PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, March 19, 2008

Members & Alternates in Attendance: Jeffrey Borkan, MD, PhD, PCPAC Chair; Thomas Bledsoe, MD; David Bourassa, MD; Denise Coppa, PhD, RNP; Steven DeToy; Michael Fine, MD; David Gifford, MD, MPH; Arnold Goldberg, MD; Christopher Jones, MD; Elizabeth Lange, MD. *Associates/Guests*: Andrea Arena, MD; Deidre Gifford, MD, MPH; Meg Lecander, MD. *HEALTH*: Carrie Bridges, MPH; Ana Novais, MA; Peter Simon, MD, MPH. *PCPAC Staff*: Carla Lundquist.

Members & Alternates Unable to Attend: Gregory Allen, DO; Munawar Azam, MD; Francis Basile, Jr., MD; Stanley Block, MD; Mark Braun, MD; Matthew Burke, MD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Sarah Fessler, MD; Ellen Gurney, MD; Cynthia Holzer, MD; Kohar Jones, MD; Victor Lerish, MD; Raymond Maxim, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; Kristin Souza; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD.

Dr. Borkan called the meeting to order at 7:41 AM. Minutes of the February 13, 2008 meeting were approved as written (motion by Dr. Coppa, second by Dr. Gifford, all in favor). A draft advisory letter re: the hospital merger is in progress.

Dr. Borkan welcomed Dr. Deidre Gifford from Quality Partners of RI, together with Dr. Bledsoe, to present on the Chronic Care Sustainability Initiative for Rhode Island (CSI-RI) multi-payer initiative to pilot and test the Patient-Centered Medical Home in Primary Care. This effort, funded by a Center for Health Care Strategies grant to the OHIC, is focused on improving chronic illness care in primary care settings through adoption of the Chronic Care Model (CCM) and the Patient-Centered Medical Home (PC-MH) model, and creation of a sustainable and attractive payment model for primary care providers delivering high quality chronic illness care in RI. Considerable time has gone into developing a sustainable body of key stakeholders including DHS/Medicaid, BCBSRI, United Healthcare, NHPRI, RI businesses, and the primary care provider community. CSI-RI is gaining national recognition for gaining involvement of all major health insurance payers in the development of financial incentives for the 2-year pilot project, which is close to implementation.

Dr. Bledsoe summarized the components of the CCM and how they align with the PC-MH principles to produce improved outcomes, noting that the physician-lead PC team provides a bridge to other areas to the health care system and extends to community support systems. Dr. Bledsoe pointed out the fractured nature of care by payer; the services available to a patient depend on what is allowed by the insurer. This is very frustrating to PCPs and this multi-payer initiative will allow all patients in the practice to access the PC-MH enhancements. The pilot project will involve five multi-physician PC practices that will observe, measure, and work to improve outcomes for their patients with coronary artery disease, diabetes mellitus, depression, and smoking cessation, based on the best practice data and national quality measures available for these conditions. It is not yet determined how depression screening will be operationalized, but it and smoking cessation were included per input from RI health care purchasers and employers, because of the morbidity and cost associated with them. David Gifford asked about other preventive measures with national data sets (immunizations, cancer screening). The list was kept limited so practice changes would be manageable and sustainable, as experience with the Chronic Care Collaboratives has shown that establishing registries and getting baseline data are lengthy tasks. Additional measures, although desirable, would present complications for the initial implementation.

The CSI-RI PCMH will include practice structural elements (patient/physician linkage), care coordination/case management, self-management support, an EHR or chronic disease registry, care based on evidence-based guidelines embedded into daily clinical practice, and enhanced access to care [appointment hours, open scheduling, other modes of interface with providers]. Ms. Novais asked if linguistic/cultural appropriateness was being addressed. Dr. David Gifford noted that patient-centeredness and cultural/linguistic appropriateness are part of the joint principles of the PC-MH adopted by the AAP, ACP, AAFP, and AOA. Dr. Deidre Gifford admitted that cultural competency is a weakness of the pilot program but is part of the vision for expansion; practices will need to have written policies for access and communications. Ms. Novais said that language access should be explicitly stated as one of the CSI-RI principles. The aspect of patient-centeredness has be problematic as well; the complex haggling with practices and plans to make the project viable has made it difficult to bring in the patients' voices. Dr. Lange commented that patient/family centeredness is more integrated in the pediatric world.

In-kind payer supports for the pilot will include training for participating practices and care management teams through the RI Chronic Care Collaborative, and Nurse Case Managers and Assistants (non-RN) located at the practice site and doing home visits, 0.8 FTE per practice. Financial incentives to adopt PC-MH will include enhanced fee-for service, PMPM management fee, and payment to participate so practices can implement performance measures and gauge changes in outcomes. All BCBSRI, UHC, NHPRI, and Medicaid patients will be included, except fee-for-service Medicare. The NCQA Physician Practice Connections-PCMH measurement tool will be used as the basis for practice participation eligibility and level of reimbursement. There is some controversy with use the NCQA standards and whether they are broad enough; this pilot will test the standards only. Dr. Deidre Gifford noted that CSI-RI is the only multi-payer PC-MH pilot in the country with momentum; as other pilots are implemented the funders will push to use the same measures for comparison.

Dr. Borkan asked for comments on the incentives. Dr. Fine pointed out that this project does not include any public financial support beyond Medicaid. Primary care infrastructure serves a public purpose and should be funded accordingly. It is not known what practice infrastructure pieces need to be supported PMPM. Dr. Bledsoe outlined the PMPM structure; the amount depends on the patient's coverage and whether the PCP feels they are high-risk. Dr. Fine mentioned that many of the costs associated with PC-MH pilot implementation are not known, such as space redistribution and opportunity costs, and costs for meetings diverting time from FFS activity.

The Nurse Case Manager (NCM) will work with the very highest risk patients in each practice, estimated caseload of 150 patients. The NCM is expected to connect with the patient's family and community, and make home visits as appropriate. Dr. Fine noted that it is unknown whether a caseload of 150 per NCM is realistic. Dr. Simon stressed that the NCMs must be trained in the subsidies, programs, and support systems available, and should work with Family Outreach Nurses. NCMs should seek patients in the practices who could be assets for peer education and family support.

Dr. Bledsoe outlined several factors that could lead to failure of the pilot project, including reluctance of practices to participate, lack of agreement between plans and practices, lack of leadership support, inability to transform practices to PC-MHs, lack of patient participation, and lack of sufficient improvement in outcomes compared to costs. As yet no practices have made the final commitment to the pilot project. Dr. Deidre Gifford noted that baseline and 2-year qualitative evaluations would be performed at each practice to look at corollaries between the efforts and the outcomes. The total number of patients anticipated to participate through five group practices is 28,000.

Dr. Simon noted that there has been an effort at Lifespan to create Medical Homes for refugees resettled in RI; if they were to participate it might assist with learning more about the role of cultural competency in the PC-MH. Dr. Borkan mentioned that PMPM plan in North Carolina has interventions at all levels, and suggested expanding beyond the focus on payment per month and assessing if support is sufficient for all of the NCQA Physician Practice Connections-PCMH scoring elements. He urged using a diversity of incentives, including HIT/EMR funding and support, and help in setting up practices. Dr. Lange agreed that all payers need to support HIT. Dr. Deidre Gifford noted that UHC has a quality and technology advisory committee, and EHR-RI and Polaris have been before them. Dr. Bledsoe said BCBSRI has various initiatives that are pieces of this project, but also are running in parallel to CSI-RI PC-MH. The ACP will vote in April whether to officially support the RI pilot project; if they vote yes additional resources will be available. Part of the role of the NCM will be to help the practice achieve higher levels on the PC-MH measurement tool and therefore higher reimbursement. Dr. Goldberg urged that the project not lose the perspective of patient- and family-centeredness, even though this is an adult medicine project. The project should follow the community health center model of having patient advisory panels to ensure their voice is heard and participation appropriately cultivated.

Dr. Borkan thanked Dr. Deidre Gifford and Dr. Bledsoe for their presentation, and adjourned the meeting at 8:45 AM.

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