

**Primary Care Physician Advisory Committee**  
**Meeting Minutes**  
November 21, 2012

*Members and Alternates in Attendance:* Elizabeth Lange, MD, PCPAC Chair; Michael Fine, MD, Director of HEALTH; David Ashley, MD; Elizabeth Brown, MD; Kathryn Konsol Banner, MD; Steven DeToy; Michael Felder, DO, MA; Diane Siedlecki, MD; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD. DOH Staff: Peter Simon, MD, Medical Director; Danielle Fontaine (Intern). Guests: Rosa Baier, Healthcentric Advisors; Stephanie Chow, Brown Geriatrics; Kristofer Granvenstein, Brown MPH student; Stefan Gravenstein, Healthcentric Advisors; David Keller, CSI-RI

*Members and Alternates Unable to Attend:* Gregory Allen, DO; Munawar Azam, MD; Thomas Bledsoe, MD; Stanley Block, MD; Jeffrey Borkan, MD, PhD; David Bourassa, MD; Mark Braun, MD; Denise Coppa, PhD, RNP; Nitin Damle, MD; Sarah Fessler, MD; Patricia Flanagan, MD; Cynthia Holzer, MD, CMD; Steven Kempner, MD; G. Alan Kurose, MD; 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. Minutes accepted for October 17, 2012.

**Ensuring Effective Hospital to Primary Care Transitions: Recommendations to HEALTH**

*Healthcentric Advisors: Stefan Gravenstein, MD, MPH, Clinical Director and Rosa Baier, MPH, Senior Scientist*

Purpose of the presentation: to help the Committee to develop recommendations that will enable HEALTH to improve care transitions (through regulations and other means). Recommendations would focus on improving communication between hospitals and primary care physicians. This is a reciprocal process - primary care physicians can improve their treatment if they are able to exchange information with hospitals about their patients (and visa versa).

Multiple Committee members discussed how information technology needs to be improved to foster better communication. For example, primary care physicians need a direct way to speak to hospitalists about their patient's treatment before discharge. Email communications between hospitalists and PCPs also needs improvement. Direct access to the EMR by either hospitalists or PCPs could significantly increase the flow of information and communication. Additionally, trying to coordinate under two different electronic systems is a struggle: different ways in which information is stored and how notes are taken make it very difficult to communicate.

Home care agencies' involvement in discharge has been problematic because of the lack of effective communication between the home care agency and the PCP (e.g. lab results). It may be necessary to require home health agencies to communicate with PCPs within a certain amount of time. One member would like the hospital to ask him (as the patient's Primary Care Physician) what agencies he likes to work with most, but this may compromise patient autonomy.

One member asked whether or not this type of integration of information is the same as Current Care. Lifespan has a similar system, EHX. The two systems are not interoperable. One member suggested, from a regulatory standpoint, would make sense to require that the two systems be interoperable? Other members agreed.

Dr. Fine explained that HEALTH is a regulatory body and has leverage through licensure requirements and professional regulation. Specifically, in the case of hospitals, home care agencies, and ambulatory care facilities, HEALTH has influence through licensure requirements and re-licensure requirements. Entities that are physician-owned are regulated through professional regulation and the determination of professional conduct. Additionally, the Certificate of Need (CON) process is useful to control expansion and protect the safety net; it does not help us in a "system-as-a-whole" perspective. Therefore, the CON process is a relatively weak lever. However, hospital conversion may be an instrument of leverage that will allow us to require conditions of a specific conversion, although these conditions only pertain to that specific hospital system and not the system as a whole. Recommendations could be centered on licensing, professional practice, and the Hospital Conversion Act.

One member commented on how patient responsibility is not included in this meeting's agenda, and it should be included in all discussions about transition. Dr. Lange explained how patient responsibility has an entire agenda dedicated to it in a future PCPAC meeting.

Timeliness of information is critical. Lab results that are received by the provider weeks later are probably no longer useful information. Some patients have their own secure uplink for all medical information and will allow the provider to access this information.

Healthcentric has been working with HEALTH's Physician and Nursing Licensure Boards to develop expectations for care transitions. Part of this discussion centers on when do you move from setting expectations to actually implementing regulations? Healthcentric has also been working with the Office of the Health Insurance Commissioner to incorporate hospital best practices for transitions into contract requirements. Dr. Fine explained how, at the end of the day, HEALTH is the enforcer because our mission is to protect the health and safety of Rhode Islanders.

One suggestion was to regulate the minimum amount of information the patient carries with them, and HEALTH can be incentivized to develop an environment where information lives with and/or follows the patient, e.g. a “smart card”, web-based information, etc. Some believe we will not have an effective system until we have a robust interoperable system. The ideal way to receive information is, however, from the patient themselves. The VA/DOD system has an effective “smart card” system. It is the Committee’s role to actively advocate for these and other changes.

One member observed that we are reactive to things other people are doing, and it may be useful to rebuild the system with the patient at the center. Building on this comment, another member observed that transition best practices do not seem to contain proactive policies that involve the PCP in building the transition plan. The PCP should be engaged days prior to discharge. Another member observed that hospitals are pushing more information to PCPs in piecemeal fashion, but not in a coherent/coordinated manner. What would be the recommendation for a regulation here – require communication with the PCP x# of days prior to discharge.

Rosa asks where the responsibility lies: the PCP who is aware of the hospital visit (and to whom?) or the hospital getting in contact with the PCP? Dr. Fine mentions that these suggestions need to be measurable and hold parties accountable. The other side of this recommendation is related to physician practice: if we require hospitals to communicate with PCPs, these doctors need to answer the hospitalists’ calls. PCPs also need to engage and make a decision about their participation in end-of-life decisions. One member mentions how it will be difficult to communicate days prior to discharge because time is an issue. In terms of getting care managers involved, they are essential yet there are simply not enough of them.

One member commented that the hospital discharge plan should be developed at time of hospital admission to improve coordination. One member added that Case Managers at RIH do begin discharge planning around the time of admission, but seem to be almost the only ones that are addressing and documenting the discharge plan at an early stage. Why not involve the hospital Case Manager with the physician or physician’s office around planning? One member commented that there are not enough Case Managers to meet the current needs.

One member stated that CSI has recently evaluated case management best practices. The most successful approach has been when nurse care managers (based in primary care practices) monitor patient admissions and actively reach out to hospitals and home health agencies to create a facilitated discharge plan. Given how schedules do not match up between hospitals and PCP practices, there needs to be an alternative for communication in which the doctor does not have to be the direct communicator. In the case of CSI, what works is to have a dedicated person in the primary care practice office to manage transitions (i.e. a Nurse Case Manager). It’s critical to ensure that there is a secure communication link between practices and hospitals – this may be a feature of Current Care.

One member commented that as we begin to introduce new technology and additional responsibilities, we need to evaluate what works and which things do not matter.

Dr Lange observed that thus far our regulatory pushes are: IT, interoperability of IT, person to person communication, and asynchronous secure electronic communication. Rosa added two more potential action areas: a way to link each patient to their PCP and a way to contact each physician reliably. Dr Fine commented that many hospitals do not have this information for their own attending staff. Currently, HEALTH is creating a “Physician Finder” to link individual physicians to practices. It could become a requirement that physicians update HEALTH about their status on a regular basis.

One member asked if there has been process in identifying a PCP on patient’s insurance cards. The related legislation passed. Outcome: PCP names are not required to be printed on patient’s cards, but the insurer has to know each patient’s PCP, medical home, preferred physician, etc.

Dr Fine asked if PCPs are paid for managing hospital discharge? PCPAC members could recommend that HEALTH discuss this issue with OHIC. One member commented that VNA forms are lengthy and difficult to complete.

### **Updates**

Health Insurance Exchange update: The Exchange has hired Christie Fegurson as its Director. The “design-gate review” (an assessment by the federal government about whether RI is meeting benchmarks) has been completed and it has been determined that the RI Exchange is on track. The Exchange is in the midst of completing their technology vendor contract and their blueprint certification (entire plan for the Exchange). The department is actively involved in network advocacy.

In terms of statewide health planning, there is a need for information about number and location of hospital beds. Additionally, on December 10<sup>th</sup> the Graham center will be reporting on primary care adequacy gaps. This work is very impressive, and Dr. Fine urges committee members to attend.

**Meeting Adjourned: 8:45 AM**