Advisory Committee on Primary Care Meeting Summary

February 23, 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
D.C. Dugdale
Ginny Weir
Gregory Marchand
Jonathan Staloff
Katina Rue
Kristal Albrecht
Lan H. Nguyen
Linda Van Hoff
Madeline Wiley
Mandy Stahre
Meg Jones
Michele Causley
Sarah Stokes
Sharon Eloranta
Staici West

Members absent

Chandra Hicks
David DiGiuseppe
Eileen Ravella
Kevin Phelan
Nancy Connolly
Sharon Brown
Shawn West
Sheryl Morelli
Tony Butruille
Tracy Corgiat

Call to order

AnnaLisa Gellermann called the meeting to order at 2:01 p.m.

Agenda items

Welcome, roll call, and agenda review

AnnaLisa Gellermann

Approval of January meeting summary

The committee voted to adopt the Meeting Summary from the January 2023 meeting.

Topics for Today

The main topics were a presentation and discussion of primary care providers, facilities, and services.

Public Comment

There were no public comments.

Presentation on Providers, Facilities, and Primary Care Services

Dr. Judy Zerzan-Thul, Washington State Health Care Authority

Dr. Judy Zerzan-Thul reviewed the high-level definition of primary care formulated by the committee, provided a recap of the January 31 committee meeting, and reviewed the following tasks for the current meeting: vote on Advanced Practice Registered Nurses (APRNs) and Physician Assistants (PAs), vote on facilities to include, and begin discussing primary care services to include. Dr. Judy Zerzan-Thul presented the current list of included APRNs and PAs as well as facility types, e.g., Federally Qualified Health Centers (FQHCs), rural health clinics (RHCs), primary care clinics (including those on-site at hospitals), etc.

Discussion of Providers, Facilities, and Primary Care Services

Providers

Committee member Madeline Wiley asked for clarification on the broad versus narrow categorization as they applied to APRNs and PAs. Dr. Zerzan-Thul clarified that the narrow fits in as standard primary care e.g., family medicine, pediatrics, and internal medicine. Broad means the provider sometimes provides primary care, and sometimes doesn't. Madeline Wiley noted that school health APRNs fall into pediatrics or family. Committee member Linda Van Hoff noted that gerontologists are included in adult APRNs. Madeline Wiley asked why nurse practitioner (NP) was used to describe a psychiatric mental health provider rather than APRN? Dr. Zerzan-Thul didn't know why but added that not all PAs have all these categorizations. Madeline Wiley suggested it could be because other categories used PA/APRN. Dr. Zerzan-Thul clarified that PAs recorded for the board of health have general, medical, and surgical categorizations. These categories given by the Office of Financial Management (OFM) were originally put in the narrow. PAs have limited specialties. There is a proposal to move psychiatric to the broad category. Madeline Wiley suggested changing all NP notations to APRN for clarity and Dr. Zerzan-Thul agreed to the proposed change.

Dr. Zerzan-Thul asked which other designations the committee wanted to add e.g., geropsychiatry. Linda Van Hoff suggested putting the obstetrics and gynecology (OBGYN) APRN in the broad category. Dr. Zerzan-Thul clarified that APRNs specializing in women's health would remain in the narrow and APRN and OBGYNs would go to the broad. Madeline Wiley moved to put OBGYN in the broad category and Linda Van Hoff seconded. Dr. Zerzan-Thul called for a vote and the motion was approved.

Madeline Wiley suggested putting all psychiatric mental health categories in the broad category due to inconsistent primary care provision. Madeline Wiley motioned to transfer all psychiatric mental health to the broad category. Committee member Katina Rue seconded. Dr. Zerzan-Thul called for a vote and the motion passed.
Linda Van Hoff made a motion to add adult health to the narrow APRN list. Katina Rue seconded, Dr. Zerzan-Thul called for a vote, and the motion passed.
Committee member Jonathan Staloff asked to hear from colleagues about the proposal to exclude NP acute care and explained that if the acute care is predominantly in an outpatient setting, that should be included, however, if acute care is the equivalent of a hospitalist, that should be excluded. Madeline Wiley replied that acute care NPs help with hospital care but also see patients in primary care offices and should be moved to the broad list.
Committee member Michele Causley seconded moving acute care APRNs to broad and made a motion. Jonathan Staloff seconded, Dr. Zerzan-Thul called for a vote, and the motion to move acute care APRNs to broad passed.
Dr. Zerzan-Thul called for a motion to approve the final, amended list of APRNs and PAs. Madeline Wiley moved to approve the final list, committee member Lan H. Nguyen seconded, Dr. Zeran-Thul called for a vote, and the motion passed.

Facilities

Dr. Zerzan-Thul explained that many of the facilities on the included list came from Josh Liao and Ashok Reddy from the University of Washington (UW). Location is a valid code. The committee may want to engage in further discussion after finalizing the facilities list and rank the importance of who, where, and what were used to define primary care. The three parameters may need to be prioritized differently. The current facilities list includes on-site clinics at hospitals. Not all facilities may be considered primary care locations, but all have providers and services that qualify as primary care.
Madeline Wiley asked if the facilities were based on place of service codes. Method II billing applies to critical access hospitals (CAHs). Dr. Zerzan-Thul agreed to do further research on Method II billing for CAHs.
Katina Rue asked whether urgent care clinics should be included as primary care facilities. Could broad and narrow categorizations apply to facilities as they did with providers? Patients often use urgent care as a primary care clinic, but that may not meet the committee's high-level definition of comprehensive, coordinated care. Madeline Wiley noted that some urgent care clinics advertise primary care. It's not clear how they're noted with insurance or definitions to account for both urgent and primary care. Committee member Gregory Marchand responded that urgent care clinics won't generally meet the committee's definition. Committee member Sharon Eloranta pointed out that a lack of a longitudinal relationship between patients and urgent care providers disqualifies urgent care as primary care. Lan Nguyen added that primary care services in urgent care may not be continuous with a panel of patients and asked whether urgent care clinics are able to provide an array of services aside from acute care.
Madeline Wiley wasn't sure but noted that with the Health Care Authority's (HCA's) primary care transformation model (PCTM) one of the main goals was to expand access to primary care offices, which would reduce reliance on more episodic urgent care. Katina Rue asked whether Emergency Department (ED) services would be included if the committee decided to include urgent care. Madeline Wiley noted that in her experience, there was never a patient transferred in who had been using an urgent care clinic as their source of primary care. Lan Nguyen noted that some of the points being made about urgent care could apply to virtual care. Gregory Marchand noted that UW medicine's urgent care facilities are usually connected to the same building where a primary care provider works to allow for full integration. Sometimes, someone from a primary care clinic may also work out of an urgent care clinic. Jonathan Staloff noted that UW is generally a more integrated delivery system, e.g., integrating the ED and primary care. Urgent care shouldn't be primary care. With regards to virtual care, there should be a distinction between Teladoc and organizations that also provide telemedicine. Organizations that *only* provide telemedicine should be excluded because they aren't comprehensive. Brick and mortar organizations that offer telemedicine as a service should be included. Karie Nicholas from the Foundation for Healthcare Quality asked about the assumptions being made about patients. Does everyone have access to primary care from 8 to 5? Does this apply to 24-hour situations? Dr. Zerzan-Thul clarified that the goal is for people to get access to primary care. Measuring the

spend means figuring out what it looks like now. There's a workforce component ensuring there are enough providers e.g., doctors, nurses, and PAs. Karie Nichola asked whether the committee would exclude people who obtain primary care outside of normal hours. Katina Rue noted that patients often get primary care through urgent care, but the state should encourage primary care that meets the agreed upon definition, which means not counting people getting primary care in non-primary care ways. It's important to improve the system so that more people receive typical primary care rather than urgent care. The committee's definition should be limited to high-quality primary care. Karie Nicholas asked what the baseline measurement would be. Michele Causley pointed out that one of the ways to measure would be to use the percentage of patients using urgent care versus primary care. The committee could trend and monitor both to show how improving access to primary care reduces the volume of patients in urgent care. Including urgent care clinics would overstate true primary care spending. Linda Van Hoff suggested that the type of services provided should be used as another lens for meeting the definition. Mandy Stahre noted that it's not possible to tell if a clinic is urgent care based on claims. The committee would need to go by providers and services on that claim. Dr. Zerzan-Thul added that there is an urgent care flag in the current system that not everyone uses. If it's unclear, e.g., multi-specialty, the committee would include it. Sharon Eloranta asked if there is a place of service code for urgent care versus ED. The committee should examine how much primary care is tracked in these non-continuous settings. Committee member Sarah Stokes explained that for Kaiser, there are several places of service codes used for urgent care. Dr. Zerzan-Thul proposed excluding urgent care facilities from the definition and not voting on it since it wasn't already included. For virtual care, if it's all virtual, it's out. There is a modifier for telehealth which the committee should encourage for primary care providers. It's unclear how fully virtual care is billed. Gregory Marchand offered to do further research on fully virtual care.

Dr. Zerzan-Thul stated that the committee wouldn't discuss Hospital-Based Outpatient Departments (HOPDs) because they're already on the existing list. Group/multi-specialty are mostly used in true specialty, not in primary care. Katina Rue noted a concern for overcounting if specialty care is inadvertently included. Dr. Zerzan-Thul noted that OFM struggled how to include group/multi-specialty clinics, too. Evaluation and management (E&M) codes make up the bulk of services categorized as primary care in specialty offices, which can't be separated out from other true specialty services. This is particularly true for PAs and sometimes for NPs. OFM decided 60 percent of PA services were primary care. Distinctions can't be made with the current billing data available. OFM relied on OnPoint to develop the methodology which was based off the proposals put forth by the workgroup who came up with an agreed upon percentage. Michele Causley agreed with Katina's concern of overcounting and Madeline Wiley agreed. Dr. Zerzan-Thul noted a consensus from the group to exclude group/multi-specialty without needing to make a motion. The group will need to do more research on CAHs.

Dr. Zerzan-Thul asked for a motion to approve the current list of facilities, with a caveat that it could still be amended later. Kristal Albrecht moved to approve the current facilities list, Gregory Marchand seconded, and the motion passed.

Primary care services

Dr. Zerzan-Thul explained that the spreadsheet developed by the Primary Care Collaborative (PCC) (emailed to committee members before the meeting) compared primary care across states. Only Washington used narrow and broad categories, and had more codes covered than most states. Other states were concerned with overcounting and decided to include a narrow list of codes.

Dr. Zerzan-Thul reviewed services highlighted by committee members to add to the existing list, beginning with skin tags. Lan Nguyen noted that this service is regularly performed in a primary care setting. Madeline Wiley explained that it is cheaper to remove skin tags in a primary care setting than a dermatology clinic or another specialty clinic. Katina Rue supported adding skin tags. Madeline Wiley moved to include tags. The motion was seconded and approved.

Dr. Zerzan-Thul explained that the committee isn't trying to capture every service that could be primary care but is focused on the bread-and-butter services. Madeline Wiley noted evacuation of a hematoma as a common in-office

procedure with minimal equipment. Mandy Stahre pointed out that if added, Washington would be the only state to include it. Katina Rue agreed with adding evacuation of a hematoma to the included list of primary care services. Linda Van Hoff made a motion to include hematoma, Lan seconded, and the motion passed.
Dr. Zerzan-Thul asked whether to add removal of a foreign object and Linda Van Hoff voiced support for adding it. Michele Causley opposed inclusion since no other states included it. Madeline asked for clarification on whether inclusion related to reimbursement of services. Dr. Zerzan-Thul clarified that either inclusion or exclusion on the measurement list wouldn't affect reimbursement for services performed. Katina Rue asked whether all three parameters, (who, where, and what) must be met to be measured. Dr. Zerzan-Thul clarified that the committee is trying to capture the bulk of spending. The goal of the list is to increase primary care spending. This group is using the intersection of all three parameters as inclusion criteria for measurement, but it won't be perfect. There are fewer categorizations for APRNs and PAs, making the intersection point more important for them. Lan Nguyen pointed out that some of these procedures aren't bread and butter. Departments pay for equipment and referrals, meaning certain procedures are discouraged. Dr. Zerzan-Thul clarified that not measuring some services for primary care spending doesn't mean discouraging those services. Payers won't stop paying for excluded services. The most common thing billed is E&M codes which are also accepted across states as primary care. Home visits are broadly covered as are preventive visits. Collaborative care codes and transitional health are also generally included. If the committee wants to increase primary care spending, the group should consider what things are targeted to achieve an increase. The committee might want to use data at a later point in the process to help decide. The committee could recommend a sensitivity analysis.
Katina Rue noted that circumcision in a rural setting is most often done by a primary care provider and less often by urology. Also, prenatal codes should be considered primary care. Dr. Zerzan-Thul asked whether there was a motion to include routine venipuncture. Katina Rue and Lan Nguyen agreed to make a motion to add routine venipuncture to the included list. Michele Causley voted nay.
A motion was made to add capillary blood draw. Michele Causley voted nay.
Lan Nguyen made a motion to add circumcision with a clamp, which was seconded by Katina. Michele Causley voted nay.
Dr. Zerzan-Thul decided that any nays meant that the service would remain up for further discussion due to the small number of votes currently being cast. Routine venipuncture, capillary blood draw, and circumcision would be revisited.
Dr. Zerzan-Thul asked for a motion on services related to infant delivery. Katina Rue agreed to make a motion. If it's happening in a primary care office by someone on the committee's list that's primary care, this is a huge chunk that would be left off. Kristal Albrecht asked if delivery services are included in the baseline of OFM for total cost of care. Dr. Zerzan-Thul replied that they are all in the broad section. Some states have decided that 60 percent of these services are included. Kristal Albrecht noted that including delivery services could have a significant effect on cost. AnnaLisa Gellermann noted that everything beginning with obstetrical care would be the starting point for the next meeting.

Adjournment
The meeting adjourned at 4:00 p.m.

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