

## **PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE**

### **Meeting Minutes, February 13, 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; Mark Braun, MD; Matthew Burke, MD; Steven DeToy; Sarah Fessler, MD; Arnold Goldberg, MD; Cynthia Holzer, MD; Elizabeth Lange, MD; Victor Lerish, MD; Raymond Maxim, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; Kristin Souza; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. *Guest Speakers:* John Hynes, Esq., President & CEO, Care New England; Arthur Klein, MD, Sr.VP & Chief Physician Officer, Lifespan; Mark Montella, Sr.VP External Affairs, Lifespan; George Vecchione, President & CEO, Lifespan.

*Members & Alternates Unable to Attend:* Francis Basile, Jr., MD; Denise Coppa, PhD, RNP; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Michael Fine, MD; David Gifford, MD, MPH; Ellen Gurney, MD; Christopher Jones, MD; Kohar Jones, MD.

Dr. Borkan called the meeting to order at 7:40 AM. Dr. Borkan noted that BCBSRI has dropped the requirement that primary care physicians obtain pre-authorization for imaging tests, and thanked the Primary Care Leadership Council for providing refreshments in celebration of this development. Minutes of the January 16, 2008 meeting were approved as written (motion by Dr. Block, second by Dr. Fessler, all in favor).

Dr. Borkan welcomed Mr. Vecchione, Dr. Klein, and Mr. Montella from Lifespan, and Mr. Hynes from Care New England to discuss the proposed merger of the hospital systems. The guests described the drivers behind the proposed merger and the anticipated impact on healthcare in the state. The Lifespan and Care New England merger is fiscally necessary in order to:

- Compete effectively with MA hospitals and maintain/grow market share
- Negotiate with the major health insurance companies as a complete network providing tertiary and trauma services (RI Hospital), and other unique services (Women & Infants), especially in view of the disparities in payments between RI and MA for both hospitals and providers
- Sustain services in RI in the face of upcoming and proposed Medicare and Medicaid cuts
- Be able to support local initiatives and the health center system
- Realize administrative cost savings and economies of scale
- Enable pursuit of plans, such as enhancing Behavioral Medicine in the state with the possible relocation of Butler Hospital, and opening a secondary trauma center at Kent Hospital
- Support the Emergency Medicine and Family Physician residency programs at Kent Hospital

Mr. Vecchione and Mr. Hynes both stated that the hospital systems recognize the value of primary care (PC) in the state and that the merger would not have any negative impact on PC. Mr. Vecchione emphasized the need to look at the funds that exist within the insurance industry, and how those funds are deployed. Dr. Klein noted that they have met extensively with Dr. Snyder to look at significant issues in PC, including:

- Graduate medical education and the supply of primary care physicians PCPs
- Support of the medical home model
- Seeking foundation funding
- Using resources in partnership with hospitals, academics, communities, and public health
- The safety-net role of hospitals in RI, and maximizing ambulatory service capacity
- Areas of opportunity for the hospital systems to provide business development functions to help practices survive
- Health information technology

Dr. Klein stated that the merged entity hopes to be a leader in special services with direct impact on PC, and this merger could provide both a philosophical framework and resources for an enhanced quality platform in the state. He views quality as a community benefit, not a proprietary issue of the health system.

The floor was opened to questions from PCPAC members.

Dr. Block asked about the role of the merged hospitals in coping with the reduction of RIte Care/Medicaid rolls and about access to tertiary care services for the uninsured, which has been very difficult with lengthy wait times. Mr. Vecchione noted that the RI Hospital tertiary clinics are the only source of care in the state for uninsured populations, as there is no charity care pool to help provide services. He acknowledged that the

schedules are very backlogged; the clinics are sized per the residency programs, and question is whether the full burden of services for the uninsured/underinsured should fall on one institution. It is hoped that the financial advantages of the merger will allow the hospital to continue to devote resources to the clinics. The anticipated savings will be on administrative functions, not front-line services.

Dr. Mark Jacobs raised the issue of PCP reimbursement; RI is almost last nationally and has high overhead and malpractice, which makes it nearly impossible to recruit. Despite 18+ months of discussion, Lifespan has not made concrete progress on ways to assist PC practices, including recruitment assistance, loan forgiveness programs, EMR software contributions, IT support, encouraging medical residents to pursue PC career tracks and stay in the community, and reimbursement of PC practices to pay for teaching. What will the merged Lifespan/Care New England do to further these initiatives? In response, Mr. Vecchione noted that while Lifespan has had operating margins of 1.5-3% over the last three years, they have a net loss over the past 10 years. Any net funds for the last three years have been reinvested in programs and physical plants, and they are running a deficit for the last four months. The 18 months of discussions have served to clarify what approaches are feasible. Mr. Hynes added that CNE has made significant commitments to assisting PC practices including loan forgiveness programs at W&I and Kent, and reiterated the need to examine how insurance companies are using premium dollars. He urged the PC community to take a more active role in self-advocacy. Mr. Montella noted that Lifespan and CNE are having discussions with diverse other groups around the state, each with specific concerns about the functioning of the health care system and how resources should be allocated. The proposed merger has galvanized legitimate concerns and frustrations, but if it does not take place these issues will still need to be addressed, albeit in a more desperate milieu.

Dr. Puerini asked if Lifespan & CNE see a role for PCPs in the governance of the merged organization, especially academic, CHC, and private practice PCPs. Mr. Vecchione noted that community physicians are represented on the hospital boards where operating decisions are made, although not on the parent board, and currently none are PCPs. Dr. Puerini urged the hospital systems to use this opportunity to develop their relationship with PCPs and give them a stronger voice in governance. Mr. Hynes remarked that Lifespan and CNE recognize the importance of PC, and are eager to move forward with the PC residency program.

Dr. Bledsoe pointed out that data has shown that a high concentration of PCPs is a direct indicator of quality of care, and asked how the merged organization will be better able to help employers, payors, and physician groups to build a robust PC system in RI. Mr. Vecchione replied that he is not convinced that excess funds do not exist on the payor side. To the extent that the merger produces cost savings, the hospital system hopes to make investments in the areas cited by Dr. Jacobs. Mr. Hynes noted that payor complexity is a huge drain on hospitals and PCPs alike, and the marketplace variation in the cost of processing transactions is further indication that dollars could be recaptured for provision of health care.

Dr. Lange commented that Lifespan and CNE's goals for the state are phenomenal, but registered concern about the viability of small practices which do not receive sufficient reimbursement to allow the PCPs to teach or invest in IT. She suggested that available investment funds be focused on PC practices instead of efforts that may not reach fruition. Mr. Vecchione would like to do both; he and Dr. Jacobs have spent considerable time on HIT with RIQI and are beginning to make progress. Lifespan and CNE have made major HIT investments for their providers, which are necessary for positioning themselves to compete regionally.

Dr. Fessler asked the speakers to address the monopoly on hospital beds that would exist after the merger; won't this have a negative impact on community hospitals? Mr. Hynes noted there is an even higher concentration of market share for payors in the state. Lifespan and CNE do not have a history that indicates they would abuse their position, and are pursuing this merger in order to sustain services for Rhode Island. Other hospitals have had opportunities to collaborate or merge, and have decided for themselves on whether to do so. All community hospitals, including the two in the Lifespan and CNE systems, face enormous problems and the merger will neither fix nor exacerbate those issues. Dr. Klein stated that the merged system couldn't achieve its vision unless the overall community structure, including community hospitals, is stronger. Community hospitals and PCPs will benefit from GME for workforce replenishment, patient safety initiatives, simulation training for health professional re-credentialing, and genetic medicine services. Mr. Vecchione mentioned that the FTC review was focused on whether the merge would be anti-competitive, and the FTC did not challenge the transaction. Small hospitals are contending with reduced admissions and reduced lengths of stays; these are

national issues, and RI needs a plan for what the service delivery system in the state should look like in the next 5-10 years and to create incentives to work toward that plan.

Dr. Braun asked how the merged system would reach out to small PC practices that do not currently admit to their hospitals, and what impact it would have on the GME programs at Roger Williams Medical Center and Memorial Hospital. Dr. Klein expressed his respect for the Family Medicine program MHRI, and his interest in partnering with them. He noted he has less information on the programs at Roger Williams. Regarding small PC practices, Dr. Klein stated that every practice in the state is important to maintain quality, and he and Dr. Snyder are interested in PCPs thoughts on how Lifespan can help small practices. Dr. Braun voiced a widespread concern of small practices in selecting an EMR system with longevity of support to protect the investment. Mr. Vecchione mentioned that there are a few established products in the state that should enhance system life, including the systems selected by EHR-RI and Polaris.

In summation, Dr. Borkan noted some important points raised, including the need for PC infrastructure development and support to achieve system balance, ways that the merged hospital systems could assist PC practices, PC representation on boards, access to tertiary/specialty care for the uninsured/underinsured, and hospital systems investment in the community. He commented that research shows that more PC produces better outcomes and saves money, but PC practices cannot do it alone. Dr. Borkan thanked the guests from Lifespan and Care New England, who remarked that they would be glad to assist the committee by returning for further discussion.

#### **Other Business -**

- 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, March 19, 2008, 7:30 – 8:45 AM in Conference Room B.



*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.*