

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, April 28, 2010

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; Gregory Allen, DO; David Ashley, MD; Stanley Block, MD; Jeffrey Borkan, MD, PhD; Stephanie Chow, MD; Steve DeToy; Michael Felder, DO, MA; David Gifford, MD, MPH; Kathryn Koncsol, MD; Al Kurose, MD; Elizabeth Lange, MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. *Guests:* Rosa Baier; Robert Carnevale, MD; Perri Leviss; Gus Manocchia, MD; Deborah Correia Morales. *HEALTH:* Carrie Bridges, MPH; Helen Drew; Tricia Leddy; Carla Lundquist; Ana Novais, MA; Mia Patriarca O'Flaherty, MA; Peter Simon, MD, MPH; Melinda Thomas; Suzanne Tobin.

Members/Alternates Unable to Attend: Munawar Azam, MD; David Bourassa, MD; Mark Braun, MD; Denise Coppa, PHD, RNP; Joanna D'Afflitti, MD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Patricia Flanagan, MD; Joseph Frank, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Cynthia Holzer, MD; Christopher Koller; 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 March 17, 2010 meeting. There were no comments and the minutes were approved as written (motion by Dr. Wagner, second by Dr. Braun, all in favor).

Discussion of the relationship between hospitals and primary care continued from the previous meetings. Ms. Leddy reviewed the comments made about hospital/PCP communications, and asked PCPAC members to translate them into recommendations. Dr. Gifford suggested the Committee think about recommendations framed on broad principles vs. specific items, which will provide greater flexibility so HEALTH can reference them as various opportunities arise.

Recommendations regarding hospital communications about inpatients:

- Hospitals should require patients to identify their PCP during the admission process.
- Hospitals should communicate information about the patient admission to the PCP as soon as possible, including the reasons the patient was admitted.
- Hospitals should consult with the PCP for information on the patient's conditions/problems, medications, recent tests, and current treatment plans.
- Hospitals should communicate any major changes in care during the hospitalization (e.g. transfer to ICU) to the PCP, including the medical content.
- Hospital communications to PCPs should be concise; important information should be easily identifiable. Reports to PCPs need to be efficient, useful, and thought out, not a daily fax of the entire patient stay chronology.
- Access to hospital data systems (such as LifeLinks) should not be limited to physicians with admitting privileges. Access should be available to members of the primary care clinical team (NPs, RNs) who do not have admitting privileges, and should not be limited to one team member per admitting physician.
- Hospitals should provide complete and timely discharge data to the PCP, including where the patient was transitioned (home, PCP, rehab, another facility), the Continuity of Care (CoC) form, and discharge summary. It is essential that the medication reconciliation be completed. The CoC should include information about the follow up appointment; patients or their family members should be required and assisted to make a follow up appointment before discharge.
- Hospitals must assure that patients understand their discharge instructions, particularly if they are told to follow up with their PCP. Patient education on understanding their condition, actions during the hospital stay, medication reconciliation, and follow up instructions should be provided in language the patient understands and in writing.
- Hospitals should provide PCPs access to transcribed consultants' notes; many are handwritten and illegible.

Dr. Wagner suggested a secure database of hospital interactions be created. Hospitals would require the patient to identify their PCP during registration, and would input names of patients admitted or seen at the Emergency Department (ED) in a database that PCPs could access via their Nation Provider Identification (NPI) number. PCPs, or members of their clinical team, could log in to the database daily to see if any of their patients were seen at the ER or admitted. Such a database eventually could be expanded to include discharge destination and follow up instructions.

Ideally, hospital-PCP communications would be real-time and two-way, affording the PCP the opportunity to provide input on major health events (hospitalization, ED visits, consults, testing, lab results, changes in status, end-of-life planning, etc.). This level of communication and access is in place for some providers at Memorial Hospital of RI.

Recommendations regarding hospital communications about Emergency Department visits:

- Many of the recommendations above regarding timely notification, concise reports, consultation with the PCP, physician notes, discharge information, and follow up, are equally applicable to ED visits.

- Notice to the PCP about an ED visit should include why the patient was seen at the ED and the disposition of the visit (discharge or admission). It is essential for the PCP to know if the ED visits was due to a chronic condition.
- It is essential for the hospital to notify the PCP if the patient has been discharged with specific, unconditional instructions to follow up with their PCP.
- Hospitals should notify the PCP of any tests (including imaging) conducted during the ED visit, the test results, and any results pending.
- ER physicians need to consult with the PCP regarding previous workup of the problem, especially before ordering testing to prevent unnecessary and duplicative tests.

Recommendations regarding PCP communications to hospitals/EDs:

- When the PCP sends the patient to the hospital or ED, the PCP has a responsibility to notify the hospital or ED that the patient is coming, provide background information, and be available for feedback/discussion. Information provided to the hospital should be concise.
- PCPs should be expected to answer phone calls on weekends and nights if the ED calls back.
- If covering for a PCP not in the same practice/group, the covering PCP should provide the patient's PCP with the information from the night/weekend ED calls. PCP practices/coverage need to ensure that ED communications are forwarded to the appropriate provider.
- If a PCP receives a hospital/ED notification or report for a patient who is not theirs, they should notify the hospital/ED so the hospital will not be expecting that PCP to be doing the follow up for that patient.
- Many EHRs have the ability to generate a brief (1-2) page patient summary of problems, medications, allergies, and recent tests. This should be both forwarded to the hospital/ED and provided to the patient to have on hand in case of emergency to prevent costly duplication of tests.
- PCPs could empower their patients to be responsible for carrying their own summary information, including imaging, from point to point in the health care system.

Some other nations have Health Information Exchanges with patient data from the PCP available at all points of care where the patient may present. Pieces of such a system in the US are under construction, but are still years away.

Ideally, the PCP would have ready access to a history and medication list that could be readily transmitted to the ED physician with list of patient information, current medical problems, and medications. This presumes the PCP has remote access to their EHR; few do at this point.

Ms. Leddy noted that discussion of HIT will be pushed to the May PCPAC meeting. Dr. Gifford noted that at some point HEALTH may reopen and rewrite the hospital regulations; some of these hospital/PCP relationship recommendations may be incorporated. The recommendations also may inform professional standards, and contract negotiations.

Other Business/Announcements –

- Dr. Gifford mentioned that Letters of Intent have been received for the June Certificate of Need (CON) cycle. The LOIs are posted on the HEALTH web site and include two imaging requests and the merger/consolidation of RI Hospital and The Miriam Hospital. HEALTH may be seeking input from PCPAC once the applications have been received; input may be conducted via email.
- Patient Centered Medical Home Act of 2010 (S2582) - the Proposed Sub A for this legislation will be heard today by the Senate HHS Committee, State House Room 212, "at the rise" (4:00 PM or sometime thereafter).
- Dr. Borkan introduced Dr. Stephanie Chow, the new Family Medicine Residency representative on PCPAC.
- Next Meeting Wednesday, May 19th, 7:30 – 8:45 AM, Conference Room B, Department of Administration.



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