

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, December 19, 2007

Members & Alternates in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregory Allen, DO; Francis Basile, Jr., MD; Thomas Bledsoe, MD; Stanley Block, MD; David Bourassa, MD; Mark Braun, MD; Matthew Burke, MD; Denise Coppa, PhD, RNP; Michael Fine, MD; David Gifford, MD, MPH; Christopher Jones, MD; Raymond Maxim, MD; Albert Puerini, Jr., MD; Richard Wagner, MD. *Associates/Guests:* Steven DeToy; Mark Jacobs, MD. *HEALTH:* Valentina Adamova; Carrie Bridges, MPH; Robert Crausman, MD, MMS; Helen Drew; William Hollinshead, MD, MPH. *PCPAC Staff:* Carla Lundquist.

Members Unable to Attend: Munawar Azam, MD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Sarah Fessler, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Cynthia Holzer, MD; Kohar Jones, MD; Elizabeth Lange, MD; Victor Lerish, MD; Patrick Sweeney, MD, PhD, MPH.

Dr. Borkan called the meeting to order at 7:35 AM. Minutes of the November 28, 2007 meeting were approved as written (motion by Dr. Coppa, second by Dr. Basile, all in favor). Dr. Borkan noted that the courtyard side door to DOA would now be locked until 7:45 AM, and advised that members and associates be notified to enter DOA through the Smith Street side.

Pre-authorization and Imaging Use – Dr. Jacobs, CEO and Founding Partner of Coastal Medical, Inc., provided a statement on the new Blue Cross Blue Shield of RI imaging pre-authorization (PA) requirements for primary care providers (PCPs) scheduled for implementation on January 1, 2008. He declared this requirement to be the single most onerous burden placed on RI PCPs by insurers to date. Key points:

- Radiology tests are expensive and sometimes may not be strictly indicated on clinical grounds, but physicians almost always make decisions to test, right or wrong, on behalf of their patients. Other reasons for test ordering can include insecurity about clinical judgment, fear of litigation, ignorance of clinical guidelines, or patient demands. Reduction of truly unnecessary testing is a worthy goal, but this long-standing issue will not be solved overnight.
- BCBSRI does not have data demonstrating if PCPs are over-testing or which PCPs are over-testing more than others, and are implementing a punitive measure on all PCPs in lieu of researching the issue.
- PA requirements create barriers to important and appropriate care. BCBSRI has pressured physicians to see acutely ill patients in their offices, rather than have them go to hospital emergency rooms. The delays caused by the PA process can negatively impact patient health. ERs are not subject to imaging PA; this sends a message to patients that timely evaluation can only be accessed in the ER, not at PCP offices.
- The primary care business model cannot tolerate any additional non-reimbursed work time, which PA will impose. This will put added strain on cost effective and high quality practices, which may be appropriately ordering radiology testing, and create a financial penalty that will hurt patient care and further undermine the economics of PC offices.
- Alternative proposal: A mandatory, licensure-contingent, radiology Continuing Medical Education (CME) program to educate MDs on imaging decision algorithms, and a program of voluntary submission of case scenarios justifying test ordering for independent judgment. This would serve to educate all PCPs and allow those physicians who can prove that they test appropriately to be exempt from PA in year two of this program.

Dr. Puerini added that physicians have pleaded for this educational alternative since the PA program was announced and are willing to work with BCBSRI to identify/resolve problem areas, but BCBSRI insisted on this punitive approach that will consume scarce staff & physician time and may require hiring extra staff. Mr. DeToy remarked that RIMS met with BCBSRI when PA was first raised in 2001 to pursue an educational resolution, but were not successful. Dr. Crausman recommended not pursuing radiology CME as a condition for licensure, but as part of provider certification for BCBSRI.

Potential consequences - PA for imaging places burdens on both PC practices and specialty practices that must get PA when ordering tests specific to their area. This likely will result in increased subspecialty referrals to avoid the PA exercise and will increase the overall cost of health care. Other possible consequences: The number of X-rays will increase, and PCPs will refer to the ER more often because they do not have time to get PA for imaging. Dr. Braun asked if a PCP gets a report from a radiologist recommending follow-up imaging, and then is denied PA for the imaging, how will this impact patient health and physician responsibility for patient care. Dr. Puerini asked who would be liable if a patient had a bad outcome due to denial of imaging tests. Dr. Block suggested physicians are obligated to tell their patients to fight with their insurance for recommended tests. Dr. Fine declared that BCBSRI is downloading an insurance function on the backs of practices, forcing PCPs to get the data the insurer cannot or will not, and making the PCPs bear the cost. Dr. Fine's practice will not hire additional staff to process PA, but until the impact on the practice is known, they will close to new patients. Dr. Bledsoe added that it is simplistic to say that targeting the PCPs will fix any problem of imaging over-use when patients, confronted with major advertising, demand such tests. This type of blunt instrument imposed by insurers is counterproductive and damaging to primary care.

Dr. Bledsoe asked if the Director of Health has authority over the implementation of PA requirements. Dr. Gifford replied the Department's authority is loose in this matter; HEALTH cannot block PA as long as certain rules are followed. He added that PA has a role in assuring appropriate distribution of limited resources, or for risky procedures, but PA for

imaging doesn't seem to fall under either category. It is not clear why high imaging use occurs; the factors listed by Dr. Jacobs are not related to knowledge deficit, and Dr. Gifford has not seen physician educational efforts have significant impact. He is willing to meet with insurers to provide his views on the appropriate role of PA and offer alternate solutions. If patients are demanding imaging, then physician education and guidelines may not impact usage. Questions to address: Is there data for over-utilization? Do EMRs have algorithms for test ordering? Can auditing be built in? Dr. Crausman noted that broad educational approaches have not been shown to be effective, but targeted efforts can be.

Dr. Fine noted that the Primary Care Leadership Council (PCLC) has worked hard to stop imaging PA from being implemented from a patient safety perspective, as the handoff of patients creates injury risk and delays in authorization can cause patient to fall through the cracks and be injured. The PCLC has developed a recording tool for member practices to document the impact imaging PA has on patient care and practice operations. Consolidated data will be publicly reported, and as many PCPs as possible are encouraged to track the impact and experiences of PA. RIMS will assist with distribution of the form and with data compilation. Dr. Coppa noted the Nurse Practitioner Council could be of assistance in getting NP response to the PA requirement.

Dr. Block suggested the PA requirement should apply only to physicians with imaging units in their offices, who have a financial incentive to order tests. Many imaging units have come into the state beneath the CON cost cap, and were not subject to CON review. A number of sub-specialists require imaging tests to be ordered before the patient is referred; this will only increase if PA is required. HEALTH should look at disallowing sub-specialists from requiring blind imaging tests to get an appointment. Dr. Gifford pointed out that if BCBSRI is going to use PA, there are three types of imaging [back, joint, and head] that are most subject to overuse; PA for these areas only would have a more rational basis.

Dr. Borkan summarized PCPAC recommendations that BCBSRI should pursue:

- Identification and education of outliers
- Reduction of the number of imaging machines in the state
- Reduction of conflict of interest/physicians with a financial motivation to order imaging tests
- Awareness of unintended consequences
- Patient education on appropriate testing
- PA requirements for a smaller subset of imaging tests
- No PA for follow-up testing recommended by a radiologist
- Prohibit sub-specialists from requiring blind imaging tests as prerequisite for a consult

Dr. Fine proposed a primary care public relations campaign to educate the public. Dr. Borkan noted a successful public campaign to reduce imaging use was conducted in Australia. Dr. Coppa advocated imposing on the insurance community the necessity of having data to define the problem and demonstrate its scope. Dr. Basile noted that BCBSRI has had major problems with their HIT systems, and they don't have supporting data because they lack a functioning system.

Dr. Fine commented that there are regulatory processes related to approval of insurance measures, but it is difficult to find out when there are opportunities for public comment. He asked if that information could be made more actively available for primary care community review. Dr. Gifford responded that HEALTH has tried to use advisory committees and boards to send out that information, and notification listservs are available for sign-up. [To join the Office of Health Systems Development/CON Program Interested Persons List, please email Valentina.Adamova@health.ri.gov. To join the Interested Parties List for the Office of the Health Insurance Commissioner, please email lmello@ohic.ri.gov.] Dr. Gifford will be sending letters to BCBSRI and Medicaid regarding his thoughts on the appropriate use of PA.

Primary Care Trust for RI - Dr. Fine described the PCLC proposal, which grew out of attempts to push bills for a primary care loan repayment program and a primary care business development center through the legislature. Primary care infrastructure development has not been successful in RI because the PC community cannot raise charitable funds. In consultation with the RI Foundation the concept of a Primary Care Trust was developed, based on a UK model.

The Primary Care Trust would support the development and distribution of primary care practices in Rhode Island, so that all Rhode Islanders would have access to robust, community-based, multidisciplinary primary care practices. Plans for the Trust include establishment of: 1) Medical School Loan Repayment for primary care physicians practicing in Rhode Island; 2) Primary Care Practice Development Center; 3) Primary Care Data Warehouse; 4) Primary Care Practice Locator; 5) Primary Care Advocacy Center; and 6) Primary Care Charitable Development Office

Authorizing legislation will be introduced to the RI General Assembly in the 2008 session, although state funding will not be sought. Next steps: Create the Primary Care Trust infrastructure, develop an advisory board, create an administrative structure, and ensure fiscal oversight for the Trust, so that it is positioned to receive funds from hospital conversions, payer litigation, and charitable giving. The PCLC will undertake advocacy and public relations efforts to help the public

and policy makers understand the value of a primary care infrastructure. The outcomes expected from a Primary Care Trust include cost savings (estimated at 30-40%), improvements in health indicators, and stronger communities.

Dr. Gifford's comments in response to the presentation:

- The PCLC needs to develop a quick "elevator speech" description of the proposal.
- The proposal comes across as contradictory in its statements regarding the high costs of health care and the need for more PCPs. The relationship between these factors should be laid out clearly.
- It is not clear why enabling legislation is needed if state funding is not going to be requested. Government affiliation can make fundraising more difficult, and it would not necessarily further the goals of the Trust.
- As stated, the proposal could encounter separation of powers issues, which would quickly erode support.

Additional recommendations from PCPAC members:

- For the legislature, provide quick bullet points, data to support projected savings, and plans for sustainability.
- Dr. Bledsoe advised involving the rest of the practice of medicine, to convey the focus of PC working to improve the health of the community versus PC advancing its own agenda. Dr. Borkan remarked that divisiveness is the weakness in RI health care, and the "elevator speech" should start with care of the community.
- Dr. Simon cautioned that affiliation with organizations/groups of physicians who derive their income from institutions or pharmaceuticals could weaken the project's credibility.

NEXT PCPAC MEETING: WEDNESDAY, JANUARY 16, 2008



PCPAC is supported by a HRSA Primary Care Services Resource Coordination and Development Grant (Program CFDA 93.130, Grant # U68CS00214) to the RI Department of Health Office of Primary Care. Opinions expressed by PCPAC are solely the responsibility of the committee members and do not necessarily represent the official views of HRSA or the RI Department of Health.

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, November 28, 2007

Members & Alternates in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregory Allen, DO; Francis Basile, Jr., MD; Thomas Bledsoe, MD; Stanley Block, MD; David Bourassa, MD; Denise Coppa, PhD, RNP; N.S. Damle, MD; Fadya El Rayess, MD, MPH; Sarah Fessler, MD; Michael Fine, MD; David Gifford, MD, MPH; Richard Wagner, MD. *Associates/Guests:* Andrea Arena, MD; Arianne Corrente; Steven DeToy; Elizabeth Gemski; Thomas Warcup, DO. *HEALTH:* Becky Bessette; Carrie Bridges, MPH; Robert Crausman, MD, MMS; Helen Drew; William Hollinshead, MD, MPH; Stephanie Kissam; Ana Novais, MA. *PCPAC Staff:* Carla Lundquist; Mary Anne Miller, RN, MPH, CHES.

Members Unable to Attend: Munawar Azam, MD; Mark Braun, MD; Matthew Burke, MD; Charles Eaton, MD, MS; Arnold Goldberg, MD; Ellen Gurney, MD; Cynthia Holzer, MD; Christopher Jones, MD; Kohar Jones, MD; Elizabeth Lange, MD; Victor Lerish, MD; Raymond Maxim, MD; Albert Puerini, Jr., MD; Patrick Sweeney, MD, PhD, MPH.

Dr. Borkan called the meeting to order at 7:40 AM. Minutes of the October 17, 2007 meeting were reviewed. Dr. Fessler asked that the minutes be clarified to better reflect Mr. Williams' comments on consumer's desire for the Retail-Based Clinic model. The minutes were approved as amended (motion by Dr. Block, second by Dr. Basile, all in favor). Dr. Borkan asked that any comments to the draft advisory letter on Retail Based Clinics be forwarded to Ms. Lundquist.

Dr. Gifford announced that this would be Mary Anne Miller's last PCPAC meeting and thanked her for all her primary care work, both on this committee, with community health centers, and as a champion of oral health and behavioral health. Ms. Miller expressed her appreciation of all PCPAC members who have given so generously of their time and energy to the committee, especially the PCPAC Chairs past and present. Dr. Borkan added his thanks to Ms. Miller on behalf of the PCPAC members.

Department of Health Legislative Priorities - Dr. Gifford provided background on the development of legislative proposals for state departments and the Governor's office, and requested input from PCPAC on HEALTH's proposed legislation package for the 2008 session. Ms. Drew summarized potential proposals the Department considers important for the public health of Rhode Islanders (see also the attached summary of impact and support/opposition):

1. **Require motorcycle drivers over age 21 to purchase disability insurance if they choose not to wear helmets.** Efforts to require helmets on all motorcycle drivers has been repeatedly defeated due to the strength of drivers' lobbying efforts. Current law requires drivers to wear helmets if they are under age 21, and during their first year of motorcycle licensing. This new approach is an attempt to relieve the financial burden on the state for long-term care of motorcycle drivers who are disabled by head injuries from accidents. Comments from PCPAC:
 - a. Will these disability policies be available and how much will they cost?
 - b. The policies should be comprehensive, to include paying for the disabled driver's health care.
2. **Lift the moratorium on new nursing home beds for proposals following the Greenhouse model of resident-focused care.** The Greenhouse model incorporates a physical environment more conducive to residents with limited mobility. Several RI nursing homes (NHs) are pursuing a culture change initiative for which the Greenhouse model would be the next evolution, and some have expressed interest in building Greenhouse facilities. Lifting the moratorium for Greenhouse projects only would give the state leverage in dealing with NH chains interested in buying into the RI market, to push the Greenhouse movement vs. merely rebuilding existing facilities. The NH industry has been very supportive of the concept, and has formed a coalition to promote it. The public does not want the current NH model; market forces eventually will push the Greenhouse model. PCPAC comments and questions:
 - a. Dr. Basile recommended linking Greenhouse facilities with the medical home movement, connecting them with willing primary care practices.
 - b. Dr. Bledsoe asked if there is a mechanism to implement Greenhouse in current nursing home beds. Dr. Gifford said the effort is for new beds, but HEALTH may consider looking at nursing home beds on reserve that will not be coming back into circulation.
 - c. HEALTH should examine if it will be possible to move the Greenhouse model along without adding nursing home beds in the state. Demographics will ultimately dictate the need for more beds.
 - d. HEALTH should assess what the demand for Greenhouse facilities will be on the care continuum [acute/sub-acute/assisted living/rehabilitation]. Facility licensure is segregated; assisted living is licensed differently than a health care facility, and innovative models must get licensed separately as each. HEALTH should explore ways to facilitate licensure of entities that allow patients to age in place.
3. **Increase fees and streamline administration for Newborn Screening and Hearing Screening programs.** Federal monies are no longer available to augment state funds for this program. To compensate, fees will go up as of February 1, 2008; there will be no change to programs and services. Research found the state was subsidizing these fees for some insured patients. This proposal would set up a restricted receipt account for these fee revenues,

allowing for better accounting. Hospitals may object to the proposal as their contracts with insurers for these tests are multi-year cycles and won't be interrupted to add more monies; there will be a three-year lag for them to recoup. Dr. Borkan voiced concern about adding tests to the screening set that are not evidence-based. Dr. Hollinshead explained that HEALTH has a stringent review mechanism for proposed additions, and adheres strongly to national guidelines.

4. **Consolidate the Nursing Board to include Nursing Assistants.** HEALTH has licensure review Boards in 33 professional categories; consolidation of NAs under the Nursing Board will allow the Nursing Board to consider the full spectrum of nursing practice. Dr. Coppa recommended that if the Nursing Practice Act will be opened, consider moving Certified Nurse Midwives under the Nursing Board.
5. **Amend CON and licensing statutes to authorize sanctions for non-compliance.** There is no clear statutory connection between CON requirements and fulfillment of conditions for licensure, so HEALTH has no recourse against entities non-compliant with CON conditions. This proposal would allow HEALTH to revoke licenses or impose fines for non-compliance. Dr. Gifford noted that HEALTH is initiating a review of the CON process and is seeking broad public input to see if regulations or statutes need to be changed to promote "level playing fields". Dr. Basile commented that this might create an incentive for providers to practice across the state line in MA.
6. **Update HIV laboratory reporting and consent procedures to be compliant with CDC guidelines.** RI is out of compliance with final CDC guidelines for HIV in two areas, and must correct these deficiencies to preserve CDC funding, which makes up 90% of HIV program monies. **Consent** - Ms. Novais explained that RI law requires separate written consent for HIV testing within routine primary and/or prenatal care, which can be a barrier to care. CDC guidelines support routine and integrated screening for HIV in primary/prenatal care, without a separate consent form. The changes also will address information transfer and results delivery via phone. **Reporting** – CD4 test results must be reported to CDC by name. CDC allocates funds based on unique individuals by name and will not count anonymous tests, nor will they accept unique identifier numbers. PCPAC comments:
 - a. Dr. Bledsoe expressed deep concern about informed consent and possible increases in those tested without consent. He will bring these issues to the ethics group at Brown University.
 - b. Dr. Fessler noted that elimination of a separate consent form would be of great assistance to those working with vulnerable populations.
7. **Increase the age to purchase tobacco to 21.** This proposal will reduce access to tobacco during the critical late teens when addictions can be most difficult to break. Major opposition is expected, so HEALTH needs more and different voices to push this measure. No other states have this law yet, although several are working on it.

Two other potential HEALTH proposals, **Primary Seat Belt** and **Seat Belts on School Buses**, were not discussed due to time constraints. Dr. Gifford asked if there are any topics PCPAC members think HEALTH should support. Dr. Coppa noted that the RI State Nurses Association and the RI Medical Society are pursuing paintball regulation legislation. They are working with the Attorney General's office on this, and need wide support for the proposal.

Primary Care Leadership Council Legislative Priorities – Dr. Fine outlined the current areas of interest for the PCLC:

1. **Advocacy** – The PCLC is very concerned about pre-authorization for imaging use and is initiating a campaign for primary care physicians to record the time & effort required for all pre-authorization attempts. Practice organizations will be asked to compile the recording documents and forward to the PCLC. RIMS will post logs on their web sites to track PCP experiences, as well as sample notices for patients explaining the pre-authorization delay in imaging scheduling. Dr. Gifford noted prior authorization is being overused and misused, and pointed out that neither HEALTH nor OHIC have any regulatory authority to prohibit pre-authorization requirements from insurers, although they would welcome such authority. The PCLC also is following the Lifespan/CNE merger closely to advocate for balanced development, devoting equal resources to primary care infrastructure as to hospital infrastructure.
2. **Regulatory** – The PCLC is troubled by substantial differences between insurers for flu shot administration reimbursement, and would like the OHIC to explore this issue.
3. **Legislation** – The PCLC has drafted legislation to create a Primary Care Trust for RI, to pull together a variety of efforts to build and strengthen primary care infrastructure in the state, including loan repayment for PCPs and a business development center. The Trust would acknowledge the public purpose of primary care, help address gaps, and advocate for PCPs and practices. Goals for 2008: Obtain legislative authority, create the Primary Care Trust structure, raise funds from charitable foundations to develop a business plan, and basic study of primary care infrastructure and cost. Dr. Gifford pointed out that the draft document does not clearly address in what branch of government this entity would reside, and could get killed due to separation of powers concerns. He recommended that the PCLC revise the document to clarify the separation of powers and the type of entity being established.

Announcements/Other Business - In follow-up to the October PCPAC discussion of Retail-Based Clinics, Dr. Borkan asked if HEALTH could support legislation to disallow for-profit distribution of medications in the same location where they are prescribed. Dr. Gifford replied that he would have to give it some thought, but noted that might impact some primary care providers, as HEALTH has received inquiries about medication dispensing machines. PCPAC members believe these machines provide medication free or at-cost, but agreed that matter should be investigated, as providers should not have a vested interest in the medications they prescribe/dispense. Dr. Borkan suggested the medical ethics group at Brown University should take up this topic.

Dr. Gifford mentioned that the Lifespan/Care New England merger had been suggested as a topic for the December PCPAC meeting. He is very interested in having significant input from PCPAC on this issue, but cautioned that he would need to consult HEALTH legal counsel and regulations on the appropriateness of such a meeting, the timing as related to receipt of the merger application, and whether an invitation can come from a HEALTH-sponsored committee.

The meeting adjourned at 8:45 AM.

NEXT PCPAC MEETING: WEDNESDAY, DECEMBER 19, 2007



PCPAC is supported by a HRSA Primary Care Services Resource Coordination and Development Grant (Program CFDA 93.130, Grant # U68CS00214) to the RI Department of Health Office of Primary Care. Opinions expressed by PCPAC are solely the responsibility of the committee members and do not necessarily represent the official views of HRSA or the RI Department of Health.