PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, January 16, 2008

Members & Alternates in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Gregory Allen, DO; Munawar Azam, MD; Thomas Bledsoe, MD; Stanley Block, MD; David Bourassa, MD; Sarah Fessler, MD; David Gifford, MD, MPH; Cynthia Holzer, MD; Elizabeth Lange, MD; Anne Neuville, RNP; Kristin Souza; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. *Associates/Guests*: Andrea Arena, MD; Thomas Warcup, DO; Elizabeth White. *HEALTH*: Becky Bessette, MS, RD; Carrie Bridges, MPH; Helen Drew; William Hollinshead, MD, MPH; Virginia Paine, RN, MPH, Patricia Raymond, RN, MPH. *PCPAC Staff*: Carla Lundquist.

Members & Alternates Unable to Attend: Francis Basile, Jr., MD; Mark Braun, MD; Matthew Burke, MD; Denise Coppa, PhD, RNP; N.S. Damle, MD; Steven DeToy; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Michael Fine, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Christopher Jones, MD; Kohar Jones, MD; Victor Lerish, MD; Raymond Maxim, MD; Albert Puerini, Jr., MD.

Dr. Borkan called the meeting to order at 7:39 AM. Minutes of the December 19, 2007 meeting were approved as written (motion by Dr. Block, second by Dr. Lange, all in favor). A draft advisory letter to BCBSRI is in review.

Adult Flu Program – Virginia Paine, Adult Immunization Program Manager, gave a mid-season update on the first year of the program, detailing the provider enrollment, vaccine distribution and usage, and adherence to the statewide start date. Many of the issues encountered related to insurance billing, coverage, and reimbursement. A CDC-funded an evaluation effort for this pilot program is underway. Discussion highlights:

- Start date: Because of the October 17th start date, PCPs were unable to vaccinate non-compliant populations seen in September. Some PCPs asked to vaccinate high-risk children early. HEALTH will review the start date for next year.
- Single-dose syringes: HEALTH is working on getting these for the next year per provider requests.
- HEALTH will streamline the provider paperwork for next year.
- Uninsured patients: PCPs were told they cannot transfer doses for insured patients to uninsured patients when the uninsured doses run out, but they can call the Immunization Program to purchase the excess insured doses from HEALTH to use for uninsured patients.
- The public did not understand that the later start date was medically optimal, and not due to a shortage of vaccine. The mid-October start date also ensured that sufficient vaccine stocks would be on hand for providers who planned immunization clinics.

Health Care Payment Reform – Dr. Gifford introduced the topic and described the current health care spending environment from a public health perspective, noting that primary care has the greatest impact on longevity and increased function, but the bulk of health funds go to advanced medical care. Medicare has demonstrated that density of primary care providers is a major factor in predicting health outcomes. Current reimbursement does not support or promote primary care, and does not provide incentive for improvement or to offer evening/weekend hours, or provide smoking cessation counseling. Fee-for-service reimbursement maintains fragmentation, and is the biggest barrier to coordination of care. Dr. Gifford asked PCPAC members for their ideas on payment reform. Discussion highlights:

Extended hours:

- Pediatricians have addressed ways to provide the best care, offer extended hours, and be economically solvent. Incentives need to be offered for other PCPs to have extended hours.
- PCPs are under pressure to provide convenient care, but there has to be some disincentive for patients who are sick for days but wait until the weekend to call the doctor.
- Establish consistent definitions of open access scheduling and sick today/seen today, and provide compensation for these access expansion efforts.
- Encourage practices to create shared systems for after-hours care, especially partnerships between practices using the same EMR.

Other access measures:

- Reducing billing intricacies would free up overhead dollars to fund extended hours.
- Establish regional outpatient congestive heart failure clinics, coordinated to accommodate PCPs and cardiologists. This model is used in Europe; outpatient CHF support works, but is too labor-intensive to do in-office for either PCPs or cardiologists.

- Require authorization from the PCP for children to be seen in the Emergency Room, to reduce inappropriate ER usage. Establish disincentives (penalties or co-pays) for ER visits with a primary care diagnosis.
- Institute/promote reimbursement for phone visits and email consults.

Bundled payments:

- Fee-for-service may work for specialties that are procedure-based, but does not pay for primary care and medical homes. Primary care physician time is reimbursed at far lower rates than specialist time. Adding hours on evenings and weekends to see more patients, or billing for phone consults, is still reimbursement based on procedure.
- Promotion of advanced medical homes will require a different payment scheme, capitation or bundled payment to the PCP or principle MD. This whole person orientation will support increased access, quality, and coordination of care.
- Bundled cost per patient, based on that patient's health status and risk level, makes sense. This will allow the PCP to spend adequate time with the patient at standard visits, and reduce patient calls for refills and other questions caused by rushed visits.

Primary care physician supply:

- New physician expectations for their careers do not match up with the current environment of providing evening/weekend hours.
- There is little incentive/attraction for new PCPs to establish or join practices in RI.
- If reimbursement in RI does not change, the state will not get any new OB/GYNs. Physicians graduating from residencies in RI rarely stay in state; some get salary offers elsewhere that are double what they could get here.

Dr. Gifford has discussed these issues with colleagues around the US; many places face similar problems. Of even more concern is the continued dismantling of primary care, and the dwindling numbers of medical school graduates entering primary care specialties. A re-balancing of the primary care/specialty payment system is necessary for the future of primary care.

Dr. Bledsoe noted that the Chronic Care Sustainability Initiative for RI (CSI-RI) pilot program would be launched at the end of March, to study if the advancement of the medical home will improve quality, improve patient satisfaction, and improve physician professional satisfaction. Dr. Gifford remarked that it might be worthwhile to have CSI-RI present to PCPAC. This project is of interest nationwide; having only four major insurers (Medicaid, Medicare, United, and BCBSRI) makes RI a testing laboratory where it is possible to achieve the critical mass needed for projects to happen.

Other Business -

- Imaging Prior Authorization Follow-Up – Dr. Gifford sent a letter to Jim Purcell at BCBSRI with his thoughts on requiring PCPs to obtain prior authorization for imaging tests. Dr. Gifford gets at least one call per week from providers about PA now that the requirement has gone into effect.
- Department of Administration building access: Please use the door on the south side of the building (facing Smith Street & the State House). The handicap-accessible door will be unlocked at 7:15 AM.
- Next Meeting: PCPAC will meet on Wednesday, February 13, 2008, 7:30 – 8:45 AM in Conference Room A at the Department of Administration. The committee will welcome leadership from Lifespan and Care New England to discuss the proposed hospital merger.

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.