

Primary Care Physician Advisory Committee
Meeting Minutes
December 19, 2012

Members and Alternates in Attendance: Elizabeth Lange, MD, PCPAC Chair; Michael Fine, MD, Director of HEALTH; Thomas Bledsoe, MD; Jeffrey Borkan, MD, PhD; David Bourassa, MD; Mark Braun, MD; Steven DeToy; Michael Felder, DO, MA; Steven Kempner, MD; Kathryn Koncsol-Banner, MD; Diane Siedlecki, MD; Patrick Sweeny, MD, PhD, MPH; Richard Wagner, MD. Guests: Mary Evans; Neal Galinko, MD; Deidre Gifford; Peter Houlmann; David Keller; Mack Johnston; Lori Keough; Gus Manocchia; Renee Rulin. DOH Staff: Cristina Carter-Vallejo; Mia Patriarca-O'Flaherty, MA; Peter Simon, MD, MPH

Members and Alternates Unable to Attend: Gregory Allen, Jr., DO; David Ashley, MD; Munawar Azam, MD; Stanley Block, MD; Denise Coppa, PhD, RNP; Nitin Damle, MD; Sarah Fessler, MD; Patricia Flanagan, MD; Cynthia Holzer, MD, CMD; Christopher Koller; Anne Neuville, RNP; Albert Puerini Jr., MD; Newell Warde, PhD

Open Meeting/Old Business: PCPAC Chair, Dr. Lange, called the meeting to order at 7:35 AM. Minutes accepted for November 21, 2012.

Adult Immunization Update

Pat Raymond, Chief, Office of Immunization, presented an update on widespread flu activity in Rhode Island, including the increased incidence of ER visits and hospitalizations. Despite the number of people affected by the flu this year, as Dr. Fine pointed out, Rhode Island is one of the best immunized states in the country. As of Dec 17, 2012, 431,000 of 461,000 doses ordered by DOH have been distributed. Of these, 315,000 have been reported as administered. In addition, pharmacies have administered 74,000 doses of their private stock. School clinics: 21,494 school age children were vaccinated at 421 school-based clinics. (This number represents 13.5% of eligible children.) Pat Raymond also briefly discussed new recommendations that adults over the age of sixty (particularly diabetics and other high-risk individuals) should receive HepB. In addition, teens and young adults between the ages of nineteen and twenty-six who have missed recommended vaccines will now be allowed to “catch-up” and will be covered by health insurance. Dr Fine and Dr Lange noted that the exceptional collaboration between public health and health plans has allowed Rhode Island to offer one of the best immunization programs in the nation.

Opportunities to Improve Primary Care

Dr John Murphy, Executive Vice President, Physician Affairs, presented an overview of Lifespan's efforts to improve primary care in Rhode Island. Dr Murphy noted that Lifespan has undergone a significant transition in the last six months as longstanding CEO George Vecchione stepped down from his position. New CEO, Tim Babineau is ready for change within Lifespan and announced in the Fall that he would be launching a restructuring. Previous Lifespan leadership was very hospital-focused. We now see significant opportunities for improvement around primary care. One of the recommendations from Dr. Babineau and the leadership team is that we need to change our model and become not just a hospital system, but a health system if we are to survive in this new funding/risk bearing environment. This requires Lifespan to develop a physician strategy and a primary care strategy that provides excellent quality, patient-centered care at reasonable rates.

Lifespan has established the Lifespan Physician Group (LPG) which is a physician-run, physician-governed, physician-led multi-specialty practice. At least half of the providers in this practice, or in an affiliated practice, must be Primary Care Physicians if we are to succeed. Barbara Starfield's work demonstrated that a higher number of Primary Care Physicians per capita results in lower healthcare costs and higher quality care; a higher number of subspecialists per capita results in higher cost and lower quality care.

Lifespan's plan is to reach out to existing groups of Primary Care Physicians and subspecialists who are not Lifespan employees (instead of "building our own"). We are starting to talk with primary care groups throughout the state about their interest in working with Lifespan. In particular, discussions are centered on how groups could be part of an organization that can work towards providing health care to the population that is patient-centered and focused on value vs. the fee-for-service model of care. We are in the early stages of this process, there is not yet a detailed plan, and Lifespan wants to actively engage physicians in developing the new model.

We do intend to move some of our ambulatory practices out of hospitals and into the community. For instance, we intend to move our medical primary care practice from APC since the physical form of the building would make it very difficult to implement a medical home/team model.

Questions and Comments from Committee:

A member asked Dr. Murphy to clarify his vision of Primary Care. The member asked if it would help re-establish trust in Lifespan if more active Primary Care providers were to take a leadership role in redesign? Dr. Murphy explained that the leadership group for

Lifespan is responsible for making sure the organization is fiscally sound and appropriately directed. The Lifespan Board plans on developing a strategic committee that will have representation by physician leaders..

Dr Murphy observed that inadequate numbers of providers (physicians, NPs, PAs, etc.) are going into primary care and that Lifespan will have to maximize use of the existing population of Primary Care Physicians and other providers. If a typical panel of patients for a family physician is 2000 patients, then if we are going to do things right in the future, then we need to have medical homes that may have panels of 3000–6000 patients, but with a really good team around the physician. There are a number of things that a physician does now that a nurse practitioner or a nurse case manager could do.

One member commented that it's great to hear that there's a shift in policy. The member asked how Lifespan can contribute, in addition to clinical service, education (i.e. medical students, residents, fellows, researchers, etc.) to get the knowledge that we need to do the practice? Both the LPG and the hospitals don't really have a structure for primary care. Is there some sense of what that emerging structure might be, and how will Lifespan contribute to educating future generations of Primary Care Physicians? In Rhode Island we are training less than 15% of our residents in primary care; we need to be at 35% to 40%.

Dr. Murphy then explained that Primary Care Physicians will not want to come into an organization shared with other sub divisions. If they do, they would want fifty percent governance in LPG given the history in Rhode Island. As far as education goes, Lifespan needs to move Primary Care clinics into a different environment where we can enforce a different model.

Giving Primary Care Physicians an opportunity to be part of something effective may make Primary Care a more intriguing field. Residency students have also observed that Primary Care Physicians are unable to create work teams due to lack of resources, however that is beginning to change. Students weren't seeing effective practices, meanwhile effectiveness draws attention. Retention of physicians trained in RI is a problem, and we need to turn this around.

One member asked if Lifespan has in mind a type of practice that they want to partner with? Most practices in the state are small with one or two physicians. Dr. Murphy affirmed that Lifespan has started by reaching out to larger groups and organizations. The reasons given are because they have been good partners with Lifespan for the last few years, they have more expertise, and finally because many of the physicians that have come together to form larger groups have either tried to create medical homes or are getting there. According to Dr. Murphy, these are the types of organizations or groups Lifespan needs to be working with. Although many small practices may be doing an exceptional job at taking care of their patients, some do not have the same vision as Lifespan. Nevertheless,

after reaching out to the larger organizations and seeing what can be done there; the next step will be bringing together those smaller organizations. Lifespan has also begun reaching out to Community Health Centers in order to expand its options.

One member asked how Lifespan will address the needs of at-risk populations served in resident clinics under this new model? We have significant at-risk populations in Rhode Island whose level of care lags. Dr Murphy responded that the move of the Primary Care Unit is planned to be designed, built and moved over 2013.

Dr. Keller stated that CSI has been reflecting on whether or not they are moving into a system that is nothing but large practices. Due to the current transformation of medicine, the smallest practices are being critically affected, and the amount of human/financial capital necessary to transform a practice is well outside the reach of most small practices. Whereas the larger groups really do have the resources internally to do it themselves. Although it seems unlikely considering the nature of the system, it's more of where the current economic forces are driving things. Or whether it is appropriate for large systems that have capital to try and support transformation in those smaller practices that really don't have the resources to do it themselves. That is something that Lifespan should consider while planning.

Dr. Murphy assured that there's no question that the resources necessary to create patient-centered medical homes with good electronic medical records and to develop the information systems necessary to manage lives is a huge investment. Smaller practices just don't have the ability to do it, while larger practices have to stretch to do it. Still, Dr. Murphy said he would rather be investing his dollars in helping Lifespan partner with the larger groups rather than investing in a wide variety of smaller practices.

Dr. Keller also commented on how electronic health records and IT capacity (also analytic capacity) doesn't get mentioned often although there are a fair number of practices that have electronic health records. They have no idea how to analyze the data they are collecting.

Dr. Murphy expressed his understanding and members agreed that this is the reason why medical practices need to have the information available to be able to manage lives. It is not just about the EMR, but also about utilization, and a lot of data unavailable data that should be available.

Dr. Sweeny questioned what plans LPG has for women's health or gynecology. Dr. Murphy informed him that Lifespan does have the Women's Medicine Collaborative and efforts are being made to bring that group into LPG.

One member asked that if Lifespan was to be successful at bringing in a few of the large practices, then about a few hundred Primary Care Physicians will be needed. Does Lifespan plan on growing their own or absorbing Primary Care practices from the community? Dr. Murphy explained that if Lifespan were to be successful, he would see that the organization would have a true partnership between physicians and the hospital system. Again, if Lifespan did become successful, the goal would be to acquire four hundred sub specialists, and four hundred Primary Care Physicians or more. This will not occur over the course of six months, one year, or two years, but if Lifespan will continue to effectively manage the population it serves, then that should be the standard goal.

One member pointed out Lifespan's great expertise with pharmacy, access to behavior health and nutrition services, and asked if there might be a way to start building those bridges out into the community. Dr. Murphy informed the members that Lifespan is looking forward to having Gateway join the Lifespan organization. Behavioral health is a huge component that is costing Lifespan plenty of money because of the numerous amounts of requests from current patients.

Updates

In terms of coordinated statewide health planning, there are two relevant studies currently going on. The first is a hospital gap analysis run by the Lewin Group, and the second is a Primary Care gap analysis put together by the Robert Graham Center. The Graham Center will be looking at how primary care panel size can affect hospital bed need. In addition, statewide health planning will also be focusing on the Certificate of Need (CON) process and the Hospital Conversion Act.

Meeting adjourned at 8:45 AM