

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, September 17, 2008

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; Stanley Block, MD; Jeffrey Borkan, MD, PhD; David Bourassa, MD; Matthew Burke, MD; Denise Coppa, PhD, RNP; Steven DeToy; David Gifford, MD, MPH; Elizabeth Lange, MD; Anne Neuville, RNP; Richard Wagner, MD. *Associates/Guests:* Meg Lekander, MD. *HEALTH:* Carrie Bridges, MPH; Carla Lundquist; Ana Novais, MA.

Members & Alternates Unable to Attend: Gregory Allen, DO; Munawar Azam, MD; Francis Basile, Jr., MD; Mark Braun, MD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Sarah Fessler, MD; Michael Fine, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Christopher Jones, MD; Cynthia Holzer, MD; Raymond Maxim, MD; Albert Puerini, Jr., MD; Kristin Sousa; Patrick Sweeney, MD, PhD, MPH.

New PCPAC Chair Dr. Bledsoe called the meeting to order at 7:41 AM. Dr. Bledsoe welcomed all attendees and thanked Dr. Borkan for his continuing assistance as Immediate Past Chair in transitioning leadership of the Committee. Minutes of the June 18, 2008 meeting were approved as written. The PCPAC meeting schedule for 2008-2009 was reviewed, noting that as of January 2009, meetings will move to the Department of Health, Health Policy Forum (lower level). Members were asked to note the dates carefully, as they will not always be on the third Wednesday of the month.

PCPAC Structure and Direction - Dr. Bledsoe reviewed the PCPAC Principles, Composition, and Processes, noting that Committee members represent specific groups and constituencies. PCPAC membership does not include Department of Health staff except for Dr. Gifford's ex-officio role. Dr. Burke noted that Dr. Meg Lekander would be filling the vacant position of alternate representative for the Family Medicine Residency. Dr. Wagner requested formal expansion of the Committee to include all areas of medicine recognized by the federal government as part of primary care, including Mental Health/Behavioral Health and Dental. Dr. Bledsoe asked Dr. Gifford if he would find it helpful to have psychiatrists and dentists on PCPAC. Dr. Gifford stated that for professional and reimbursement reasons, healthcare sectors have isolated themselves, causing care coordination problems for providers and confusion for patients. The current issues facing health care are generating recognition of the importance of primary care, care coordination, wellness, and integration across the spectrum. There is an opportunity for primary care to come together and step into the leadership vacuum, and a coordinated voice with mental health/behavioral health and oral health would assist in effecting the transformative changes the health care system needs. Dr. Gifford noted that conditions in RI for Medicaid are an indication of the problems that Medicare and commercial insurance will face later. Crises in health care and health insurance costs will force broader changes and present an opportunity for primary care to step up with its creative solutions in communications, coordination, and medical homes. Regardless of the passage of the global waiver, Medicaid reform is coming and the state must come up with integrative efforts to avoid draconian cuts. Dr. Bledsoe noted that dental and psychiatry representatives would be invited to join PCPAC.

HRSA/RI State Strategic Partnership Meeting – Ms. Novais provided background information on the meeting to be held Friday, September 19th. Over the past 2-3 years there has been a realignment of programs and infrastructure at HEALTH, and one of the priorities identified was to address the public health approach to primary care. Different programs within HEALTH have focused on various aspects of primary care (pediatrics, chronic diseases, disparities, access to care, community health centers) and it was recognized that to bring these programs together, HEALTH had to establish a common understanding, language, and values for what the primary care system should look like. As part of a Performance Review, HRSA asked HEALTH to select a topic to address strategically with key internal and external partners. HEALTH has chosen to build on its internal effort to define a departmental agenda for primary care, and work on getting consensus on the agenda from key stakeholders and a commitment to coordinate efforts to move it forward for the state. Dr. Borkan and Dr. Bledsoe will attend Friday's meeting to represent PCPAC.

PCPAC Priorities for Change – In preparation for the Friday meeting, Dr. Borkan led an exercise to identify the Committee's current priorities for change in the primary care system. Seven categories for change were identified and prioritized. (There were two sets of tied rankings.)

(1) Change Primary Care Payment Methodology

The payment methodology for primary care must be reformed from the current fee for service system to a payment structure that is population-based and promotes and funds care coordination and medical homes. Encourage reimbursement for clinical training sites/providers.

(1) Promote Integrated, Care-coordinated, Interdisciplinary Primary Care

The primary care system should have coordinated care with integrated mental/behavioral health and dental services, and connections with community-based services for wellness and prevention. The responsibility for patient care coordination and communication should be shared between the primary care provider and appropriate specialty care. Primary care should include interdisciplinary health and reimbursement thereof.

(3) Workforce Development, Recruitment, and Retention

The state needs to engage in a wide range of activities to develop the primary care health professional workforce, including incentives for recruitment and retention, loan repayment, improvement of the practice climate for primary care in RI, geographic distribution of providers, and training opportunities and reimbursement. Encourage primary care providers to provide training/preceptorships/clinical placements for health professions student. Improve the unfavorable practice climate for primary care in the state.

(3) Improve communications, enhance care coordination, and sharing of health information through HIT tools including EHRs and the HIE

Improve the mechanisms of communication and coordination of care through adoption of Electronic Health Records (EHR) and other Health Information Technology (HIT), with data transfer through the Health Information Exchange (HIE). Develop data for quality assurance and measures.

(5) Make insurance more collaborative with and supportive of primary care

Increase primary care input and impact with commercial health insurers. Increase the number of health insurers in the state to foster competition for good primary care providers. Increase access to affordable health insurance.

(6) Increase access to care

Increase access as measured by quality indicators. Improve statewide physician-patient ratios and financing. Ensure non-discrimination for patients with co-occurring conditions. Assure that primary care is patient-centered with cultural and linguistic competence.

(7) Community education around primary care

Engage in public education efforts to better inform the population what primary care is, what it does, and why it is important for their health.

Dr. Gifford stated that it is very valuable for him to have this kind of defined priorities and action targets list in front of him when representing the Department. He explained that most prospects for making change are opportunity-driven and unpredictable. He leverages his authority to support primary care when opportunities arise, such as Certificate of Need, Change in Effective Control, and Hospital Merger applications, and this list can help provide a basis for decisions. Ms. Novais noted that prioritization of issues will be part of the HRSA/RI meeting Friday, along with defining the roles and responsibilities of HEALTH, Medical Academies & Societies, Community Health Centers, Area Health Education Centers, and other stakeholders in moving the primary care priorities forward.

Department of Health Responsibilities & Authority - Dr. Gifford voiced his grave concerns that acute and immediate health care needs will take priority over long-term preventive and care coordination efforts, draining all funding. He stressed that HEALTH needs the assistance of the primary care community to help elected officials make difficult policy decisions. The leadership role of primary care will be essential to promote policies that maintain a balance of resources and support efforts that will improve population health.

PCPAC Legislative Objectives for HEALTH – Two questions were presented to the Committee:

1. Does PCPAC want to advocate for HEALTH to have additional authorities to help Primary Care flourish in RI? All Committee members present strongly concurred.
2. Should HEALTH have regulatory powers over Prior Authorization requirements, and if so, what should HEALTH be able to regulate? Dr. Gifford noted that entire managed care regulation package must be reviewed to determine if HEALTH presently has this authority. HEALTH would prefer to address this through a voluntary regulatory approach versus by statute. Dr. Gifford is interested in hearing from PCPAC the criteria under which an insurer should utilize Prior Authorization. This will be discussed at a future PCPAC meeting.



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