

1
2
3
4
5
6
7
8
9
10
11
12
13
14
15
16
17
18
19
20
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COMMONWEALTH OF PENNSYLVANIA
HOUSE OF REPRESENTATIVES
HOUSE PROFESSIONAL LICENSURE COMMITTEE

RYAN OFFICE BUILDING
ROOM 205
HARRISBURG, PENNSYLVANIA

WEDNESDAY, APRIL 29, 2009
9:30 A.M.

IN RE: PUBLIC HEARING ON

DRUG THERAPY MANAGEMENT
HB-1041, PN-1212

BEFORE:

- HONORABLE MICHAEL P. MCGEEHAN., CHAIRMAN
- HONORABLE WILLIAM F. ADOLPH, JR.
- HONORABLE HARRY READSHAW
- HONORABLE CHERELLE L. PARKER
- HONORABLE JARET GIBBONS
- HONORABLE KEITH GILLESPIE
- HONORABLE NEAL P. GOODMAN
- HONORABLE JULIE HARHART

1 (CONT'D)

2

HONORABLE SUSAN C. HELM
3 HONORABLE T. MARK MUSTIO
HONORABLE JOSEPH A. PETRARCA
4 HONORABLE DOUGLAS G. REICHLEY
HONORABLE JOHN P. SABATINA, JR.
5 HONORABLE MARIO M. SCAVELLO
HONORABLE TIMOTHY J. SOLOBAY
6 HONORABLE RICHARD R. STEVENSON
HONORABLE JAMES WANSACZ
7 HONORABLE RONALD G. WATERS

8

9

ALSO PRESENT:

10

MARLENE TREMMEL, MAJORITY EXECUTIVE DIRECTOR
11 WAYNE CRAWFORD, MINORITY EXECUTIVE DIRECTOR
DIANNE L. NICHOLS, ESQUIRE, LEGAL COUNSEL
12 KRISTIN MILLER, COMMITTEE LEGISLATIVE
ASSISTANT

13

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BRENDA S. HAMILTON, RPR
15 REPORTER - NOTARY PUBLIC

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21

22

23

24

25

	INDEX	
	NAME	PAGE
1		
2		
3	OPENING REMARKS	
4	CHAIRMAN MICHAEL P. MCGEEHAN	6
5	HONORABLE DEBERAH KULA	6
6	BASIL MERENDA, COMMISSIONER,	11
7	DEPARTMENT OF STATE, BUREAU OF	
	PROFESSIONAL AND OCCUPATIONAL AFFAIRS	
8	MICHAEL A. PODGURSKI, CHAIRMAN,	20
9	PENNSYLVANIA STATE BOARD OF PHARMACY	
10	THOMAS M. SNEDDEN, DIRECTOR,	30
11	PENNSYLVANIA PHARMACEUTICAL	
	ASSISTANCE CONTRACT FOR THE	
	ELDERLY (PACE)	
12	ADAM WELCH, PHARM.D., SECOND VICE	39
13	PRESIDENT FO THE PENNSYLVANIA	
	PHARMACISTS ASSOCIATION	
14	RICK MOHALL, PHARM.D., DIRECTOR,	55
15	FIELD CLINICAL SERVICES, RITE AID	
	CORPORATION	
16	MELANIE HORVATH, EXECUTIVE DIRECTOR,	64
17	PENNSYLVANIA PHARMACY COUNCIL	
18	ROBERT J. WEBER, M.S., FASHP,	70
19	CHIEF PHARMACY OFFICER, UNIVERSITY	
	OF PITTSBURGH MEDICAL CENTER	
20	LUIS S. GONZALEZ, III, PHARM.D., BCPS,	83
21	ASSOCIATE PROGRAM DIRECTOR, DEPARTMENT	
	OF MEDICINE RESIDENCY PROGRAM,	
	DIRECTOR, PHARMACY PRACTICE RESIDENCY	
	PROGRAM, CHAIR, MEMORIAL MEDICAL	
	CENTER IRB, MANAGER, CLINICAL PHARMACY	
	SERVICES, MEMORIAL MEDICAL CENTER	
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P R O C E E D I N G S

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CHAIRMAN MCGEEHAN: Good morning. I want to call this hearing of the House Professional Licensure Committee to order.

I welcome the members and the guests. And I'll begin by having the members introducing themselves, and we'll have members coming and going throughout this meeting. We'll start on our left with Representative Helm.

REPRESENTATIVE HELM: Sue Helm, 104th District of Dauphin County.

REPRESENTATIVE GILLESPIE: Thank you, Mr. Chairman. Good morning, everybody. Keith Gillespie, 47th District, York County.

REPRESENTATIVE ADOLPH: Bill Adolph, Republican Chair, 165th Legislative District, Delaware County.

CHAIRMAN MCGEEHAN: Mike McGeehan from Philadelphia County.

REPRESENTATIVE SABATINA: John Sabatina, Philadelphia County.

REPRESENTATIVE READSHAW: Harry Readshaw, Allegheny County.

1 REPRESENTATIVE WANSACZ: Jim Wansacz,
2 Lackawanna County.

3 REPRESENTATIVE WATERS: Ron Waters,
4 Philadelphia and Delaware Counties.

5 REPRESENTATIVE STEVENSON: Dick
6 Stevenson, Mercer and Butler Counties.

7 REPRESENTATIVE SCAVELLO: Mario
8 Scavello, Monroe.

9 REPRESENTATIVE GOODMAN: Neal
10 Goodman, Schuylkill.

11 CHAIRMAN MCGEEHAN: And we're being
12 joined by Representative Parker from
13 Philadelphia County.

14 Just an -- an editorial comment
15 before we begin, or a housekeeping, we are on
16 a tight set schedule today. The House
17 convenes at eleven o'clock.

18 So we're going to limit both the
19 presentation and the questions to ten minutes
20 each, and we'll have the executive secretary
21 keep note of that.

22 We want to hear from each and every
23 testifier today on this important bill that's
24 sponsored by Representative Kula. However, if
25 you can depart from your written testimony --

1 and we have your written testimony from each
2 of the testifiers today -- and trust that
3 they'll be reviewed by each member and -- and
4 recorded as part of the official record of
5 this hearing. So feel free to provide your
6 remarks extemporaneously outside of your
7 written testimony.

8 Having said that, I want to recognize
9 our esteemed colleague, Representative Kula,
10 who has done a lot of work on this.

11 Welcome, Representative, and you may
12 begin whenever you are comfortable.

13 REPRESENTATIVE KULA: Thank you,
14 Mr. Chairman. I guarantee you I will not use
15 my ten minutes though. I'll be very brief.

16 Good morning, Chairman McGeehan,
17 Chairman Adolph, and committee members. I
18 thank you for holding this hearing today and
19 allowing this to come forward and hopefully
20 become law soon.

21 I -- I hope all of you can imagine
22 that you are a person with diabetes or high
23 blood pressure or something that requires
24 medication and requires that medication to be
25 closely monitored. Sometimes it's difficult

1 to make those appointments or to see a doctor
2 at a time that you need or just have the
3 opportunity to really deal with your
4 medications if there are problems.

5 You may live a long distance from
6 your doctor and so it could be difficult. And
7 for some people, it's even more difficult,
8 such as our senior citizens.

9 If you could go to your local
10 pharmacy and receive counseling and monitoring
11 you need, you may not have those difficulties
12 in accessing this care. You may even be able
13 to spend more than five minutes talking a --
14 with doctor's schedules and -- sometimes it's
15 hard to have the time that you need to discuss
16 your particular issue. So with a pharmacist
17 doing that, you may be able to spend a little
18 more time discussing your needs.

19 Pharmacists currently perform the
20 management of drug therapy in hospitals and
21 institutional settings. And many pharmacists
22 are now earning doctorate level degrees which
23 include training on how to manage drug
24 therapy. Even our federal government
25 recognizes the benefits of allowing

1 pharmacists to perform the management of drug
2 therapy and covers this service under
3 Medicaid -- Medicare Part D.

4 House Bill 1041 would allow a
5 pharmacist to practice the management of drug
6 therapy in a setting other than an
7 institutional setting. A collaborative
8 agreement between a physician and pharmacist
9 would be required, and a pharmacist would be
10 required to provide proof of training in the
11 management of drug therapy for the disease or
12 the condition or symptom of disease which is
13 the subject of the collaborative agreement.

14 Pharmacists must comply by
15 registration with the board and must utilize a
16 consultation area that ensures the
17 confidentiality of the patient information
18 being discussed. So they must have an area
19 where -- when they're meeting with the patient
20 to discuss these issues, that it's a private
21 area.

22 The pharmacist must carry liability
23 insurance in the amount of one million dollars
24 per occurrence, and this is currently being
25 required. The collaborative agreement between

1 the physician and the pharmacist must specify
2 the terms under which the pharmacist may
3 adjust the drug regimen, drug strength,
4 frequency of administration without prior
5 written or oral consent of the physician.

6 For a patient to utilize a pharmacist
7 for the management of drug therapy, the
8 patient must have a written referral from a
9 physician which must specify the frequency a
10 pharmacist must see the person -- the patient
11 in person.

12 I believe this bill will offer better
13 services and more accessible health care to
14 many citizens of our Commonwealth.

15 I strongly urge you to consider House
16 Bill 1041 in committee so it may move to the
17 House floor and hopefully pass again out of
18 the House.

19 We thank you for allowing this
20 testimony here today for the stakeholders to
21 obviously give their views on this very
22 important legislation. And I thank you.

23 CHAIRMAN MCGEEHAN: Thank you very
24 much, representative. Thank you for your
25 advocacy on this important issue.

1 Are there questions for
2 Representative Kula?

3 Yeah. Representative Scavello.

4 REPRESENTATIVE SCAVELLO: Thank you,
5 Mr. Chairman.

6 Representative, I thought we did pass
7 this bill last session.

8 REPRESENTATIVE KULA: We did. There
9 were some issues in the bill that have been
10 removed from the bill that stopped it in the
11 Senate.

12 The Senate did not support the bill
13 because of certain issues, and those issues
14 have been cleared up, and we believe this bill
15 now is pretty much on its way.

16 REPRESENTATIVE SCAVELLO: Thank you.

17 CHAIRMAN MCGEEHAN: Thank you very
18 much, Representative Kula, for your
19 testimony.

20 REPRESENTATIVE KULA: Thank you.

21 CHAIRMAN MCGEEHAN: We've also been
22 joined by Representative Solobay and
23 Representative Mustio.

24 Our next -- our next testifier is
25 certainly no stranger to the committee. His

1 name is Basil Merenda. He's the Commissioner
2 of the Bureau of Professional and Occupational
3 Affairs.

4 Good morning, commissioner.

5 COMMISSIONER MERENDA: Good morning,
6 Mr. Chairman.

7 CHAIRMAN MCGEEHAN: You know how the
8 drill works.

9 COMMISSIONER MERENDA: Yes.

10 CHAIRMAN MCGEEHAN: And you're being
11 timed.

12 COMMISSIONER MERENDA: Chairman
13 McGeehan, Chairman Adolph, and members of the
14 committee, and thank you for permitting the
15 Department of State here today to testify on
16 House Bill 1041 that provides for the
17 expansion of drug therapy management.

18 For the record, my name is Basil
19 Merenda, and I am the Commissioner for the
20 Bureau of Professional and Occupational
21 Affairs. I administer the Commonwealth's 27
22 licensing boards and I sit as a voting member
23 on 25 of those boards.

24 House Bill 1041 is without a doubt a
25 historic piece of legislation. And because of

1 that, with me today is Michael Podgurski, who
2 is the chairman of the State Board of
3 Pharmacy.

4 Mr. Podgurski has been a practicing
5 pharmacist for 37 years and represents
6 community chain pharmacies, is a very
7 effective board chair, and very supportive of
8 House Bill 1041.

9 The bill amends the definition of the
10 practice of pharmacy to expand drug therapy
11 management beyond the confines of
12 institutions, like hospitals and nursing
13 homes, to all practice settings.

14 In essence, House Bill 1041 builds on
15 the 2002 amendments to the Pharmacy Act which
16 first defined the practice of pharmacy to
17 allow drug therapy management in the
18 institutional settings and will authorize
19 pharmacists to provide drug therapy management
20 most notably in the community pharmacy setting
21 and more often than not as part of a group
22 physician practice.

23 If I could put this into perspective,
24 it is worth noting that the 2002 amendments
25 also authorized pharmacists to administer

1 injectable medications, biologicals, and
2 immunizations to persons who are 18 years of
3 age and older. In fact, as a result of the
4 2002 amendments, you can actually see
5 pharmacists administering flu vaccines and
6 other medications at community pharmacies all
7 across the Commonwealth. And I'd like to note
8 for the record that the legislatures foresight
9 in 2002 in granting this authority to the
10 profession could prove to be valuable to
11 address the growing worldwide swine flu
12 epidemic.

13 Now, the amendments included in House
14 Bill 1041 will enable the General Assembly in
15 2009 to further enhance the pharmacy
16 profession in the Commonwealth.

17 Under House Bill 1041 drug therapy
18 management by a licensed pharmacist will be
19 allowed in all practice settings and would
20 allow pharmacists to practice more fully
21 within the scope of practice.

22 By permitting a pharmacist to have a
23 direct role in drug therapy management,
24 Pennsylvania patients would be able to benefit
25 directly from the pharmacist's expertise in

1 drug use and interaction. A pharmacist's
2 advice and counsel regarding drug use and
3 interaction could prove to be a welcomed
4 assistance to the physician as well as an
5 invaluable service to patients across the
6 Commonwealth.

7 It is indeed time for the
8 Commonwealth of Pennsylvania to provide the
9 Commonwealth patients with drug therapy
10 management. According to the American
11 Pharmacists Association website, 45 states
12 currently authorize collaborative drug
13 management therapy practices. Thirty-four of
14 the 45 states authorize drug management
15 therapy in all practice settings.
16 Interestingly enough, all of the
17 Commonwealth's border states, except New York,
18 have some form of drug therapy management as
19 part of their pharmacy practice act.

20 Most significantly, I would like to
21 bring to the committee's attention that
22 underpinning the drug therapy management
23 provisions of House Bill 1041 is the
24 outstanding education and training of the
25 Commonwealth's current licensed pharmacists,

1 like Mr. Podgurski and the other board members
2 of the -- the board.

3 As commissioner, I have first-hand
4 knowledge of the professionalism of
5 Pennsylvania licensed pharmacists and how well
6 they serve the public. If enacted, currently
7 licensed Pennsylvania pharmacists will
8 administer drug therapy management with
9 intelligence and effectiveness.

10 Also I can submit that the future
11 holds much promise if drug therapy management
12 is enacted. As part of what I call taking the
13 boards on the road, we have conducted pharmacy
14 board meetings at most of the pharmacy schools
15 in the Commonwealth with students
16 participating in the meetings. And I can
17 report that the students that our pharmacy
18 schools are training and educating at doctoral
19 levels are simply outstanding and will embrace
20 drug therapy management and will have
21 absolutely no problem with its
22 administration.

23 Moreover, drug therapy management is
24 in line with Governor Rendell's Prescription
25 for Pennsylvania and his vision of providing

1 all health care providers, in this case
2 pharmacists, with the ability to fully use the
3 training to assist all patient populations
4 throughout the Commonwealth.

5 Indeed, the physician and the
6 pharmacist working together as a team through
7 drug therapy management will be -- will enable
8 -- will be able to -- will be able to
9 monitor -- excuse me -- a patient's reaction
10 to a particular drug therapy and detect
11 adverse reactions more quickly. This
12 ultimately will save lives and reduce
13 unnecessary costs.

14 Equally important, House Bill 1041
15 adds a new section to the Act that set
16 forth -- that sets forth the mechanics, the
17 nuts and bolts, of how drug therapy management
18 will be administered in the Commonwealth.

19 The cornerstone of a successful drug
20 management therapy regimen and protocol will
21 be the collaboration between the physician and
22 the pharmacist.

23 To assist in the successful
24 administration, the bill requires a
25 collaborative agreement between a licensed

1 physician and a licensed pharmacist for drug
2 therapy management in the non-institutional
3 setting. The collaborative agreement between
4 the physician and the pharmacist puts the
5 patient's health, safety, and welfare first.

6 Under this provision, drug therapy
7 management must be initiated by a written
8 referral from the physician to the
9 pharmacist. The licensed physician, who is a
10 party to the collaborative agreement must be
11 in active practice and in good standing and
12 the agreement must be within the scope of the
13 physician's current practice.

14 In addition, House Bill 1041 also
15 requires the patient -- that patient records
16 may be maintained in an automated system and
17 that the pharmacist who is authorized to
18 manage drug therapy must have access to the
19 record of the patient who is receiving drug
20 therapy.

21 I'd like to commend Representative
22 Kula for including this provision in the
23 legislation. This access is critically
24 important to the entire drug management --
25 drug therapy management protocol, because a

1 pharmacist must have access to the patient's
2 medical records so that they have the
3 opportunity to see all the drugs that have
4 been prescribed and all the treatments the
5 patient is undergoing. Denying the pharmacist
6 access to patient records would make drug
7 therapy management unworkable.

8 In short, House Bill 1041 will make
9 drug therapy management a reality here in
10 Pennsylvania. It is a good, solid piece of
11 legislation.

12 As envisioned by Prescription for
13 Pennsylvania, House Bill 1041 and drug therapy
14 management will provide greater access to high
15 quality health care for all the citizens of
16 the Commonwealth.

17 And above all else, because of the
18 excellent training, education, and
19 professionalism of Pennsylvania pharmacists,
20 drug therapy management will be effectively
21 administered in the Commonwealth of
22 Pennsylvania. Its time has come.

23 Once again, thank you for the
24 opportunity to appear before the committee and
25 myself and Chairman Podgurski welcome any

1 questions that you may have.

2 CHAIRMAN MCGEEHAN: Thank you very
3 much, Commissioner. Thank you very much,
4 Mr. Podgurski.

5 We've been joined by Representative
6 Harhart and Representative Reichley as well.

7 Chairman Adolph has a question.

8 REPRESENTATIVE ADOLPH: Thank you,
9 Mr. Chairman. Good morning, gentlemen.

10 COMMISSIONER MERENDA: Good morning,
11 Mr. Chairman.

12 MR. PODGURSKI: Good morning.

13 REPRESENTATIVE ADOLPH: Thank you for
14 taking time out of your schedule.

15 I have a question regarding what
16 makes a pharmacist qualified to do drug -- a
17 drug management.

18 In looking at the bill itself, it's
19 kind of open-ended, leaving it up to the board
20 to make sure that the pharmacist is qualified
21 in this area.

22 For the members of this committee,
23 could you please go over what makes a
24 pharmacist qualified to do this?

25 COMMISSIONER MERENDA: Well, what I

1 would say, Mr. Chairman, is that a pharmacist
2 is qualified to engage in drug therapy
3 management because of the extensive training
4 that they receive in school in pharmacology.

5 It's even more so than a physician.
6 And that pharmacist as part of his job is
7 continually keeping up with the developments
8 in that area and will be able to see the
9 forest from the trees and would add
10 significant value to the entire process and be
11 an invaluable assistance to the physician.

12 And I don't know if, Mr. Chairman, if
13 Mr. Podgurski would like to add to that.

14 MR. PODGURSKI: The minimal training
15 for any pharmacist that graduates is six
16 years. There's usually two primary. Most
17 people have a degree before entering pharmacy
18 school.

19 Pharmacy school is usually a
20 four-year curriculum. The last two years are
21 mostly devoted for clinical activities. Those
22 type things that we're talking about here
23 today.

24 And that's why pharmacists have
25 become the drug experts, and we believe

1 that -- we strongly support this legislation.

2 COMMISSIONER MERENDA: I would just
3 like to add, Mr. Chairman, that -- that the
4 pharmacist knows the drug regimen and sees the
5 entire picture. And not that it occurs here
6 in Pennsylvania, but on the rare occasion when
7 two physicians do not talk to each other, the
8 pharmacist will be in a position to see the
9 entire picture of the patient's treatment.

10 So that's an additional value that
11 the pharmacist brings to this process.

12 REPRESENTATIVE ADOLPH: I -- I -- I
13 understand. And I actually agree with what
14 we're trying to do here.

15 I'm just trying to -- I'm just
16 reading: Must be able to provide to the board
17 satisfactory evidence of training in the
18 management of drug therapy.

19 But from what I got out of your
20 testimony just then is that if you're a
21 licensed pharmacist you are qualified.

22 MR. PODGURSKI: I believe that.

23 REPRESENTATIVE ADOLPH: I mean
24 that -- I mean that's -- it -- you know, by my
25 reading of that legislation, it sounds like

1 this pharmacist would have additional training
2 in order to perform the practice and
3 management of drug therapy.

4 And I'm just trying to find out and
5 put it on record is that, is every licensed
6 pharmacist in Pennsylvania qualified for drug
7 therapy management?

8 MR. PODGURSKI: I believe that they
9 are.

10 REPRESENTATIVE ADOLPH: Okay.
11 That's -- that's all I wanted to know.

12 MR. PODGURSKI: Yes.

13 REPRESENTATIVE ADOLPH: And so I
14 didn't know if there was any additional
15 training that's going to be given to these
16 pharmacists, or -- et cetera, et cetera.

17 MR. PODGURSKI: Additional training
18 that's in the bill and -- and I'm going to use
19 an anecdote for you, that two pharmacists
20 graduated from the University of Pittsburgh
21 Pharmacy School today. They are both well
22 qualified. Those individuals that are
23 practicing there today, even if they graduated
24 years ago, do continuing education to keep up
25 with the profession and also the new drugs.

1 Those individuals should be able to
2 do drug therapy management, whether they're in
3 an institutional setting or they're in
4 community pharmacy.

5 REPRESENTATIVE ADOLPH: Right. I
6 agree. So really under what circumstances
7 would the board not think a pharmacist is
8 qualified? A licensed pharmacist in good
9 standing in Pennsylvania to -- to perform drug
10 therapy management.

11 COMMISSIONER MERENDA: I guess the
12 only scenario that I can envision,
13 Mr. Chairman, is if the pharmacist has not
14 kept up with his or her continuing education
15 requirements.

16 REPRESENTATIVE ADOLPH: And in
17 that -- and in that he would not be -- he
18 would not have his license -- he or she would
19 not have their license.

20 COMMISSIONER MERENDA: His license
21 would be subject to discipline or whatever.

22 REPRESENTATIVE ADOLPH: Fine. Thank
23 you. I just wanted to get that on the record.

24 COMMISSIONER MERENDA: Sure.

25 REPRESENTATIVE ADOLPH: To make sure

1 that there's not additional courses or tests
2 given to these pharmacists that are going into
3 this practice of drug therapy management.

4 Thank you.

5 CHAIRMAN MCGEEHAN: The chair -- if I
6 may, the chairman raises a good point in the
7 continuing education requirements.

8 As I understand it now, every two
9 years each pharmacist has to do 30 credits of
10 continuing education for new drugs that are
11 coming onto the market.

12 MR. PODGURSKI: Right.

13 CHAIRMAN MCGEEHAN: What about those
14 long-standing pharmacists? They are also
15 required under -- under the law to participate
16 in this continuing education program. Is that
17 correct?

18 COMMISSIONER MERENDA: Correct.

19 MR. PODGURSKI: That's correct. From
20 the early '80s we've had that.

21 CHAIRMAN MCGEEHAN: And my
22 understanding is in crafting this bill
23 Representative Kula was farsighted in allowing
24 pharmacists to access patients' records
25 directly from the doctors on the particular

1 regimen that this drug is attempting to
2 ameliorate or to solve --

3 COMMISSIONER MERENDA: Correct.

4 CHAIRMAN MCGEEHAN: -- or to -- to
5 relieve. Is this -- is that something
6 that's -- that's -- that you think is critical
7 in this -- in this scenario?

8 COMMISSIONER MERENDA: I would
9 believe so, Mr. Chairman.

10 MR. PODGURSKI: And today pharmacists
11 do contact prescribers to find out other
12 medications, if there's an issue, that may not
13 have even been filled at that pharmacy.

14 So they've even contacted multiple
15 prescribers at any point to try to get a clear
16 picture of what the patient's medication needs
17 are.

18 CHAIRMAN MCGEEHAN: Thank you.

19 Representative Waters had a question.

20 REPRESENTATIVE WATERS: Thank you.

21 Thank you, Mr. Chairman.

22 And thank you, Commissioner --

23 COMMISSIONER MERENDA: Sure,
24 Representative.

25 REPRESENTATIVE WATERS: -- for

1 testifying today.

2 Last year, along with the
3 Prescription for Pennsylvania that the
4 Governor was moving for quality access or
5 increased access to quality care, there --
6 there was certain bills that came out of the
7 committee that you found out along the way
8 that the board -- members of the board or
9 members of the society had some issues with.

10 How do they feel about this
11 particular legislation?

12 COMMISSIONER MERENDA: The other
13 stakeholders involved in that are affected by
14 this board. I'm -- I'm not aware of any
15 strong opposition, but I'm sure they'll
16 testify and present their views on their own.

17 REPRESENTATIVE WATERS: Well, whether
18 they were absolutely opposed, but sometimes,
19 you know, resistance to change sometimes kicks
20 in.

21 COMMISSIONER MERENDA: Correct.

22 REPRESENTATIVE WATERS: And -- and,
23 for instance, with the nurses being able to
24 practice within the scope that they're already
25 dedicated and it appears that this is only

1 going to allow physicians and the doctors who
2 practice today, that they are already educated
3 and whether they're resistant to change, and I
4 just wanted to ask you about that.

5 MR. PODGURSKI: And you have to
6 remember that physicians don't have to
7 participate. So if -- if they don't want to
8 have an agreement with the pharmacist, they
9 won't.

10 So those that really want a
11 relationship with the pharmacist will proceed
12 after this law is passed.

13 REPRESENTATIVE WATERS: Thank you.

14 Thank you, Mr. Chairman.

15 CHAIRMAN MCGEEHAN: Thank you,
16 Representative Waters.

17 Representative Mustio had a question.

18 REPRESENTATIVE MUSTIO: Thank you,
19 Mr. Chairman.

20 As a follow-up to what Chairman
21 Adolph had said, the -- the initial question
22 he had about whether all pharmacists would be
23 and he said yes. I noticed Representative
24 Kula in the back started to shake her head no
25 and then he answered and said yes and then he

1 qualified it and followed up. I just wanted
2 to make sure --

3 REPRESENTATIVE KULA: I think it was
4 the point they raised.

5 REPRESENTATIVE MUSTIO: Okay.

6 REPRESENTATIVE KULA: That -- that
7 the ones that were not -- that did not keep
8 up --

9 REPRESENTATIVE MUSTIO: Okay.

10 REPRESENTATIVE KULA: -- with their
11 continuing ed and their --

12 REPRESENTATIVE MUSTIO: Okay.

13 REPRESENTATIVE KULA: -- and training
14 then would not be qualified. So I have -- I
15 didn't know I was shaking my head there.

16 REPRESENTATIVE MUSTIO: I just wanted
17 to make sure we were on the same page.

18 MR. PODGURSKI: Thanks for your
19 support.

20 REPRESENTATIVE KULA: Sure.

21 REPRESENTATIVE MUSTIO: Right.

22 Mr. Commissioner?

23 COMMISSIONER MERENDA: Yes.

24 REPRESENTATIVE MUSTIO: Just on Page
25 5 of your testimony, I want to make sure that

1 we're saying the right thing here. You say
2 that in addition, HB 1041 also requires that
3 the patient records may be -- those two words
4 don't go together. I think in looking at this
5 bill, you would be all right if we would
6 remove the word requires from -- from that
7 testimony there.

8 The bill, I think, just says the
9 records may be automated.

10 COMMISSIONER MERENDA: Yeah. I
11 apologize for that.

12 REPRESENTATIVE MUSTIO: We're not
13 saying they're required to be automated.

14 COMMISSIONER MERENDA: Right.

15 REPRESENTATIVE MUSTIO: Thank you,
16 Mr. Chairman.

17 CHAIRMAN MCGEEHAN: Is that it?

18 Commissioner, Mr. Podgurski, thank
19 you for your testimony.

20 COMMISSIONER MERENDA: Thank you,
21 Mr. Chairman.

22 CHAIRMAN MCGEEHAN: Our next
23 testifier is Tom Snedden, who is director of
24 the Pennsylvania Pharmacological [sic]
25 Assistance Contract for the Elderly, commonly

1 referred to as PACE.

2 Good morning, Mr. Snedden.

3 DIRECTOR SNEDDEN: Good morning,
4 Mr. Chairman.

5 CHAIRMAN MCGEEHAN: Get yourself
6 comfortable and begin when you're prepared.

7 DIRECTOR SNEDDEN: Good morning,
8 Chairman McGeehan and Chairman Adolph, other
9 members of the committee.

10 Thank you for the opportunity to --

11 CHAIRMAN MCGEEHAN: We're having a
12 tough time, Mr. Snedden. For the
13 stenographer, pull that microphone, if you
14 would, closer to you.

15 DIRECTOR SNEDDEN: Okay. How is
16 that?

17 CHAIRMAN MCGEEHAN: Better, but...

18 REPRESENTATIVE REICHLEY: Is it on,
19 Tom?

20 DIRECTOR SNEDDEN: Great. We're on.
21 How is that? Can you hear me now?

22 I think most of you are familiar with
23 the PACE program. It's where the rubber meets
24 the road when it comes to serving an elderly
25 population that is quite vulnerable to drug

1 misadventures, both of an over-utilization
2 nature and under-utilization nature.

3 Average PACE cardholder, 79-year-old
4 widowed female, living alone, private
5 residence, four and five different disease
6 states, five and six different medications,
7 sometimes not using medications that they
8 should be using, less than a tenth grade
9 education, with anxiety off the charts.

10 The majority of our enrollment, which
11 is 360,000 people like this, are at great risk
12 to drug misadventures. The PACE program,
13 which has been around now for 25 years, has
14 spent most of that time trying to effectively
15 intervene on this issue in such a way that
16 people who are enrolled in the PACE program
17 get a better quality of life and a longer
18 life.

19 And the way we can most effectively
20 do that is to intervene at the pharmacy to
21 make sure that people aren't getting too much
22 medication or they're getting enough of the
23 right medication.

24 The program has a well-deserved,
25 nationally recognized reputation for being

1 very effective at this. If you're in the PACE
2 program, you are well protected from drug
3 misadventures.

4 But PACE represents only 15 percent
5 of Pennsylvania's elderly population. Many
6 others are very, very vulnerable to these drug
7 misadventures.

8 As me and my staff have looked around
9 the country, over the past 20 years, to see
10 what else can we possibly do to better manage
11 the drug regimens of our enrollment, we have
12 often been struck by the presence of
13 medication therapy management in other
14 states.

15 As Chairman Merenda pointed out, many
16 other states do medication therapy
17 management. We think from our review of other
18 state programs that these programs have
19 something to offer in the armamentaria of
20 things that you can do to protect people from
21 drug misadventures.

22 Like anything else, it's not a silver
23 bullet. But it's one more thing that can be
24 done to help people in PACE and to help people
25 outside of PACE avoid drug misadventures and

1 get the right medications that they need.

2 From the perspective of the PACE
3 staff, which has considerable experience in
4 trying to deal with medication therapy
5 management, this proposal is something that's
6 long overdue in Pennsylvania. We -- we are
7 elated to see that it is in legislation and
8 that it is before the House and hope at this
9 time that it gets through both chambers of our
10 legislature and becomes the practice in
11 Pennsylvania.

12 Thank you for the opportunity to
13 come.

14 CHAIRMAN MCGEEHAN: Thank you very
15 much, Mr. Snedden, for being here and offering
16 your expert testimony.

17 As the -- Chairman Merenda pointed
18 out, 45 other states have some type of
19 collaborative agreement that exists now. So
20 we're not certainly reinventing the wheel.
21 And we all know of cases, whether it's our
22 family members or our neighbors or
23 constituents who have been over-medicated. We
24 hear horror stories. And for lack of a better
25 word, they're dopey. But not for the lack of

1 intelligence but from the overuse of drugs,
2 whether they're forgetful or sluggish --

3 DIRECTOR SNEDDEN: Right.

4 CHAIRMAN MCGEEHAN: -- or any number
5 of other ramifications of the overuse of
6 drugs.

7 Are there statistics -- because it's
8 important for me to understand and some of the
9 committee members to understand -- visits to
10 doctors as opposed to visits to pharmacies,
11 what's the difference in -- in times of the
12 year? You know, do most of them visit the
13 doctor four times a year but are at the
14 pharmacist ten times a year?

15 My question goes to they're more able
16 to spot the ramifications of overuse or
17 misprescribing of drugs before a doctor would
18 simply because of the -- of the number of
19 visits to each of these prospective
20 individuals. Can you help me on that?

21 DIRECTOR SNEDDEN: Well, there are --
22 there are statistics on that, Chairman
23 McGeehan, and as you might expect, as you
24 said, I -- I -- people generally, the elderly
25 in particular, because they use more drugs

1 than any other age group, they are more likely
2 to see a pharmacist during the course of the
3 year than a physician.

4 The PACE program is a good example.
5 You know, on -- on average, our enrollment
6 sees a pharmacist once a month. From other
7 information that we have, Medicare statistics
8 on doctor visits, our people see a physician
9 much less frequently than that. I can't -- I
10 can't quantify it for you now, but I'll get
11 that information for you.

12 So seeing a physician once a month,
13 okay, I think is probably on average what
14 most -- I should say pharmacist once a month
15 is on average what older people generally
16 see.

17 It's largely a function of their
18 ability to afford the medication or their drug
19 coverage. A lot of pharmacy benefits have
20 30-or 60- or 90-day limits on what they'll pay
21 for, and most people that don't have coverage
22 are -- are generally going once a month to get
23 their prescriptions.

24 So the contact with pharmacists is
25 far more frequent than with physicians.

1 CHAIRMAN MCGEEHAN: Okay. Thank you
2 very much.

3 Chairman Adolph.

4 REPRESENTATIVE ADOLPH: Just a quick
5 comment. I appreciate the work that you do,
6 and the PACE program and PACENET in
7 Pennsylvania is probably the most successful
8 drug program out there for rebates, et
9 cetera. Keep up the good work and hopefully
10 it's solvent over there.

11 DIRECTOR SNEDDEN: Yeah.

12 REPRESENTATIVE ADOLPH: Okay. And,
13 you know, I just wanted to take this
14 opportunity. I don't get face-to-face with
15 you too often.

16 So I know it's helped an awful lot,
17 thousands of Pennsylvania seniors over the
18 years.

19 DIRECTOR SNEDDEN: Chairman Adolph,
20 thank you. It's a great staff in the PACE
21 program.

22 CHAIRMAN MCGEEHAN: Representative
23 Reichley.

24 CHAIRMAN REICHLEY: Thank you,
25 Mr. Chairman.

1 Mr. Snedden, this is more of a
2 background question, but based on your
3 experience maybe you can help us because of
4 the number of elderly patients that utilize
5 the PACE and PACENET system.

6 On Page 8 of the bill over onto Page
7 9 it talks about the access to medical records
8 from automated systems, and it just sort of
9 sparked curiosity on my part.

10 We've heard a lot about electronic
11 medical records, and I do notice that this
12 provides for a HIPAA waiver for the
13 pharmacists to be able to have access to those
14 records.

15 But how cumbersome is that going to
16 be? And then the second part, within all the
17 stimulus money, is there going to be money
18 accessible to physicians through these drug
19 therapy management arrangements to be able to
20 have funds to move to electronic records
21 management at all? Do you know?

22 DIRECTOR SNEDDEN: Well, I can't,
23 Representative Reichley, give you a detailed
24 response to that right now. But I'll be happy
25 to get back to you with that.

1 But I -- I would say generally, from
2 our experience and perspective, this should
3 not be that difficult from a technical
4 standpoint.

5 As to affordability and monies
6 available in federal stimulus legislation, I'm
7 not sure. But it's a great question, and
8 we'll check it out and get back to you.

9 CHAIRMAN REICHLEY: All right.
10 Thanks.

11 CHAIRMAN MCGEEHAN: Thank you very
12 much, Representative Reichley.

13 Any other questions? We've been
14 joined by Representative Petrarca.

15 Thank you very much, Mr. Snedden --

16 DIRECTOR SNEDDEN: Thank you.

17 CHAIRMAN MCGEEHAN: -- for presenting
18 your testimony to this committee.

19 DIRECTOR SNEDDEN: Thank you.

20 CHAIRMAN MCGEEHAN: Our next
21 testifier is Dr. Adam Welch. He is the second
22 vice president of the Pennsylvania Pharmacist
23 Association.

24 Good morning, doctor.

25 DR. WELCH: Good morning.

1 CHAIRMAN MCGEEHAN: You may begin
2 when you're prepared.

3 DR. WELCH: You will have my -- my
4 narrative on file there. I don't see a need
5 to read that word for word, and in the
6 interest of time I'll try to summarize that.

7 Good morning, chairman and members of
8 the committee. My name is Adam Welch. I'm an
9 assistant professor at Wilkes University at
10 the Nesbitt College of Pharmacy.

11 I also practice with an independent
12 pharmacist, the DeBalko Pharmacy, in McAdoo,
13 Pennsylvania, which is the northern part of
14 Schuylkill County, small town of about 2200
15 people.

16 But I'm here today on behalf of the
17 Pennsylvania Pharmacist Association as their
18 second vice president. PPA, the Pennsylvania
19 Pharmacists Association, wholeheartedly
20 supports House Bill 1041 and we applaud
21 Representative Luka -- Kula for introducing
22 this at this session as well as the last
23 session.

24 We really think that this is going to
25 optimize our ability to help patients and

1 optimize their medication use and ultimately
2 control costs in that matter as well.

3 Since 2002, your work has allowed us
4 to administer medications to patients and
5 since then several pharmacists, over a
6 thousand pharmacists, are involved in the
7 Commonwealth in vaccinating patients and
8 administering other medications as part of
9 patient care initiatives.

10 In addition, in 2002 that law allowed
11 pharmacists to practice collaborative drug
12 therapy management in an institutional
13 setting. And certainly pharmacists in many
14 institutions -- and some speakers behind me
15 will be discussing that in further detail --
16 have been doing that and have been successful
17 in those initiatives.

18 We believe that House Bill 1041 will
19 ultimately expand that scope of practice and
20 allow us to do this collaborative drug therapy
21 management in a community or retail pharmacy
22 setting.

23 When Medicare Part D was enacted, it
24 identified pharmacists as providers for what
25 we call medication therapy management, and

1 it's really taken an active role in managing a
2 patient's drug therapy, identifying problems,
3 utilizing generic medications, and controlling
4 costs.

5 But pharmacists have been doing this
6 for -- for years, and it's something that
7 we've been a part of with this, with the Part
8 D plan there, and we think that with House
9 Bill 1041 we will be able to expand and remove
10 certain barriers with providing comprehensive
11 medication therapy management to our
12 patients.

13 Pharmacists, we are drug experts.
14 And to echo on some of the comments that were
15 made before, the curriculum that pharmacists
16 go through today, and even the curriculum that
17 pharmacists go through before we went to the
18 doctor of pharmacy degree, is very intensive
19 in pharmacotherapy and pharmacology and
20 provides the necessary skills to manage drug
21 therapy.

22 In addition, accreditation standards
23 for continuing education programs have also
24 changed and some of the requirements become a
25 little -- more stringent and our continuing

1 education, our CE programs, are -- are more
2 productive in my opinion.

3 In addition, community pharmacists
4 are also very accessible. We -- as it was
5 mentioned, before pharmacists come to --
6 patients come to the pharmacy once a month and
7 even more often when they're taking multiple
8 medications. So we see them in all hours of
9 the day. Some stores are open 24 hours a
10 day. So we see them in the evenings. We see
11 them on the weekends and the typical Monday
12 through Friday 9:00 to 5:00.

13 You're probably thinking what -- you
14 know, what would this bill add to what we're
15 already doing? And this will really help us
16 manage medication therapies while working
17 under a written collaborative practice
18 agreement with the physician.

19 This would be an optional agreement
20 with physicians. So certainly physicians who
21 do not feel comfortable or do not have the
22 innovative nature within their practice may
23 not -- may not -- do not have to participate
24 with this.

25 I wanted to -- as a practicing

1 pharmacist, I wanted to actually give you just
2 a short example here of what we've done. And
3 I actually met with this patient at the
4 pharmacy at a few weeks ago.

5 She was a senior citizen with
6 diabetes, came in asking about how to use her
7 blood glucose monitor, and it's something
8 that -- we get a lot of questions about that,
9 because the new technology, it can be
10 confusing for some folks.

11 She came in. I worked her through
12 the process and told her how to use the
13 machine appropriately. And we tested her
14 blood sugar and it was 353. Now, normal
15 sugars should be no more than 200. So there
16 was something -- something wrong with her
17 therapy and with her -- the way she's
18 controlling her disease. Puts her at risk for
19 eye problems, kidney problems, and several
20 other complications.

21 At that particular time when I met
22 with the patient, she -- her physician's
23 office was -- was closed. It was later in the
24 afternoon. They took a half day on that
25 particular day. So I had no way of contacting

1 the physician to monitor any therapy or make
2 any adjustments.

3 Under -- if House Bill 1041 were to
4 be enacted, I could have the authority to bump
5 up her insulin dose a little bit, help her
6 manage her disease, do that in a timely manner
7 to help her prevent some of those
8 complications.

9 And I think that's where the -- where
10 the benefits are, is helping these patients
11 get healthier faster. And then when she goes
12 back to her doctor's appointment in two
13 months, she -- the pharmacist, the physician
14 can sit down with the patient and make a
15 decision on how to -- to best optimize her
16 care. Maybe we need to start a new drug
17 therapy with her.

18 So there's certainly a time issue in
19 helping our patients get healthier.

20 Some important points in this
21 proposal, it is strictly voluntary. It's an
22 optional program for patients. We do believe
23 that it will help them considerably.

24 Only physicians who want to be
25 involved with this collaboration have the

1 ability to do that. The physician still has
2 the medical home and is still in control of
3 the therapy. We're not diagnosing any
4 diseases. We're just managing the -- the
5 prescribed medications that were already given
6 out or administered -- or prescribed by the
7 physician.

8 The written agreement, this
9 collaborative practice, will outline step by
10 step what a pharmacist has the ability to do,
11 so they're not put in -- you know, they will
12 be following protocol.

13 And all these consultations will
14 be done in a -- in a private area that would
15 maintain privacy and comply with HIPAA laws.

16 There are some examples of this going
17 on managing drug therapy management in several
18 areas. Lancaster County is -- is having a
19 project right now where they sit down -- where
20 patients with diabetes sit down and meet with
21 pharmacists and optimize their medication.

22 And there have been some good outcomes showing
23 the health benefits and even cost benefits of
24 that.

25 There's also the Ten City Challenge.

1 One of the cities across the country that is
2 doing this is in -- Pittsburgh. Your -- the
3 materials in the appendix has some more
4 information about that.

5 Another point of this bill that we --
6 we think is important is that this allows
7 pharmacists to be employed by physician
8 practices, and that's something that we didn't
9 have the ability to do before.

10 This would be in a nonretail,
11 nondispensing role, but more as a consultant
12 to physicians so you're providing that
13 medication expertise to the physicians, you
14 know, when they leave -- to patients when they
15 leave the physician's office. This will allow
16 them to optimize the care at ground zero, so
17 to speak.

18 Just to summarize here, PPA,
19 Pennsylvania Pharmacist Association, does
20 support House Bill 1041.

21 We have struggled with some of the
22 language that was added into it, but we -- we
23 do approve the concept of this and we're
24 looking forward to this being passed through
25 the House and -- and -- and beyond that.

1 So I'm happy to take any question at
2 this point.

3 CHAIRMAN MCGEEHAN: Thank you very
4 much, doctor, for being here, for adding your
5 perspective on Representative Kula's bill.

6 The opt-in/opt-out provision language
7 in this bill, it certainly would behoove a
8 pharmacist and a doctor to establish that
9 collaborative agreement obviously because you
10 could only then refer patients if you were a
11 doctor to a -- a participating pharmacist. Is
12 that correct?

13 It goes to signed collaborative
14 agreements with the doctor.

15 DR. WELCH: The signed collaborative
16 agreement would be an optional -- you're
17 asking if the --

18 CHAIRMAN MCGEEHAN: It would
19 certainly behoove any doctor and any pharmacy
20 to opt in?

21 DR. WELCH: Sure. Sure. We believe
22 that -- that it would optimize the medication
23 use and their management and ultimately get
24 all our patients healthier, absolutely.

25 CHAIRMAN MCGEEHAN: Representative

1 Reichley had an excellent question about the
2 sharing of information and the pharmacist
3 having access to particular medical files on
4 individual patients.

5 In that sharing of information, on
6 that particular prescription or a series of
7 drugs, the medical records would only be
8 accessible to that condition, to that
9 prescription, or their entire medical history
10 would be available?

11 DR. WELCH: The medication history
12 and the medication records, when you're
13 looking just at the medication, it's
14 important -- you need to take care of the
15 patient. You're not taking care of the
16 disease. So certainly access to pertinent
17 information. And I can't identify what
18 pertinent would be. It would be very patient
19 specific, and it would vary from time to
20 time.

21 But the pharmacist would -- would
22 need to make well-informed decisions based on
23 relevant factors that are going on with their
24 patients. So access to those records would be
25 crucial for -- for them to make the best and

1 most appropriate decision.

2 CHAIRMAN MCGEEHAN: And how is that
3 done now? Is there -- is there -- is there an
4 example that you can give us how the
5 pharmacist accesses that information?

6 DR. WELCH: A lot of times right now
7 pharmacists will access information by picking
8 up the phone, calling the doctor's office,
9 sending a fax.

10 There's -- there are some inherent
11 logistical barriers for -- for accessing
12 information from the physician's office to
13 the -- to the pharmacies.

14 In addition, pharmacists will simply
15 ask the patients and patients will offer the
16 information because they -- they understand
17 that if we make more informed decisions it
18 will ultimately help them.

19 CHAIRMAN MCGEEHAN: Are there other
20 states that you're aware of, doctor, that are
21 doing it on a more technologically advanced
22 basis, whether that's doing that
23 electronically via the computer? Is there a
24 technology out there that could be helpful in
25 sharing that information if this bill does

1 pass and becomes law?

2 DR. WELCH: Yeah. I cannot speak to
3 any other specific states of -- of how, you
4 know, they're overcoming some of these
5 logistical barriers to -- to information and
6 health information.

7 I really don't know exactly what
8 states are doing at this point.

9 CHAIRMAN MCGEEHAN: We'll look
10 forward to working with Representative Kula in
11 solving those future problems.

12 Chairman Adolph.

13 REPRESENTATIVE ADOLPH: Thank you,
14 Mr. Chairman.

15 Dr. Welch, thank you for your
16 testimony. I like your taste in suits.

17 The -- my question is regarding the
18 payment for services. Okay. As I understand
19 today that this drug therapy management that
20 is being performed in institutional settings,
21 the hospital sends out the -- the bill for
22 payment.

23 Is -- is that correct? Are you aware
24 of that?

25 DR. WELCH: The hospital would bill

1 for their staff.

2 REPRESENTATIVE ADOLPH: Okay. And
3 this -- if this bill passes -- and I -- I
4 support the bill. Okay. Who gets billed for
5 the services?

6 DR. WELCH: It would most likely be
7 the patient's health plan. Now, pharmacists
8 are recognized recently as -- as providers.
9 We do have our own set of CPT codes or billing
10 codes that we can use revolving around the
11 amount of time we spend with our patients. So
12 as providers we could bill health plans.

13 And it's important to note that when
14 you effectively manage medications, sometimes
15 medication costs may go up but overall health
16 costs have been shown to -- to decrease
17 significantly.

18 By helping them control their
19 diabetes with proper insulin use, we're
20 preventing them from spending the night in the
21 emergency room.

22 So when you look at the bottom
23 line...

24 REPRESENTATIVE ADOLPH: I have a
25 93-year-old mother-in-law that lives with us,

1 okay, and she has -- we live in the tri --
2 tri-state area and my brother-in-law, who
3 shares the responsibility of taking care of --
4 of this woman, because some of her doctors are
5 in Delaware, some are in Pennsylvania, and so
6 on and so forth. You know, I can see the
7 problem.

8 If you go down to her medicine
9 cabinet, you know, I mean you need a Ph.D. to
10 figure out how many pills she takes a day.
11 All right.

12 But what I'm interested in, and I
13 want to get it on the record and so forth, is
14 that -- how often would she need to have this
15 drug therapy management session with the local
16 pharmacist and what type of bill is that -- is
17 going to be sent out to either her insurance
18 company or Medicare, et cetera, okay, and is
19 this one-hour consultation or is this a
20 half-an-hour consultation and what type of
21 payment is expected by the pharmacist for
22 their services rendered?

23 DR. WELCH: Sure. If you take a
24 healthy patient, they should meet with the
25 pharmacist to look over their medications once

1 a year. And as you identify problems with the
2 patient and their drug therapy, you need to
3 meet with them as needed.

4 Now, generally a session with the
5 pharmacist could range -- they're in 15-minute
6 increments. A typical session could be a half
7 hour to one hour, more if it's the first time
8 you're meeting them, and then follow-ups could
9 be certainly less amount of time.

10 As far as how much compensation is
11 appropriate, I -- I cannot speak to that. I
12 think that's something that -- at this point,
13 you know, we look at models from CMS and --
14 and what Medicare Part D is doing with their
15 medication therapy management and they're
16 allowing the plans to -- to kind of, you know,
17 let -- let it work itself out.

18 REPRESENTATIVE ADOLPH: Okay. Do you
19 have a dollar amount for this consultation?
20 Is there a national average?

21 You know, we have other states
22 that -- is there a national average and does
23 Medicare covers this?

24 These are the type of questions I
25 just wanted --

1 DR. WELCH: Sure.

2 REPRESENTATIVE ADOLPH: -- to get
3 on.

4 DR. WELCH: Sure. Medicare does
5 cover this. Now, there's a distinction
6 because at some points with medication therapy
7 management some plans are choosing to do all
8 of this in-house over a phone. They have a
9 call center where a couple pharmacists, couple
10 nurses are on staff, and they call the
11 patients over the phone.

12 Collaborative drug therapy management
13 and what's in House Bill 1041 would allow
14 face-to-face interactions. You can really see
15 what the patient is doing and their senses --
16 and some of those nonverbal clues to get a
17 sense of how compliant they are.

18 So that's, in our opinion, the
19 preferred way to -- to manage drug therapy
20 management. And as far as -- as a dollar
21 amount, it varies from -- from region to
22 region and I really -- I don't have a clear
23 amount to give you.

24 REPRESENTATIVE ADOLPH: Okay. Thank
25 you, doctor.

1 DR. WELCH: Thank you.

2 CHAIRMAN MCGEEHAN: Thank you very
3 much, Chairman Adolph.

4 Any questions?

5 Dr. Welch, thank you for your
6 testimony. Thank you for being here today.

7 DR. WELCH: Thank you, committee.

8 CHAIRMAN MCGEEHAN: Our next
9 testifier is Rick Mohall. He's a Pharm.D.
10 He's the Director of Field Clinical Services
11 for Rite Aid Corporation.

12 Good morning, Mr. Mohall.

13 DIRECTOR MOHALL: Good morning. Good
14 morning, Chairman McGeehan, Chairman Adolph,
15 members of the Licensure Committee.

16 I am the director for field clinical
17 services of Rite Aid, as stated. I'm here
18 today to represent the Pennsylvania
19 Association of Chain Drug Stores or PACDS and
20 I very much appreciate the opportunity to
21 testify.

22 We strongly support this measure.
23 PACDS is composed of 15 member companies.
24 They include Rite Aid, Giant Eagle,
25 Walgreen's, Target, Weis Markets, and that

1 organization -- the organization represents
2 over 1500 pharmacies in the state, employing
3 nearly 130,000 Commonwealth residents, and
4 more than 6,750 pharmacists.

5 We strongly support this bill. This
6 bill allows pharmacists to do what they are
7 already trained to do, and we strongly believe
8 that this would improve the quality of a
9 patient's life and save a great deal of money
10 in the health care system overall.

11 This is indeed a solution waiting to
12 happen and it makes a great deal of sense for
13 our patients, consumers, the health care
14 industry and the state.

15 This bill specifically allows
16 pharmacies to offer MTM services under written
17 collaborative agreements with physicians, as
18 well as allowing pharmacists to have access to
19 patient's vital signs and lab values.

20 That's extremely important. That
21 would allow us to monitor those values so that
22 the patient could reach desired,
23 evidence-based medication outcomes from their
24 drug therapy.

25 Again, we support this bill because

1 we're ready to provide these services. We're
2 very accessible to our patients, and these
3 interventions help our patients and save money
4 in the health care system.

5 Let me reiterate briefly. I'm
6 certain that you can read the testimony that I
7 have, but let me reiterate briefly that I
8 believe that a pharmacist is the medication
9 therapy expert among health care
10 professionals.

11 The curriculum that a pharmacist goes
12 through now results in a Pharm.D degree. It
13 is a minimum of six years, two years in the
14 pre-professional courses, four years in the
15 professional courses, and many pharmacists,
16 including myself, had a degree in something
17 other than that before they went to pharmacy
18 school. I had a biology degree before I
19 started pharmacy school.

20 So these are six- to seven-year
21 educated individuals with a -- with a very,
22 very high amounts of pharmacology, disease
23 state management, physiology, et cetera, that
24 really, I believe, uniquely positions a
25 pharmacist to provide the service.

1 I also want to stress what was said
2 previously in that currently this is allowed
3 in an institutional setting. There is really
4 no difference in the education of a pharmacist
5 that goes out to practice in a community
6 pharmacy after pharmacy school or in an
7 institutional or hospital setting after
8 pharmacy school. So I do want to highlight
9 that.

10 I'd also kind of highlight the fact
11 of our accessibility. I believe someone asked
12 the question about how many more times does a
13 pharmacist be seen than a physician. We have
14 some studies that show that's about four to
15 one. So for every encounter with the
16 physician there are four encounters with the
17 pharmacist.

18 All Americans, 92 percent live within
19 five miles of the community pharmacy. So we
20 are not only trained to provide this service,
21 we are highly accessible to provide the
22 service.

23 I also want to highlight some of the
24 health care costs that we'll say medication
25 misadventures or improper use can lead to.

1 We have a study that's noted in my
2 testimony that says \$76 billion were spent to
3 treat health issues related to medication
4 problems. Five years later another study was
5 done and that figure went up to \$177 billion.

6 Senior citizens are especially at
7 risk for medication therapy problems. And
8 there was also a study that compared the
9 quality of drug therapy care the senior
10 citizen received in a nursing house, where
11 there was access to a consultant pharmacist,
12 and that consultant pharmacist had access to
13 their vital signs and all their medical
14 records, and that study showed that the
15 quality of care for those seniors was
16 significantly improved because of that
17 pharmacist intervention.

18 As a director of clinical services
19 for Rite Aid Corporation, we do do medication
20 therapy management in a number of areas in our
21 geography.

22 And my colleagues have all given you
23 a very good overview of what MTM is. I
24 thought that perhaps that I could give you
25 some real life examples of what MTM can

1 accomplish and the health savings that
2 occurs.

3 So just let me give you two brief
4 examples. We had an encounter with a patient
5 where one of our medication therapy management
6 specialists noted that the patient was being
7 treated for pulmonary fibrosis.

8 As a result of interacting with this
9 patient -- and we use a variety of means to
10 obtain access to the patient's records. For
11 one thing, the patients themselves are often
12 very forthcoming in a face-to-face encounter
13 in providing us with all their medication
14 history and even with their lab values. And
15 we have a lab waiver form in our program that
16 we can fax to a physician to obtain those
17 types of values.

18 This patient was on a drug called
19 Macrobid for a chronic condition, chronic
20 urinary condition. What was not realized is
21 long-term use of the drug is -- can actually
22 as a side effect cause pulmonary fibrosis.

23 We contacted the physician. The
24 therapy was stopped. The patient's problems
25 were resolved, and, as a result of that, they

1 discontinued all their asthma and COPD
2 medications.

3 So it's a very concrete example of an
4 improved quality of life for the patient and
5 a -- a great deal of savings to the health
6 care systems in terms, not only of medicines
7 that were no longer used, but of decreased
8 hospitalizations for that patient.

9 An easier example perhaps of what
10 pharmacists can do was highlighted in
11 another case that I received in which a
12 patient had a poly pharmacy and poly physician
13 issue.

14 They had seen two different
15 physicians. They had had two products filled
16 at two different pharmacies, a mail order and
17 a retail pharmacy. Not being aware that it
18 was similar therapy. It was two statins,
19 Lipitor and Crestor. These drugs are
20 remarkable in what they can do for lowering
21 cholesterol and preventing heart disease and
22 stroke.

23 But they also have some side
24 effects. Among them liver disorders, but
25 probably the most severe is a chronic muscle

1 wasting condition.

2 We discovered that the patient was on
3 multiple therapy in, again, a face-to-face MTM
4 encounter.

5 We had been working with the health
6 plan for these patients. It is indeed a
7 Medicare Part D plan. That plan estimated the
8 savings based on what we found with that
9 patient to be \$45,000 dollars in terms of what
10 they were saved in medical -- overall medical
11 costs.

12 So I hope that those two real life
13 examples can help you better understand what
14 pharmacists can do in regards to patient
15 quality of life and in regards to what we can
16 save the overall health care system in dollars
17 spent.

18 We are an under-utilized resource as
19 pharmacists for this type of encounter. A
20 simpler example of what we can do is being
21 sure that a patient reaches drug therapy
22 goals.

23 So as an example of that, if we
24 had -- if we had access to blood glucose
25 levels, et cetera, and a patient was on

1 therapy for diabetes and we're still not
2 meeting those goals, we could make recommend
3 -- recommendations, therapy adjustments, et
4 cetera, on a collaborative practice agreement
5 to maximize that therapy and be sure that that
6 patient reaches their goal which, in turn,
7 makes them healthier, saves hospitalizations,
8 dollars spent, et cetera.

9 So we strongly support this bill. We
10 encourage the committee to move this
11 legislation forward. And I thank you for your
12 time and would welcome any questions.

13 CHAIRMAN MCGEEHAN: Thank you very
14 much, Dr. Mohall, for providing your testimony
15 and I know I speak for the committee in
16 thanking you for your service that your member
17 stores provide to the people of the
18 Commonwealth and, in particular, thank you for
19 those two real life examples that demonstrate,
20 first of all, the -- the health cost savings
21 certainly and -- and the human costs as well.

22 Are there any questions from the
23 committee?

24 Doctor --

25 DIRECTOR MOHALL: Thank you.

1 CHAIRMAN MCGEEHAN: -- thank you very
2 much --

3 DIRECTOR MOHALL: Thank you very
4 much.

5 CHAIRMAN MCGEEHAN: -- for being here
6 today.

7 DIRECTOR MOHALL: Thank you.

8 CHAIRMAN MCGEEHAN: Our next
9 testifier is Melanie Horvath. She's the
10 executive director of the Pennsylvania
11 Pharmacy Council.

12 Good morning.

13 MS. HORVATH: Good morning.

14 CHAIRMAN MCGEEHAN: Make yourself
15 comfortable. Begin whenever you're prepared.

16 MS. HORVATH: Marlene -- I have a
17 question to Marlene before I start. What's
18 included in the packets, that is -- that's not
19 been amended? That's the original bill.
20 Right?

21 MS. TREMMEL: Right.

22 MS. HORVATH: Okay. Because you know
23 what topic I'm going to talk about.

24 I have in front of -- or you have in
25 front of you -- my name is Melanie Horvath.

1 I'm from the Pennsylvania Pharmacy Council. I
2 represent any pharmacy that is located within
3 a supermarket or grocery store.

4 The testimony that I had prepared --
5 well, first of all, before I -- before I say
6 anything, I -- I can't add anything to the
7 discussion on -- on how beneficial
8 collaborative practice would be for the
9 patient and the community in general.

10 So I can read through the testimony
11 that you have or I can skip to what I really
12 want to discuss and throw some ideas out to
13 you. Is --is that okay?

14 CHAIRMAN MCGEEHAN: That's fine as
15 long as you keep it to the ten-minute time
16 limit we placed. We're up against session I
17 know.

18 But we certainly want to hear from
19 you and appreciate you -- you availing
20 yourself to the committee.

21 MS. HORVATH: Thank you. The -- the
22 one issue that remains un -- unresolved for us
23 had to do with the requirement to provide to
24 the board satisfactory evidence of training in
25 a specific area.

1 A question that you had raised
2 earlier, Representative Adolph. I believe you
3 asked the chair -- the state board is any
4 pharmacist who graduates from a pharmacy
5 school capable of performing drug therapy
6 management and his answer was -- was yes.

7 So -- am I -- am I saying that
8 correctly?

9 COMMISSIONER MERENDA: You're good.

10 MR. PODGURSKI: You're correct.

11 MS. HORVATH: Okay. So based --
12 based on that premise, that is why I would
13 like to address one issue that remains
14 standing for us as far as amendments that
15 we're considering on the bill.

16 Although it's in there now, it has
17 been struck. In House Bill 1041 pharmacists
18 operating in a community setting will be
19 required to prove to the State Board of
20 Pharmacy before practicing drug therapy
21 management satisfactory evidence of training
22 in the management of drug therapy for disease
23 or for a condition or symptom of the disease
24 which is the subject of the collaborative
25 agreement.

1 As it stands now, that requirement is
2 not currently mandated for pharmacists
3 practicing in institutions, nor is it part of
4 House Bill 1041. I understand it is here now,
5 but it's been -- but it's been tentatively
6 struck.

7 In regards to that, my -- my first
8 question is to whom does the pharmacist
9 practicing in the institutional setting
10 provide evidence to that he or she is
11 proficient or trained to manage a certain
12 disease or condition? The physician who
13 initiated the order? Another member of the
14 medical staff? How do they know? In other
15 words, that the community pharmacist is being
16 demanded to provide that they are indeed
17 trained, how -- how does one know? If you're
18 in an institutional pharmacy, how does one
19 know that they, too, have met those
20 requirements if they're not mandated to report
21 that to the board?

22 Second question is what kind of
23 special training -- and I know we're not
24 talking about special training, but proof of
25 proficiency in the institution is received

1 before practicing drug therapy management or
2 do they simply receive on-the-job training?

3 Again, we don't have an issue. We
4 believe that the pharmacists are trained
5 regardless of what practice setting they enter
6 into, but it has to do more with the inclusion
7 of one of these sections of the bill.

8 Third question is why must a
9 pharmacist graduating under Pharma.D., a
10 six-year rigorous program that involves
11 additional clinical training, be subjected to
12 more stringent requirements, proof of
13 proficiency, to practice drug collaborative
14 practice in a community setting than one with
15 a five-year degree who has not had to do
16 something extra, prove nothing extra, simply
17 because he or she has chosen to practice in a
18 institution?

19 Fourth question, does it make sense
20 that a pharmacist practicing in a community
21 setting is subjected to more state scrutiny
22 than a pharmacist practicing in a hospital
23 setting whose patients are more critically
24 ill?

25 And I have several other questions,

1 but I'll cut to the chase. Do the issues
2 raised in these questions make sense to you?
3 If not, I propose we work on language to
4 address these perceived inequities and
5 misunderstanding of the education and training
6 required of all Pennsylvania's pharmacists.

7 The fact is that a pharmacist's
8 formal education trains and prepares them to
9 practice drug therapy management/collaborative
10 practice equally, whether it be in an
11 institution, hospital, or a community
12 setting.

13 If policymakers are more comfortable
14 imposing additional requirements on one
15 setting, those same requirements should be
16 applied to every setting as our schools of
17 pharmacy don't train pharmacists depending
18 upon their future practice setting.

19 For the record, PPC members are not
20 advocating for additional training or proof of
21 proficiency to practice drug therapy
22 management or collaborative practice, but does
23 respect the will of the General Assembly if it
24 decides to impose them across the board.

25 Those are my questions.

1 CHAIRMAN MCGEEHAN: Thank you very
2 much for being a forceful advocate for the
3 Pennsylvania Pharmacy Council.

4 MS. HORVATH: You've been talking to
5 Marlene.

6 CHAIRMAN MCGEEHAN: I would encourage
7 you to continue to work with Representative
8 Kula and her executive director, my executive
9 director, and Chairman Adolph's executive
10 director and the members of this committee to
11 address your concerns as this bill moves
12 forward.

13 MS. HORVATH: Thank you.

14 CHAIRMAN MCGEEHAN: Thank you for
15 your testimony.

16 MS. HORVATH: Thank you.

17 CHAIRMAN MCGEEHAN: Our next
18 presenter is Robert Weber. He is the chief
19 pharmacy officer of the UPMC.

20 MR. WEBER: Thank you. Good morning.

21 CHAIRMAN MCGEEHAN: Good morning.

22 MR. WEBER: To the Professional
23 Licensure Committee members, I am very pleased
24 to support House Bill 1041.

25 In the next several minutes I'll tell

1 you who I am, explain how drug therapy
2 management has helped our patients at UPMC,
3 the University -- the University of Pittsburgh
4 Medical Center, and how expanding pharmacists'
5 drug therapy management to a private setting
6 will further improve the quality of life for
7 patients and improve the use of our health
8 care resources.

9 I've been a licensed pharmacist in
10 the Commonwealth since 1983 when I relocated
11 to Pittsburgh after graduate training in
12 clinical and hospital pharmacy at the Ohio
13 State University.

14 I am also licensed to administer
15 injectable medications and have immunized over
16 300 patients since July 2006.

17 During my career I have held various
18 practice and operational positions and am
19 currently the chief pharmacy officer at UPMC.
20 I have been a pharmacist for almost 30 years,
21 and actually I can take care of any patient.

22 Actually, you know, speak to Mike's
23 comments. I have been clinically trained and
24 I can handle many medication situations with
25 most patients. So -- and I've been a

1 pharmacist for a very, very long time.

2 Since the revision of the
3 Commonwealth's Pharmacy Act, the medication
4 therapy management at UPMC partners
5 pharmacists with physicians, nurses, and
6 others to assure for safe and cost effective
7 medication therapy. Pharmacists practice
8 medication therapy management through the use
9 of protocols allowing the pharmacists to
10 monitor such dangerous therapies as
11 intravenous medications, blood-thinning
12 agents, antibiotics, and diabetes
13 medications. These protocols are designed
14 collaboratively with physicians. The
15 pharmacists then work with the nursing staff
16 and other health care professionals in
17 adjusting a patient's drug regimen, adjusting
18 drug strength, frequency of administration or
19 route, administration of drugs, and ordering
20 laboratory tests consistent with UPMC policy
21 result. For all protocols, physicians are
22 permitted to revise or change a pharmacist's
23 medication dose adjustment. Finally, the
24 pharmacist educates patients on how to take
25 their medication and, importantly, what to do

1 if a drug reaction occurs. Pharmacists work
2 with nearly 35 protocols at UPMC.

3 I highlight three examples where the
4 management of drug therapy a by UPMC
5 pharmacist improves medication safety and
6 effectiveness. Warfarin, a blood thinner, has
7 long been noted to cause serious and even
8 fatal bleeding because prescribed doses are
9 either too high or patients misunderstand how
10 to take this medicine. Pharmacists working
11 with patients, through the UPMC Warfarin
12 medication management protocol, have reduced
13 serious bleeding by 50 percent and the doses
14 for almost 70 percent of our patients are at a
15 safe and effective level, far above the
16 national average of 55 percent.

17 In hospitals, many patients are
18 administered medications by the intravenous
19 route since they may be too sick to eat or
20 take oral medications. There are risks to
21 intravenous medications, such as infection,
22 vein irritation and being administered too
23 much fluid.

24 As a result, it is important to
25 administer intravenous medications for the

1 shortest time possible. By using a set of
2 approved criteria, pharmacists convert
3 patients from intravenous to oral medications,
4 where available. Pharmacists have been able
5 to reduce the amount used and the cost of
6 intravenous medications, in turn reducing the
7 potential for harm to our patients.

8 And, finally, the media has written
9 recently about the danger of super bugs to
10 include methicillin-resistant Staphylococcus
11 aureus, known as MRSA, and Clostridium
12 difficile that attack patients with weakened
13 immune systems, such as the young and the
14 old.

15 A medication management protocol at
16 UPMC assigned a pharmacist to adjust
17 antibiotic doses and limit the duration of
18 their use. Pharmacists working under this
19 protocol reduced the resistance to super bugs
20 at UPMC by almost 50 percent and decreased the
21 C. difficile rate by almost 25 percent. This
22 program helps patients assuring that powerful
23 antibiotics, when really needed, will be
24 effective to cure their infection.

25 I know of several patients where

1 pharmacist collaborative drug therapy
2 management would have helped. One that comes
3 to mind is an 80-year-old man who did not
4 understand how to measure his blood sugar and
5 administer the appropriate amount of insulin.
6 And after four visits to the emergency room
7 for low blood sugar, he finally got it right.

8 A 52-year-old man who took his
9 Warfarin wrong based on a message left on his
10 answering machine by his doctor ended up in
11 the hospital with major bleeding. The list
12 goes on.

13 These events are prevented by a
14 pharmacist working in collaboration with a
15 physician to manage medication therapy. My
16 colleagues have presented very good reasons
17 why this bill should pass and, most,
18 importantly to protect our patients.

19 Pharmacy education has seen the value
20 of medication therapy management by training
21 our students in these skills and by offering
22 education programs to practicing pharmacists.
23 The University of Pittsburgh School of
24 Pharmacy leads the Pennsylvania coalition with
25 representatives from each of the seven

1 Pennsylvania schools of pharmacy in developing
2 training courses for pharmacists to provide
3 medication therapy management.

4 And this course, which will begin in
5 the fall of 2009, will be available to all
6 pharmacists throughout Pennsylvania.

7 I strongly encourage you, the
8 political leaders of Pennsylvania, to take my
9 testimony and that of my colleagues to heart
10 and approve this bill.

11 The patients we all serve will
12 hopefully enjoy a state of improved health and
13 quality of life as a result of this
14 pharmacist-expanded role.

15 Thank you for allowing me to testify
16 today as well. But I do, if you don't mind,
17 have just a few comments related to
18 Ms. Horvath's testimony as it relates to
19 competency assessment of the pharmacists that
20 do medication therapy management within
21 hospitals.

22 At the University of Pittsburgh
23 Medical Center, which you all know is the
24 largest academic medical center in the
25 country, we have a very sophisticated system

1 of measuring competencies of our staff,
2 whether it's observational competencies,
3 whether it's written competencies.

4 Also in our job descriptions we have
5 very specific job training and degree
6 requirements, as well as residency trainings,
7 which also promotes a qualified person to
8 perform this activity.

9 But, importantly, we have an ongoing
10 process of quality review both by our medical
11 staff as well as our pharmacy leaders. And
12 that actually is case reviewed. If there are
13 issues related to a specific way a pharmacist
14 handled the patient's case, there is follow-up
15 and feedback to that pharmacist. And so it's
16 an ongoing, almost realtime review of the
17 pharmacist's activities.

18 All our protocols are reviewed by a
19 peer review committee called the Pharmacy and
20 Therapeutics Committee, which is intra --
21 intra-disciplinary group of professionals,
22 including physicians, who review and approve
23 the protocols based on the best evidence in
24 the medical literature.

25 So we are comfortable that the

1 competency assessment and evaluation program
2 within our institution is appropriate to
3 provide safe and effective medication therapy
4 management.

5 In addition, we are surveyed by the
6 Department of Health, which you know is the
7 only institution and only body that can close
8 a hospital in Pennsylvania. And the
9 Department of Health looks very closely at
10 what we do within the pharmacy as it
11 relates to storage and security of
12 medications. But, most importantly, the
13 pharmacist's activities.

14 And we have reviewed our medication
15 management protocols with our Department of
16 Health surveyors as well and they found no
17 problems with them.

18 I just wanted to provide that piece
19 of information to the group as a follow-up.

20 CHAIRMAN MCGEEHAN: Well, we
21 appreciate you taking the time to be here.
22 The question was asked just for the education
23 of the members. It certainly is no reflection
24 on the professionalism or competency of
25 Pennsylvania pharmacists.

1 Are there any questions from the
2 committee?

3 Yeah, Chairman Adolph.

4 REPRESENTATIVE ADOLPH: Thank you,
5 Mr. Chairman.

6 Thank you for your testimony.
7 Currently you are able to perform the drug
8 therapy management?

9 MR. WEBER: Yes.

10 REPRESENTATIVE ADOLPH: In the
11 institutional setting?

12 MR. WEBER: Yes.

13 REPRESENTATIVE ADOLPH: All right. I
14 had asked earlier regarding the payment for
15 services.

16 MR. WEBER: Yes.

17 REPRESENTATIVE ADOLPH: Could you
18 explain to the committee how you go about that
19 currently which may shed some light on how it
20 will happen in the -- in the actual retail
21 pharmacist's end?

22 MR. WEBER: Yeah. Well, currently
23 there's no direct payment to pharmacists for
24 their function within institutions. Patients
25 are charged for their medications. They're

1 also charged a room rate which is an
2 institutional room rate and a fee.

3 And as a result of that, the
4 organization provides and pays for the
5 pharmacist's activities as a -- as a service
6 and benefit to the patient and as a commitment
7 to the safety and effectiveness of medication
8 therapy.

9 REPRESENTATIVE ADOLPH: Okay. Now,
10 what I'm trying to -- what I'm trying to
11 accomplish and I -- is -- I can see the cost
12 savings. Okay? I can see an instant cost
13 savings when they review, you know, audit
14 prescriptions that an individual may be
15 taking -- and some prescriptions that they
16 should not be taking at the same time. I can
17 see all of that.

18 But what I'm trying to get at, and
19 someone is probably going to have this answer
20 for us, because other states have similar
21 legislation, is that I'm trying to find out if
22 that -- if when a senior citizen here in
23 Pennsylvania, after this bill becomes law,
24 when he or she goes in to a pharmacist and has
25 a consultation, okay, with their pharmacist,

1 will that individual receive a bill from the
2 pharmacist for services rendered and can that
3 individual then submit to Medicare Part D for
4 those services or a pharmaceutical plan, drug
5 plan that they may have and, you know,
6 someone --

7 MR. WEBER: I mean I can --

8 REPRESENTATIVE ADOLPH: -- someone
9 has to have the answer.

10 DIRECTOR MOHALL: I do have the
11 answer.

12 REPRESENTATIVE ADOLPH: Okay. Thank
13 you.

14 DIRECTOR MOHALL: Many Medicare Part
15 D plans do contract for face to face with the
16 patient based on certain criteria, certain
17 number of disease states, certain number of
18 drug therapies, certain number of dollars
19 spent, and then they do pay and cover that
20 benefit for the patient.

21 Other health plans do not. And
22 really we think that one of the keys is this
23 health plan benefits greatly in terms of cost
24 savings. So the health plans should certainly
25 reimburse the pharmacist for the time spent

1 with that cost savings.

2 Some of our programs currently range
3 from an \$80 to \$120 fee paid by the health
4 plan based on time spent with the patient.

5 REPRESENTATIVE ADOLPH: That
6 information that you just gave us is what I've
7 been trying to get to, sir, and I appreciate
8 it. I should have asked you when you were up
9 testifying, and I apologize for that.

10 But I think that -- that helps and
11 any information that you have regarding the
12 other states that have this, because I think
13 the General Assembly, and the members of this
14 committee, in particular, before it leaves, we
15 need to understand the aspect of billing for
16 the consultation.

17 Okay. Thank you very much. And
18 thank you very much.

19 CHAIRMAN MCGEEHAN: Thank you,
20 Chairman Adolph.

21 And for the stenographer, the answer
22 was given by Rick Mohall. He's the Pharma.D.
23 representing the Rite Aid Corporation.

24 And I'd also invite Chairman Adolph
25 and the executive directors to meet with Tom

1 Snedden from PACE to have a definitive answer
2 on that, if one does exist.

3 Our next and last testifier is Luis
4 Gonzalez, III. He's a Pharma.D., BCPS,
5 Associate Program Director, Department of
6 Medicine Residency Program, et al.

7 And, Mr. Gonzalez, as we say in
8 Philadelphia, it looks like you have more
9 degrees than a thermometer. I'm not going to
10 read them all.

11 MR. GONZALEZ: I think it just looks
12 that way because my name is so long.

13 Thank you very much, both -- both
14 chairs, as well as the other members of this
15 committee, in allowing me at the eleventh hour
16 to come here.

17 I would not like to repeat the
18 testimony that I have submitted ahead of time,
19 which was done very quickly. What I'd like to
20 do, though, is also to thank Representative
21 Kula for a bill that I think is just
22 brilliant.

23 And why do I think it's brilliant?
24 Because it emphasizes collaboration in health
25 care. And right now what we lack in health

1 care is collaboration. Health care is
2 practiced in silos for the most part, and it's
3 taken a long time for physicians to give up
4 the autonomy to allow other qualified
5 professionals to participate in the management
6 of patients to achieve optimal health
7 outcomes.

8 We still struggle with that in
9 hospitals, but we've come a long way in
10 hospitals and one of -- one of my
11 responsibilities at Memorial Medical Center in
12 Johnstown, Pennsylvania is to participate in
13 the education of physicians in training, as
14 well as staff physicians in clinical
15 pharmacology and the Accreditation Council for
16 Graduate Medical Education, one of the core
17 competencies for physicians now, which is
18 really relatively new, is to recognize their
19 role as the leader of a health care team.

20 And I would like to say that the
21 ability of a pharmacist to participate in a
22 collaborative way with a physician, not
23 independently, is an important aspect to
24 improve not only drug therapy management but
25 just the health of patients in general.

1 Because when health care is practiced
2 in a silo fashion, one physician not talking
3 to another, one nurse not talking to a
4 physical therapist, one pharmacist not talking
5 to the physician, we have a lot of very
6 dedicated, highly trained and educated
7 professionals, but there isn't a lot of
8 interaction. There's so much less interaction
9 in the outpatient setting than there is in the
10 inpatient setting.

11 So I don't want to keep you any
12 longer than you want to be here, which I'm
13 sure you're about ready to give up and go
14 now. But I can give you many examples of how
15 we've improved the health of our community,
16 especially within the institutions where we do
17 this in a collaborative fashion, in a team.

18 But what I'd like thank you and the
19 other members of this committee, and
20 especially Representative Kula, is to
21 recognize the fact that this bill supports
22 collaboration. There is no silo opportunities
23 in this bill.

24 It's to support a collaborative
25 opportunity between the leader of the team,

1 which is the physician, and the ultimate
2 benefactor of health care, which is hopefully
3 the patient.

4 And I really am just delighted to
5 have the opportunity to come out today from
6 Johnstown. I thank you once again. That's
7 all I'd like to say.

8 CHAIRMAN MCGEEHAN: Thank you very
9 much, Dr. Gonzalez. And you've given
10 Representative Kula her quote for her
11 re-election brochure.

12 Are there any other questions from
13 the members of the committee?

14 Dr. Gonzalez, thank you very much for
15 making an effort to be here.

16 In closing, I just want to thank
17 Representative Kula for all her efforts in
18 arranging this hearing and for presenting
19 this -- this bill to the committee. Thank you
20 very much.

21 REPRESENTATIVE KULA: Thank
22 you, Mr. Chairman.

23 CHAIRMAN MCGEEHAN: And for the
24 testifiers, thank you, and the members who
25 attended.

1 REPRESENTATIVE KULA: Thank you so
2 much.

3 CHAIRMAN MCGEEHAN: This meeting is
4 adjourned.

5 (The hearing was concluded at
6 10:57 a.m.)

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I hereby certify that the proceedings
and evidence are contained fully and
accurately in the notes taken by me on the
within proceedings and that this is a correct
transcript of the same.

Brenda S. Hamilton, RPR
Reporter - Notary Public