

**Primary Care Physician Advisory Committee**  
**Meeting Minutes**  
October 17, 2012

*Members and Alternates in Attendance:* Elizabeth Lange, MD, PCPAC Chair; Kathryn Konsol Banner, MD; Stanley Block, MD; Mark Braun, MD; Elizabeth Brown, MD; Denise Coppa, PhD, RNP; Steven DeToy; Michael Felder, DO, MA; Richard Wagner, MD. DOH Staff: Peter Simon, MD, Medical Director; Carrie Bridges, MPH; Leah McPhail, MPA; Danielle Fontaine (Intern). Guests: Linda Andrews, nriAHEC; Rosa Baier, Healthcentric Advisors; Stefan Gravenstein, Healthcentric Advisors; George Bottomley, DVM, PA; Mary Evans, RIHCA; Gus Manocchia, MD, BCBS. *Present via teleconference:* David Keller, MD; Diane Siedlecki, MD

*Members and Alternates Unable to Attend:* Gregory Allen, DO; David Ashley, MD; Munawar Azam, MD; Thomas Bledsoe, MD; David Bourassa, MD; Jeffrey Borkan, MD, PhD; Patricia Flanagan, MD; Nitin Damle, MD; Sarah Fessler, MD; Michael Fine, MD; G. Alan Kurose, MD; Cynthia Holzer, MD; Steven Kempner, MD; Anne Neuville, RNP; Albert Puerini, Jr., MD; Patrick Sweeney, MD

**Open Meeting/Old Business:** PCPAC Chair, Dr. Lange, called the meeting to order at 7:33. The amended meeting minutes from June 20, 2012 were acknowledged. Minutes accepted for September 19, 2012

**Best Practices: Patient-Centered Care Transitions**

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

*Handout: Safe Transitions Best Practice By Setting (updated 5/31/12)*

Previously, Healthcentric Advisors shared updates on the project. Currently, they would like to hear PCPAC's ideas and thoughts; and to discuss primary care needs, and perspectives on new best practices, and to seek input on remaining opportunities and next steps

With regard to the best practice entitled "Notify community physician office about outpatient observation and hospitalization", it was pointed out that getting a discharge summary the following day will not necessarily reduce or prevent a re-admission. Emphasis was made on the "bundling" of tactics, and the individual best practices are specifications that when "bundled" together reduce re-admissions, however it was recommended starting with one individualized one task at a time.

Dr. Simon asked about a way to quantify the magnitude of the impact of evidence-based best practices in RI. Stefan stated that only things which can be measured will be paid for. The issue of insurance reimbursement was discussed. Often, requests for changes are refuted because there is no evidence to support the request, and they can not move forward with change without solid evidence. The results are based upon ongoing feedback from providers and community coalitions, and what they are

trying, what they are finding, and using that information to determine quality improvement. People are very concerned about short term readmissions because of the high cost.

Using a point system could be a way to prioritize the list by developing a way to weight them, and deciding which is most important. For example, determining what information is most helpful (i.e. learning that the patient is on a new medication, without knowing they were even hospitalized in the first place).

Dr. Wagner spoke about a Mental Health Program for the indigent population that he previously oversaw. They found that if the program provided a patient with a prescription, rather than a medication, upon discharge, their readmission rate dropped by 50%. The idea was to change Medicaid reconciliation to a follow-up appointment. When approached with this, Medicaid said no. In the letter that PCPAC wrote to Director Gifford in 10/2010 (copy included with meeting materials), this same idea was discussed.

The issue of data being all over the place, and the absence of communication was discussed. The transition of care from skilled facilities and hospitals back to primary care is inconsistent. There are many changes in between the hospitalization and/or skilled facility, back to the primary care provider. There is a push back from medical directors, and from skilled facilities.

If a patient has private insurance, their EMR can show full history. This is not the case if it is state-funded insurance or self-pay. Another suggestion was to type paperwork so it can be read; the forms are useless if you can't read them. Healthcentric Advisors are working to improve the Continuity of Care (CoC) form.

The idea of developing patient best practices, and what would constitute the "good patient" was discussed. Being clear about what is expected of them and their caregiver, and developing a patient code of responsibilities. It can be as simple as taking medications, showing up for appointments, reporting symptoms, etc.

A discussion then took place about the difference between evidence-based, research-based, or consensus-based. Rosa will rename some of the Evidence-Based Practices and look at unintended consequences.

There are mixed messages to physicians: are we doing evidence-based or not? Another problem is that many of the issues in any setting are a moving target—patients may not be contacting the same individual in the community when they leave the hospital. To "Notify the community physician office" is limiting, and should expand to RNP's, PA's, etc.

Dr. Liz Brown suggested that offering a different perspective to providers could be helpful. Currently, during residency education in a hospital, residents don't see how helpful the forms and communications to the PCP are. One solution could be to talk to residents early in their training. This transition piece is something that is done last minute at the end of the day.

Dr. Simon stated that what has been brought up around the role of patients needs to be more focused on life course framework. Research shows that at 18 years old, the brain is not fully developed and the expectations relative to the life cycle

should be considered. We do not allow people to make decisions at a young developmental age, when in fact they are capable of saying what they want or don't want. In order to be collaborative, we need to recognize basic fundamental things that a patient should know. We must be realistic in goals with patients, as medicine is a very technical thing. Patient can be a great help of information sharing, but must consider where the person is developmentally, and in their life cycle. We need to look at who these patients are, and how they process information.

The one common thread among all providers is the patient. How do we change the expectations of patients? Looking at what we teach patients and what they know about their care, the role of a patient in hospital is much different than the role of the patient out of the hospital. Providing patient with a narrative, of what happened to the patient, this is what we did; this is what you came in for, etc. The COC form is intended to be patient-friendly.

### **Actionables:**

From an insurance provider perspective on the issues of communication and collaboration, something to keep in mind is that medication reconciliation takes a lot of time. Also regarding question #9 on the hospital best practices handout—BCBS feels that when a hospital contacts a PCP, that it is valuable to have a patient's PCP present, and BCBS would like to be able to compensate a doctor for coming to the hospital and seeing their patients. Dr. Manocchia asked what would it take to get a PCP to leave their office in the middle of a busy afternoon to go to the hospital?

Some responses included having 3<sup>rd</sup> party payers promote different models of care. In terms of wraparound services, there is not sufficient information to justify whether a 20-mile drive from the PCP office to the hospital is necessary. Additionally, to look at different approved methods, such as via phone, skype, etc., and other options to get things done alternatively and be reimbursed for time.

Look at ways to change patient behaviors. When people want something, they will likely change behaviors to get it (i.e. adhering to an opiate contract to maintain the prescription).

Rosa stated that the vision is broader than the project. Healthcentric Advisors will be moving forward with a White Paper, and will come back to talk about a Patient Bill of Responsibilities, and to make the system meet people half-way, and support and empower them.

### **Updates**

*Carrie Bridges, MPH, Team Lead: Health Disparities and Access to Care*

#### **Health Insurance Exchange:**

See handout from the Lt. Governors Office, "Update from Exchange Director" including: Upcoming Deadlines, Policy and Communications Update, Operations Update, Technology Update.

**Statewide Health Planning:**

None

**Other Business/Announcements:**

Carrie Bridges-Feliz has accepted a position with the Providence Public School Department, and her last day at the Health Department will be Friday, October 19, 2012. Mia Patriarca will continue to provide HEALTH staff support to PCPAC. The Committee congratulated her and wished her luck.

Dr. Lange acknowledged that the RI Free Clinic honored Dr. Gus Manocchia for being a dedicated volunteer since 2005, having contributed more than 400 hours of his time to care for patients and also serving as a member of the Medical Advisory Committee.

**Meeting Adjourned:** 8:40 AM

Next meeting: Wednesday, November 21, 2012, 7:30-8:45 AM

Rhode Island Department of Health, Conference Room 401