

Primary Care Physician Advisory Committee
Meeting Minutes
February 20, 2013

Members and Alternates in Attendance:; Kathryn Koncsol-Banner, MD, PCPAC Co-Chair; Stanley Block, MD; David Bourassa, MD; Denise Coppa, PhD, RNP; Michael Felder, DO, Steven Kempner, MD, Diane Siedlecki, MD; Patrick Sweeny, MD, PhD, MPH; Richard Wagner, MD. *Guests:* Susan Cerrone Abely, Rosa Baier; Kenneth Belcher, George Bottomely, PA; Otis Brown, Stephanie Chow, MD; Stephen Davis, MD; Michael Fine, MD, Director of HEALTH; Deidre Gifford; MD, David Keller, MD; DOH Staff: Cristina Carter Vallejo; David Robinson, EdD, Steven Sepe, Peter Simon, MD, MPH.

Members and Alternates Unable to Attend: ; Gregory Allen, Jr., DO; David Ashley, MD; Munawar Azam, MD; Thomas Bledsoe, MD; Jeffrey Borkan, MD, PhD; Mark Braun, MD, Nitin Damle, MD; MA; Steven DeToy; Sarah Fessler, MD; Patricia Flanagan, MD; Cynthia Holzer, MD, CMD;; Christopher Koller, Elizabeth Lange, MD, PCPAC Co-Chair; Anne Neuville, RNP; Albert Puerini Jr., MD; Newell Warde, PhD, Ana Novais, MA,

Open Meeting/Old Business: PCPAC Chair, Dr. Koncsol-Banner called the meeting to order at 7:35. Minutes accepted for February 20, 2012.

1st Presentation: Kenneth H. Belcher & CharterCARE Organization – efforts in primary care and role within the community with the primary care physicians and practices.

Mr. Belcher: joined by **Steve Sepe:** Chairman of Medicine at the Roger Williams Medical Center

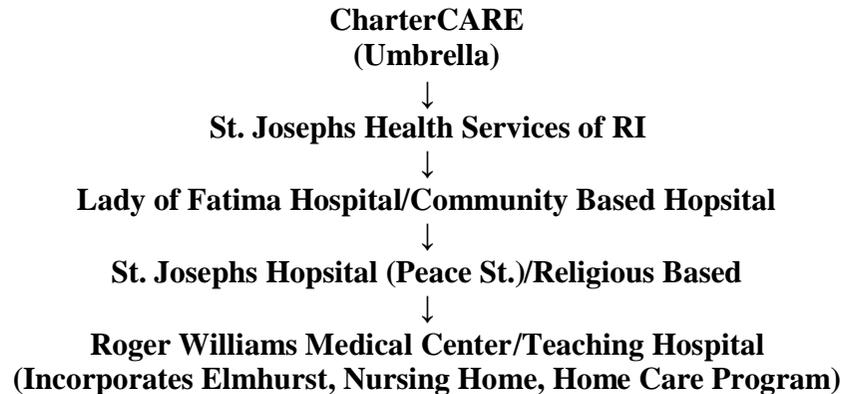
Susan Cerrone Abely: Vice President & Chief Information Officer (CIO) for CharterCARE

Otis Brown: Vice President of Development and External Affairs for CharterCARE

Kenneth Belcher: President & CEO of CharterCARE

Overview of CharterCARE by Kenneth Belcher: CharterCARE came together about 3 years ago. Two heritage hospitals make up CharterCARE – RWMC and St. Joe's Health Services of RI. Organizational structure – not a merger, but an affiliative structure with

a single board over CharterCARE (15 member board, 8 of them were appointed by the bishop, the other 7 elected from the board of RWMC)



For years, boards of two heritage hospitals spoke about collaborating instead of competing but never came together. Roger Williams had what is called an administrative transgression - almost a complete change in the board and many changes in administration (results brought new visions and directions which lined up very nicely with what was going on at St. Joe's and Our Lady of Fatima). The community hospitals' taskforce came together to evaluate some financial challenges that the independent hospitals were going through at the time and what to do about it. There were two primary findings: There should be more of a leveled playing field of reimbursement or uniformity during the race; and, Healthcare institutions and hospitals should be collaborating with each other rather than competing against each other.

When interviewed for CEO position at Roger Williams Mr. Belcher explained his personal vision which he said was for the institution to move forward by looking towards collaboration in developing the system as far as a network for healthcare delivery. The board of St. Joe's and Our Lady of Fatima agreed with his vision because they agreed on stopping the competition and also because neither one of the institutions came from a very strong financial condition. Coming together would help strengthen the overall finances for both organizations for the primary reason that they would continue to exist to provide healthcare for the communities they serve and also to work on best practice for both organization, and that is what has been going on. There have been some organizational challenges throughout the process. First year of coming together Our Lady of Fatima lost 19.9 million dollars, last year was 11 million and this year that just ended was 4.3 million. A little bit over 29 million worth of expenses have been saved by coming together. The

organizations are in a stronger position now to continue to provide service to the community; therefore, coming together has been successful.

The vision is to have a network delivery system where “we are out in the community networking with physicians, helping support them and their particular practices, and for the hospital to be there as the mother/fathership.” The home care program is busier than it should be because some patients can be treated in an ambulatory setting due to medical advances. CharterCARE is looking for a capitol partner because they realized that having additional capitol is important, but we have not looked at any companies for acquisition but for partnership under a joint venture type model. A decision may be coming soon. Whoever is chosen for partnership must maintain the mission and vision of CharterCARE.

Steve Sepe presented a progress report: In Aug. 2011 – assembled all the directors from all departments and started a strategic planning process which lasted about 6 months. Approach: to look at everything from the purview of the health reform, what was being asked of them and how could they prepare. Key questions: How do we plan for primary care? CharterCARE sees four strategic imperatives, strategic items, tactical and action plans that have been successfully executed throughout the last 15 months.

- What challenges would there be when looking at primary care in the context of reform efforts?
- Vital element is physician-hospital integration: how do we get doctors and hospital administration, and the infrastructure of each to work in a way that focuses now on a community base?
- What will it take to move from the inpatient to the outpatient venues?
- How do we bring ever more sophisticated services to the community, and is that possible at all?

This is carried out within three elements: governance, physician compensation, and inpatient modules. Key question is how would we need to reform/reconstruct what we do as an inpatient program to make the transitions of care safe during these interval periods – this is vital because this is where 80-85% of medical errors are seen.

We have discussed plans with larger primary care groups like Anchor, Coastal, and Bristol and asked questions – What do they need? What can we provide? Where is the overlap? How do we work together? From discussions, we put out a model – tiered business plan – to look at the large groups who are/have been successful at risk management, practice management, medical management. Next, what about the smaller practice groups? Rhode Island is a melting pot of a 3-5 member physician groups. Three models are being considered: 1st model: employment model; 2nd model: Master Service Agreement (MSA) – model has been tested for 15 months.

CharterCARE signed three contracts w. specialty groups, now working with primary care groups. Model has worked very well; and 3rd model is an affiliation agreement.

System development – developing primary care medical home activities, and continuing work with care centers. Patients who have multiple chronic episodic illnesses actually do better in ACO like models because they almost always require hospital level care, are more complex, and different services may be offered on site that have not been offered to the community yet. Things that have been done: 1) converted and reformed the residency model to a firm model for general medical education and quality improvement initiatives – i.e., how to get a patient from ER door to bed in less than three hours? Next step to connect ER to primary care practices. Data management is very expensive not very affordable, and not refundable. Comparative Effectiveness Research (CER) can be an early warning system.

Payer contracting reforms: co-develop together with payers:

- Recommend use novel upfront pre-payment model, enhanced fee-for-service
- Taking a different approach and tone when talking to payers. Being savvier about how to get the work done together. Risk assumptions will happen but you better be ready, there's a lot of verbiage going around in the state regarding whose ACOs is doing what in Boston. That's great, but no one knows how to do this yet, period!
- There are different models out there, but with risk assumptions you better know what you are doing or else you will be out of business very quickly.

Would like providers to join us in the three types of tiers and at the same time generate some revenue for the doctors in primary care.

Kenneth Belcher next discussed the three types of tiers for primary care involvement. Primary Care Initiatives in three types of flexible tier elements. Providers want the model to be flexible, whether it is employment model with primary care, affiliate model with primary care, foundation type of model with primary care. Primary care physicians are looking to have as much support as they can in the hospitals; and to have a strong hospitalist program that can help them when their patients go in the hospitals. CharterCARE recognizes that in order to do it well, there are three components that are expected of the hospitals to support the primary care physicians.

- a) Notify primary care physicians when their patients go to ED and are admitted.
- b) Notify primary care physicians if there's a change of status while their patients are admitted.
- c) Notify primary care physicians when a discharge occurs and let them know what the position is, what the next steps are, and the appropriate continuity of care.

Those are the general precepts and requirements in the model they are looking to provide to the primary care physicians. Those are the strategies that have been put in place thus far.

Susan Cerrone Abely – Two primary technology strategies, it is important to have a fully integrated technology platform -- not just for the financial efficiencies, but to have one EMR to have all of the CharterCARE clinical data in it. We now have one platform, one vendor for inpatient facilities, nursing home, clinics in Providence, home care, and soon to include telehealth. CharterCARE now has a central repository of all the information no matter where the patient is seen in the CharterCARE continuum. Further developments include:

- Employed primary care physicians being brought into this system, their data is fully integrated.
- Primary care physicians that are not employed and are a part of the affiliated group, they are provided access to the EMR system if their patients are being seen in the system of care, and they are able to see all of their patient information in one place.
- Support primary care physicians that have EMR in their own offices. Developed an inter-operability strategy, where physicians can exchange information with any EMR as much as possible. The exchange is limited by technology and multiple priorities of practices, and will work to have anyone that is in CharterCARE to have access to all of the information all of the time to follow patient care.

Otis Brown discussed efforts for network development. Physicians say they are looking for options; not everyone is a Lifespan or Care New England doctor. CharterCARE has 600 physicians between the two combined staffs, 100 primary care family practice physicians, and there are still people out there looking for options. CharterCARE options bring flexibility, improvement in quality, easy access to the hospitals; all attractive selling points that CharterCARE brings to the table. The response has been very positive.

Questions:

Susan has been very helpful in getting physicians to the health centers that have privileges to Roger Williams access to the electronic database. Would you be able to do what Life Links have done to bring to those physicians without privileges to Roger Williams, referring physicians, cat scans, chest x-rays and labs to those who have privileges elsewhere? Answer: Yes, it is possible. When you are in the EMR one can see all patient information. It seems now we would not be violating any rights by opening that up. If a referring physician has a relationship with a patient already, they can see all of the information. Yes, we can do that.

Question: What platform is that? Answer: Meditech.

Question: To what extent is primary care involved at the board level, decision making, and setting mission statements, overall directions?

Answer: Mark Braun of this group is on the CharterCARE board. With the transition to CharterCARE, we also made transition to two heritage hospital boards. Those boards have strong authority, but the majority of the power goes to CharterCARE level. Primary care level leadership, Roger Williams and Our Lady of Fatima boards. CharterCARE has been very clear that board makeup should include at least one-third of the board members need to be physician-based. As search for affiliative partners, all should have 50% of board members be physicians and a high percentage should be primary care. Primary care is and should be the gate keeper of the process.

Comment: All of Lifespan hospitals are now calling Coastal physicians from ER before patients are admitted. “We don’t need to be notified when our patients are admitted to the ER; we need to know they are at the ER before they are admitted, so we can make a joint decision whether or not they should be admitted. A large number of times, they don’t need to be admitted and we have information that will tell them why they don’t need to be admitted. We have been collecting data for this pilot project for seven months. We have identified 75-80 patients whose admissions have been averted because of this consultation. So, I would say we need to look at new ideas about how to take care of our patients involving primary care at the earliest levels.”

Response: Fair comment. I agree completely at the front end. The flow from door to bed, put resources at the resident, ER and attending using mobile tablets with templates to guide efficiency. Sooner patient gets to floor, better they do. CharterCARE has development project underway to provide physicians with more information about the primary care physician and the primary care preference. CharterCARE is working on getting that information in place so that physicians in the ED have a basic profile of each of the physicians.

Question: Do you have in place especially across both hospitals for those patients that present in the ED with mental illness issues and how do you integrate that and especially the long stays that some patients have in the ERs currently?

Answer: Yes, there is a connection through the Providence Centers who have been working with CharterCARE through that process of coordinating across both hospitals. Behavioral Medicine program (very large programs) has been looking at opportunities to become a teaching program. Currently working with Domenic Ciraulo, the Chairman of Psychiatry at Boston University School of Medicine coming to CharterCARE to review the process of better coordination of behavioral medicine across the system.

Behavior medicine is currently under “medicine” in both hospitals, working towards moving behavioral medicine psychiatry into its own department, meaning it would be a single department across CharterCARE. A decision needs to be made as far as which hospital this department will be placed in. Mental illness has been a very difficult area; it has always been carved out and in a corner and hasn’t been reimbursed very well. Although as far as the ACA mental illness has not been carved out of the community risk. The goal is to improve the healthcare status of the community, and that includes mental health. Part of the consolidation looks at what CharterCARE’s segmented strengths are. There is a very comprehensive rehab and psych, the addiction unit is the only one in the region that is very successful. But then you have to think about if that can be coupled with geriatrics, or rehab/mental rehab, and is there a continuum of real life mental illness and how can the inpatient/outpatient be addressed? In every primary medical home being developed each one has a psychiatrist.

Question: When you first talk about disease management including mental health in that, Rhode Island was part of 16 states that actually looked at morbidity/mortality in the chronic mental illness. And if you have schizophrenia in Rhode Island your life expectancy is 49 years not because of schizophrenia, but because of the attendant other things.

Suggestion: Hope CharterCARE (Roger Williams Medical Hospital) will encourage better communication with other hospitals that do not admit to RWMC and are not affiliated with CharterCARE.

Question: Something that may be helpful or useful from primary care sampling is that so often many primary care folks are managing a lot of behavioral health meds, and sometimes we should look for a source of advice from someone like a psychiatrist. Also about organizational structure, you talked about moving psychiatry out on its own. Is there a department of family practice, or a division, or is it carved out underneath?

Answer: There is not a formal division of family practice or section of family practice, but we are very close to setting off an initiative in family practice. CharterCARE believes family practice is one of the core primary care groups, and would like to build a teaching program around that. Everything we are saying here is relevant to both legacy hospitals. CharterCARE has a very strong cadre of family practitioners. There is a small sub section at Our Lady of Fatima, but it’s also under the department of medicine.

We have been working with the chair of family practice at Our Lady of Fatima looking at opportunities to actually slip that out into a separate department, that’s where I think it should be.

Rosa Baier – Patient Responsibilities

Working on having a group interactive discussion – scheduled for March. Please review handout from AMA on “patient responsibilities.” Upcoming session next month – ask for help for March looking for patient speakers (more than one patient) who are willing to speak about personal experiences. Learning session coming up on March 21st, anyone with a patient who is willing to speak about patient engagement and patient motivation. Hard time identifying patients to speak. Open to more than one patient. Please think about a patient who can help with this presentation.

Jason Smoot – CDC Fellow working with Dr. Fine about this topic. Pediatric vaccine program

Part of the marriage and integration of population health and primary care. Appreciate comments or advice. Basic general idea of this program is, through a vendor we would be paying practices for taking a closer look at their data and their rates of immunization, and then paying again a year or two later for raising those rates. One question that jumps out when we talk about this with practices is that doesn't KIDSNET already exist? And it does, but we actually have a pediatrician on contract that has been going to some providers that have lower rates of immunization around the state, and actually going into their patient list and finding errors, and even issues with who is and is not a patient. That will certainly be something that we need to define. Two years is usually the standard. The two general age groups being looked at are pre-kindergarten/kindergarten entry and 13-17years. We have not figured out how to do this because kids can enter kindergarten at different ages, but that's the general idea so that we also have some synchronicity between this program and other health initiatives from population health.

Question: Are you looking at pediatrics practices only or also family practices?

Answer: Family practices as well. The idea is we would likely tier practices by how many kids fall in these age groups. The whole idea of these payments is that this work takes time. We have various reporting requirements that already need to be done, and this takes time, so we compensate for that.

Question: Hopefully you are aligning the measurement you are going to do on these two age groups. We should be talking as we are designing the measures that are going into the new CSI children's initiative. It would be great if we could align the two.

Updates by Dr. Fine

Statewide health planning is actually an active and ongoing process. The statewide health planning group was charged with specifically addressing three things: hospital bed need, the modifications that might be made to CON and the hospital conversion act. Most relevant for this group is part of trying to understand that there was a report prepared by the Robert Graham Center on primary care need and organization, and possible impact on bed use; and it is something we need to distribute. The report focused on the following:

1. Get better data on work force. Use licensure process to do that. Our work force data had to be constructed on bunch of assumptions. We do not have good primary care work force data yet. That's clearly something we need to get.
2. Three different models of primary care organizations:
 1. CSI at increasing primary care supply, so that the primary care supply is at the level that the best the states have, and we are pretty good at where we are at already according to the numbers.
 2. Advanced primary care ACO from Texas called WellMed, looked at what their results have been and their impact on hospitalizations. When you put all those together, it appears that their may be an impact of 8-42% reduction on hospital beds as primary care organizations improves, and that translates into a potential reduction of about 150-900 needed hospital beds in the state. That will be integrated into a report to the legislature in March.
 3. There is a set of HCA and HCN suggestions that have not been formalize and will talk about those at the next session.

Health Insurance Exchange Update: Dr. Pete Allen, a retired pediatrician joined the Health Insurance Exchange as a physician representative.

Article in the New York Times : Impact or the potential impact of small businesses opting out to be self insured, as opposed to going to commercial products. Apparently the past 10 years, small businesses have gone from 40% of self insured to 60%. The anticipation is that it might get greater since the mandate is to provide insurance and it doesn't mean you would have to go through a commercial product. The point of the article was, if that happens to a significant amount in certain areas, they may cherry pick because they are only going with self insurance if they have a fairly healthy population and then pay another insurance company to stop loss. I am just curious, that would mean that the sicker and most expensive patients/population would be left to purchase their insurance in the exchange. I'm wondering if we have any idea how that might potentially play out or what our past history might be at the state.

Dr. Fine deferred the question to the health exchange folks and admitted he is not as knowledgeable as he should be. The self insured process has been difficult in terms of running the vaccination program, because of the way the program has been running, self-insured

employers may have gotten a free ride. Some of us are trying to look at how that works and making sure that they are included in the rest of the process. Patient of ours brought in a note from Cardi's encouraging them to go with Coastal, and implied there would be financial benefits for them.

Announcements:

Dr. Fine thanked everyone. We immunized 100,000 more people this year than last year against influenza. That was very great work and impressive, but it still only puts us at 50% of the population. So, we are going to keep beating this drum and ask everyone's help as we go forward.

The provisional numbers we have right now suggests that new cases of HIV went from 106 cases in 2011 to 62 cases in 2012. The provisional numbers will probably be revised upwards by 10-15 cases, but it still suggests a great improvement. However, before we go around proclaiming victory, there's a certain amount of humility that comes from asking the question, did we screen as many people? And that is a denominator we do not have control over. I am hoping we can get some advice on and ask the primary care community on how essentially they can prove us wrong and make sure that we screen even more people next year and see what happens to the numbers. If this is real and we can keep it down, in 3 years we are done and that is a pretty amazing process. Here we have right in front of us, a hope and a time line of getting rid of diseases in our life time.

Meeting adjourned at 8:45 AM.