

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, October 21, 2009

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; David Ashley, MD; Munawar Azam, MD; Stanley Block, MD; Jeffrey Borkan, MD, PhD; David Bourassa, MD; Denise Coppa, PHD, RNP; Michael Felder, DO, MA; Joseph Frank, MD; David Gifford, MD, MPH; Christopher Koller; Al Kurose, MD; Elizabeth Lange, MD; Richard Wagner, MD. *Guests:* Paul Block, PhD; Mary Evans; Deb Faulkner; Neal Galinko, MD, MS; Dona Goldman, RN, MPH; Sharon Kernan, RN, MPH; Perri Leviss; Peg Malone, LICSW; Amy Mendillo; Jeff Migneault, PhD. *HEALTH:* Carrie Bridges, MPH; Robert Crausman, MD, MMS; Carla Lundquist; Mia Patriarca O'Flaherty, MA.

Members & Alternates Unable to Attend: Gregory Allen, DO; Mark Braun, MD; Matthew Burke, MD; Joanna D'Afflitti, MD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Patricia Flanagan, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Cynthia Holzer, MD; Kathryn Kocnsol, MD; Meg Lekander, MD; Raymond Maxim, MD; Lauren Meisel, MD; Tom Murphy, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; Patrick Sweeney, MD, PhD, MPH; Newell Warde, PhD.

Open Meeting/Old Business: PCPAC Chair Dr. Bledsoe called the meeting to order at 7:38 AM, and asked the Committee members present to review the minutes of the September 16, 2009 meeting. There were no comments and the minutes were approved as written (motion by Dr. Block, second by Dr. Lange, all in favor).

Health Insurers' Plans for Increased Primary Care Investment in 2010 per OHIC Affordability Principles: Chris Koller, RI Health Insurance Commissioner, reviewed the Affordability Priorities and Standards as developed by the Health Insurance Advisory Committee. Each insurer must submit a plan to increase the proportion of their medical spending that goes to primary care by 5% over the next five years. PCPAC has provided input to this process over the last several months, and the health insurers now are presenting their final proposals for 2010. The total estimated investment for 2010 is \$11 million, \$5 million of which will go to Patient Centered Medical Home (PCMH) projects (both all payor and plan-specific). \$1.2 million is planned for Electronic Medical Records (EMR) initiative, and smaller amount to fee schedule improvements, educational loan repayment, delivery system improvements, and other initiatives. Investment breakdowns for Blue Cross Blue Shield RI (focused on the PCMH projects) and United Healthcare (focused on their national pay for performance (P4P) project) were presented. Over the next year, OHIC will look at Emergency Room diversion and may introduce legislation to require health insurers to collect data on patients' PCP so ER utilization may be analyzed by primary care practice. To monitor the health plans' additional primary care investment, OHIC will meet with the plans quarterly and require semi-annual spending reports which will be released to the public.

Mr. Koller asked for PCPAC member feedback on the final plans. Discussion highlights:

- Since it will be some time before the long-term objectives (i.e., increased professional satisfaction, decreased ER overuse) can be assessed, PCPAC members asked about setting measurable goals for each year (e.g., # of EMRs implemented). For primary care in RI to move toward becoming more coordinated and integrated with wide PCMH implementation over the next four years, we will need interim assessments of the effectiveness of the investments being made. Both process change in the short term and spending/utilization indicators in the long term will be useful, but should be kept separate.
- The UHC investment plan allocated 25% of spending toward P4P, but P4P is based on claims data which can be faulty. EMR data is much more accurate, and UHC should consider a more balanced distribution of funds between these items. A maximum EMR incentive of \$7,500 per practice is not very useful for large practices.
- Evening and weekend access to care are a large part of the PCMH model, and will have a great impact ER utilization. More weight should be given to the incentives for after-hours care, as it is very expensive for primary care practices.
- Primary care provider supply is a critical issue for RI, both in influencing medical students to enter primary care and to retain those graduating from primary care residency programs in the state.
- In RI, Nurse Practitioners are trained to be part of a primary care team, a cost-effective way to increase access to primary care. The primary care investment plans need to include initiatives to employ NPs and measure/demonstrate the impact and cost savings. Third party payors need to create incentives for practices and clinics to have collaborative interdisciplinary teams. PCMHs require interdisciplinary team training to maximize effectiveness.

Mr. Koller would like PCPAC to have a continuing role in implementation of the affordability standards. This will include meetings next year to advise on development of the investment plans for 2011, which will be challenging.

RI DHS Alternate Non-Emergency Provider Network Project: Sharon Kernan, RN, MPH, and Peg Malone, LICSW, provided an overview of the CMS-funded DHS project to reduce inappropriate Emergency Room (ER) use and diversion of patients to more appropriate care settings. The first phase of the project, analyzing Medicaid ER users and primary

care practices, is nearly complete. Target groups with the highest ER use have been identified - RIte Care children under 21, RIte Care adults (mostly pregnant women), and adults with disabilities including the Severe and Persistently Mentally Ill population (SPMI). DHS is working to identify initiatives that will have the biggest impact on the issue, and will be establishing a stakeholder advisory in early November.

PCPAC Member discussion of contributing factors to ER overuse:

- RIte Care parents see the ER as free (no co-pay) and available at all times. They do not have an appropriate perception of what is an emergency.
- Staffing issues for practices to have sufficient capacity for worst times, like winter/flu season. Parents would prefer to use the PCP versus the ER if they could get in to see the provider at a convenient time for the patient, such as evenings and weekends.
- Patient education and anticipatory guidance, key elements of the PCMH, are necessary in addition to extended practice hours. Patients need tools to use at home, and follow-up, to be better able assess their situation.
- The health care system is designed with no barriers to ER use and no facilitators to ensure appropriate usage. An enormous investment in practice redesign is needed to provide extended telephone triage, open hours, etc.
- Regarding the SPMI population, RI has a naturalistic model in RI with mental health catchments areas. All SPMI patient ER visits cannot be lumped into co-occurring condition groups.
- Some practice data indicates more overuse of walk-in/urgent care centers versus ERs, even during office hours. Communications with ERs and urgent care centers is difficult – the PCP most often does not know the patient visited the ER or urgent care.

Ms. Kernan and Ms. Malone noted they have met with some urgent care centers, and will be meeting with the urgent care association to follow up on those issues. DHS is looking at developing alternatives to ER for non-emergency care. There are possibilities of collaborative efforts between PCPs and urgent care centers. There is wide variability between the services and communications provided a different urgent care centers. It is important to find out which urgent care centers work well with PCPs, and also to identify those that over-utilize procedures such as chest x-rays and operate like a miniature ER.

Flu Update: Dr. Gifford provided a summary of seasonal and H1N1 flu activity and vaccine planning:

- The increase in ILI seen in September and early October was likely rhinovirus outbreak in RI, as 90% of those tested did not have influenza. Of the 10% positive for flu, nearly all were H1N1. Most hospitalizations and deaths have been in high-risk individuals (25% were generally healthy) presenting very ill and/or with bacterial pneumonia.
- One third of the state's seasonal pediatric flu vaccine order has been delayed until December, and the adult seasonal vaccine order has been cut 18%; 50-60K fewer adult doses. We were able to get an additional 20K doses of intranasal vaccine – use for healthy adults. Reserve injectable seasonal adult vaccine for high-risk patients.
- CDC has revised Tamiflu guidance: Use for high-risk, hospitalized patients and those with respiratory infections. Tamiflu still is not recommended for healthy patients.
- H1N1 vaccine has the exact same risk profile as the seasonal vaccine. The vaccine does contain thimerosal and the data is very clear that it is safe. If a parent wants thimerosal-free vaccine for their child, they will need to wait until January or February. H1N1 vaccine is being rolled out very slowly. Intranasal vaccine for children 2-5 years of age has been distributed to pediatric practices. Eventually we will have plenty of the vaccine, but now are prioritizing pregnant women and children. The school clinics probably will start by November 2nd and will require 30K doses per week. Schools will only have the multi-dose injection form. Letters with consent forms have been sent out to parents. Middle school age and up will be during the school day, and elementary school clinics will be in the evenings. We are still looking for volunteers to help run the clinics. We hope to have injections for 6 mos-2 years by the time we start the school clinics. Health care workers will get vaccine in January.
- Dr. Gifford encouraged PCPAC members to contact Gary Alexander and Elena Nicolella regarding Medicaid administration fees for H1N1 vaccine. The meeting was adjourned at 8:50 AM.



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