new markets, such as invasive cardiology, will come with costs that will slightly reduce the profitability. In this instance, it will be the provision of preventive services to the uninsured ranging from basic cholesterol to work-ups for patients with chest pain. These requirements are not meant to unfairly burden any one hospital, but should be standard for all hospitals looking to expand into new markets; the facilities must promote primary care and prevention of disease.

Dr. Fine voiced concern that this process persists the hospital-centric health care system in Rhode Island. Dr. Borkan noted that there is no regulatory authority over the big picture at this point, but this effort is a small way to tie in prevention measures. The advisory should include a recommendation for oversight of what is happening around the state in addition to addressing individual needs via CON applications. PCPAC is looking to link each CON request with the primary, secondary, and tertiary prevention measures surrounding the conditions the CON request will treat.

Dr. Hollinshead noted that the recommendations for low-cost preventive screening services makes sense, but patients should not be trained to go to a hospital for these screenings; they should be at the medical home. Unless instructed otherwise, hospitals will set up the screening services at their facilities. Dr. Wagner argued that the screening could be set up anywhere and that hospitals could be directed to collaborate with primary care practices at no cost. Dr. Fine suggested that the recommendations include that the CON applicants will financially support the activities of their affiliated primary care practices in engaging in screening activities.

RI Specialty Hospital - The Rhode Island Specialty Hospital (RISH) CON application seeks to establish a 40-bed long-term acute care facility on the campus of the existing Rehabilitation Hospital of RI (RHRI), North Smithfield, part of Landmark Health Systems. In conjunction with the establishment of RISH, the operating capacity of RHRI will be reduced by 40 beds. Dr. Allen noted the major unmet need related to this CON is access to long-term acute care facilities for poor/uninsured patients. Dr. Block commented that the requirements set on the CON must be specific; he suggested that 10% of beds in the facility be reserved for poor/uninsured patients. The CON application cites 11.4% uninsured in the population to be served.

PCPAC Topics for 2007-2008 - Possible discussion topics suggested (in addition to ad-hoc meetings for emergent issues):

- Retail based clinics
- Structural planning for the state / a state primary care and prevention plan
- Elimination of "all products" clauses in insurer/provider contracts
- Making sure every insured patient has a designated PCP, trackable from an insurance perspective
- Strengthening primary care training in RI to keep it viable
- Promotion efforts for primary prevention
- Integration of Electronic Health Records across various systems and entities for true compatibility
- Dialog with insurance companies to ensure their adherence to coding practice standards
- Standardized formularies statewide between insurers
- Primary care reimbursement as compared to neighboring states
- Adolescent mental health in schools; how to approach kids and address high suspension rates
- Nutrition in schools and in the WIC program/efforts to reduce unhealthy foods and excessive juice consumption
- Discussion with Bradley Hospital leadership on how they are fulfilling CON requirements

Dr. Borkan noted that he agreed to chair the committee for one more year, and invited members to send him comments on any changes they would like to see in how the meetings are run. Comments may be sent via email; members also were asked to complete the annual PCPAC evaluation form. He thanked all members for their help in building this two-way communication process with HEALTH.

NEXT PCPAC MEETING: WEDNESDAY, SEPTEMBER 19, 2007