

Primary Care Physician Advisory Committee
Meeting Minutes
June 19, 2013

Members Present: Kathryn Koncsol-Banner, MD, Co-Chair; Michael Fine, MD, Director of HEALTH; Elizabeth Lange, MD, Co-Chair; Jeffrey Borkan, MD; David Bourassa, MD; Steven DeToy; Anne Neuville, RNP; Diane Siedlecki, MD; Peter Simon, MD, MPH; Patrick Sweeny, MD, PhD, MPH; Guests: Rosa Baier; Liz Brown; George Bottomley; Cristina Carter-Vallejo, HEALTH Staff; Mary Evans; David Robinson, EdD, HEALTH Staff.

Members and Alternates Unable to Attend: Gregory Allen, Jr., DO; David Ashley, MD; Munawar Azam, MD; Thomas Bledsoe, MD; Stanley Block, MD; Mark Braun, MD; Denise Coppa, PhD, RNP; Nitin Damle, MD; Michael Felder, DO, MA; Sara Fessler, MD; Patricia Flanagan, MD; Cynthia Holzer, MD, CMD; Steven Kempner, MD; Christopher Koller; Ana Novais, MA; Albert Puerini Jr., MD; Richard Wagner, MD; Newell Warde, PhD.

Open Meeting/Old Business: PCPAC Chair, Dr. Lange, called the meeting to order at 7:35. Minutes accepted for May 15, 2013.

➤ **1st Presentation: State Health Care Planning and Primary Care – Kim Paul**

- PCPAC Guest, Kim Paul, also Director of Analytics and member of the Health Care Planning & Accountability Advisory Council, shared the Council's final report summary on the study conducted regarding the state's health care needs and health care system capacity.
- The Health Care Planning and Accountability Council is a legislatively directed group chaired by the Commissioner of Health insurance, the Secretary of Health and Human Services with leadership from Dr. Fine in the Department of Health.
- The Council's goal is to advocate a unified health plan to help improve Rhode Island's health care delivery system, while also trying to understand what has been accomplished in the state, what improvements need to be made, and how to make those changes. HCPAC is also focused on the payment reform for services, the geography, and the people.
- HCPAC's report looked at two things: the Certificate of Need in the Hospital Conversion Act, and also a gap analysis on Primary Care and hospital inpatient services. Consequently, two reports were developed considering how the primary care gap analysis affects how inpatient hospital services are used.
- Two consultants were brought in, one for each report. The Lewin Group conducted their report on inpatient services, and the Graham Center worked on the Primary Care report.
- Based on all of the data received from multiple sources, the first nine findings show a decline in utilization of hospital inpatient services per capita and overall, certainly translating into declining occupancy rates.

- Full hospital occupancy is between 75% -85%. Rhode Island is now at 67% Rhode Island has had historically high occupancy rates and is just now reaching the New England average.
- **Finding #1** showed that in Rhode Island there are about two hundred extra beds. This takes into account the ACA, demographic changes, and other factors including the shift to outpatients.
- **Finding #2** projected inpatient need for 2017. The surplus of two hundred beds is enough to satisfy the needs of one medium sized hospital in Rhode Island if the Primary Care infrastructure and delivery system remains the same.
- **Finding #4** looks at import/export patterns and revealed that Rhode Island is a net-importer of patients taking in more out of state patients than exporting patients out of state. However, this gap seems to be declining over time.
- **Finding #5** shows that having ideal occupancy will save about \$12 million dollars a year. Eliminating the surplus of beds can occur in different ways. One option is to take twenty beds from each hospital and shrink the hospital's infrastructure. The other option is to close a hospital. This study also analyzed taking beds from each hospital one bed at a time.
- **Finding #7** scrutinized procedure volumes vs. volume thresholds. There is a volume quality consideration that needs to be taken into consideration in Rhode Island when looking for ways to right size the hospital system. The Leapfrog Group has identified several procedures as volume quality sensitive.
- **Finding #8** studies the distance many Rhode Islanders are willing to travel for their medical services. The results from the study shows that about 50% of the population in each service hospital area travels elsewhere for medical attention, however, Providence sees the most non-Providence residents. This study also includes people who travel into Rhode Island, and does not include any of the Rhode Island population that leaves out of state to seek service.
- **Finding #10** reviews Rhode Island's primary care system, including the number of physicians per capita, what types of physicians there are, how Rhode Island compares to other states, and the Rhode Island primary care needs be by 2017. Rhode Island will need an increase in physicians by 2025 due to an aging population growth and a slight increase through the ACA. Rhode Island remains at eighth in the nation for primary care supply.
- **Finding #11** analyzes the impact that the workforce, architecture, and organization of primary care can have on medical services. The more that is contributed towards primary care the better the outcomes will be, and the need for inpatient and emergency rooms services will lessen looking at supply alone.
- **Finding #12** examined different models of high quality primary care in the nation.
 1. The **CSI-RI** model was found to have an average decrease of 6%-8% in utilization of inpatient services, if every primary care practice in Rhode Island was to function like a CSI practice. This decrease will help eliminate about 136 to 153 beds.
 2. The **Nationwide Medicare** is estimated to have a decrease of 7.5% in bed use if a ratio of a certain number of physicians per population was applied. The 7.5% decrease can eliminate about 165 to 185 beds.
 3. The **WellMed** model which is now a seven state program is being used mostly in Texas. It is a Medicare focused ACO and has been effective for twenty five years. Their well integrated program results in a 43%

decrease in the number of inpatient utilizations eliminating nearly one thousand beds. However, it is unclear if this model can be successful in Rhode Island since there can only be so many thousands of beds eliminated before the state will end up with a negative number of beds.

➤ **Questions, Answers, and Comments**

1. Was surge capacity studied?

Surge capacity is not figured into this analysis, however, occupancy is at about 78% and it is safe to assume that surge capacity is included in that percentage. A healthy hospital capacity which has enough capacity for a surge would be between 75% to 85%. Occupancy rates also vary greatly by hospitals, especially those that may receive more of the surge patients in the core cities, although, there will be times when the surge capacity is overwhelmed, those times will be rare. There is also a very sophisticated Emergency Planning that develops hospital like capacity in non-hospital buildings for emergency and surge situations.

2. Looking at projector cost savings, what is the difference in doing a bed-by-bed reduction and doing a reduction in the number of institutions?

In a most-likely scenario, a bed-by-bed reduction will save about \$13.6 million a year, on the other hand, the savings from an entire hospital can average around \$100 million and more in a year for the same number of beds.

3. Has anyone considered how the Boston based hospitals presence will affect Rhode Island?

It really looks like this is about economic development more than it is population health outcomes. We're talking about Rhode Island's jobs more than we are talking about Rhode Island's health. For example, the town of Westerly was unable to sustain and maintain a maternity unit. For those who reside in Westerly this means people will have to commute farther to deliver babies and half of those jobs will now be in New London rather than in Rhode Island. These trends and changes in utilization of hospital based procedures mark the beginning of a C-change in the health services delivery environment. When certain services are no longer necessary, what happens to the critical mass of an institution? The big picture here seems to be the market shrinkage of the hospital sector and the development of a more community based health service sector.

4. Would it be possible to get all of the background data and what fields and specialties are included in the numbers?

The report online has the full report plus the two consultant reports. Each of those consultant reports have appendices with a fair amount of back up data. If there is more that has not been answered in the online report we can always work with the Graham Center to get the full analysis.

5. Comments: The fact that we are eighth in the nation is not a huge surprise. Despite the fact that we are better than most doesn't mean that we are good enough. We have yet to figure out what the most effective ratio should be to get the best health outcomes. What we have is the number to produce the outcomes we have been producing, which is not so good. The intellectual question is what number we should have to produce the best health outcomes. In addition, from a health service research perspective about primary care physicians, three predictors need to be considered: primary care supply, primary care system architecture, and primary care practice architecture. These three components can have a great influence on population health and cost outcomes. As employer based insurance markets begin to penalize employees for not having a primary care provider, there may be a shift in demand for primary care. Demand is the same thing as need, so how much that demand is shifted by other economical forces may become a factor as to whether or not there will be enough physicians. The Graham Center was very sophisticated about deriving what they call social deprivation index which predicts need in a different way. It appears that our social deprivation index is relatively high compared to surrounding states.

6. What is the Medicare bed utilization in WellPoint and in Rhode Island?

The Medicare population is the easiest population to show bed reduction in because it is the population that uses hospitals the most. Considering that it uses hospitals the most, it constitutes 60% to 70% of the beds being used in the hospitals. It is unlikely we'll get to one thousand beds, but for the whole population, we might get to six hundred.

7. Is there any correlation between medical homes and health outcomes for the population beyond utilization?

Yes, but it wasn't studied.

8. Was the impact of behavioral health on primary care studied? Behavioral health is the cause for many hospitalizations, and from the primary care perspective it seems as though the state lacks Primary Care Behavioral Health services, resulting in frequent admissions.

Behavioral Health beds were part of the hospital inpatient analysis in the main report, this area was not studied separately. The council has identified a gap analysis of behavioral/mental health as one of its next priorities because we understand that our outcomes, use, and spending are excessively high.

➤ **Preliminary Discussion of Emerging Urgent Care Centers**

- The provided data on the map demonstrates where centers are located, however, many locations operating as urgent care centers are not included. A state assessment needs to be done analyzing how many hours each physician works, what or whom he or she sees, who is employed by him or her, how many patients use him or her, and what his or her geographical draw. (Note: The data was drawn from the KIDSNET database from physicians who reported immunization services.)

- Urgent care centers are defined by how the establishments are licensed. There is currently only one urgent care center in the state that has paid the appropriate fees, the rest are all self-designated.
- The corporate practice and medicine statute suggests that a physician practicing on their own and calls their practice an urgent care or a walk-in can do that without a specific license.
- There is not a reliable way of compiling data for urgent care centers yet.

➤ **Questions, Answers, and Comments**

1. Members discussed a PCPAC Advisory Letter asking the Department of Health to evaluate the urgent care capacity; in addition, the letter will also ask for the licensing procedures to be reviewed in order to collect better workforce data for all licensed professionals. Overall, the goal is to be able to a database of information that can be assembled into a much more robust workforce map.

2. Do we have any idea of what the insurance companies use as credentialing information for urgent care centers?
Insurance companies use different criteria, however, an urgent care visit is classified as an office visit, and patients' co-pays can vary depending on the location.

3. Are retail based clinics more urgent care or are they more walk-in focused?
Most urgent care have more capability than retail based clinics so they may look more like a basic walk-in, or primary care practice, which is the current trend.

4. What is the ratio of how many urgent cares and walk-in patients are needed in the state, and does that go along with the PCP data?

From a population health outcome perspective, there is not much information regarding the impact the number or location of any service has on population health outcome with the exception of primary care supply. Anyhow, most of our population health outcomes are related to social organizations, not medial care organizations.

➤ **Updates**

1. Incoming Flu

A new strain of bird flu, H7N9, is now present in China. There have been nearly one hundred and thirty cases and about forty deaths. There doesn't appear to be a human to human transition. It doesn't look like CDC will be able to develop a vaccine that can be combined with the seasonal flu vaccine. Despite the fact that it is still unclear of when the H7N9 vaccine will be ready, this season everyone will be immunized for the seasonal flu and the H7N9 at the same time. Nevertheless, the bird population control measures in China have substantially reduced its transmission, and that may be

why CDC has backed down from putting together two vaccination campaigns and is easing off the notion of immunizing all Americans.

CDC does have a more intense focus on a MERS corona virus in the Middle East. This virus does have a human to human transmission and has a high case fatality rate. This virus could possibly emerge as the next infectious disease threat the United States may need to respond to if it spreads widely.

The second part of this update pertains to Medicare being included in this year's seasonal vaccine purchase program. Seeing how their reimbursement process is different, they believe that they should not be held responsible for patients who use health centers and have Medicare. Medicare has already told Community Health Centers to buy their own vaccines. It is important to convince Medicare to keep health centers and Medicare itself in the pool because pulling out would mean disaster for Community Health Centers.

2. 2013-2014 PCPAC Meeting Schedule

Next year's meeting schedule has been listed. The schedule remains on every third Wednesday of the month.

3. PCPAC Departures

Liz Brown graduates residency, this meeting marks her last meeting where she will be present. In addition, Dr. Lange held her last meeting as PCPAC Co-Chair. Dr. Fine presented two certificates from the Department of Health and Governor Chafee for her exceptional service throughout the past years.

Meeting adjourned at 8:45 AM