

PRIMARY CARE PHYSICIAN ADVISORY COMMITTEE

Meeting Minutes, December 16, 2009

Members & Alternates in Attendance: Thomas Bledsoe, MD, PCPAC Chair; David Ashley, MD; Stanley Block, MD; Jeffrey Borkan, MD, PhD; David Bourassa, MD; Mark Braun, MD; Steve DeToy; Michael Felder, DO, MA; David Gifford, MD, MPH; Kathryn Koncsol, MD; Christopher Koller; Al Kurose, MD; Elizabeth Lange, MD; Anne Neuville, RNP; Patrick Sweeney, MD, PhD, MPH; Richard Wagner, MD.
Guests: Mary Evans; Rebecca Kislak. *HEALTH:* Carrie Bridges, MPH; Helen Drew; Rilwan Feyisitan; Carla Lundquist; Suzanne Tobin.

Members & Alternates Unable to Attend: Gregory Allen, DO; Munawar Azam, MD; Matthew Burke, MD; Denise Coppa, PHD, RNP; Joanna D’Afflitti, MD; N.S. Damle, MD; Charles Eaton, MD, MS; Fadya El Rayess, MD, MPH; Patricia Flanagan, MD; Joseph Frank, MD; Arnold Goldberg, MD; Ellen Gurney, MD; Cynthia Holzer, MD; Meg Lekander, MD; Raymond Maxim, MD; Lauren Meisel, MD; Tom Murphy, MD; Albert Puerini, Jr., MD; Newell Warde, PhD.

Open Meeting/Old Business - PCPAC Chair Dr. Bledsoe called the meeting to order at 7:38 AM, and asked the Committee members present to review the minutes of the October 21, 2009 meeting. There were no comments and the minutes were approved as written (motion by Dr. Block, second by Dr. Wagner, all in favor).

Department of Health Legislative Priorities for 2010 - Dr. Gifford opened the discussion of HEALTH’s legislative priorities, requesting feedback from PCPAC and suggestions of other issues for consideration. He noted that legislation often requires multiple years to pass, and several current initiatives will be re-introductions of items previously defeated. HEALTH’s legislative efforts are coordinated by Helen Drew and Pam McCue.

1. Health Information Technology – EMRs and E-Prescribing capacity in provider offices. This legislation would require all health care professionals (MD/DO, NP, PA) with prescriptive privileges to have access to e-prescribing in the office (the office must have software installed and connected) by January 1, 2012, although there would not be a mandate for usage of e-prescribing. The goal of the legislation is to move beyond the current early adopters of E-prescribing toward having 75% of prescriptions sent electronically, while capitalizing on support from CMS and insurers for EMR installation and use of e-prescribing. ARRA funding for EMR “meaningful use” may provide some incentives. This was defeated last year due to comments from one doctor who was concerned about cost and one pharmacist concerned about swapping legibility issues for clicking errors. These risks are small compared to the net effects of reduced medication errors and hospitalizations. Dr. Gifford emphasized that the influence of the medical community (“white coat authority”) is very significant, even in casual conversation. PCPAC members expressed concerns about the current state of e-prescribing and whether a mandate is appropriate at this time.

- Pharmacy Benefit Managers (PBMs) have increasing clout and are a large impediment to e-prescribing. Consider joining with CT and MA to form a large block to negotiate with PBMs for e-prescribing.
- Some e-prescribing software is expensive. There are low- or no-cost options, such as Allscripts, but not all e-prescribing software is considered “effective”. EMR is not required for e-prescribing, but most EMRs incorporate it. Staffing time for data entry adds to the cost of e-prescribing.
- Once a prescription is sent electronically there is no way to reverse it, and the physician must spend time on the phone with one or more pharmacies to make changes.
- Pharmacies should generate return receipts with transaction number and time stamp so the provider will know if the e-prescriptions went through. This would help resolve cases where the pharmacy claims not to have received the prescription. Some physicians have to give the patient a back-up written prescription to show the pharmacist.
- Problems with automatic prescription renewal systems are not unique to e-prescribing and will be addressed off-line.
- Limitations on e-prescribing controlled substances continue to be a major barrier.
- Health plans should be mandated to have real-time online formularies access. This passed the Senate last year.

Dr. Bledsoe noted that the Quality Institute has done a fantastic job doing outreach for electronics and medical care. Legislation addressed toward removing the barriers identified would be a better approach than creating mandates. Additional funding for EMR adoption will be available and can help remove barriers to e-prescribing. Motivating patients to request e-prescribing from their physicians may be an effective strategy.

2. Reducing Obesity – regulate nutrition in childcare settings. The state has worked to establish and implement nutrition standards for schools; this legislation would set standards for food nutrition, TV time and physical activity in childcare settings, where over 70% of RI children (up to age 5) participate. One goal is to reduce the intake of sugar-sweetened beverages and make milk and water the beverages of choice. HEALTH believes this can be done via its statutory authority in state regulations, which have public input but do not need approval by the legislature. Dr. Gifford noted that the final decisions would rest with the departments issuing the regulations. Changing regulations is a 6 to 9 month process, unless it is a true emergency. DCYF currently has regulations online.

PCPAC members were highly supportive of this initiative, noting that school or childcare is the primary food venue for children. Dr. Lange noted that pediatricians don't know what day care menus include, but based on national data they are not healthy. Tools are available online, including the AAP website, to develop healthy menus. Mr. DeToy noted this goes hand-in-hand with last year's bill to increase the tax on soft drink syrups. Dr. Gifford recommended changing that to a point of purchase tax on soda, to add barriers to consumption.

3. Youth Tobacco Uptake – eliminate “two for one” sales. This legislation would ban “two for one” cigarette sales promotions in RI, which tobacco companies target to youth, low socio-economic status, and minority populations. Data mapping shows “two for one” sales are congregated around schools, bus routes, low-income areas, and minority neighborhoods. Youth are especially price sensitive regarding tobacco. This bill may have a better chance now that FDA has oversight of tobacco. RI has the highest tobacco tax nationally, and the most restrictive age limits for tobacco sales. The biggest issue is enforcement of the laws within statutory authority, i.e. sales to minors.

Dr. Gifford noted that the argument that people could drive out of state to buy cigarettes proves the point that the strategy will impact behavior. Local opposition from convenience stores will argue that 50% of their receipts are from cigarette sales, and tobacco companies will lobby hard against the legislation. Most convenience stores are independently owned and they will make their voices heard on the lost revenue. The underlying message the convenience stores are conveying is that their revenue is more important than the health of children. The voice of the medical community is needed to push this measure and protect RI children. PCPAC members agreed this issue should be strongly supported, and the power of the tobacco companies must not be underestimated. The primary care community must get to the State House to testify. HEALTH will inform PCPAC when the legislation is introduced and testimony is being heard. Dr. Gifford stressed that legislation rises and falls on constituency communications (phone calls, email, and letters) not testimony, and it is essential to contact local legislators, especially your patients.

4. Drunk Driving – mandate ignition interlock. Court-ordered ignition interlocks to prevent driving while intoxicated are covered in current statute as an option after the second offense. This legislation would amend the ignition interlock statute to make it mandatory after second offense and to make it an option for the courts to use after first offense as a drunk driver. There is considerable data on use of this measure in other states and countries, with recidivism cut by 73%. Many people who lose their license for DUI continue to drive anyway, and sometimes judges do not suspend licenses due to the economic impact on the offender. Ignition interlocks provide a different way to address drunk driving and reduce injury and death.

PCPAC members asked why the courts are not ordering ignition interlocks more frequently. Arguments against using interlocks are the burdens placed on the individual; cost of installation, inconvenience, and that it is not foolproof. The offender could pay for the cost of installation in lieu of paying a fine to the state. An additional argument is that some persons with pulmonary conditions may not be able to use the system reliably, due to intermittent breathing difficulties. For those who have the capacity to properly operate the system, the ignition interlock should be mandatory after the second offense and enforced by parole officers. The duration of the installation would vary depending on the offenses and judges orders.

Mr. Koller pointed out that any work on this effort needs to be done with the courts. This measure could be seen as impinging on judicial discretion. PCPAC members would like to see more data about usage of this system in other states/countries. Dr. Gifford noted that if this issue were brought forward by PCPAC it would be considered important; it is essential to create a buzz about the topic so the bill is seen as a solution to the problem.

PCPAC suggestions for additional legislative initiatives. PCPAC exists to advise HEALTH, but may also send independent letters in support or opposition to legislation. HEALTH can help push issues that PCPAC advises about as long as the Governor does not object.

1. Identify Primary Care Provider. Mandate that health plans require their patients to identify a primary care provider, and include this information on the insurance card. Dr. Gifford remarked that this item would be coming from Lt. Gov. Roberts with the support of OHIC. Mr. Koller noted the Lt. Gov. will reach out to several primary care groups.

2. Formulary issues. Dr. Block expressed concern about patients being harmed if they continue to be denied medications because they are not on the patients' specific formulary. Providers sometimes are reduced to guessing what might be in a certain formulary and might work. Uniform formularies are needed statewide. Mr. DeToy clarified that the RIMS bill would give providers online access to the formularies, not create uniform formularies.

Other Business/Announcements

H1N1 Update - Dr. Gifford reported HEALTH has received 150K more vaccine doses than expected, and is moving vaccination timelines up, as publicized in a conference call yesterday and a newspaper article today. Primary care practices with >50 patients with chronic conditions will start getting vaccine this week. Vaccine is shipped in 100-dose packages. Providers must report the vaccine they give out in order to get more vaccine. Vaccination is expected to be open to the general public in January, and ordering will likely be reopened as well. Doctors will be able to vaccinate themselves and their staff. Dr. Gifford noted that HEALTH is very interested to see how different practices handle contact/outreach to patients, and that valuable lessons have been learned on getting vaccine out quickly.

E-prescribing Statewide Subcommittee – HEALTH and the RI Quality Institute are putting together a small workgroup to reach the top 500 e-prescribers in the state, those that do 75% of all e-prescribing. The group will meet biweekly for the next three months (some meetings may be via conference call). Any PCPAC member interested in participating should contact Carla Lundquist (222-7626, Carla.Lundquist@health.ri.gov).



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