

Primary Care Physician Advisory Committee
Meeting Minutes
December 18, 2013

Members Present: David Bourassa, MD, Co-Chair; Kathryn Koncsol-Banner, MD, Co-Chair; Elizabeth Lange, MD; Thomas Bledsoe, MD; Stanley Block, MD; Steven DeToy; Michael Fine, MD, Director of HEALTH; Diane Siedlecki, MD; Patrick Sweeny, MD, PhD, MPH; Richard Wagner, MD; John Solomon, DO. Guests: James McDonald, MD; Rosa Baier; Allen Dennison, MD; Katherine Jarrell; Deidre Gifford; Jill D'Errico.

Members and Alternates Unable to Attend: Gregory Allen, Jr., DO; David Ashley, MD; Munawar Azam, MD; Jeffrey Borkan, MD; Mark Braun, MD; Denise Coppa, PhD, RNP; Michael Felder, DO, MA; Nitin Damle, MD; Sara Fessler, MD; Patricia Flanagan, MD; Cynthia Holzer, MD, CMD; Steven Kempner, MD; Albert Puerini Jr., MD; Anne Neuville, RNP; Newell Warde, PhD.

Open Meeting/Old Business: PCPAC Co-Chair, Dr. Bourassa, called the meeting to order at 7:40 AM. Notes were discussed concerning individuals naming a facility instead of a person as a PCP. One of the problems is that individuals may know the name of a health center, but not the doctor itself. There is a state requirement that patients identify their PCP. Rosa will be looking at an off-agenda meeting in March to discuss this issue and others. An invitation will be forthcoming. Notes were accepted at 7:44 AM.

First Agenda: James McDonald, MD

Information from the Board of Medical Licensure and Discipline:

- Handouts were given on supervision, scope of practice, and conduct for medical assistants and what these should look like.
- Dr. McDonald discussed the background of this document which was the result of a workgroup that convened to create policy statements regarding medical assistants.
- A reminder that this is an educational document, not a regulation. These guidelines do not have the force of a regulation or statute. They exist to help physician community know the “rules of the road.”
- A reminder that medical assistants don't practice under their own license, they practice under the physician or RN's license, therefore if you train and use them, their mistake becomes your mistake.
- The concern by the board is that if they do nothing, the fear is physicians will be disciplined and be surprised as to why, which would seem unfair.
- Please send all comments, MA job descriptions, suggestions, and protocols that you use to Dr. McDonald at HEALTH and to the co-chairs so they can compile one letter from the committee. An invitation was extended to please come to the open sessions of the medical board meetings the second Wednesday of the month.

Suggestions:

- One concern was that it was debatable whether they have the force of rule or regulation. Many feel that this type of rule making in the absence of statutory authority is outside the department's scope. You can get into trouble for not following guidelines and what would prevent the board from bringing a person in. These guidelines don't define things in enough specifics, as they are currently written and don't define what an MA is, which may be different in different settings.
- It is hard to regulate top down decisions. Job descriptions should be written first and the missions of schools should be included in this to figure out what MA's can and cannot do. A build from a ground up approach may be more effective.
- There are many states that don't define MA's but do define specifically forbidden tasks.

Questions:

1. Will there be a grandfather or certification process regarding medical assistant who have already been practicing things such as vaccinations?

The wording is in the process of being refined but the general thought was that medical assistants should be allowed to give vaccines. The IV pushing of narcotics was the board's concern.

2. Is there a total prohibition on triage? If the desk individual makes a suggestion as to where to go for medical services is this triage?

We have to define what triage is. Every state agrees that triage is not an MA function. MA's are not trained to interpret in most places and maybe a more specific definition of MA is needed.

Second Agenda: Allen Dennison, MD

A perspective from Evergreen Nursing Home Medical Director on preventable re-hospitalizations

- Evergreen has been working towards improving the rate of re-admissions to hospitals from their facility. The state rate is 20% of all adults hospitalized will be re admitted within 30 days.
- Although warm hand offs, communication, follow-ups, and better paperwork are necessary they are not sufficient because they don't involve what the physician is writing for the care plan.
- Some interventions they have used are the SBAR (situation, background, assessment, and recommendation) communications, patient care and UTI protocols, polypharmacy reviews, staff education, palliative care, and the employment of a full-time nurse practitioner.
- Discharge policies include follow up appointments, home safety evaluations, records to PCP, a two week-month supply of medications, and possible telehealth procedures.
- Some of the components of success that are used include empower your staff, support doctors, good communication with family, provider, and hospital, symptom management, and realistic and obtainable goals of care.

- In regards to a PCP's office shared used of protocols, polypharmacy reviews, and shared staff with hospitals are things that work, but each center has its own policies.

Question:

1. Are there any regulations in regards to transitions from nursing homes to primary care in regards to COC and reconciliation of medicines?

Rosa will check on this.

Suggestions:

- PCPAC to provide a letter of recommendation to HEALTH to require regulations or suggestions regarding preventable re-hospitalizations.
- Make sure meaningful use transitions of care are communicated and valid.

Meeting adjourned at 8:45 AM

Next Meeting: January 15 at 7:30 AM in 401.