

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, May 19, 2010

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; David Ashley, MD; Stanley Block, MD; Jeffrey Borkan, MD, PhD; David Bourassa, MD; Stephanie Chow, MD; David Gifford, MD, MPH; Christopher Koller; Kathryn Koncsol, MD; Al Kurose, MD; Elizabeth Lange, MD. *Guests:* Rosa Baier; Robert Carnevale, MD; Jennie Chiller; Stefan Gravenstein, MD, MPH; Deborah Correia Morales. *HEALTH:* Carrie Bridges, MPH; Helen Drew; Tricia Leddy; Ana Novais, MA; Mia Patriarca O'Flaherty, MA; Melinda Thomas; Suzanne Tobin; Amy Zimmerman.

Members/Alternates Unable to Attend: Gregory Allen, DO; Munawar Azam, MD; Mark Braun, MD; Denise Coppa, PHD, RNP; Joanna D'Afflitti, MD; N.S. Damle, MD; Steve DeToy; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Michael Felder, DO, MA; Patricia Flanagan, MD; Joseph Frank, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Cynthia Holzer, MD; Raymond Maxim, MD; Lauren Meisel, MD; Tom Murphy, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD; Newell Warde, PhD.

Open Meeting/Old Business - PCPAC Chair Dr. Bledsoe called the meeting to order and asked the members present to review the minutes of the April 28, 2010 meeting. There were no comments and the minutes were approved as written.

Relationship of Hospitals to Primary Care - Dr. Gifford is seeking recommendations to improve patient care as it relates to hospital/primary care relationship. HEALTH can act on recommendations through measures such as the revision of hospital licensing regulations, the Certificate of Need (CON) process, Hospital Conversions (HCA), and responses to complaints. As HEALTH cannot predict the particular issues that will come before the Department, it is most useful to have broader recommendations than specific items. Mr. Koller noted the recommendations also would be useful to inform health plan and Medicaid contracts with hospitals.

Using Health Information Technology (HIT) to support patient care transitions – Questions for discussion:

- What are the areas of opportunities for HIT to improve the interaction of primary care physicians and hospitals in order to improve the delivery of patient care?
- What HIT applications currently work well and what needs to be improved?

Dr. Borkan voiced the need for a single information system or format for information systems for hospitals, so the communications and information PCPs receive/send from/to hospitals would be uniform. Dr. Bledsoe suggested an electronic Continuity of Care (CoC) system with a single log-in, a “health system exchange” to track patient transitions.

RI Quality Institute (RIQI) recently received one of only 15 Beacon Grants to communities nationwide, to demonstrate the HIT can move quality metrics in three years. One of the components of the \$19.6M grant HIT grant is a project to let PCPs know when a patient has been seen at the Emergency Department, and to use CoC as a communication method. RIQI has three major initiatives ongoing - getting all stakeholders connected to the Health Information Exchange (HIE), helping physicians adopt EMRs and achieve meaningful use per CMS, and show how HIE and EMRs will improve patient outcomes. The application selected metrics for diabetes, hospital admissions, and immunizations (being re-assessed).

- Develop portals for hospitals physician to access PCP outpatient records/EMRs (read-only) for patients presenting at the ED or for inpatients. [Permissions and HIPAA privacy issues would need to be addressed.]
- Greater access for PCPs to hospital clinical information for their patients admitted or seen at the ED. This is critical from a Patient-Centered Medical Home perspective. A bi-directional record viewing system would help avoid duplicative work-ups and facilitate patient follow-up.
- Access to patient records for substance abuse and mental health; currently need special permission to access.
- To assist patients in being activated partners in their own care (key for the PCMH model) patients should be able to review their health information in a format that is accessible and user-friendly.

The RIQI Beacon grant includes a proposal for a patient portal into CurrentCare to provide patient education using a “teach-back” method. The scores from the teach-back would be sent to the PCP so they understand what information/concepts need to be reinforced. This is a critical component of an evidence-based model shown to reduce readmissions by 25%. Care New England has a patient portal, but usage rates are not known. PCPs could ask their patients to use it to notify them of ED visits or admissions; this would increase patient participation and serve as a back-up notification to the PCP.

The Quality Partners of RI (QPRI) Safe Transitions project is working to improve continuity of care. The current CoC forms often are incomplete or illegible; this could be alleviated by using HIT to create an electronic CoC form driven with required fields. Building on the form would advance continuity of care, improving transitions and outcomes. Ideally, an electronic CoC form would mesh seamlessly with EMRs for upload and include:

- Pre-discharge patient education conducted at the hospital, noting who received it (patient/parent/spouse/etc.)
- Pre- and post-hospitalization medications
- Patient oriented discharge summary describing everything that happened in the hospital, written in language the patient can understand
- List of procedures
- List of pending tests
- Enable technology to require key fields to be completed; include drop-down lists, etc.

A CoC that forces essential data inclusion and is electronically accessible/uploadable by the PCP and other points of care (e.g. nursing homes, rehab) would facilitate seamless patient transitions. The CoC could be integrated into the hospital patient information system to populate many of the necessary fields.

Pharmacies should be involved in patient education around medication changes and the medication summaries, and should be copies on the post-discharge medication reconciliation. The pharmacies have true patient medication lists, particularly for patients identified with one pharmacy.

Dr. Ashley remarked that ideally, all patient records would be paperless virtual charts, connected by HIT and appropriately accessible by pharmacies, educators, hospitals, the primary care team, and the patient.

Dr. Gifford noted that a condition was out on Charter Care to make their version of LifeLinks available to all physicians in the state and to create a patient portal. He asked if this incremental requirement was helpful as an intermediate standard. PCPAC members agreed this was a critical interim step that would help prevent duplicative testing, but there are many silos still unconnected. Dr. Gifford also brought up the example of robotic surgery that HEALTH limits through the CON process, effectively centralizing the services – is it helpful from an IT viewpoint? It hard to generalize the IT question for specialty care, but it is important for all physicians, including specialists, to have access to patient information. Recommendations:

- All new health care services/facilities that open in the state should be required to be able to send results electronically.
- PCPs should be able to access their patients' records at all RI hospitals, for referrals to hospitals in which they are not staffed.
- There needs to be balance between pulling all the patient's records at the hospitals, and identifying key information that should be accessible to the PCP. The hospital system should flag and push that information out in an EMR-friendly format.
- The HIE should be able to track who views hospital records and primary care EMRs.

Dr. Kurose asked if there might be a way to require facilities to meet technical specifications now that will increase information exchange utility in the next 5-7 years, so systems can be integrated in the HIE, and not require redesign. Dr. Gifford noted that the pace of standards development is much slower than the pace of change in operation, so it would be very difficult to set or control technical specifications. Ms. Zimmerman pointed out that EMR Meaningful standards would need to be aligned with an electronic CoC form.

Dr. Block pointed out that an area hospitals need to improve is access to specialty clinics, and they need to remove the requirement for pre-testing before seeing the patient for specialty care as it is unnecessarily costly. The relationship between primary care and specialty clinics needs improvement; PCPs should be able to refer patients electronically.

In the future, Mr. Koller would like to have a discussion about the development standards of care in a community – is it by fiat, leadership, pioneers, or other mechanisms?

Other Business/Announcements –

- Next Meeting Wednesday, June 16th, 7:30 – 8:45 AM, Conference Room B, Department of Administration.



PCPAC is supported by a HRSA Primary Care Services Resource Coordination and Development Grant (Program CFDA 93.224, Grant # U68HP11505) to the RI Department of Health Office of Primary Care. Opinions expressed by PCPAC are solely the responsibility of the committee members and do not necessarily represent the official views of HRSA or the RI Department of Health.