MICROFILM DIVIDER

OMB/RECORDS MANAGEMENT DIVISION
SFN 2053 (2/85) 5M

ROLL NUMBER

DESCRIPTION

1432

2007 HOUSE HUMAN SERVICES

HB 1432

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1432

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 30, 2007

Recorder Job Number: 2228

Committee Clerk Signature	Judy Kelsch

Minutes:

Vice Chair Pietsch: opens HB 1432.

Representative Clara Sue Price, district 40 from Minot, ND: We should almost address the next two bills together, HB 1433 and HB 1432. Every session we try to save the state money for Insurance. We need to make changes and have a cost saving measure. I have some testimony and information from others to share with you.

David Olig, member of the ND Pharmacy Association: This is a win, win situation. There is no need for a pilot study. There is no reason to not do these things. It is hard to come up with anything negative. PERS works with Blue Cross Blue shield. This is a tremendous opportunity for wellness. We need clinical coordinator in place to collect data. Diabetes is an extended study. You have quick results with asthma you feel better faster.

Bob Frieline: We do know this works. In my own practice, people need to be reaffirmed. We need to know the effects long term. It is not what we are going to spend today; it is what we save down the way.

Mark Hardy, Pharmacy student from Neche, ND: See attached testimony. I too think this is a win, win situation.

Bruce Levi, with the Medical Association: We wanted to indicate our support to a drug therapy program as part of the bill.

Chairman Price: asks for any more testimony for HB 1432. Is there any opposition to HB 1432?

Sparb Collins: we have 3,200 diabetics, 4,000 with asthma. This information comes from claims we get. We have 54,000 in the PERS program. PERS supports disease management. Our dilemma is money. This bill gives support.

Rod St. Aubyn, with Blue Cross Blue Shield: We have a lot of questions. Where is the funding? It is not spelled out. Physicians would have a significant roll. The program has tremendous merit. Who provides the data? It goes over to HB 1432, who is responsible for what. We would have to go over some possible amendments.

Chairman Price: Anyone else in favor or opposition on HB 1432? Hearing none we will close HB 1432.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1432

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 30, 2007

Recorder Job Number: 2231

Committee Clerk Signature	Judy Schock

Minutes:

Representative Weisz is chairing this sub committee: and calls the committee to order, Representatives Weisz, Hofstad and Kaldor are present to work on HB 1432 and 1433..

Mary Koenecke: see attached.

Sparb Collins: PERS would look at it and if it goes to bid we would have to see if there are sufficient funds. How much does it cost, do we extend it to retire?

Ms Koenecke: American Pharmacist Association estimates 2-3 dollars per minute. The first visit costs could be 20-75 dollars, and the follow ups would be shorter.

Rod St. Aubyn, with Blue Cross Blue Insurance: These should be combined into one bill. It would give flexibility.

Representative Weisz: Our chairman prefers not.

The committee discusses the fiscal note changing the language, and should it be sent to appropriations?

Representative Weisz: adjourns the meeting.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1432

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 30, 2007

Recorder Job Number: 2229

Committee Clerk Signature	Judy Kelsch

Minutes:

Chairman Price: We will open hearing on HB 1432 which is basically in the same testimony as HB 1433, unless there is anyone who wishes to say anything different concerning this potential program? Does anyone else have any other comments? We will close the hearing on HB 1432.

The minutes and testimony will be found separately.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1432

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 31, 2007

Recorder Job Number: 2356

Committee Clerk Signature Judy Lebsack

Minutes:

Chairman Price: Take out HB 1432.

Representative Weisz: has 2 sets of proposed amendments and goes over them with the committee. See attached. In sub committee it came up to go to the emergency commission for authority to spend the money. I did visit with the chair of appropriations. In reality they don't like the idea of starting up front, going to the emergency commission. This basically says what ever they get in grants they do have the appropriations. I move these amendments, seconded by **Representative Kaldor.** The verbal vote is all yeas.

Representative Weisz goes over the seconded set of amendments and moves those amendments, seconded by **Representative Kaldor**. The verbal vote was all yeas. See attached amendments.

Representative Hofstad moves a do pass as amended, second **Representative Kaldor.** The vote is 11 yeas 0 nays and 1 absent. **Representative Hofstad** will carry the bill to the floor.

FISCAL NOTE

Requested by Legislative Council
01/16/2007

Bill/Resolution No.: HB 1432

1A. **State fiscal effect:** *Identify the state fiscal effect and the fiscal effect on agency appropriations compared to funding levels and appropriations anticipated under current law.*

	2005-2007 Biennium		2007-2009 Biennium		2009-2011 Biennium	
	General Fund	Other Funds	General Fund	Other Funds	General Fund	Other Funds
Revenues						
Expenditures						
Appropriations						

1B. **County, city, and school district fiscal effect:** *Identify the fiscal effect on the appropriate political subdivision.*

2005-2007 Biennium			2007-2009 Biennium			2009-2011 Biennium		
Counties	Cities	School Districts	Counties	Cities	School Districts	Counties	Cities	School Districts

2A. **Bill and fiscal impact summary:** *Provide a brief summary of the measure, including description of the provisions having fiscal impact (limited to 300 characters).*

This bill enacts specific authority for the board to establish a collaborative drug therapy program, seek funding for such a program and expend the funds received

B. **Fiscal impact sections:** *Identify and provide a brief description of the sections of the measure which have fiscal impact. Include any assumptions and comments relevant to the analysis.*

In is not anticipated that this bill would have any direct fiscal effect on state expenditures since implementation would be subject to PERS finding a funding source. If a funding source is found a continuing appropriation is provided subject to approval of the emergency commission.

3. **State fiscal effect detail:** *For information shown under state fiscal effect in 1A, please:*
   A. **Revenues:** *Explain the revenue amounts. Provide detail, when appropriate, for each revenue type and fund affected and any amounts included in the executive budget.*

   B. **Expenditures:** *Explain the expenditure amounts. Provide detail, when appropriate, for each agency, line item, and fund affected and the number of FTE positions affected.*

   C. **Appropriations:** *Explain the appropriation amounts. Provide detail, when appropriate, for each agency and fund affected. Explain the relationship between the amounts shown for expenditures and appropriations. Indicate whether the appropriation is also included in the executive budget or relates to a continuing appropriation.*

Name:	Sparb Collins	**Agency:**	NDPERS
Phone Number:	328-3901	**Date Prepared:**	01/21/2007

70794.0101
Title.

Prepared by the Legislative Council staff for
Representative Weisz
January 30, 2007

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1432

Page 2, line 9, remove "Funds appropriated under this subsection may be spent only"

Page 2, remove line 10

Renumber accordingly

Date: 1/30
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES HB 1432 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Move Amendment

Motion Made By Rep. Weisz Seconded By Rep. Kaldor

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman			Kari L Conrad		
Vonnie Pietsch – Vice Chairman			Lee Kaldor		
Chuck Damschen			Louise Potter		
Patrick R. Hatlestad			Jasper Schneider		
Curt Hofstad					
Todd Porter					
Gerry Uglem					
Robin Weisz					

Total (Yes) 12 No 6

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1/30
Roll Call Vote #: 2

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES Committee HB 1432

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Move Amendment

Motion Made By Rep Weisz Seconded By Rep Kaldor

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman			Kari L Conrad		
Vonnie Pietsch – Vice Chairman			Lee Kaldor		
Chuck Damschen			Louise Potter		
Patrick R. Hatlestad			Jasper Schneider		
Curt Hofstad					
Todd Porter					
Gerry Uglem					
Robin Weisz					

Total (Yes) "Click here to type Yes Vote" 12 No "Click here to type No Vote" 0

Absent 0

Floor Assignment _____

If the vote is on an amendment, briefly indicate intent:

Date: 1/31
Roll Call Vote #: 3

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. "Click here to type Bill/Resolution No."

House HUMAN SERVICES HB 1432 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do pass as Amended

Motion Made By Rep Hofstad Seconded By Rep Kaldor

Representatives	Yes	No	Representatives	Yes	No
Clara Sue Price – Chairman	✓		Kari L Conrad	✓	
Vonnie Pietsch – Vice Chairman	✓		Lee Kaldor	✓	
Chuck Damschen	✓		Louise Potter	✓	
Patrick R. Hatlestad	✓		Jasper Schneider		
Curt Hofstad	✓				
Todd Porter	✓				
Gerry Uglem	✓				
Robin Weisz	✓				

Total (Yes) 11 No 0

Absent 1

Floor Assignment Rep Hofstad

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1432: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (11 YEAS, 0 NAYS, 1 ABSENT AND NOT VOTING). HB 1432 was placed on the Sixth order on the calendar.

Page 1, line 17, after "providing" insert "face-to-face"

Page 1, line 23, replace "to work with the board to provide annual outcome updates on the plan." with "or a specified delegate to implement a formalized disease management program with the approval of the prescriptive practices committee established in section 43-15-31.4, which must serve to standardize chronic disease care and improve patient outcomes. This program must"

Page 1, remove line 24

Page 2, line 1, remove "self-management program to" and after the underscored comma insert "provide"

Page 2, line 2, remove "evidence-based" and replace "provide" with "enable"

Page 2, line 3, replace "provide" with "structure"

Page 2, line 9, remove "Funds appropriated under this subsection may be spent only"

Page 2, remove line 10

Renumber accordingly

2007 HOUSE APPROPRIATIONS

HB 1432

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1432

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 8, 2007

Recorder Job Number: 3165

Committee Clerk Signature Holly N. Stanek

Minutes:

Rep. Svedjan: You are correct in saying there is no appropriation on HB 1432 but I wanted it down here because it relates to HB 1433.

Rep. Weisz: This is a bill that would authorize PERS to solicit money from whatever sources they can, federal or private, to set up a drug therapy collaboration program within PERS. All we are doing is giving them spending authority to spend whatever money they may get in the grant whether it is private or federal.

Rep. Svedjan: Would it be helpful for us to get a read on HB 1433 to see the relationship? We can take these independently but if there is a close link maybe we should have a brief on HB 1433 as well.

Rep. Weisz: They are definitely closely linked. One is general and it has to do with chronic diseases. HB 1433 is very specific because it has to do with diabetes.

Rep. Svedjan: Really we can take these indecently. What HB 1432 is saying that if they can access funds to do this then the authorization is here to do it. If they don't get money from anywhere else they wouldn't be able to do it.

Rep. Weisz: That is correct. As far as why this bill is put forward to you, maybe it would be better if I can explain what we are going to do in HB 1433. I don't want to double up.

Rep. Svedjan: If you would all refer to HB 1433 you should have the first engrossment in your files. Also contained in your folders should be a statement that is a couple of paragraphs long from the Employee Benefits Program committee. Rep. Klein chairs that. It addresses the proposal and the actuarial analysis.

Rep. Weisz: HB 1433 has to do with setting up a cooperative drug therapy program. The reason this bill is in front of you is because we received information about a project that happened in Ashville, NC called the Ashville project. What they did was took a certain population and established a collaborative drug therapy program. They looked at what we considered chronic disease and diabetes. They took a look at these and often they are life long conditions. You aren't going to get over diabetes. What they found was that they are taking the medication to control the diabetes, they aren't necessarily following the proper lifestyle that will ensure that their diabetes is controlled and that they don't have other side effects. Most of you are aware that diabetes has some very severe side effects like amputation and heart attacks. What they found was there was a very high medical cost incurred by this group of chronic disease. What the Ashville project is was to pay pharmacists to sit down with their patients and monitor their condition. Monitor what they were doing, ask them questions, and check glucose readings. Now they can track them by plugging something into their computer. Now they can track them by seeing what their blood sugar was every day and whether or not it was high or low. Now they can sit down and question. Here is a case that was brought up in committee. The one doctor had someone come in on Tuesdays and Thursdays who had a spike in her reading. Every Tuesday and Thursday. Otherwise she was doing a good job in controlling her diabetes. Her pharmacist asked her why this was happening. She was eating steak. They were able to say that she needed to change a little bit of what she ate and put her on a different level. They found a savings for every dollar that they invested. They

were getting a savings of over $4. They tracked that group of people that were on the program vs. the rest of their diabetic people that were covered, and the costs were $13,000 for every $1,000 invested depending on the person. It averaged on having a return of 4 to 1. What 1433 does is takes the PERS program, takes the diabetic, and stakes their claims. What your committee decided to do was set up a program that will pay the pharmacists to have this face to face monitoring of the patient. There is money to act as an incentive to ensure that we have people that will participate in this. Basically this usually means waving the co-pay or purchasing some of the supply. What the hope is, is that the dollar amount or fiscal effect will be based on 800 diabetics for one year. By the time the program gets up and you get people to participate, you are looking at one year of the biennium. What we are looking at doing is paying the pharmacist and waving co-pays to get people to participate. Your committee is firmly convinced that this will save money. It is one of those things. We can track this but that is the beauty of it. We are going to spend some money and it's not going to have the return tomorrow but two years down the road we are going to know if indeed that population that is in this program is effective.

Rep. Svedjan: Tell us how you want to fund this.

Rep. Weisz: The original bill had a direct appropriation. We took a look at it and because there are 19,500 PERS plans, roughly 5,000 of those are non state – like counties, other political subdivisions. This program would be available to those. What your committee did was add $2 to the premium on all PERS plans. That generates a little over $900,000 to the PERS plan. Of that, the state is actually on the hook for about $500,000. The reason being is the political subdivisions would pay their $2. The insurance covered by professional funds, etc. The plan is going to cost us about $900,000 to do those 800 people. The states cost will be about $500,000 as it applies to the $2 increase to PERS. That is the bill.

Rep. Kerzman: Wouldn't this coincide with the wellness program that the PERS is now doing? Are we doubling up here?

Rep. Weisz: The wellness program was brought out. No it doesn't. This is really different. This is an intensive management program. This puts the pharmacist with the patient. You have to sign a contract to agree to participate. It is more intense then the wellness program. This will be a contract to have.

Rep. Svedjan: This clarification now, I'm looking at the fiscal note. This has not been included in the executive budget. The engrossed bill does not have an appropriation in it. Is it that the PERS budget would need to be amended if we did this? It will show up in all budgets.

Rep. Weisz: That $2 increase is going to show up in every budget. That is what this will do.

Rep. Svedjan: What is the vehicle to see that it happens?

Rep. Weisz: My understanding was that when Al prepared the amendment that page 2 lines 3 and 4 would take care of that.

Rep. Klein: When we had testimony in the other committee there was additional information from people who have followed through on this program. This is indeed an experimental program. The results of the 4 to1 payback give us the option to try this and see if it works. The record keeping is going to be monitored on a very close basis to see if it pays out. If in two years it doesn't we can always take a look at it. When I think of a 4 to 1 payback what have we go to lose?

Rep. Svedjan: Yes and it is just a matter of being able to wait for that payback because we won't have it tomorrow. In a way this relates to some of what we tried in the last session with Medicaid. We put disease management aspects into that program. This is something that should pay off.

Rep. Klein: Diabetes and weight problems are getting to be a major issue all over the country. It is certainly showing up in ND.

Rep. Svedjan: Once you identify this population of people, I think you are talking about 800 patients. How does the payment then get to the pharmacists and at what amount?

Rep. Weisz: We left this intentionally vague. It will be up to PERS to contract with someone to implement the program and determine the payments to the pharmacists and determine what it is going to take to incentives the participants.

Rep. Skarphol: When you talk about a payback when do we recognize it and how do we recognize it. Is there any certainty anywhere that we are going to have that reflect?

Rep. Weisz: There is no certainty that there will be a payback. I can't stand up here and guarantee that. I believe that there is a certainty that we will be able to probably at least within three years determine if there is a payback or not. We will be able to identify. We will know what it is costing us for our diabetic population within the PERS plan. We will know what it is costing the 800 people. We will be able to compare the two.

Rep. Klein: My question is will we recognize this and hopefully lower Blue Cross premiums being assessed on state employees? Is that the mechanism that is going to reflect the payback that we are referring to.

Rep. Weisz: I would hope that they can decide that with the premium. Yes we are basically self funded in a sense. If our costs have dropped by $7 million, our premiums will drop. They base it on actuarial from the prior. We will have them drop the premiums. We obviously can't project the $4 million savings so we can drop the premium. In future biennium's I think absolutely.

Rep. Kempenich: On the mechanics again, you know we are talking about the contacts with pharmacists and stuff. Would that be throughout the state?

Rep. Weisz: Yes. What will happen is from the indications the pharmacists are 100% behind this. The school of Pharmacy in Fargo will have a program which will be a two day program for the pharmacists to go through for additional training. They will get certified in this program. Then they will be able to contract with the state. The state will determine for each participant. The range is probably going to be somewhere between $400-600 per participant for the pharmacist. They will get a flat fee. It will be their job to monitor and make sure that person fulfills their end of the contract by showing up for a bid. That handles the pharmacist end of it. That is up to the PERS but that is the intent and what is happening in other states.

Rep. Svedjan: The information I have on this prior to coming into this today is that the cost is about $864,000 but less than 50% of that would be general fund. That is because of how the premiums are paid.

Rep. Weisz: The latest fiscal note, the number we were given in committee and that you were using was $18,000. PERS did come to me this morning and the fiscal note reflects that. There are actually $19,500 contracts. It would be covered.

Rep. Svedjan: It is still true that less than half would be general fund dollars.

Rep. Monson: I am very frustrated and disappointed in PERS and Blue Cross who won't go into a program like this that should potentially save us a lot of money without having some money up front. If the projections are that we are going to save $4-6 by going into this program, it seems to me that they should be promoting this and saying that they are willing to go out on a limb here. What is the guarantee that we give them the $2 up front? Are we ever going to see that money reflected in lower premiums? I doubt it. Are we going to see that?

Rep. Weisz: They don't have a choice. When the actuarial comes they can't plug in that they are going to spend $500,000 of general fund money. We don't have to reflect that in the premium costs. They can't do that. They have to look where the actuarials are. They tell them

this is where they are at and this is what the projected costs are going to be. That is what they have to go with. I don't believe that until we implement this and go in that they have the ability to take that money and use it for this.

Rep. Svedjan: From my point of view, what is key to this is how effective we can be in tracking this by itself. There are many other things that impact what the ultimate premium is for all of our PERS contracts. We have got to make sure that this can be tracked in isolation and we get the feedback that we need.

Rep. Weisz: That is the beauty of this. Everyone of these persons signed a contract so we can track every individual that participates and compare them to the rest of our population.

Rep. Svedjan: This bill comes to us as a high priority from the human services committee. It was also looked at by the employee benefits committee. It was advanced out of that committee with a favorable recommendation. Is there any more discussion?

Rep. Wald: I serve on that employee benefits committee and I just thought that if we don't have enough diabetics come forward to work out this contract so therefore you don't get a large enough sample to really determine. If only 10% of the people who are eligible come forward and work with the company to be tracked in that. 10% wouldn't be a relative sample to arrive at any kind of concrete conclusion that this really helped. I'm a diabetic. Do I have to switch drug stores if they only sign up one guy at a pharmacy in Dickinson? Maybe I don't want to go to the pharmacist that signed the contract.

Rep. Weisz: It's a legitimate question. If there wasn't a pharmacist that wanted to do it, they would personally drive out to meet these contracts. Again the person who does the contract has incentives If he is paying $300 copays and that is waived, that is a good incentive. The big benefits for almost all of these diabetics are that they have better health. That may not be why they walk in the door to start with, it may be to get that co pay. I strongly believe that they will

continue in it as far as the numbers to make it valid. That is the reason that the amount of dollars are here. We do need to get a fair amount. That is why we looked at the 800. That is why we are looking at the amount of premium to ensure that we have enough to make it a valid representation of the diabetics in this state.

Rep. Svedjan: We don't have a motion on the floor. Let's first take up HB 1432. This is the bill that is dependent on attracting funds from another source.

Rep. Weisz: HB 1432 says chronic disease which would be asthma or anything else. It can only happen if they can pull together the grant money to give them spending authority to do it. There is some money in a couple of pharmaceutical companies and some other deals.

Rep. Klein: I move a do pass on HB 1432.

Rep. Aarsvold: I Second that.

Rep. Svedjan: Is there any more discussion? If not we will take a roll call vote on a do pass motion for HB 1432. The motion passes 20-1-3.

Rep. Hofstad: I will carry this bill.

Rep. Svedjan: Let's then take up HB 1433.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1432

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 8, 2007

Recorder Job Number: 3165

Committee Clerk Signature

Minutes:

Rep. Klein: I move a do pass.

Rep. Glassheim: I second that.

Rep. Svedjan: Is there any discussion on the motion? Seeing none we will take a roll call vote on a do pass motion for HB 1432. The motion passes 20-2-2

Rep. Weisz: I will carry that bill.

Date: 2/8/07
Roll Call Vote #: 1

2007 HOUSE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1432

House Appropriations Full Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number —

Action Taken Do Pass as engrossed

Motion Made By Klein Seconded By Aarsvold

Representatives	Yes	No	Representatives	Yes	No
Chairman Svedjan	✓				
Vice Chairman Kempenich	✓				
Representative Wald		✓	Representative Aarsvold	✓	
Representative Monson	✓		Representative Gulleson	—	—
Representative Hawken	✓				
Representative Klein	✓				
Representative Martinson	✓				
Representative Carlson	—		Representative Glassheim	✓	
Representative Carlisle	✓		Representative Kroeber	✓	
Representative Skarphol	✓		Representative Williams	—	
Representative Thoreson	✓				
Representative Pollert	✓		Representative Ekstrom	✓	
Representative Bellew	✓		Representative Kerzman	✓	
Representative Kreidt	✓		Representative Metcalf	✓	
Representative Nelson	✓				
Representative Wieland	✓				

Total (Yes) 20 No 1

Absent 3

Floor Assignment Hogstad

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1432, as engrossed: Appropriations Committee (Rep. Svedjan, Chairman) recommends **DO PASS** (20 YEAS, 1 NAY, 3 ABSENT AND NOT VOTING). Engrossed HB 1432 was placed on the Eleventh order on the calendar.

2007 SENATE HUMAN SERVICES

HB 1432

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1432

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: 3-13-07

Recorder Job Number: 4973

Committee Clerk Signature Mary K Monson

Minutes:

Chairman Senator J. Lee opened the hearing on HB 1432 relating to health treatment management services for state employees and their families; and to provide a continuing appropriation.

Representative Robin Weisz (District #14) introduced HB 1432 and said that it basically expands on HB 1433. If the board can find funding through grants, private and otherwise, they would then have the ability to set up virtually the same program that is being done in HB 1433 for other conditions such as asthma and other chronic health conditions. There is no fiscal note and no funding involved from the state. It merely gives them the authority to spend the money if they can raise it and be able to use it to establish a similar program.

He pointed out that in the House a change was made in 1433 that they neglected to make in 1432 and would appreciate it if the Senate committee would make that change. It wasn't their intent that the board should have to send out bids for this program so they requested that the language pertaining to that on page 1, lines 10-11, be deleted.

Senator J. Lee asked if the only change to put 1432 and 1433 in sync would be deleting that language.

Rep. Weisz said yes it would.

Senator Dever asked if it is PERS that puts the program together or is it the blues.

Rep. Weisz replied that PERS is in charge. They will most likely contract with the blues. Both of these bills are meant to give PERS the flexibility to establish a program that makes the most sense and is cost effective.

David Olig (Fargo Pharmacist) testified in support of HB 1432. (Meter 06:30) Before 1432 was written, early last fall the pharmacy association met with the granting agency to look at the possibility of a soft money grant to do a pilot program for asthma. The granting process has been tabled temporarily. There is a possibility that if they can put together a grant to do a pilot project, possibly in asthma, HB 1432 would be the door opened to do just that type of thing. There was no opposing testimony.

In a neutral manner Sparb Collins (PERS) testified that, from their perspective, removing the bidding requirement and adding that flexibility would be helpful. They do support the amendments.

Senator Warner asked if actuarially he thought one biennium would be enough to collect the kind of data that they expect to see.

Mr. Collins said they are looking at a year just to get the mechanism set up so they are really talking about running it in the second year of the biennium. It will be into the next biennium before they would start getting any real data back. He wouldn't expect anything at the end of the next biennium beyond how the program has been developed and implemented and offered, etc. Not so much results.

Senator Warner said it would be interesting to find metrics to show where the trends are so they can anticipate faster rather than waiting years for the outcome.

Mr. Collins said that is a challenge with all wellness things—being able to target it and get people involved who can get the best outcome from the effort.

The hearing on HB 1432 was closed.

Senator Dever moved to amend HB 1432 to remove the sentence regarding bidding.

Senator Erbele seconded the motion.

Senator Warner asked if they could craft language which would allow this to be expanded outside of the fairly narrow base of providers.

Senator J. Lee asked if adding something like that would be practical since they didn't know which disease they are talking about. She didn't want to legislate specific disease management.

Mr. Collins suggested ways of adding language to expand for other providers (meter 12:45).

Further discussion followed on adding, "and other health professionals" on line 14 and 17 following the word pharmacists. This was included in the amendment.

Roll call vote 6-0-0. Amendment accepted.

Senator Dever moved a Do Pass on HB 1432 as amended.

Senator Erbele seconded the amendment.

Roll call vote 6-0-0. Motion carried. Carrier is Senator Dever.

Date: 3-14-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1432

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken amendment - adding line 14-17 other health prof. delete bedding sentence

Motion Made By Sen. Dever Seconded By Sen. Erbele

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair 2	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever 1	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment

If the vote is on an amendment, briefly indicate intent:

Date: 3-14-07

Roll Call Vote #: 2

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1432

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 70794.0201 Title .0300

Action Taken Do Pass / amended

Motion Made By Sen. Dever Seconded By Sen. Erbele

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair 2	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever 1	✓		Senator John M. Warner	✓	

Total (Yes) 6 No 0

Absent 0

Floor Assignment Senator Dever

If the vote is on an amendment, briefly indicate intent:

REPORT OF STANDING COMMITTEE

HB 1432, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1432 was placed on the Sixth order on the calendar.

Page 1, line 10, remove "The board shall"

Page 1, line 11, remove "receive bids for this program under section 54-52.1-04."

Page 1, line 14, replace "and" with an underscored comma and after "pharmacists" insert ", and other health professionals"

Page 1, line 17, after "program" insert an underscored comma and after "pharmacists" insert "and other health professionals"

Renumber accordingly

2007 TESTIMONY

HB 1432

Sue com

Price, Clara Sue

From: Mary.P.Koenecke@gsk.com
Sent: Monday, January 22, 2007 8:51 AM
To: Price, Clara Sue
Subject: Asheville Info - Testimony, Potential Revisions
Attachments: Bunting ND State Employee initiative.doc; Bunting Testimony ND condensed.doc; Miall Asheville Testimony.doc; Asheville Fact Sheet 1-07.doc; CDTM program description.doc

Dear Clara Sue;

I hope you were able to see the feature on the Asheville Project on the NBC Nightly News last night. I thought it was very compelling and hope that many people saw it.

Is the hearing for HB 1432 and 1433 scheduled for 1/30? I am attaching some written testimony from Barry Bunting, who was interviewed in the NBC piece last night. There is a long version and condensed version of his testimony to be used at your discretion. I am also attaching testimony from John Miall, who was also very involved in the Asheville Project. He provides a good overview of the structure of the program, as well as health outcomes, cost savings and analysis. My colleague, Ann Gustafson, has also put together a one-page fact sheet.

We have been working with Howard Anderson and NDPhA to identify local pharmacists with experience in diabetes disease management to testify. Do you remember Rick Detwiller, who preceded Brendan Joyce as Medicaid Pharmacy Manager? He is over at St. A's and has recommended a couple of pharmacists.

(See attached file: Bunting ND State Employee initiative.doc)(See attached file: Bunting Testimony ND condensed.doc)(See attached file: Miall Asheville Testimony.doc)(See attached file: Asheville Fact Sheet 1-07.doc)

Also, my sincere apologies for this, but since the legislation was drafted, there has been additional conversations with APhA and some information has come to light that may necessitate some revisions to the language regarding the Patient Self Management Program. Evidently that is a proprietary program of APhA's and there is a fee for it. In visiting with the Executive Directors of the Iowa Pharmacists Association and the SD Pharmacists Association, their thoughts were that specific reference to an APhA program may not be as desirable as broader language allowing other programs.

Since the last version, we have included a more 'generic' description of a "formalized diabetes management program" and removed APhA Foundation from the legislative language. The APhA program is included in the CDTM program description document as an example of a diabetes management program.

We also removed the "evidenced-based" verbiage in describing the function of the diabetes management program. Evidenced-based can be misinterpreted to mean a comparative drug review process. Providing standards of care means following treatment guidelines and decisions are not based solely on cost.

Here is the proposed revised language for HB 1433, Section 2. #3:

3. The North Dakota pharmacists association shall work with the board to provide annual outcome updates on the plan. The North Dakota pharmacists association or a specified delegate shall implement a formalized diabetes management program, which will serve to standardize diabetes care and improve patient outcomes. This program will facilitate enrollment procedures, provide standards of diabetes care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.

Here is the proposed revised language for HB 1432, Section 1. #3:

3. The board may request the assistance of the North Dakota pharmacists association to work with the board to provide annual outcome updates on the plan. The North Dakota pharmacists association or specified delegate may be authorized to implement a formalized disease management program, which will serve to standardize chronic disease care and improve patient outcomes. This program will facilitate enrollment procedures, provide standards of care, enable consistent documentation of clinical and economic outcomes, and structure an outcomes reporting system.

Options for a specified delegate are in the CDTM description document.
(See attached file: CDTM program description.doc)

Clara Sue, I hope this is not too problematic. This legislation is ground-breaking with ND being the first state to introduce such a bill and some kinks needed to be worked out. We are checking with the President of NDPhA to get his thoughts on this and I thought I would also run it by PhRMA.

Thanks much and please call me when you get a chance at 612 840-5654.

Best regards,

Mary

Mary Koenecke, R.Ph.
Director, State Government Affairs
GlaxoSmithKline
5567 Bristol Lane
Minnetonka, MN 55343
952 933-6171 Office
612 840-5654 Cell

North Dakota State
Board of Medical Examiners

DUANE HOUDEK
Executive Secretary and Treasurer

LYNETTE McDONALD
Deputy Executive Secretary

January 29, 2007

The Hon. Clara Sue Price
Chair, Human Services Committee
North Dakota House of Representatives
State Capitol
Bismarck, ND 58505

RE: House Bill Nos. 1432 and 1433

Dear Chair Price:

Enclosed are copies of testimony I request be distributed to committee members and placed in the record of these bills.

On behalf of the North Dakota State Board of Medical Examiners, I appear "neutrally" on these bills, seeking only to record the distinction between the "collaborative drug therapy program" contemplated in this legislation, and the current "collaborative agreements" by which pharmacists have limited prescriptive authority under current law.

It is my understanding that there is no intent to expand or change the current process for authorizing a pharmacist's limited prescriptive authority now contained in 43-15-31.4, NDCC.

Thank you for your consideration.

Sincerely,

Duane Houdek
Executive Secretary

DH/md

enclosure

cc: Howard Anderson, R Ph
Bruce Levi
Lorri Giddings

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BEFORE THE HOUSE HUMAN SERVICES COMMITTEE
HB NOS. 1432 AND 1433

Testimony of Duane Houdek
North Dakota State Board of Medical Examiners

January 30, 2007

Madam Chair, members of the Committee, my name is Duane Houdek, executive secretary for the North Dakota State Board of Medical Examiners. Thank you for the opportunity to testify regarding House Bill Nos. 1432 and 1433.

It is my understanding that these bills do not intend to authorize any new or expanded prescriptive authority for pharmacists. Rather, they seek to formalize, and to provide a payment mechanism for, management practices that pharmacists already perform.

Section 43-15-31.4, NDCC, authorizes limited prescriptive practices for pharmacists in institutional settings pursuant to collaborative agreements with physicians, approved jointly by the boards of medical examiners and pharmacy. Subject to approval of these two boards, and under certain conditions, which include supervision of the collaborative physician, pharmacists in institutional settings may initiate or modify drug therapies.

Because House Bills 1432 and 1433 authorize "collaborative drug therapy program[s]", I wanted the distinction between the practices contemplated in these bills and the limited prescriptive practice of pharmacists authorized under current law to be recorded in these hearings.

Thank you for the opportunity to do so.

THE ASHEVILLE PROJECT FOR DIABETES

DIABETES FACTS

- Diabetes is the **5th leading cause of death** in the U.S.
- More than **200,000 Americans die** of complications from diabetes each year
- **12,000-24,000 people become blind each** year as a result of diabetic eye disease
- **42,813 people** with diabetes are diagnosed with **kidney failure** each year, and over 100,000 are treated for this condition
- **82,000** diabetics undergo **leg, foot, or toe amputations** annually

The Cost of Diabetes (2002)

- **$132 billion:** medical care and lost wages associated with diabetes
- **$91.8 billion:** medical care costs associated with diabetes

Annual Overall Cost of Health Care

- People with diabetes: $13,242
- People without diabetes: $2,560
- Studies have shown that A1C levels are directly linked to healthcare costs.
- Every successive 1 percent rise in A1C above 6 percent was associated with an increase in medical costs of 4 percent (A1C of 7 percent), 10 percent (A1C of 8 percent), 20 percent (A1C of 9 percent) and 30 percent (A1C of 10 percent).

(Source: American Diabetes Association, www.diabetes.org)

ABOUT THE ASHEVILLE PROJECT[2]

- The Asheville Project was first implemented in 1997 as a pilot community-pharmacy care program with 46 diabetes patients covered by two self-insured employers' health plans
- The results: **50 percent reduction in sick days within 14 months, consistent after 5 years**
- **Zero workers compensation claims in the City of Asheville diabetes group between 1997-2003**
- Today, more than 1,000 patients from five employers are enrolled for diabetes, asthma, hypertension and lipid therapy management through the Asheville Project

[2](Source: American Pharmacists Association Foundation)

Five-Year Results of the Asheville Project[3]

- Mean A1C levels (blood sugar) decreased at all follow-up appointments and more than 50 percent of patients improved each time
- Number of patients with optimal A1C values (less than 7 percent) increased at each follow up
- **Payers realized decreases in total direct medical costs that ranged from $1,622 to $3,356 per patient per year**
- **Total mean direct medical costs decreased by $1,200 to $1,872 per patient per year compared with baseline**
- **Number of sick leave days decreased every year between 1997-2001 for one employer group, with increases in productivity estimated at $18,000 annually**

[3](Source: "The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program," *Journal of the American Pharmaceutical Association*, March/April 2003)

Regarding the Collaborative Care Bills HB 1432 & 1433:

My name is Barry Bunting, I work for a large hospital, Mission Hospitals, in Asheville, North Carolina. I am a Clinical Manager in the Pharmacy Department. Ten years ago I began coordinating a community initiative that uses pharmacists in the community as personal health coaches for people with diabetes. This project has come to be known as, "The Asheville Project".

The focus of this approach is to provide intense self-care education and very regular follow-up with specially trained community pharmacists. The program is voluntary but participation qualifies participants for significant savings on their medication costs.

In our community the participating employer's health plans (12,000 covered lives) have realized an average of $2000/person/year net reduction in health care costs for people with diabetes. By net, I mean, including the program costs: fees for counseling and the cost of the reduced medication co-payment incentives.

Also we saw a $725/person/year net reduction in health care costs for people with asthma, and an additional $1230/person/year gain in productivity. People were six times less likely to have an emergency department or hospitalization event. Sick days were cut by half in the diabetes group and by 400% in the asthma population.

The outcomes of this simple model have been very compelling and, we believe, demonstrate the potential for such models to help control health care costs in people with chronic illnesses, like diabetes.

The current U.S. healthcare system "invests" heavily in fixing people when they break. It's actually a misnomer to say we "invest" in care, because we really don't. Mostly we pay for the consequences of many years of individuals receiving less-than-ideal care.

I am not being critical of the medical community per se when I say that many people with chronic illnesses in the U.S. are not receiving the attention they need, and the attention they deserve. It's the system that's broke. We have an acute care system, a "sick" care system, not a "health" care system. We get what we pay for, and we pay for acute care, not for prevention.

I said I work at a acute care hospital. It happens to be a very good hospital, including recognition as one of the best heart centers in the country. We have six thousand employees, two helicopters, and six critical care units. We are very good at fixing people when they break. But you don't want to come to our hospital. Not because you wouldn't get good care, but because when you do need us, it's expensive.

The acute care side of the health care equation is the main driver of costs. Therefore, it seems logical to me that the most viable solution to controlling healthcare costs would be to figure out ways to prevent avoidable hospitalizations and emergency room visits. However, the current strategy for controlling health care costs does not focus on keeping

people out of the hospital. It focuses on negotiating discounts on these events when they happen. And how successful has that strategy been - - - in your experience - - - - - ??

Would it not be better to spend $1000 and avoid a $30,000 hospital admission, than to "successfully" negotiate a 30% discount on the hospitalization. You didn't "save" $10,000, you spent $20,000 on an admission that could have, in many cases, been avoided. Not to mention the cost in individual suffering, loss of personal quality of life, and work-related productivity.

The problem is, it takes a leap of faith to believe that there are actually effective preventative approaches. And I suspect that some of you have been burned in the past by "disease management" programs. Much promised, little delivered. I believe that is because the typical "nurse call center" disease management approach, although it has some benefit for some patients, is not as effective as community-based disease management interventions.

Most health care is delivered on the community level. I believe that any strategy that is to have significant impact must be on the community level. And the principle strategy should be to avoid hospitalizations.

So my advice to you is, do the same thing you would do when investing in a stock. Do your homework. Invest in something that has a track record of success. It should be simple, it should deliver tangible measures of success, and it should be something that your gut tells you makes sense. And if it doesn't deliver, pull the plug.

In our community, simple interventions, an emphasis on self-care knowledge, and very regular follow-up with community pharmacists in a health coach role has made a tremendous difference in outcomes.

As one of our patients recently told an NBC Nightly News reporter, "it's about accountability". "It's about knowing that I'm going to be asked on a regular basis, how are you doing, let me see your glucose meter and let's see how often have you been checking your blood sugar, and how are you doing on that exercise goal?"

What HB1432 & 1433 are not asking you to do is to pour more money down the black hole of healthcare.

It is important for you to realize that you are already paying for the consequences of less than ideal care. We are simply suggesting that you consider taking some of that money and spending it differently. That you invest in the health of your employees the way you would invest in a stock, with an expectation of a ROI.

The return-on-investment for this approach in our community has been 4:1 for people with diabetes. If you could find a stock that, every year, paid back 4 dollars for every dollar you spent, would you buy more?

Is it time to invest in prevention? Should you at least give it a try? And if you fail, will you be any worse off than you are now?

STATEMENT
OF
SUPPORT
For
HB 1432 and 1433

PROVIDED
TO
The Honorable Clara Sue Price, Chairman
And The Members of the North Dakota House Human Services Committee

January 30, 2007

BY
John P. Miall, Jr.
President
Miall Consulting
18 Northwood Rd.
Asheville, NC 28804
(828) 777-8873
jpmiall@charter.net

Chairperson Price and Members of the Committee:

Thank you for the opportunity to provide testimony today in this most important matter. My name is John Miall. I retired as the Director of Risk Management for The City of Asheville, NC in May, 2005 following a 30 year career in human resources, benefit, and risk management. I now have my own consulting business and provide lectures, programs and hands on expertise to employers and communities desiring to reduce health care costs and improve patient outcomes.

Of interest to the Committee, my work exclusively is fee paid and under no circumstances do I seek nor receive commissions or in any other way financially benefit from my recommendations and advice neither to my clients, nor through this statement to you.

My testimony in this matter is offered to the Committee in light of the fact that I have had the opportunity over the course of my career to have been part of a life changing design for delivering improved care to chronic disease patients and achieving significant improvements in cost of care, clinical outcomes, and workplace productivity.

Beginning as a community based initiative for the City of Asheville's Employee Health and Benefit Plan in 1998 the program focused originally on employees, retirees, and their dependents with a diagnosis of **diabetes**. The success of the initial program has led over the past ten years to the model being replicated into other disease states including **asthma, hypertension, lipids,** and one new application under testing at present for patients with **depression**. Further, the replications have grown far beyond the confines of the local community in Asheville, NC and have been successfully replicated in locations throughout the United States from Maryland to Honolulu and over 40 other locations in between.

In the interest of providing you with the most information possible in the least time I will highlight the structure and achievements of the model as relates to diabetes care specifically for your consideration:

Structure

1) The design of the model draws upon **all** the resources a community has for health care. Physicians, pharmacists, nurses, patient educators, clinicians, dieticians, employer / payers, patients, and hospitals.
2) Pharmacists engaged in the model undergo a core curriculum designed by physicians and others designed to provide pharmacists with the skills to engage in hands-on care with patients once a month or as scheduled.
3) Patients with diabetes entering the model sign a contract with the employer / plan sponsor to do certain things in exchange for certain considerations under the plan design. Specifically, **patients covenant to:**

a) Undergo a basic patient education class taught by certified diabetes educators and dieticians offered through community resources and adapted from the American Diabetes Association module for patient education. (Approximately 9 contact hours)
b) Attend monthly or other periodic visits as required with participating pharmacists.
c) Allow for all clinical and humanistic data collected at each visit to be shared in a HIPPA compliant manner with treating physicians, clinicians and researchers engaged in the model.
d) Comply with all reasonable requests to make themselves available when requested (approximately once every three months) for blood draws for purposes of securing Hemoglobin A1c levels.
e) Regularly do self test finger stick blood sugar measurements as recommended by care providers.

4) In consideration of the patient's signing the agreement the **employer / plan sponsor agrees** to:
   a) Provide all patients in the model with a free glucose meter for self testing. (Monitors are usually donated by manufacturers.)
   b) Waive all health plan fees and deductibles for lab services, education, pharmacist consulting fees, and disease specific prescription medications and supplies (e.g., insulin, test strips, syringes, etc.) so long as patient is compliant in the model.
5) Pharmacists and the employer / plan sponsor also contract that in consideration for the employer / plan sponsor paying their fees for patient interventions the **participating pharmacists** will:
   a) Provide specific services to patients at each intervention including: Downloading glucometers to evaluate 30 days worth of blood sugar levels; eye exams; blood pressure levels; coaching for on-going support of patient education previously received; counsel regarding drug therapies and drug interactions; and diabetic foot exams.
   b) Provide treating physicians with a full report of all interventions with their respective patients.
   c) Enter patient data on a secured system for evaluation and reporting of blinded (de-identified) patient data.
6) **Pharmacist Networks** of pharmacists engaged in the model take steps necessary to report all de-identified patient data to researchers and clinicians for analysis and report purposes.

It is noted here that all outcomes by all replications of the model to date have equaled or exceeded the following outcomes achieved from the following highlights from the original "Asheville Project." The following data represents outcomes for The City of Asheville, NC and / or Mission Hospitals in Asheville, NC the site of the first replication of the model beyond the City.

DATA OUTCOMES

Data outcomes include, but are not limited to:

1) A 40% reduction of first year average, aggregate (total) claims costs for all patients in the model from $6,127 per patient per year for the full year before implementation of the model to $3,554.
2) Continuing, **sustained** reductions of average, aggregate claims costs over the next four years of the model at $5,021; $4,535; $3,902; $4,651, respectively. This represented a total reduction of average, aggregate costs of care of over 58% through the first 5 years of the program.
3) Immediate and **sustained** reductions in Hemoglobin A1c levels for patients from the first 8 months of the model throughout its application to date. (Note: According to the New England Journal of Medicine a one (1) point reduction in H1Ac levels for a patient with diabetes will result in a 50% reduction of the co morbidities associated with the disease, (i.e., less amputations, blindness and kidney failure.)
4) Over a 50% reduction in sick leave utilization by patients in the program in the first year of the model, **sustained** over time. Sick Leave utilization for patients in the program went from an average of 12.6 days per patient per year for the year before implementation of the program to 6.0 in the first year. Sick Leave utilization reduction has been **sustained** across time at or below 6.0 days per patient per year (with a maximum deviation of no more than .25 per patient per year) since the programs inception.
5) Patients in the model had over 200 more outpatient encounters with physicians the first year of the program than they had for the year prior to implementation.

Analysis

Based on experience in the model to date it is known that:

1) Patients with chronic disease states (diabetes) will access the **current** health care system typically when they encounter a serious to sever medical complication.
2) Patients are typically discouraged from engaging in aggressive self care modalities due to the cost of prescription medications, supplies, and care.
3) Physicians with patients in the model typically see their patients **more frequently** as a result of Pharmacist interventions due to the feedback of current and useful data provided to treating physicians by pharmacists engaged in the model.
4) Cost are reduced by limiting / reducing the need for acute care (i.e., fewer Emergency Room visits, Fewer ICU admissions, and fewer critical care interventions by physicians in those tertiary care settings) in lieu of more frequent / lower cost pharmacist and outpatient visits via treating physicians.
5) Reduced absenteeism / increased presenteeism are recognized to relate to improved productivity in the workplace.
6) Aligning patient and provider incentives with "wellness and prevention" is more effective and less costly that traditional models for care where financial incentives are predisposed toward "sick" care.

7) Collaborative models of care based upon providers, patients, and payers focused on improving outcomes and not toward traditional approaches for care where providers are competing for fewer and fewer payer dollars, or attempting to reduce single component costs of care (i.e., drug spend, reducing in-patient days, etc.) is more productive to achieving better outcomes and simultaneously reducing the total costs of care.

SUMMARY

It is my pleasure to have provided the Committee with this overview of "The Asheville Project" as part of your deliberations of **HB 1432 and 1433.** To my experience it seems the State of North Dakota would be well served by the adoption of this legislation.

For your further consideration I offer you and your staff the following articles for your consideration of the impact and efficacy of the model for care these bills represent.

Please do not hesitate to call upon me at any time if I may either clarify this **Statement of Support** or provide you with any additional information that would allow you to fully and successfully consider this legislation.

Suggest making available:
Washington Post Article
New York Times Article
Business Insurance Articles 2005 (2)
JAPhA Articles
News Release for TCC Diabetes from APhA / GSK

The Diabetes TEN CITY CHALLENGE

NATIONAL FACT SHEET

Overview

Launched in October 2005, the Diabetes Ten City Challenge is an innovative program that employers and communities can use to fight diabetes and reduce health care costs. It invites employer groups in 10 communities to establish a voluntary health benefit for employees and dependents, which provides employee incentives and helps people take control of diabetes by working with pharmacist coaches, physicians and diabetes educators.

Conducted by the American Pharmacists Association (APhA) Foundation with support from GlaxoSmithKline, the Diabetes Ten City Challenge is modeled after two other highly successful programs: the Asheville Project (1997-present), a diabetes management program shown to improve overall health, reduce absenteeism, shorten hospital stays and reduce health care costs; and the APhA Foundation's cholesterol management program, Project ImPACT: Hyperlipidemia™ (1996-1999).

What the Program Does

The Diabetes Ten City Challenge creates a collaborative team of employers, employees, pharmacists, physicians and diabetes educators _ and aligns incentives _ to focus on wellness, patient self-management and workplace cost savings:

- Educates and supports employees with information and guidance to become active participants in managing diabetes, based on a proven model and demonstrated research outcomes:
    - Employer waives co-pays on diabetes-related monitoring supplies and medication
    - Employee or dependent meets regularly with pharmacist to discuss their diabetes care and learn new ways to monitor and control diabetes
- Centers care around the patient and positions pharmacists as accessible, valuable resources in helping patients understand and control diabetes
- Reduces unscheduled absenteeism in the workplace and associated costs
- Improves health (by controlling diabetes)
- Saves health care dollars by investing in patient well-being _ keeping people healthy rather than paying for care when they become seriously ill

(more)

Proudly supported by:

GlaxoSmithKline

APhA FOUNDATION
1100 15th Street, N.W.
Washington, DC 20005
www.aphafoundation.org

Demonstrated Results

Results in organizations where the Asheville Project model has been implemented have shown:

- Employer saves estimated $918 per participant, the first year, in total health care costs (overall annual medical costs per patient decreased $1,622-3,356 each year in Asheville)
- Absenteeism is cut by 50%; workers comp claims are reduced or eliminated
- Employee satisfaction is very high – 95% are satisfied with pharmacist care
- Patients save an average of $400-$600/year with incentives such as waived co-pays
- Employers indicate they achieve Return on Investment (ROI) of at least 4:1 beginning in the second year
- After nine years, Asheville employers pay less to insure program participants than people without diabetes

How the Program Works

1. Specially trained community pharmacists "coach" people on how to manage their diabetes, including setting goals, using medications properly, and tracking their condition consistently with indicators such as cholesterol tests, blood pressure, foot exams and eye exams.
2. Collaborative care teams _ including pharmacists, diabetes educators and physicians _ are assembled in the community, educated about the program and are compensated for their involvement. Team members communicate regularly to optimize patient care.
3. Employers contract with APhA Foundation to establish the program in their community, and align employee benefit incentives to encourage success (co-payments for diabetes medications and related supplies typically are waived for patients who participate).
4. Employees choose to participate through a voluntary benefit offered by their employer.
5. Program available to new organizations began October 1, 2005.
6. Success is measured with clinical assessments including:
   - improvement in A1C concentrations (blood sugar control)
   - increased patient satisfaction with pharmacy services
   - decreased costs of medical care

(more)

Who is Involved

- American Pharmacists Association (APhA) Foundation provides the resources and project management tools; supports employers in setting up their programs; and guides local pharmacists as they work with physicians, diabetes educators and other community resources to establish the program and necessary local relationships.

- GlaxoSmithKline is supporting the Diabetes Ten City Challenge to help bring the benefits of the program to more employers, employees and their dependents throughout the U.S.

- An Advisory Committee of industry leaders is providing input and guidance as the project expands its reach. The group includes:

Tommy G. Thompson
Honorary Member
Former U.S. Secretary for Health and Human Services

Lawrence Blonde, MD
Chairman
National Diabetes Education Program
Ochsner Clinic
New Orleans, LA

Marsha Henderson, BA, MCRP
Health Programs Director
Office of Women's Health
U.S. Food and Drug Administration
Washington, D.C.

Robert F. Burgin, BA, MA
President Emeritus
Mission Hospitals
Asheville, NC

John P. Miall, BA, ARM
Retired Director of Risk Management for
the City of Asheville
President, Miall Consulting
Asheville, NC

Gregory Pawlson, MD, MPH
Executive Vice President
National Committee on Quality Assurance
Washington, D.C.

Nathaniel Clark, MD, MS, RD
Staff Endocrinologist and Medical Faculty Associate
George Washington University
Washington, D.C.

Stuart T. Haines, Pharm.D, BCPS, BC-ADM
Member, National Diabetes Education Program
Professor and Vice Chair for Education
University of Maryland School of Pharmacy
Baltimore, MD

Andrew Webber
President and Chief Executive Officer
National Business Coalition on Health
Washington, D.C.

###

For more information, contact ECI Communications:
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Caren Kagan Evans, President and CEO, 301-309-8487

NDPhA
NORTH DAKOTA PHARMACISTS ASSOCIATION

House Bills 1432 and 1433

Madam Chairman Price and members of the House Human Services committee, for the record my name is Mark Hardy and I am a pharmacy student from Neche, ND. I am here to represent the North Dakota Pharmacists Association (NDPhA).

The NDPhA would like to assist on whatever scale it can to help with the collaborative drug therapy program. The NDPhA can provide this annual outcome update of this program and work with pharmacists around the state to ensure its success. This program looks like a win-win for the patients and pharmacists. It has been consistently shown that when a pharmacist is actively involved with a patient's drug regimen there is an improvement in health outcomes and a decrease in health care costs. The NDPhA looks forward to this program. I would be happy to answer any questions.

1661 Capitol Way, Ste. 102 | Bismarck, ND 58501-2195 | Ph: 701-258-4968 | Fax: 701-258-9312 | www.nodakpharmacy.net