

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, February 24, 2010

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; David Ashley, MD; Jeffrey Borkan, MD, PhD; David Bourassa, MD; Mark Braun, MD; Steve DeToy; Michael Felder, DO, MA; Patricia Flanagan, MD; David Gifford, MD, MPH; Christopher Koller; Kathryn Koncsol, MD; Al Kurose, MD; Elizabeth Lange, MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. *Guests:* Anton Dodek, MD; Gus Manocchia, MD; Elena Nicoletta. *HEALTH:* Carrie Bridges, MPH; Helen Drew; Tricia Leddy; Carla Lundquist; Ana Novais, MA; Virginia Paine, RN, MPH; Mia Patriarca O'Flaherty, MA; Peter Simon, MD, MPH; Melinda Thomas; Suzanne Tobin.

Members & Alternates Unable to Attend: Gregory Allen, DO; Munawar Azam, MD; Stanley Block, MD; Matthew Burke, MD; Denise Coppa, PHD, RNP; Joanna D'Afflitti, MD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Joseph Frank, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Cynthia Holzer, MD; Meg Lekander, MD; Raymond Maxim, MD; Lauren Meisel, MD; Tom Murphy, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; 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 December 16, 2009 meeting. There were no comments and the minutes were approved as written (motion by Dr. Braun, second by Dr. Lange, all in favor).

Expansion of Adult Immunization Program – Dr. Gifford reminded those present that PCPAC serves as the decision committee for additions to the Adult Immunization Program. Ms. Paine, the program manager, provided PCPAC the 2010 Recommended Adult Immunization Schedule from the Advisory Committee on Immunization Practices (ACIP), and other materials from CDC and ACOG on the tetanus toxoid, reduced diphtheria toxoid and acellular pertussis vaccine (Tdap). For adults, Tdap is recommended for everyone ages 19-64, especially adults who have or who anticipate having close contact with an infant aged <12 months, and health-care personnel who work in hospitals or ambulatory care settings and have direct patient contact. HEALTH would like to add the Tdap vaccine to the Adult Immunization Program (AIP) for centralized purchase and distribution. HEALTH currently has ARRA funds to purchase Tdap to immunize all post-partum women prior to discharge; this now is a standing order at all birthing centers. The AIP also is working with birthing centers and obstetric practices to get educational materials out to patients and encourage vaccination for caregivers of infants too young for immunization.

Dr. Felder asked if protocols have been established for the birthing centers to contact primary care physicians (PCPs) before giving a patient Tdap, to avoid patients getting multiple doses. This is important if the administration of Tdap is a standing order for post-partum women. As more women have subsequent children and as girls who received Tdap in the pediatric vaccine schedule age into childbearing years, fewer patients will need Tdap post-partum. Likewise, PCPs need to know when a patient receives the vaccine. There are paper systems in place to notify pediatricians when vaccines are given to infants; the AIP will work with the birthing centers to include questions to verify if Tdap is needed in the hospital screening of pregnant women, and will make sure that adult immunization records go to PCPs. The Immunization Program is working toward a lifelong vaccine registry so providers can look up a patient's immunization history, as done in KIDSNET. It was noted that Tdap is authorized for patients up to age 64, so is not a covered Medicare expense. PCPs should urge patients to get Tdap before age 65, especially if they anticipate being caregivers for infants.

Once in the AIP, Tdap vaccine, along with adult flu vaccine and pneumococcal vaccine, will be available for registered providers to order free of charge. All providers currently enrolled in the seasonal flu and H1N1 flu vaccine programs are automatically enrolled for purchasing Tdap and pneumococcal vaccines. Providers will bill insurers (including Medicare and Medicaid) only for administration; the insurers will no longer pay providers for vaccine when it is established in the program. Insurers currently are still paying for Tdap and pneumococcal vaccine purchased by practices, but that will change later this spring. Some PCPs were unaware that pneumococcal vaccine was available through the program; HEALTH will send information to all providers when vaccine ordering is open. Providers will be required to submit monthly online reports of doses administered/ remaining. HEALTH will be changing the AIP to align with the wastage/reimbursement policies of the pediatric vaccine program.

Dr. Bledsoe called for PCPAC members to vote on adding Tdap vaccine to the Adult Immunization Program. A motion was made by Dr. Lange and seconded by Dr. Braun; the committee voted 12-1 to recommend adding Tdap to the program. Voting in favor were Drs. Bledsoe, Ashley, Borkan, Bourassa, Braun, Flanagan, Koncsol, Kurose, Lange, Sweeney, and Wagner, and Mr. DeToy; Dr. Felder was opposed. A letter of recommendation will be sent.

Relationship of Hospitals to Primary Care -

Dr. Gifford noted that there have been a number of changes in RI hospitals/hospital systems recently, which are coinciding with changes in primary care. Delivery of health care occurs between patients and physicians and between patients and hospitals. There are opportunities to improve the delivery of patient care through improved collaboration, communication and processes between primary care physicians and hospitals. The next several PCPAC meetings will be spent discussing the relationship between primary care and hospitals, and the impact of hospital changes and Certificate of Need (CON) requests, with the goal of improving the quality of care through better collaboration between primary care physicians and hospitals. These discussions will be facilitated by Tricia Leddy, Senior Policy Advisor at HEALTH, who is in charge of overseeing the hospital mergers and is looking at the role hospitals play in RI healthcare. The areas of focus for change identified at these meetings will be used to inform broader policy decisions at HEALTH.

Ms. Leddy provided an overview of the approach to this issue; the goal is to have a summary report of PCPAC ideas/recommendations for implementing change by the summer. For today, she presented two questions:

- What are the areas of opportunity where primary care physicians and hospitals interact, or could interact, to help improve the delivery of patient care?
- In your experience, what currently works well and what is not working well in the relationship between hospitals and primary care physicians?

The majority of PCPAC Member comments focused on communications issues with hospitals:

- There are little to no communications between hospitalists and PCPs regarding inpatients unless the hospitalist is from your practice, and no calls to PCPs when a patient presents at the Emergency Room
- The hospital should make notification/communication in real time so the PCP knows about the hospitalization while the patient is there and why, so the PCP can assist, provide information, and participate in decisions on the direction of care. PCPs often don't learn about a hospitalization until after discharge, even though the hospital needs the patient's medical history from the PCP to make diagnosis and treatment decisions.
- PCPs must rely on communications from hospitals to be aware of the patients' status and participate in the course of care. In the current environment, PCPs schedules do not permit visiting multiple sites daily to follow hospitalized patients.
- Discharge planning is abysmal; there are serious deficiencies in medication reconciliation, communication to the PCP, and follow-up planning. Quality Partners of RI has a committee working on the Safe Transitions project, but there has not been enough hospital interest thus far. Care New England was the only hospital participant at a recent meeting about gain sharing.
- Medication reconciliation is essential on discharge, including addressing non-formulary medications that were prescribed in the hospital, and medications that are duplicative of those the patient is already taking. Often it is unclear if medication changes were made due to medical or formulary reasons.
- What efforts are ongoing in the state to develop systems of information exchange technology for communication between hospitals and PCPs, and what is the status of these efforts? Tools are needed to help PCPs track their patients who are hospitalized; some larger practices or organizations may have staff to do this but it remains difficult to keep apprised without communication from the hospitals early on.
- It would be helpful to have discharge planning and medication reconciliation linked to Electronic Health Records, but PCPs do not have linkages to hospital systems. (About 50% of RI PCPs have EHR.)
- GME needs to train residents to communicate with PCPs when patients present at the ER and/or are admitted.

Integration/coordination - Hospitals are not using their own processes to facilitate integration and communication, such as the software available to generate patient reports in Emergency Departments. There needs to be a hospital culture change and system pressure to force usage and communication. There is lack of integration and continuity at every step of the process, from admissions through stay and discharge; individuals do not function as a team. Hospitals need to streamline the process for direct admissions, with hospitalist involvement, not just GME staff. Integration and information sharing varies widely among caregivers/healthcare facilities/organizations; some share

information (such as the Lahey Clinic) and some do not. The reconciliation system works best – if there is a change in ongoing recommended care/medications, all caregivers are notified.

Financial issues/incentives - The incentives for patient care and outcomes for hospitals and PCPs are not aligned; this financial relationship puts PCPs and hospitals at odds. The incentives need to be aligned in order to achieve quality of care, integration of care, and system efficiency. System changes can be made with incentives. Until compensation is driving the changes, they will not happen. Consultation codes did not work to enhance communications, and now have gone away. Dr. Gifford pointed out that 55-60% of hospital revenue is from outpatient activities vs. inpatient care. An Accountable Care Organization (ACO) is a group of primary care practices affiliated with specialists and hospitals, with which they work in concert and share risks. This approach is used in other states and serves to align incentives and augment communication.

End of life - End of life care is an area that particularly needs integration and communication between hospitals and PCPs, from the quality of life, quality of care, and waste perspectives. A hospitalist unfamiliar with a patient and the patient's family may unnecessarily involve specialists and additional procedures. If the PCP is contacted when a patient is hospitalized, the PCPs will be able to apprise the hospitalist of an end of life situation and assist the family; PCPs also should have incentives to go to the hospital for an end of life consult.

Other issues -

- There are considerable problems with access and wait times for uninsured patients. Access to specialty clinics is especially difficult; private practice specialists shunt the uninsured and publicly insured to the hospital clinics.
- No primary care networks
- Duplication of testing
- The lack of new GME investments for primary care in RI.
- Hospitals have very few PCPs on their Boards

None of these issues is new, and they have been discussed in other venues, but change has not yet happened. HEALTH will continue discussions of the hospitals/primary care relationship over the next few months.

Other Business/Announcements

- Next Meeting Wednesday, March 17th, 7:30 – 8:45 AM, Conference Room B, Department of Administration



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