Advisory Committee on Primary Care Meeting Summary

January 31, 2023
Health Care Authority
Meeting held electronically (Zoom) and telephonically
2:00 p.m. – 4:00 p.m.

Note: this meeting was video recorded in its entirety. The recording and all materials provided to and considered by the committee is available on the Advisory Committee on Primary Care webpage.

Members present

Judy Zerzan-Thul, Chair
Chandra Hicks
David DiGiuseppe
D.C. Dugdale
Ginny Weir
Gregory Marchand
Jonathan Staloff
Katina Rue
Kristal Albrecht
Lan H. Nguyen
Linda Van Hoff
Madeline Wiley
Mandy Stahre
Michele Causley
Nancy Connolly
Sarah Stokes
Sharon Brown
Sharon Eloranta
Sheryl Morelli
Staici West
Tony Butruille

Members absent

Kevin Phelan
Meg Jones
Shawn West
Tracy Corgiat

Call to order

Dr. Judy Zerzan-Thul, Committee Chair, called the meeting to order.

Agenda items

Welcome, roll call, and agenda review

Dr. Judy Zerzan-Thul provided an overview of the agenda.

Approval of November meeting summary

The committee members present voted to adopt the Meeting Summary from the November 2022 meeting.

Topics for Today

The topics were listed as presentation and discussion of primary care providers and facilities.

Presentation on primary care providers and facilities

Dr. Judy Zerzan-Thul, Health Care Authority (HCA)
Judy Zerzan-Thul presented a proposed list of primary care providers and facilities for the committee to vote on.

Public Comment

No public comment.

Discussion of primary care providers and facilities

Dr. Judy Zerzan-Thul, Health Care Authority
Mandy Stahre asked whether an internal medicine pediatrician would provide primary care services. Sheryll Morelli said they are primarily primary care providers, and they are double boarded. Judy Zerzan-Thul said it's like family medicine with a longer residency. Nancy Connolly asked if there's a separate taxonomy code to account for an internist. What about medical psychiatry? They probably do primary care, too. Judy Zerzan-Thul asked staff to research the internal medical psychiatry. Jonathan Staloff made a motion to include the internal medicine, pediatrics provider in the narrow list. The motion was seconded and approved.
Sharon Eloranta suggested adding obstetricians (OBs) to the narrow list because many women see this provider type but do not have a primary care provider (PCP). Ginny Weir affirmed Sharon's point about women seeing OBs. If the committee is focused on improving population health, OBs should be included in the narrow list. Nancy Connolly suggested that if a relationship is present, all specialties can provide primary care. Dr. Judy Zerzan-Thul agreed and highlighted that it's an overlap of the who, what, and where. Sheryl Morelli disagreed that OBs, advanced practice midwives (APMs), and midwives are primary care providers, even though they sometimes provide services. Mandy Stahre pointed out that for many women, OBs are their only contact with the health care system. For Medicaid, there have been many efforts to expand postnatal care. OB providers aren't just providing services related to pregnancy since they manage other conditions, too. In the broader umbrella of women's health, including this group will help increase primary care services. For OFM's prior work, where both providers and services were considered, some services were excluded while others were included, which is why OBs were included in the broad definition of primary care. David DiGiuseppe noted that other states have benchmarked for spending and asked whether OB was included by those states. Dr. Zerzan-Thul directed staff to research this further. Jean Marie Dreyer, HCA staff, noted that Colorado included OB in their narrow category. Sarah Stokes noted that the Washington Health Care Alliance assigns patients to OBGYN as though they are PCPs. Sheryll Morelli said that the committee's agreed upon primary care definition should serve as the reference for determining whether providers count as primary care. OBs don't coordinate care except for primary OBGYN diagnoses. For spending, OBs shouldn't' be included as PCPs according to the newly formulated definition. Even if patients treat a specialist as a PCP, that doesn't make them a PCP e.g., cardiologists. Lan Nguyen noted that many OBGYNs don't consider themselves as PCPs even when they provide primary care services due to their residency training. OBs shouldn't be included due to scope of practice and not meeting the definition of comprehensive primary care

services. Jonathan Staloff voiced support for retaining the broad definition rather than the narrow using cardiology, OBs, and pediatrics as examples. Cardiologists are often first point of contact for a large subpopulation, but they don't provide comprehensive care. OBs provide care for roughly 50 percent of the population, but they don't provide the same comprehensiveness as pediatrics (for every medical need). Michele Causley suggested retaining OBs, APMs, and midwives in the broad definition and maybe specifically excluding these providers for the Medicare population.

Tony Butruille asked for more clarification between the narrow and broad providers list. In general, states that use both definitions view narrow as definitively primary care and broad captures people and services that are not consistently primary care. Chandra Hicks asked whether the group was working towards one list. Dr. Judy Zerzan-Thul noted that narrow and broad were both used before, which is common with other states. The group could decide to merge and use one list and use an intersection of the who, what, and where to make final decisions. Chandra Hicks said if two buckets are used, it would be helpful to see how that would affect the spending target. Dr. Judy Zerzan-Thul clarified that the two buckets would provide two different ranges with the "true" percentage somewhere in between. It isn't clear which bucket/category is referred to with the 12 percent target in statute. There's also not a date by which to attain 12 percent. Sharon Eloranta expressed confusion and concern about having two lists – it would be harmful to overinflate the target by making the list too inclusive. Nancy Connolly asked how the list would be incentivized to attach patients to primary care doctors. The intention of the statute was to increase continuity. Sharon Eloranta pointed out that the definition used by the Washington Health Care Alliance is close to the narrow list. It's difficult to attribute patients, almost half are unattributed. People don't like being told to have a PCP. Nancy Connolly asked whether the group should consider the narrow or the broad list. Jean Marie Dreyer proposed that the group make a motion to decide on whether to use one or two categories. Tony Butruille expressed agreement and noted a preference for one list rather than two. David DiGiuseppe said that two categories allow for sensitivity analysis. Nancy Connolly asked whether if with two lists, there would be two ranges. Dr. Judy Zerzan-Thul said a range would continue to be reported. David DiGiuseppe suggested discussing behavioral health before deciding on narrow and broad. Michele Causley expressed support for two lists – narrow is useful for benchmarking with other states and the broad list provides a full range, and both need to be trended. Mandy Stahre said it would be helpful to identify what's not primary care. Dr. Judy Zerzan-Thul said that this refinement has already taken place and suggested members show by raise of hands their preference of whether to retain the narrow and broad categories. Nine members voted to retain two categories and nine voted for one category. Chandra Hicks offered to change votes from supporting one to supporting both lists if the purposes for each were clarified – narrow could be used for primary care transformation versus broad for primary care capacity. There need to be limitations outlined for both. Gregory Marchand also voiced changing support to two lists if the purpose for each list is clear. Linda Van Hoff suggested that if things are based on a percentage of primary care activity, the percentage threshold should be used for determining placement on the narrow list. Dr. Judy Zerzan-Thul observed that a majority seemed comfortable with retaining two lists – the narrow would be used for primary care transformation investment and the broad is more inclusive to account for providers who might provide some primary care. Sheryll Morelli, who initially voted for a single, agreed with Dr. Zerzan-Thul's rationale for two lists.

Dr. Judy Zerzan-Thul asked for committee members' feeling on including women's health on the narrow list. Two members voted to include women's health practitioners on the narrow, and all other members voted to retain them on the broad list. Sheryll Morelli proposed that if more than half of what OBs do every day is primary care, they could be moved to narrow list. Dr. Judy Zerzan-Thul concurred. No additional motion was made for OBs and other women's health care practitioners.

Dr. Judy Zerzan-Thul moved to considering registered nurses (RNs) for inclusion on narrow list. Nancy Connolly asked how often RNs are considered the highest level of service. Michele Causley noted that from a claims data perspective, RNs are not often billed on their own, rather they are billed with a supervising physician. Sheryl Eloranta noted that some places like transitional care management (TCM) coding where a step is accomplished by

a licensed professional like an RN, but the full claim is submitted by the physician. Mandy Stahre pointed out that with no way to measure RNs' service provision, it can't be measured, and shouldn't be included. Ginny Weir asked whether RNs should be removed from the broad list.

Dr. Judy Zerzan-Thul asked whether the group wanted to add homeopaths to the narrow list. Sheryll Morelli asked how homeopaths are separate from naturopaths. Dr. Judy Zerzan-Thul clarified that they have different trainings and philosophies. Nancy Connolly asked about where homeopaths trained. Mandy Stahre noted that if they are covered by commercial insurers, they will appear in claims and asked if they are MDs or DOs. Sharon Eloranta highlighted that the tenet of homeopathy is that the less of an active ingredient there is, the more powerful it is. Dr. Judy Zerzan-Thul noted that there isn't a separate program for homeopathy at Bastyr. Mandy Stahre asked if homeopaths have their own taxonomy. Jean Marie Dreyer clarified that homeopaths do have their own taxonomy code. Linda Van Hoff explained that based on a Google search, homeopaths might be a licensed professional, such as a naturopath or nurse in Washington, but they also have a separate homeopath designation. Sarah Stokes clarified that there are no homeopath taxonomies in their system. Sheryl Morelli made a motion to remove homeopaths as a provider type from narrow and broad. This motion was seconded and approved. Katina Rue moved to add Internal Medicine Pediatrics to the narrow list. Dr. Judy Zerzan-Thul added that advanced practice nurses might be added to the list, as could internal medicine psychiatry.

Dr. Judy Zerzan-Thul moved to proposals to amend the broad list. Mandy Stahre pointed out that "accountable" should be further. Dr. Judy Zerzan-Thul clarified that accountable is not attribution. Sharon Eloranta asked who is accountable when it's billed. Sheryl Morelli noted that social workers are not PCPs since they don't provide for physical health. Psychologists don't provide for physical health. None of these can be accountable for all of health or all primary care. Dr. Judy Zerzan-Thul suggested applying "accountable" to narrow providers. The broad provider list includes those that are part of the team that provide primary care. Sheryll Morelli pointed out that most of those in the broad can't be independent providers. Nancy Connolly stated that these providers must be on a team to be considered primary care providers. Michele Causley noted that the group is using claims data to identify primary care spend. If providers don't match the exact definition of physical primary care but primary care physicians are required to add those services, then that's the only way to capture those pieces. Sheryll Morelli asked whether cognitive behavioral therapy would be included in the primary care spend? Michele Causley responded that other states put behavioral health providers on a broad list and acknowledged some services would be captured that aren't primary care but mental health is important for physical health. Nancy Connolly noted that social workers and pharmacists bill independently but are part of primary care physicians' practice. Jean Marie Dreyer noted that most states put these providers in the broad category and emphasized the statute's direction to integrate behavioral health. Katina Rue asked how the next step of identifying the "where" would intersect with the discussion e.g., if someone goes across town to a separate practice versus a shared practice that's part of a network. Dr. Judy Zerzan-Thul noted that a psychologist could be at the same address as another primary care clinician. Tony Butruille asked if social workers, pharmacists, or others could be linked with another traditional primary care practitioner on the narrow list.

Dr. Judy Zerzan-Thul noted that most of the broad providers would remain and asked for committee members' view on additional providers to include, like perinatal. Karie Nicholas asked for clarification on whether the emphasis was on whole-person care. Dr. Judy Zerzan-Thul responded this was part of the definition. Sheryll Morelli asked what broad providers could count as primary care in a traditional setting. Some of the specialists, addiction medicine, etc., wouldn't be provided in a primary care setting. Dr. Judy Zerzan-Thul asked for feedback on adding perinatal providers and neonatologists. Sheryl Morelli expressed skepticism for including neonatologists since they are specialty and only a small subset performs post-natal intensive care unit (NICU) care. D.C. Dugdale pointed out that neonatal specialists most often practice in hospitals. Sheryll Morelli pointed out that most neonatal providers work in a hospital setting. Neonatologists represent a big spend that would skew the data. Katina Rue agreed with Sheryll's point regarding adding too much spend. Dr. Judy Zerzan-Thul noted that based on feedback, perinatal specialists would be excluded. Sheryll Morelli proposed removing psychologist rehab and psychologist mental

retardation/developmental from the broad list. For family medicine, it would be helpful to hear from family medicine providers on the committee. Should addiction medicine, bariatric, and palliative be included? Do these providers maintain a general family practice scope? Katina Rue responded that many family doctors work with addiction as part of their scope of practice and are board certified in addiction medicine. For other family docs, they work in sports medicine but no primary care. There are providers who fit both. There's not a huge spend associated with including these types of providers. Jonathan Staloff agreed with Katina's points and noted that there are dedicated fellowships for these family practitioners – some have just a niche and some have a broad practice in family medicine. Dr. Judy Zerzan-Thul noted that this happens with internal medicine providers, too, who are double boarded. Sheryll Morelli noted that pediatrics (peds) has these same specialties but were excluded. Katina Rue suggested that maybe peds providers dedicate more time to specialty. D.C. Dugdale noted that most internists continue to practice primary care and often serve as informal consultants for colleagues in a primary care group. Sheryll Morelli asked D.C. whether all of the specialties in family medicine should be included. D.C. Dugdale noted that sleep and sports medicine are different from addiction and bariatric. Nancy Connolly suggested that a setting is more important for making a determination rather than double boarding. Sheryll Morelli noted that if the facility addition clarifies primary care provision, it would be fine to retain the specialists on the list. Mandy Stahre pointed out that place of service is difficult to clarify. It's not possible to pinpoint place of service for measurement. Looking at services will also help weed out providers as well. It's both what is being billed and what the place of service is. Dr. Judy Zerzan-Thul proposed making no changes to the broad list. Krystal Albrecht noted that allopathic codes were missing. Linda Van Hoff noted that the APM and midwife are on the broad list but that ARNPs would likely get included on the narrow list. Dr. Judy Zerzan-Thul proposed sorting the NPs and PAs into narrow and broad. Sharon Eloranta asked about the school social worker. Jean Marie Dreyer replied that it does have its own code. Dr. Judy Zerzan-Thul noted that the school social worker could work elsewhere and Katina Rue agreed and noted that they could practice a school-based clinic practicing primary care.

Nancy Connolly made a motion to accept the broad list in its current form. The motion passed.

Dr. Judy Zerzan-Thul discussed next steps for future discussions. At the next meeting, NPs and PAs will be sorted into narrow and broad. Facilities will also be discussed. A list of primary care services to include will be emailed to the committee. There will also be several presentations to other groups, the Advisory Committee of Providers and Carriers and the Cost Board on the primary care committee's progress.

Adjournment

The meeting adjourned at 3:50 p.m.

Next meeting

March 30, 2023
Meeting to be held on Zoom
2:00 p.m. – 4:00 p.m.