

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, March 25, 2009

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; Gregory Allen, DO; David Ashley, MD; Stanley Block, MD; David Bourassa, MD; Mark Braun, MD; Matthew Burke, MD; Denise Coppa, PhD, RNP; Steven DeToy; Patricia Flanagan, MD; Elizabeth Lange, MD; Meg Lekander, MD. *Guests:* Andrea Galgay, Owen Heleen; Gus Manocchia, MD; Neil Steinberg; Robert Trachtenberg. *HEALTH:* Carrie Bridges, MPH; Carla Lundquist; Jessica Magnoli; Catherine Morin; Mia Patriarca O'Flaherty, MA; Peter Simon, MD, MPH.

Member/Alternates Unable to Attend: Munawar Azam, MD; Francis Basile, Jr., MD; Jeffrey Borkan, MD, PhD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Michael Fine, MD; David Gifford, MD, MPH; Arnold Goldberg, MD; Ellen Gurney, MD; Christopher Jones, MD; Cynthia Holzer, MD; Raymond Maxim, MD; Lauren Meisel, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD.

Open Meeting/Old Business – PCPAC Chair Dr. Bledsoe called the meeting to order at 7:36 AM. Minutes of the February 25, 2009 meeting were approved as written (motion by Dr. Braun, second by Dr. Bledsoe, all in favor).

The Fund for a Healthy Rhode Island– Dr. Bledsoe welcomed Neil Steinberg, President & CEO, and Owen Heleen, Senior Community Philanthropy Officer, from the Rhode Island Foundation. The \$20 million Blue Cross Blue Shield RI (BCBSRI) settlement funds negotiated by the US Attorney have been designated as a permanent endowment for the Fund for a Healthy Rhode Island (FFHRI). The income from the fund, estimated at \$800K annually for the first three years, will be dedicated to building a model primary care system in RI. The RI Foundation recognizes that primary care is central to making a difference in health care, and in addition to the FFHRI, the RI Foundation will work as an advocate, convener, and leader to push for primary care improvements.

75% of the available funds each year will be allocated to grants for innovations in three focal areas: making primary care services more accessible for working families; creating access to affordable medications; and education and outreach approaches that engage all Rhode Islanders. Grants will range from \$50K - \$250K for one- to three-year projects. The short and user-friendly application package is available online with a due date of April 15th. The FFHRI grants are open to private practices as well as non-profits, as long as a public purpose and charitable intent for the project is demonstrated, and it is framed as a model for the larger primary care community. It is unlikely that grants will be made to cover capital costs. Because eligibility is statewide and the number of awards will be small, applicant organizations are advised to focus on their best idea vs. submitting several applications. The top rated applicants will receive site visits before award decisions are made. Collaborative efforts are highly encouraged.

The remaining 25% of the annual available funds will be used to develop a loan forgiveness program for doctors and other primary care medical professionals. The RI Foundation is actively seeking partners for the program with a goal of creating \$5 million funding pool; an additional \$500K has already been pledged by BCBSRI but fundraising is difficult at present. Details of the program and criteria for applicants will be determined collectively by the partners sponsoring the loan repayment pool, and have not yet been determined since fundraising is still in progress. The application process is expected to open in the fall. Clinicians will apply for loan repayment and awards will be made directly to loan servicing organizations. The RI Foundation is working to identify an organization to administer the program.

In addition to the FFHRI, the RI Foundation has refocused the Health Sector of their Strategy Grants Program to promote the development of a successful and effective system of primary care, and increase the access, affordability and quality of primary care for RI citizens. Mr. Heleen asked PCPAC members to forward contacts for any national organizations that might be interested in joining with the RI Foundation to build primary care in the state, in addition to any prospective donors. Mr. Heleen stated that if RI could become a model for public education and health care, particularly for primary care, it would go far to improve the quality of life and bring jobs, economic development, and people to the state. Mr. Steinberg requested ongoing conversation PCPAC for ideas, inputs, and recommendations.

Update from Blue Cross and Blue Shield of Rhode Island – Dr. Bledsoe welcomed Gus Manocchia, MD, Chief Medical Officer for Blue Cross Blue Shield RI (BCBSRI), to discuss improvements for primary care in the state. Dr. Manocchia acknowledged that the past relationship with the primary care community has been rocky, but has improved since the low of 2004 following a leadership change at BCBSRI and improvements in the primary care fee schedule. He felt BCBSRI is moving in the right direction although there is still progress to be made, particularly in reimbursement. Recent BCBSRI efforts to support primary care include the “Quality Counts” program which began in 2005 and supported 80 MDs/DOs statewide in the purchase/implementation of electronic health records (EHR) and process/outcome measures; EHR implementation in two additional large practices (160 physicians), the EHR-RI Program for PCPs and specialists (including bonus payments for practices with qualified EHR), and a current Patient Centered Medical Home (PCMH) initiative (10 physicians, IM and Pedi) with BCBSRI-funded nurse case managers. In response to a question from Dr. Braun, Dr. Manocchia stated that BCBSRI has tried to be vendor neutral for EHRs and would like to see fewer predominant EHR vendors in RI. BCBSRI will be moving to direct funding of EHRs after ending funding through EHR-

RI. All current commitments funded by BCBSRI through EHR-RI will be honored, but any practices that do not have a commitment should contact Jessica Lopes in Provider Relations (Jessica.Lopes@bcsri.org).

BCBSRI has supported EHR for physicians as a foundation for building upon and a proxy for quality improvement. Moving forward, they would like to see a significant expansion of the PCMH statewide. Health plans need to be responsive to purchasers seeking value and quality, and need to work with providers to ensure safe, high quality, cost-effective care. Within the next 5-10 years BCBSRI would like to 200-250 physicians in true PCMHs that would include on-site nurse case managers, nutritionists/dieticians, pharmacy, and behavioral health integrated into the practice (some adjunct staff may be part-time). On site support is critical for complex patients with chronic illnesses and/or behavioral health needs. For small practices, a model of shared adjunct staff between several offices in close proximity could be developed. Another possibility is a PCMH structure in which the practice and space are owned by BCBSRI, and the clinical staff are salaried employees. Specialty care in relationship to the PCMH must be addressed in terms of accessing specialty care, preventing waste of resources for care that should be provided in primary care vs. specialty, and identifying those few situations in which a specialist may serve as a medical home. BCBSRI may explore creating incentives and a “preferred specialist network” of those practicing per evidence-based clinical guidelines. A preferred network of primary care providers who follow practice guidelines and reduce waste also may be considered. If a primary care system can be developed that reduces waste, rewards quality, is supported by an integrated interdisciplinary team with strategic roles, and is appropriately paid, patients will experience better care and outcomes, primary care physicians will be more satisfied in their work, and the primary care specialties will be more appealing to medical students. As a result hospitals would experience revenue drops due to fewer ER visits and hospitalizations, so options for “gain sharing” will need to be explored to ensure hospital participation in a system change. Dr. Manocchia noted that the Office of the Health Insurance Commissioner recently solicited comments on draft standards for health insurers that included affordability principles with three tenets. If adopted, all payers in the state would be required to 1) significantly increase their percent of payments to primary care over the next five years; 2) support EHR purchase and implementation; and 3) expand the Rhode Island Chronic Care Sustainability Initiative (CSI-RI) PCMH pilot project by at least 15 doctors over the next year.

Dr. Lange noted that one of the most expensive parts of the medical system is after-hours care; the PCMH requires staff for patient education, and practices need to cover costs. More patients are seeking phone consults, which have proven more litigious than office visits. How is BCBSRI addressing these issues? Dr. Manocchia responded that BCBSRI has CPT codes for Saturday care, but not for evenings. They will be developing a payment policy for evening care including sick and preventive visits. BCBSRI is concerned that reimbursement for phone calls could be abused; they hope to make the PCMH per patient per month (PMPM) payments enough to cover the cost of phone consults. Dr. Lange reported that strict guidelines and standards for phone consults are available; she will forward the latest version to Dr. Manocchia. Additionally, BCBSRI is looking into reimbursement for “virtual visits” via email or secure web site..

Dr. Manocchia noted that CSI-RI provides PMPM payment for all patients in a practice, but BCBSRI is looking to focus on chronic disease patients, a much smaller group for whom the PMPM would be higher. Dr. Ashley questioned whether patient panel sizes would need to go down due to the additional the extra care given to patients. Dr. Manocchia explained that some activities currently performed by the physician could be provided by other members of the interdisciplinary team, freeing up time to concentrate on patients with chronic illnesses. Dr. Simon and Dr. Block noted the success of the Pediatric Practice Enhancement Project (PPEP) in placing parent consultants in practices, which has eased the burden of care on physicians. Dr. Manocchia requested that the Committee provide feedback and input on the concepts discussed.

Dr. Bledsoe thanked the presenters, guests, and PCPAC members for their time, and adjourned the meeting at 8:47 AM.



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