JOINT INTERIM COMMITEE ON HUMAN RESOURCES

February 11, 1998 Hearing Room F

8:30 A.M. Tapes 1 - 8

MEMBERS PRESENT:

Sen. Bill Fisher, Co-Chair

Rep. Jeff Kruse, Co-Chair

Sen. Jeannette Hamby

Sen. John Lim

Sen. Susan Castillo

Sen. Thomas Wilde

Rep. Jane Lokan

Rep. Patti Milne

Rep. Richard Devlin

Rep. Frank Shields

MEMBERS EXCUSED:

Sen. Lenn Hannon

Rep. Margaret Carter

Rep. Eldon Johnson

STAFF PRESENT:

Anne Tweedt, Policy Analyst

Lori Long, Researcher

Sandy Thiele-Cirka, Administrative Support

ISSUES HEARD:

Organizational Meeting

Adoption of Rules

Discussion of Workplan

Appointment of Subcommittee on Long Term Care

Overview and Current Status of Oregonís

Section 1115 Waiver Process

Hersh Crawford, Director

Office of Medical Assistance Programs

Overview of Case Management of Anti-Psychotics, SSRIs and

Related Agents

Hersh Crawford, Director

Office of Medical Assistance Programs

Review of Board of Pharmacy Proposed Rules

Pharmacy Technicians, Collaborative Drug Therapy

Management Arrangement, Pharmaceutical Care; Services to Community Based Care Facilities

John Block, Chair

Joe Schnabel

State Board of Pharmacy

These minutes are in compliance with Senate and House Rules. Only text enclosed in quotation marks reports a speakerís exact words. For complete contents, please refer to the tapes.

Tape/#	Speaker	Comments
TAPE 1, A		
ORGANIZATIONAL		
006	Co-chair Fisher	Calls meeting to order at 8:49 A.M. Reviews committee rules. **MOTION: Moves to ADOPT the proposed Committee Rules dated 02/11/98.**
016	Co-chair Fisher	**Hearing no objection, declares the motion CARRIED.**
019	Co-chair Fisher	Comments on the sub-committee for Long Term Care.
026	Co-chair Kruse	States that the sub-committee will be charged with developing a comprehensive understanding of the current system. Appoints Rep. Kruse, Chair, Milne, and Devlin.
053	Co-chair Fisher	Appoints Sen. Fisher, Hannon, Hamby and Castillo to the sub-committee.

		Reviews the workplan.
064	Co-chair Kruse	Notes that this workplan is a working document. **MOTION: Moves to ADOPT the proposed workplan dated 02/11/98.**
088	Co-chair Fisher	**Hearing no objection, declares the motion CARRIED.**
OREGONíS SECTION 1115 WAIVER PROCESS		
099	Hersh Crawford	Director, Office of Medical Assistance Programs, provides overview and summary of the 1115 Waiver process **(EXHIBIT A)**. Notes this waiver allows the federal government to waive compliance with certain Medicaid requirements to allow states to develop alternative approaches to the Medicaid program.
143	Crawford	Continues overview of the Oregon Health Plan, SB 27 (1989). Reviews the necessary waivers to operate the health plan.
166	Crawford	Continues review of the Oregon Health Plan Medicaid Demonstration process. Notes public scrutiny resulting from Oregonís waiver application in August 1991 and the second waiver request in November 1992.
198	Co-chair Kruse	Questions the difference between the two applications.
201	Crawford	Responds and discusses that the original prioritized list violated ADA regulations. Comments on the development of two follow-up lists.
215	Co-chair Kruse	Asks if the final list was accepted as a result in compliance with ADA regulations.
222	Crawford	Responds that the initial list was the result of a random survey to solicit information from the general public. Continues explanation of federal scrutiny surrounding the waiver process. Every component requires a federal application. Notes concern regarding the duration of this process, 3-12 months per application.
277	Crawford	Remarks that the Health Care Finance Administration (HCFA) is supportive of the waiver process. Notes that items on page 3 of **EXHIBIT A** are the foundations to the Medicaid program.
298	Co-chair Kruse	Questions if HCFA waited until the end of the six-month period before responding.
305	Crawford	Responds that the time line was very close.
308	Co-chair Kruse	Questions if this action could be considered a barrier to Oregonís process.

318	Crawford	Responds that he does not believe that HCFA is interested in slowing down the process, they are backlogged in the waiver process. Continues the chronology of Oregonís involvement in the Medicaid Demonstration Waiver process.
360	Co-chair Fisher	Questions if co-pays are prohibited.
369	Crawford	Responds that co-pays are used in a restrictive manner. Outlines the Medicaid regulations limiting co-pays. Explains how OHP addressed the co-pay issue by evaluating and altering the premium payment structure.
403	Co-chair Fisher	Questions if premium payment structure limits access to health care.
410	Crawford	Responds that premiums are established for six-month periods. There are situations in which premiums are waived. If premiums are not paid on a monthly basis, the individual is covered until the end of the six-month period and then re-evaluated. Acknowledges concerns regarding access to health plans, but states that premiums are important for individuals to accept responsibility for their health care.
479	Co-chair Fisher	Asks the type of questions asked by HCFA.
487	Crawford	Responds that the questions relate to dental coverage, when a specific dental procedure is allowed, and the expansion of coverage to include bone marrow transplants for breast cancer.
TAPE 2, A		
003	Crawford	Comments that HCFA responded very quickly on the reestablishing of full time higher education students.
011	Sen. Lim	Questions why full time students were eliminated in 1995 and why were they reinstated in 1997.
016	Crawford	Responds that it was eliminated in 1995 in an attempt to reduce the cost of the health plan. The 1997 legislature partially reinstated full time higher education students.
038	Rep. Lokan	Questions the effective date of the reinstatement.
041	Crawford	Responds January 1, 1998.
044	Lynn Reed	Deputy Director, Office of Medical Assistance Programs, continues review of Medicaid Demonstration Extension.

092	Rep. Devlin	Asks if the extension is from the time of application or from the original expiration date. Requests a summary of questions asked.
098	Reed	Responds the extension is from the end date of the current demonstration. Remarks that seven questions were asked relating to dental care access problems and how those problems were resolved, pre-natal care, description of the hearings process, budget neutrality, risk adjusters for managed care plans, patient needs for services not on the prioritized list, and public notification and comments relating to extension requests.
127	Co-chair Kruse	Asks if these questions would indicate an attempt by HCFA to change the conditions.
129	Reed	Responds no. Comments that earlier actions by HCFA would have indicated that, however that is not currently the case.
140	Co-chair Fisher	Asks what type of public response has OMAP received.
141	Reed	Responds that that information has not been calculated at this time. States the results will be available the week of March 2.
151	Sen. Lim	Asks if the extension process is ongoing or will Oregon receive permanent waiver status.
155	Reed	Responds that the demonstration is not a permanent decision. However, it is not prohibited to return every three years for additional extensions.
164	Co-chair Fisher	Requests a copy of OMAPís response letter to be sent to the committee and its members.
168	Sen. Castillo	Questions if other states are using Oregonís plan as a model.
175	Crawford	Responds that portions of the OHP are being looked at and incorporated into other state health care reform alternatives.
183	Sen. Hamby	Questions if it would be appropriate to take the list back to the people of Oregon for debate.
218	Crawford	Responds that OMAP believes it is time. States that discussions have begun in that direction.
229	Sen. Hamby	Questions if that information should be provided to HCFA.
232	Crawford	Responds that this information will not be available for this response.

233	Sen. Hamby	Questions if that information will be provided to HCFA at a future time.
238	Crawford	Responds that experience has proven to provide HCFA only with information being requested.
249	Sen. Hamby	Questions if the opportunity will arise to change the line items.
251	Crawford	Responds affirmatively. States that the information obtained from the community would be given to the Health Services Commission for future adjustments.
256	Sen. Hamby	Questions the term future.
257	Crawford	Responds that work has begun to present a list to the 1999 legislature.
265	Sen. Hamby	States that medical research should be integrated into the list that would provide savings for the health plan.
271	Crawford	Responds that inclusion of newer technology does not require a public process.
281	Reed	Continues and reviews the process should HCFA not grant the extension request.
293	Rep. Shields	Questions and a requests the impact assessment if the extension is denied.
298	Reed	Responds that enrollment would stop in August 1998 and by February 1, 1999, 110,000 individuals would be dropped from enrollment.
311	Rep. Shields	Questions the type of individuals that figure includes.
314	Reed	Responds single adults, couples without children, women, low income, Single parents + families, does not include seniors or developmentally disabled individuals. Notes that the department would have to return to the traditional Medicaid benefits.
350	Co-chair Fisher	Recess 10 minutes, reconvenes at 9:55 A.M.
<u>CASE MANAGEMENT OF ANTI-PSYCHOTICS, SSRIs AND RELTATED AGENTS</u>		
359	Crawford	Introduces Bev Castor, Manager, Drug Program, and Dr. Ralph Hemingway, First Health Corporation. Provides overview and background for case management of mental health drugs **(EXHIBIT B)**. Discusses that the January E-Board addressed the drug case management issue.

		The decision was that the program be placed on hold and revise the proposed guidelines. These guidelines would be addressed by the Joint Interim Committee on Human Resources and re-submitted to the E-Board at a later date.
408	Crawford	Discusses how mental health drugs are covered by a fee-for-service basis through OMAP. No restrictions on access to mental health drugs and the budget has increased from $123 million beginning this biennium to approximately $152 million currently.
469	Co-chair Fisher	Requests a definition of SSRI drugs and asks why mental health drugs are treated differently than other prescription drugs.
478	Crawford	Responds that SSRI drugs are anti-depressants. Mental health drugs are treated differently because mental health services were originally outside the health plan; mental health services phased in January 1995. In July 1997, mental health phased into the health plan for 100% of the state.
TAPE 1, B		
003	Crawford	Reviews the proposal of ten mental health drugs on case management. Defines ëretrospectiveí as case management that would have occurred after the drug has been dispensed. Explains and outlines what the program would have accomplished and what it would not have done, **EXHIBIT B**.
031	Sen. Hamby	Questions the consequences if the case manager does not approve a prescribed drug.
039	Crawford	Responds that the treatment option recommended by the provider would be approved for a year. This program was intended to be an educational interaction with the physician.
050	Sen. Hamby	Questions the cost per intervention.
053	Crawford	Responds that $12 per interaction, the estimated cost was $35,000 per month. Continues with how the program was intended to operate.
085	Rep. Lokan	Questions who this case management would be targeting.
096	Crawford	Responds that it could have applied to everyone already on the health plan.
102	Rep. Lokan	Asks if all 350,000 individuals would be placed on case management.
104	Crawford	Responds no. Limited to patients on mental health drugs.
115	Rep. Lokan	Questions the definition of ëa clinical pharmacistí.

128	Crawford	Responds that the physician would make the decision to change medications or not. The clinical pharmacist specializes in the current changes and provides recommendations in drug therapy.
142	Rep. Lokan	Notes concerns about the possibility that a pharmacist may have a prescribing bias and the necessity for the physician and pharmacist to have the ability to coordinate the patientís care. States that the qualified pharmacist be closely evaluated.
151	Crawford	Responds that the clinical pharmacists would interact with the physicians and they have no financial gain by dispensing drugs.
163	Rep. Milne	Asks to whom the clinical pharmacist would be responsible.
169	Crawford	Responds that Oregon would establish the operating guidelines. The OHP, Drug Utilization Review Board, and physicians would participate.
188	Sen. Wilde	Notes the $12.50 per call cost appears to be grossly understated.
198	Sen. Hamby	Questions potential fraud and abuse of dispensing of drugs.
208	Dr. Ralph Hemingway	Representing First Health Corporation, responds that the $12.50 is an added on expense to existing costs, allowing for cost reduction. Comments that a clinical pharmacist is licensed and is in a clinical rotation under the companyís supervision. This service is classified as a value-added service to the state of Oregon.
242	Sen. Hamby	Notes concerns about a student resident pharmacist interacting with an Oregon psychiatrist.
253	Hemingway	Responds that the licensed clinical pharmacists are assigned to projects, and the oversight of students. States that the pharmacist is not making the decisions. They are evaluating the Oregon decision. Discusses the fraud and abuse in the evaluation. The program evaluates trends; First Health provides the figures from these statistical analyses. Reviews drug over and under utilization.
320	Hemingway	Continues explanation and clarification of the current system in Oregon.
357	Crawford	Responds to Sen. Hambyís concerns, page 5 EXHIBIT B, reviews the percentages for mental health drugs.
383	Sen. Hamby	Questions if Oregon pharmacists are able to conduct these types of services.

396	Hemingway	Responds that First Health has been electronically communicating (Pro-Dur Alerts) with Oregon pharmacies since March 1994. Acknowledges that retail pharmacists are overworked and these messages are being missed.
435	Sen. Hamby	Questions if the messages are scripted.
437	Hemingway	Responds that the responses are standardized.
456	Rep. Devlin	Questions if OMAP is aware of the intent for the individual prescribing the medication.
488	Crawford	Responds that that is not the intent of the language. Notes this field is complex and rapidly changing and this type of program could be a benefit to the physician.
507	Rep. Devlin	Questions if there a cost benefit in this program and what are the expectations based on.
515	Crawford	Responds it would save $1.4 million dollars over a 17-month period.
TAPE 2, B		
005	Rep. Devlin	Questions what was used to calculate the costs.
009	Crawford	Responds that examples are provided on page 7, EXHIBIT B.
025	Rep. Milne	Questions implementation costs.
040	Crawford	Responds that there will be no additional costs for personnel or office space. Estimated cost of the program is $35,000/monthly and the estimated monthly savings $200,000.
046	Sen. Hamby	Discusses the time of the physician and staff to place the phone call.
052	Crawford	Responds that that information is not available. Notes this type of interaction already exists between plans and physicians. Discusses the retrospective drug utilization review program.
070	Rep. Milne	Questions if the prospective review is currently being contracted out.
074	Crawford	Responds affirmatively. Notes that page 8 EXHIBIT B outlines services currently contracted with First Health Corporation.

085	Sen. Hamby	Questions if this protocol applies to Clozaril.
090	Crawford	Reviews the exceptions outlined on page 2 EXHIBIT B. Notes that case management does not begin until after the prescription is issued.
123	Sen. Wilde	Discusses concerns regarding the starting of medications at high dosage levels.
131	Crawford	Responds that the physician determines medication dosage levels. Notes that a clinical consultation may be indicated.
146	Sen. Hamby	Remarks on the savings.
151	Crawford	Responds that the average cost for a Clozaril prescription is approximately $77.00.
161	Rep. Shields	Questions if this program will slow down the effectiveness of treating a mentally ill patient.
180	Crawford	Responds that this program does not slow down or prevent treatment to the patients.
186	Rep. Shields	Questions the role of insurance companies, HMOís, etc.
190	Crawford	Responds that the department has reasonable concerns with prescribing practices.
245	Crawford	Discusses the programís clinical benchmarks. Identifies interdisciplinary groups to participate in discussions in developing new guidelines that will be reviewed by this committee. The process should take 4-6 months.
300	Crawford	States that the public process will develop guidelines that will be better supported. Notes that this area will always draw resistance.
322	Co-chair Kruse	Requests current data from First Health regarding this programís outcome in other states and what the overall impact on the health care system will be. States that the proposed program appears to be intrusive.
362	Hemingway	Responds that case management programs in other states target specialized populations. Pennsylvania targets elderly populations and HIV/AIDS patients in New Jersey, and Washington, D.C. Notes the ultimate goal for case management is to improve the quality of care.
433	Hemingway	Continues presentation. States that case management is not a cost savings program; the objective is to improve the health of a targeted population. States that the outcome assessments provide feedback for evaluation of the programís effectiveness.

462	Co-chair Kruse	Requests this information in writing.
468	Rep. Milne	Requests background information on First Health Corporation and questions how patient information is obtained.
477	Hemingway	Responds that the information is obtained at the point of sale from the pharmacy. First Health is the point of sale contractor for the state of Oregon.
TAPE 3, A		
006	Rep. Milne	Questions how First Health knows what is good for the patient.
012	Hemingway	Responds that case management add a personal interaction with the prescriber and pharmacists.
026	Rep. Milne	Notes concerns regarding First Health determining what is appropriate or not appropriate for a patient.
032	Hemingway	Responds that First Health is not determining that. They just notify the physician and the physician makes the determination.
035	Rep. Milne	Asks why case management needs to be implemented.
037	Hemingway	Responds that the prescriber may not have all pertinent patient information that is available to First Health.
044	Co-chair Fisher	Discusses past experiences with pharmacy consultants.
080	Rep. Lokan	Comments and questions why other mental health agencies are not being included to provide OMAP with the information being requested.
093	Crawford	Responds that those organizations are the providers of services. They would be recipients of the information from First Health.
102	Rep. Lokan	Questions if the proposed program implies that the providers are doing an inadequate job.
107	Crawford	Responds that this program is to offer additional information to the providers.
114	Sen. Hamby	Questions if First Health contracts with other states that have provided additional funding to cover the expense of mental health drugs.

125	Hemingway	Explains and discusses the Harvard study from New Hampshire. Notes that New Hampshireís philosophy was a slash-and-burn approach. Comments that the study revealed that the volume and type of patient care, within the state, increased dramatically from this approach.
185	Sen. Hamby	States concerns regarding First Healthís attempt to lower medication dosage of mental health patients.
201	Hemingway	Remarks that dosage adjustment is not a variable in their statistical model. Non-compliance rates and under utilization are used to determine cost savings.
223	Rep. Milne	Requests a copy of the current contract of services and the proposed contract. Notes concerns regarding patient care and patient privacy.
245	Crawford	Responds that federal regulations require a prospective and retrospective drug utilization review program. The company providing these services will not require any additional information.
273	Jim Gardner	Representing Pharmaceutical Research and Manufacturers of American (PhRMA) provides testimony clarifying 1993 drug utilization review legislation. Notes concerns regarding OMAPís administration of the program.
330	Gardner	Continues testimony stating the cost impact to physicians and time spent on generating refills and the barrier to patients.
385	Gardner	Discusses concerns and comments in support of the workgroup. Suggests that upon review of the revised OMAP plan, it be forwarded to the 1999 legislative session.
449	John McCulley	Representing Oregon Psychiatric Association comments in support of the workgroup.
466	William Wilson, M.D.	Oregon Psychiatric Association, presents testimony and concerns regarding the proposed OMAP case management program **(EXHIBIT C)**.
TAPE 4, A		
005	Wilson	Continues presentation covering: analysis of medications used, cost effectiveness, dosage information, and guidelines for treatment.
055	Wilson	Continues testimony. Reviews the depression guidelines used by OMAP and compares with the American Psychiatric Association guidelines for using anti-depressants **(EXHIBIT D)**.
118	Sen. Hamby	Comments in support of Dr. Wilson being involved with this process.

125	Co-chair Fisher	Questions how much time a phone evaluation would take.
127	Wilson	Responds 15 minutes to one hour. Remarks that the explanation and justification of treatment could be time consuming.
140	Co-chair Fisher	Questions the hourly rate of a psychiatrist.
143	Wilson	Responds $80-120 per hour.
146	Co-chair Fisher	Comments that the time this process would take could cost the doctor $20-120 dollars.
152	Sen. Hamby	Comments and questions the speed of obtaining current prescription information.
158	Wilson	Responds it can be difficult for doctors to stay current and pharmacists are valuable in that area. Remarks on the filtering effect of this proposed program.
168	Co-chair Fisher	Questions if it is possible for the local pharmacist to have the overall drug profile of a patient.
181	Wilson	Responds affirmatively and recommends that the company forward that information to all attending physicians.
196	Co-chair Kruse	Questions if this type of treatment is outside the normal guidelines.
200	Wilson	Responds that he researches, contacts other physicians and experts in the field and determines the course of action.
216	Co-chair Kruse	Asks how effective is the patient-physician consultation.
219	Wilson	Responds that consultations are vital to appropriate and complete patient care.
227	Scott Gallant	Representing Oregon Medical Association, provides testimony in opposition to the proposed case management program **(EXHIBIT E)**.
265	Jim Davis	Co-chair of Oregon Medicare/Medicaid Coalition and representative of the Oregon State Council of Senior Citizens. Provides testimony in opposition in the development of OMAPís case management program. Comments in support of forming two workgroups addressing this issue.
315	Davis	Continues testimony.

365	Davis	Continues and summarizes testimony **(EXHIBIT F)**.
419	Elizabeth Byers	Representing Project Equality provides testimony in opposition to OMAPís case management proposal.
494	Anne L. Potter	Representing Mental Health Coalition provides testimony in opposition to OMAPís case management proposal.
TAPE 3, B		
010	Potter	Continues testimony.
048	Ellie Jenny	Consumer and representative of Project Equality, provides testimony in opposition to OMAPís case management proposal **(EXHIBIT G)**.
100	Jenny	Continues testimony.
133	Co-chair Fisher	Acknowledges the concerns and notes that costs are a factor.
140	Jenny	States that the program was not implemented to address clients currently in the system.
156	Co-chair Fisher	Recess for lunch 12:14 p.m. Reconvenes at 1:25 p.m.
168	Tweedt	Submits testimony by Bill Dalton, Maggie Johnson, Jackson County Mental Health Services, United Seniors of Oregon, and Governorís commission on Senior Services. Notes that the Oregon Health Plan is concluding two-client satisfaction surveys. Results will be available late spring.
212	John Pointer	Consumer, provides testimony in opposition to OMAPís proposed case management program. Notes primary concerns: • physicianís continuing education • keep the management locally
287	Pointer	Continues testimony.
310	Pointer	Continues with review of the current system to monitor over medication and abuse, doctor shoppers, multi-pharmacy users and abusers.

380	Pointer	Continues testimony.
474	Susan Ragen	Consumer, chronic pain patient testifies in opposition to the OMAPís proposed case management program.
TAPE 4, B		
BOARD OF PHARMACY PROPOSED RULES		
014	John Block	President, Oregon Board of Pharmacy, provides testimony and summary of pharmacist education, responsibilities, and changes occurring in the profession **(EXHIBIT H)**. Begins review of proposed rule changes.
065	Co-chair Kruse	Questions definition of the PEW Commission.
067	Block	Responds that health care is an issue that is reviewed by the PEW Foundation. Continues review of the pharmacy technician registration process generated by HB 2123 (1997).
110	Block	Continues review of drug delivery in a retail outlet, definition of confines of a pharmacy and the duties of pharmacists.
122	Co-chair Kruse	Questions why the portion addressing support personnel was removed.
132	Block	Responds that the rule did not allow enough flexibility to move the pharmacists into the front area.
145	Co-chair Kruse	Questions if that category of staff were removed would it limit the pharmacy.
149	Block	Responds that is addressed in another area of the rules.
164	Rep. Lokan	Questions if there is a current policy requiring that every patient receiving a prescription receive medication counseling.
183	Block	Responds that that issue is addressed in the pharmaceutical care rule. Notes that routine refills may not require any additional counseling.
205	Rep. Lokan	Remarks on the importance of adequate documentation.
216	Block	Responds that generally documentation is questioned when a complaint is filed against the pharmacy/pharmacist.
237	Rep. Lokan	Questions whether it is the individual

237	Rep. Lokan	Questions who is cited, the individual or company.
242	Block	Responds that both can be levied fines.
254	Co-chair Fisher	Questions how technicians are utilized in a mail order facility.
259	Block	Responds that he believes they would be utilized in the same fashion as a retail store.
273	Co-chair Fisher	Questions how the counseling aspect of the regulation is accomplished.
274	Block	Responds that there is no personal counseling, the information is provided in writing with a toll free number included with prescription.
281	Co-chair Kruse	Questions if technician verification is supplied by the Board of Pharmacy.
285	Block	Responds affirmatively.
286	Co-chair Kruse	Questions the relevancy of section 14.
292	Joe Schnabel	Board of Pharmacy, responds that the board cannot deny a technician status to anyone. The registration procedure does not require a background check of any kind.
299	Co-chair Kruse	States that pharmacy technicians can be drug dealers.
300	Schnabel	Responds in agreement.
302	Block	Continues comments that the pharmacy outlet and the pharmacists, who are licensed by the board, are responsible for the actions of their pharmacy technicians.
310	Co-chair Kruse	Questions if the board conducts any type of background check on the technician applicants.
316	Block	Responds that the background check begins and information is available upon renewal of the license.
326	Co-chair Kruse	Questions if the Board of Pharmacy does not have the background information how is the pharmacist going to access the information.
332	Block	Responds that there is a national clearinghouse for technicians.

333	Co-chair Kruse	Comments if a greater burden is being placed on the pharmacists rather than the Board.
348	Schnabel	States that inserting the word knowingly would correct the situation.
367	Lis Merten	Representing National Association for Chain Pharmacy, provides testimony in support of the Board of Pharmacy proposed revisions.
376	Gary Oxley	Representing Rite-Aid Corporation, provides testimony in support of the revised Board of Pharmacy rules.
388	Ed Patterson	Representing Oregon Association of Hospitals, provides testimony regarding concerns surrounding the definitions of registration versus licensure.
450	Patterson	Continues testimony addressing concerns of section 14 and the disciplinary authority.
TAPE 5, A		
005	Patterson	Continues discussion and clarifications of registration and licensure.
023	Block	Responds that these concerns will be taken to the board counsel.
032	Co-chair Kruse	Questions if this issue was raised during the rule making process.
033	Block	Responds that the board is sensitive to registration versus licensure and the issue was raised with the boardís counsel.
041	Co-chair Kruse	Requests that burden of proof be better defined.
049	Co-chair Fisher	Questions if the Board of Pharmacy could provide follow-up at the March 4th meeting.
051	Block	Responds the Board of Pharmacy will not meet until March 12 and 13, but the board counsel will be consulted.
066	Co-chair Fisher	Questions if the board reconsiders and agrees with Mr. Patterson can changes and voting take place on March 12th. Requests an update at the March 4th meeting before the boardís March 12th meeting.
068	Block	Responds affirmatively.

078	Sen. Wilde	Comments on the language used in the rules and remarks that it implies licensure more than registration.
090	Block	Reviews and summarizes collaborative drug therapy proposed rule changes.
148	Co-chair Fisher	Questions the definition of collaborative drug therapy.
152	Tweedt	Requests description of the rule, and what the current practice entails before raising concerns.
154	Block	Responds affirmatively.
164	Schnabel	Responds with describing collaborative drug therapy as physician and pharmacist together with drug therapy in advance. States the pharmacist is not acting independently.
178	Co-chair Kruse	Questions if this action is expanding the scope of practice of the pharmacist.
179	Schnabel	Responds no.
184	Sen. Castillo	Requests example of this type of arrangement.
190	Schnabel	Responds that these arrangements are very drug specific. Cites anti-coagulation therapy (Coumadin). Notes that this type of arrangement is currently utilized throughout Oregon.
218	Sen. Castillo	Questions if the physician enters this type of relationship willingly.
225	Schnabel	Responds participation is voluntary.
237	Co-chair Fisher	Questions if the pharmacist increases and decreases medication level depending on the laboratory results.
248	Schnabel	Responds affirmatively.
254	Co-chair Fisher	Questions if the pharmacist will require a patient to return on a regular basis or is it the same for all patients on Coumadin.
261	Schnabel	Responds that the return treatment is individually based, but the procedure is similar for all Coumadin patients.
271	Co-chair Kruse	Questions if the pharmacist is responding to the diagnosis or providing a diagnosis.

274	Schnabel	Responds they are responding to the diagnosis with authorization from the physician.
295	Block	Continues overview of rule modifications. Physician initiates the order and/or changes, and no therapeutic substitution.
320	Rep. Devlin	Questions if chemical structure includes dosage modifications.
322	Block	Responds no.
334	Sen. Castillo	Questions the advantages of these proposed changes.
343	Schnabel	Responds that many of these protocols are complex, for the physician to fill out and submit these protocols for each patient is extremely time consuming. Having the protocols established and agreed upon in advance is more efficient for the physician and patient.
365	Co-chair Kruse	Questions how many of these protocols are being used.
367	Schnabel	Responds at Salem Hospital six are being used. These types of protocols are increasing slowly.
389	Block	Comments that these types of protocols are expanding in the areas of asthma, hypertension, and in Type 2 diabetes.
417	Co-chair Fisher	Discusses personal experience with this type of arrangement.
430	Sen. Castillo	Questions benefits to the patients.
433	Schnabel	Responds that patientís treatments are monitored closely. In some cases hospital stays have been shortened because of this monitoring ability.
461	Rep. Devlin	Questions if the liability is equally shared between the physician and pharmacist and has the Board of Medical Examiners had input in the drafting of this rule.
472	Schnabel	Responds affirmatively. States that the Board of Medical Examinerís medical consultant worked closely on the task force and helped draft language for this rule.
491	Co-chair Fisher	Questions why this is an issue now.
499	Block	Responds with the expansion of cooperative care management and the cost effectiveness of these arrangements and increased delegation between health care

		professionals, clearer guidelines are a concern.
TAPE 6, A		
010	Fisher	Questions if there has been any liability issues.
012	Block	Responds that one situation arose seven years ago and it was a refill error, not a protocol error.
028	Schnabel	Comments that the only change has been that the protocols are increasing in a variety of forms.
051	Gardner	Provides testimony in support of collaborative therapy, however there are concerns regarding legislative intent, scope of practice and the need for additional oversight.
100	Gardner	Continues testimony and concerns of the therapeutic substitution definition. Notes that the term prior authorization could be used in a broader sense than intended.
148	Co-chair Fisher	Requests accurate wording to satisfy stated concerns.
149	Gardner	Responds insert ëwithout a prior prescription for the drug with a different chemical structureí.
164	Gallant	Provides testimony noting concerns regarding collaborative drug therapy management **(EXHIBIT I)**. Notes the American Medical Associationís position on collaborative drug therapy.
220	Gallant	Continues explanation regarding these types of arrangements taking place in institutional settings with the appropriate checks and balances for patients and patient safety, not in retail settings.
270	Gallant	Notes the fundamental issue of the pharmacist being included in the definition of health care provider implies that the pharmacist may initiate and/or change drug therapy. The OMAís position is supportive of changes, but this service is an expansion of the scope of practice.
340	Co-chair Fisher	Comments that these actions need to be initiated by a physician.
343	Gallant	Responds that a physician writes a prescription for a patient. Notes concerns regarding a pharmacist substituting something else. Comments on the different situations and different treatment settings.
382	Co-chair Fisher	Questions the definition of therapeutic substitution.

387	Gallant	Responds in agreement with the proposed language change.
403	Co-chair Fisher	Questions if there are concerns that a rural physician might agree to an arrangement that they should not enter into.
407	Gallant	Responds that if a physician writes a prescription for a specific medication, that is the medication that they want the patient to be given.
433	Co-chair Kruse	Questions OMAís position on collaborative drug therapy settings.
449	Gallant	Responds they are supportive of collaborative drug therapy in controlled settings.
491	Co-chair Kruse	Questions the concerns about the protocol.
TAPE 5, B		
005	Gardner	Responds that the importance of the protocol receives the same respect and detail as the prescription itself.
017	Gallant	States that the physician needs to consciously and knowingly identify the individual patient.
027	Rep. Devlin	Questions if the OMA has had discussions with the BME and the Board of Pharmacy regarding their concerns.
036	Gallant	Responds affirmatively. States that the BME has concerns with the rules, but has not issued any documentation. Notes the issue over jurisdiction and the regulatory authority over physicians and the care of patients.
069	Co-chair Fisher	Requests the OMA, BME, and Board of Pharmacy meet and collaborate to resolve these issues.
079	Gallant	Responds in agreement. Notes that all parties are attempting to collaborate and requests that the board not adopt these rules until the discussions have taken place.
098	Co-chair Kruse	Encourages the groups to reach an acceptable compromise.
104	Gardner	Requests an extension of time for these discussions.
115	Co-chair Fisher	Comments in agreement.

121	Rick Sahli	Regional Pharmacy Director, Providence Health System, provides testimony in support of the collaborative therapy in a non-hospital setting.
144	Co-chair Fisher	States that the concerns surround the replacement/substitution of specific drugs.
150	Sahli	Responds that he understood the rules to not allow therapeutic substitution.
197	Steve Stoner	Assistant Director of Pharmacy, Providence Health System, provides summary of present system and monitoring of the anticoagulation clinic **(EXHIBIT J)**. Notes the involvement of an oversight committee.
259	Stoner	Continues testimony reviewing the results of the patient and physician satisfaction survey.
281	Jacqueline Hunt	Clinical Pharmacy Specialist, Portland Medical Group. Provides testimony including professional background and reviews departmental guidelines **(EXHIBIT K)**.
330	Hunt	Continues overview.
365	Sahli	Summarizes and provides closing comments.
376	Co-chair Kruse	Comments that the presentation addresses clinical settings. Notes the concerns surround the retail settings.
387	Sahli	Responds that the examples given are non-institutional settings, and could be used in a Fred Meyer, Rite-Aid or any other public setting.
415	Lis Merten	Representing National Association of Chain Drug Stores (NACDS) provides testimony in support of this therapy agreement. Notes these agreements are voluntary not mandatory. Comments on Section D, and the quality assurance panel **(EXHIBIT L)**.
468	Gwen Dayton	Legislative Counsel, provides testimony regarding the definition of therapeutic substitution and prior authorization. Comments on the prescriptive authority
TAPE 6, B		
003	Dayton	Recommends clarification of guidelines/rules should provide clear directive for the prescriber.
024	Co-chair Fisher	Recommends that all parties continue to work together.
029	Schnabel	Comments that therapeutic substitutions are not what these arrangements are

029	Schnabel	Comments that therapeutic substitutions are not what these arrangements are intended for. Notes that the guidelines are intended to be very explicit.
071	Schnabel	Continues responses to earlier testimony.
082	Sen. Castillo	Questions the Boardís position on the recommendation to change the definition of therapeutic substitution.
085	Schnabel	Responds that the current definition is from the AMA policy to make any changes would have an unknown impact.
102	Block	Reviews the proposed rule change on pharmaceutical care.
130	Rep. Lokan	Questions what disciplinary action is taken if counseling is not completed.
136	Block	Responds and reviews what penalties are issued if the procedure is not followed.
186	Gallant	Provides testimony and concerns regarding the revisions of pharmaceutical care. Requests clarification of patient records and legal standard of prudent pharmacist.
245	Gallant	Continues review of concerns outlining chronic medical conditions. Notes that this rule was originally connected to the drug utilization review process, and the revision has incorporated a new definition of utilization review.
303	Co-chair Kruse	Requests definition of chronic medical condition.
304	Gallant	Responds that it is very broad. Reviews concerns regarding Measure 16 and states that the Board of Pharmacy, OMA and the BME will come to an agreement.
342	Co-chair Fisher	Requests assurances from OMA that a summary be available by the March 4th meeting.
353	Gardner	Continues testimony regarding definition of chronic medical conditions, patient privacy and pharmacy liability. Assures working with all parties regarding these concerns.
377	Merten	Provides two points of concerns: medication history and the record keeping being proposed.
420	Co-chair Fisher	Questions if mail order pharmacists have to document that they have sent counseling documents with the prescriptions.
425	Nick Willard	Representing Owens Retired Persons Pharmacy, supports the mail order

425	Nick Willard	Representing Oregon Retired Persons Pharmacy, responds that mail order pharmacies are not required to document counseling.
436	Merten	Remarks that this is an extra administrative procedure that pharmacies do not need.
472	Block	Responds to concerns raised. Continues summary and overview of community based care facilities and proposed revisions.
TAPE 7, A		
013	George Gerding	Consulting pharmacist, provides testimony in support of community based services.
060	Gerding	Continues review of community based care facilities.
082	Co-chair Fisher	Discusses the role of the pharmacist in long-term care facilities.
098	Gerding	Responds that the role of the pharmacists is changing.
109	Block	Responds that this is not a mandatory rule; it will establish a standard of practice if it is utilized.
130	Co-chair Fisher	Notes the usage of shall. Suggests changing it to may.
138	Block	Responds that may does not require the pharmacist to do what is outlined in the rule.
148	Rep. Devlin	Discusses if the pharmacist is providing a service then they have to comply with the list included in the rules.
159	Block	Continues clarification and explanation.
180	Rep. Devlin	Discusses the language used.
225	Co-chair Fisher	Comments on legislative intent.
227	Co-chair Kruse	Questions if the board has any objections in changing shall to may.
230	Block	Responds that with may the items in the rules must be followed.
239	Rep. Lokan	Questions the position of the community based care facilities.

251	Block	Responds that the Board of Pharmacy does not have jurisdiction over the community based facilities.
256	Rep. Lokan	Questions who would be supervising the distribution and storage of drugs.
259	Gerding	Responds that the pharmacist would provide the facility with a policy/procedure that would be followed.
290	Rep. Lokan	Questions who would have jurisdiction if a problem should arise.
303	Gerding	Responds that if the facility did not comply with the policy, the pharmacist would probably go directly to the director of the facility. In a smaller facility the pharmacist may sever the working relationship.
328	Rep. Lokan	Questions the response from providers.
337	Gerding	Responds that they have been varied. The attitude of the facility is determined by the need of the service.
362	Rep. Lokan	Questions if there are duplicate inspections.
372	Block	Responds that the board does not inspect the facilities.
384	Co-chair Fisher	Discusses that community based facilities have different regulations.
419	Tina Kitchin	Medical Director, Office of Developmental Disability Services, provides testimony stating concerns with the rule and the proposed changes **(EXHIBIT M)**.
469	Kitchin	Continues testimony.
TAPE 8, A		
010	Margaret Murphy-Carley	Oregon Health Care Association, Counsel, provides testimony noting appropriate language changes and the potential fiscal impact to the community-based facilities **(EXHIBIT N).**
053	Murphy-Carley	Comments that this proposed change is viewed as an indirect mandate and the board is attempting to regulate pharmaceutical services that must be purchased. The association supports the concept and the service but requests changing the language from ëshallí to ëmayí.
069	Sen. Castillo	Questions if it is voluntary program how can it be mandated.

073	Murphy-Carley	Responds that the problem lies in the broadness of how arrangement can be interpreted.
099	Co-chair Fisher	Questions if the act of providing drugs falls under pharmaceutical care.
134	Kitchin	Responds SDSD would absorb the expense and that Mental Health Division would bear the cost.
141	Co-chair Fisher	Discusses the fiscal impact of this service.
162	Co-chair Kruse	Comments and recommends that the board consider the recommendations being made.
183	Schnabel	Responds that board members in an informal conversation have discussed removing the rule completely. Notes that there are standards of practice for pharmacists to distribute drugs.
209	Co-chair Fisher	Discusses the importance of people having a choice for their treatment. Recommends working with interested groups to resolve these issues.
297	Co-chair Kruse	Recommends holding these issues until a resolution is achieved.
322	Schnabel	Comments that it was not the Board of Pharmacyís intent to surprise anyone or any organization with these rules and the proposed changes.
329	Co-chair Fisher	Requests summary at the March 4th meeting. Announces Sen. Wildeís birthday. Adjourns the meeting at 5:04 P.M.

Submitted By, Reviewed By,

Sandy Thiele-Cirka, Anne E. Tweedt,

Administrative Support Administrator

EXHIBIT SUMMARY

A - Oregon and Section Medicaid Waivers, Hersh Crawford, 10pp

B - Case Management of Mental Health Drugs, Hersh Crawford, 8pp

C ñ Written Testimony, William Wilson, 1pp

D ñ Informational, William Wilson, 20pp

E ñ Informational, Scott Gallant, 25pp

F ñ Written Testimony, Jim Davis, 3pp

G ñ Written Testimony, Ellie Jenny, 3pp

H ñ Oregon Board of Pharmacy, 11pp

I - Written Testimony, Scott Gallant, 8pp

J ñ Written Testimony, Steve Stoner, 13pp

K ñ Anticoagulation Operation Policies and Procedure, Jacqueline Hunt, 23pp

L - Written Testimony, Lis Merten, 2pp

M ñ Written Testimony, Tina Kitchin, 1pp

N ñ Written Testimony, Margaret Murphy-Carley, 19pp