MICROFILM DIVIDER

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

ROLL NUMBER

DESCRIPTION

1433

2007 HOUSE HUMAN SERVICES

HB 1433

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1433

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 30, 2007

Recorder Job Number: 2228

Committee Clerk Signature	Judy Schock

Minutes:

Vice Chair Pietsch: opens HB 1433.

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 1433. Is there any opposition to HB 1433?

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 amendments.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1433

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 30, 2007

Recorder Job Number: 2231

Committee Clerk Signature	Judy Dibock

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 1433

House Human Services Committee

☐ Check here for Conference Committee

Hearing Date: January 31, 2007

Recorder Job Number: 2356

Committee Clerk Signature	Judy Schock

Minutes:

Chairman Price: take out HB 1433.

Representative Weisz: has proposed amendments and goes through them with the committee. The sub committee took a long hard look at HB 1433, and the funding. See attached. I move the first set of amendments, seconded by **Representative Hatlestad**. The verbal vote was all yeas. **Representative Kaldor** moves the second set of amendments, seconded by **Representative Conrad**. The verbal vote is all yeas.

Representative Weisz: The third set of amendments done up by legislative council about the funding. If PERS didn't get enough funding they would be able to use funding from HB 1432 if it is offered, for chronic disease management. **Representative Conrad** moves a do pass on the 3rd set of amendments, seconded by **Representative Kaldor**. The verbal vote was 11 yeas and1 nay. **Representative Weisz** moves a do pass as amended RR/Appropriations, **Representative Hofstad** seconds the motion. The vote was 12 yeas 0 nays and all were present. **Representative Weisz** will carry the bill to the floor.

FISCAL NOTE

Requested by Legislative Council
03/14/2007

Amendment to: Engrossed HB 1433

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			$208,300	$500,700	$208,300	$500,700
Appropriations			$208,300	$500,700	$208,300	$500,700

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
			$88,000	$49,000	$57,000	$88,000	$49,000	$57,000

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).*

To establish a collaborative drug therapy program to improve the health of members with diabetes and to manage health care outcomes.

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.*

The legislation proposes to add $2.00 on to the NDPERS Health Plan premiums to fund the collaborative health care program. This funding would provide payments to health care providers for services to individuals with diabetes. This program is modeled after other successful programs in other parts of the country that have demonstrated a long-term effect of reducing health care costs relating to these services.

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.*

N/A

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.*

The bill affects all budgeted FTE's and employees of Higher Education.

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.*

The bill affects all budgeted FTE's and employees of Higher Education. The appropriation is not included in the executive budget.

Name:	J. Sparb Collins	**Agency:**	NDPERS
Phone Number:	328-3900	**Date Prepared:**	03/15/2007

FISCAL NOTE

Requested by Legislative Council
02/05/2007

Amendment to: HB 1433

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			$202,300	$500,700	$202,300	$500,700
Appropriations			$202,300	$500,700	$202,300	$500,700

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
			$84,500	$48,700	$55,200	$84,500	$48,700	$55,200

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).*

To establish a collaborative drug therapy program to improve the health of members with diabetes and to manage health care outcomes.

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.*

$2.00 has been added on to the premiums to fund the collaborative health care program. This funding would provide payments to health care providers for services to individuals with diabetes. This program is modeled after other successful programs in other parts of the country that have demonstrated a long-term effect of reducing health care costs relating to these services.

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.*

N/A

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.*

The bill affects all budgeted FTE's and employees of Higher Education.

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.*

The bill affects all budgeted FTE's and employees of Higher Education. The appropriation is not included in the executive budget.

Name:	Sparb Collins	**Agency:**	NDPERS
Phone Number:	328-3900	**Date Prepared:**	02/07/2007

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 1433 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Move 1st Amendment

Motion Made By Rep Weisz Seconded By Rep Hatlestad

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 "Click here to type Yes Vote" No 0 "Click here to type No Vote"

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 HB 1433 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken None 2nd set of Amendments

Motion Made By Rep Kaldor Seconded By Rep Conrad

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 0

Absent 0

Floor Assignment Rep.

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

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

PROPOSED AMENDMENTS TO HOUSE BILL NO. 1433

Page 1, line 3, after the semicolon insert "and"

Page 1, line 4, replace "; and to" with a period

Page 1, remove line 5

Page 2, line 10, after the second "**program**" insert "**- Funding**"

Page 2, replace lines 29 through 31 with:

"4. The board shall fund the program by implementing a two dollar per month charge on the policy premium for medical and hospital benefits coverage."

Page 3, remove lines 1 and 2

Renumber accordingly

Date: 1/30
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 1433 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 70745.0101

Action Taken Do Pass as Amended 3rd per Amendment LC

Motion Made By Rep Conrad 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" 10 No "Click here to type No Vote" 1

Absent 1

Floor Assignment Rep.

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

Date: 1/31
Roll Call Vote #: 4

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

House HUMAN SERVICES HB. 1433 Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken Do pass as Amended RR/ Rep

Motion Made By Rep Weisz Seconded By Rep. Hofstad

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" 17 No "Click here to type No Vote" 0

Absent 0

Floor Assignment Rep Weisz

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

REPORT OF STANDING COMMITTEE

HB 1433: Human Services Committee (Rep. Price, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (12 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). HB 1433 was placed on the Sixth order on the calendar.

Page 1, line 3, replace "; to amend and reenact section 54-52.1-04 of the North Dakota Century Code," with a period

Page 1, remove lines 4 and 5

Page 1, remove lines 7 through 24

Page 2, remove lines 1 through 7

Page 2, line 10, after the second "program" insert "- Funding"

Page 2, line 12, remove "The"

Page 2, line 13, remove "board shall receive bids for this program under section 54-52.1-04."

Page 2, line 19, after "providing" insert "face-to-face"

Page 2, line 23, replace "shall work with the board to provide" with "or a specified delegate shall implement a formalized diabetes management program with the approval of the prescriptives practices committee established in section 43-15-31.4, which must serve to standardize diabetes care and improve patient outcomes. This program must"

Page 2, remove line 24

Page 2, line 25, remove "shall provide a standardized patient self-management program to"

Page 2, line 26, after the first underscored comma insert "provide", remove "evidence-based", and replace "provide" with "enable"

Page 2, line 27, replace "provide" with "structure"

Page 2, replace lines 29 through 31 with:

"4. The board shall fund the program by implementing a two dollar per month charge on the policy premium for medical and hospital benefits coverage."

Page 3, remove lines 1 and 2

Renumber accordingly

2007 HOUSE APPROPRIATIONS

HB 1433

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1432/1433

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 8, 2007

Recorder Job Number: 3165

Committee Clerk Signature

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 1433

House Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: February 8, 2007

Recorder Job Number: 3165

Committee Clerk Signature Holly N. Smith

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 1433. 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. 1433

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 Glassheim

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 2

Absent 2

Floor Assignment Weiss

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

REPORT OF STANDING COMMITTEE

HB 1433, as engrossed: Appropriations Committee (Rep. Svedjan, Chairman) recommends **DO PASS** (20 YEAS, 2 NAYS, 2 ABSENT AND NOT VOTING). Engrossed HB 1433 was placed on the Eleventh order on the calendar.

2007 SENATE HUMAN SERVICES

HB 1433

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. Engrossed HB 1433

Senate Human Services Committee

☐ Check here for Conference Committee

Hearing Date: March 13, 2007

Recorder Job Number: 4972, 4974

Committee Clerk Signature Mary K Monson

Minutes:

Job #4974

Senator Judy Lee opened the hearing on Engrossed HB 1433 relating to diabetes treatment services for state employees and their families.

Representative Weisz introduced Engrossed HB 1433 which is a collaborative drug therapy program. This bill is an attempt to help lower the costs and improve the health of our state employees that are on the states PERS Plan. He said this bill will set up a drug collaborative therapy program which will have personal one on one dialogue between the pharmacist and people with diabetes. The attempt of this bill is to help manage a life long condition.
He sees the program working like this: A pharmacist would have a contract with PERS saying that they will work with a client one on one. The Client will also sign a contract saying they will work with the pharmacy. The pharmacist will get paid for doing that service and the client will be given the incentive to do this, for example the co-payment could be waved or it would be up to PERS to see what incentives are needed to get them to sign a contract and become part of the plan.

This bill came about because of the Asheville Project. In this project they set up a collaborative program for diabetes and they found substantial savings. They found that for

every dollar invested they got five dollars back. The bill is funded by a two dollar per month charge on the policy. That would generate $890,000. He said the fiscal note is broken out by all agencies and it will cover everyone, not just state employees. He said that they will need at least 800 people to sign a contract to do this project. There will have to be enough people signing up for the project for it to work and to develop a data base to show the results. He said he feels this is an important piece of legislation and will help us lower medical costs and improve the productivity in the state.

Senator Lee clarified that it was a voluntary proposal, and asked if that was correct?

Rep. Weisz said it was definitely voluntary and they will have to screen them.

Senator Lee asked if he gave any consideration to Diabetes Educators playing a role in this.

Rep. Weisz said that we will hear from the Pharmacists and they can better address that.

Senator Heckaman said her husband is diabetic and in her area their local health care facility does this already. She wondered why the pharmacist would be the lead person. Judging from her own experience with her husband she would think that the pharmacist would be the least likely person to lead this team.

Rep. Weisz said that this is another step higher to manage and go beyond the basics. It is intended to be a much more intensive therapy program.

Rep. Weisz handed out some amendments (#1). He said that these were prepared by PERS. Written attachment enclosed.

Senator Dever said the two dollars has been added to the premium to fund the collaborative program. He asked if that meant it is already in place?

Rep. Weisz said it hasn't been added but in the fiscal note it has been added.

David Olig a Fargo Pharmacist testified in support of HB 1433. His written testimony is enclosed along with information on the Asheville Project for diabetes. (22:25) He also said

that the committee had a question about the CDE's – Certified Diabetic Educators, he said that there is no reason that they could not be a provider because all you need is a provider number so you can identify someone.

Senator Heckaman asked if this would involve a certain line of controlled medication.

David Olig said we don't know. He didn't see any reason to change products. (26:40) He did state that down the road if there was a huge savings on certain things that it might be something they would want to look at if it produced the same outcomes.

Senator Heckaman said that they do have a plan in their area and the pharmacists are not involved.

David Olig said historically pharmacists have not been viewed as health care providers. They do not have provider ID numbers. They now have Medicare Part ID?

Senator Heckman said she is looking at the work load of the pharmacist in her area and wonder whether he would have time. It would possibly require him to add staff. She could see this working in the larger areas but not sure about the more rural areas.

David Olig said one of the things they are looking at is traveling clinical pharmacists that will cover regions where they don't have providers.

Senator Lee asked if a CDE could work for a pharmacist.

David Olig answered absolutely. Economics are changing and pharmacists are looking forward to doing this and getting paid for it.

Senator Dever asked how they choose which employees get to participate in the program.

David Olig said that is a good question. A1C is a nice indicator and if we can get that data we can go for the biggest bang for the buck. Go for the people with the highest risk.

Senator Lee said that the money is important but the health outcome is most important.

Opposed – none.

Neutral

Sparb Collins with the Public Employees Retirement System said that they thought it was a good idea. He said the bill states that it would be funded (Subsection 4) "That the board shall fund the program by implementing a two dollar per month charge on the policy premium for medical and hospital benefits coverage." The bill tells us how the program is funded. The fiscal note reflects what that funding will be and the cost of that funding. (38:40) The purpose of the amendment is taking the two dollars and putting it in. The second thing is paying CDE's, the bill as written now is saying the board should involve physicians and pharmacist and pharmacists may be reimbursed. If the intention is to include CDE's it could be added.

Senator Lee referred to written testimony by Mary Koeneck. Written testimony is enclosed (#4).

Senator Lee closed the hearing on Engrossed HB 1433.

Job #4974

Senator Lee called the committee to order to discuss Engrossed HB 1433. She said that we have the amendments that would pledge the appropriation and we also discussed including Certified Diabetes Educators (CDE).

Senator Warner moved the amendments to include CDEs and appropriation spread.

Senator Heckaman seconded the motion.

The clerk called the roll 6-0-0.

Senator Warner moved a Do Pass to amended Engrossed HB 1433 and rerefer to appropriations.

Senator Heckaman seconded the motion.

The clerk called the roll 6-0-0.

Senator Dever will carry the bill.

Date: 3-13-07

Roll Call Vote #: 1

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1433

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number _____

Action Taken Include CDE's and approp spread

Motion Made By Sen. Warner Seconded By Sen. Heckaman

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

Total (Yes) 6 No 0

Absent 0

Floor Assignment _____

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

Date: 3-13-07

Roll Call Vote #: 2

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES

BILL/RESOLUTION NO. HB 1433

Senate **HUMAN SERVICES** Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number 70745.0201 Title .0300

Action Taken DP Iamend Irerefer

Motion Made By Sen. Warner Seconded By Sen. Heckaman

Senators	Yes	No	Senators	Yes	No
Senator Judy Lee, Chairman	✓		Senator Joan Heckaman	✓	
Senator Robert Erbele, V. Chair	✓		Senator Jim Pomeroy	✓	
Senator Dick Dever	✓		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 1433, as engrossed: Human Services Committee (Sen. J. Lee, Chairman) recommends **AMENDMENTS AS FOLLOWS** and when so amended, recommends **DO PASS** and **BE REREFERRED** to the **Appropriations Committee** (6 YEAS, 0 NAYS, 0 ABSENT AND NOT VOTING). Engrossed HB 1433 was placed on the Sixth order on the calendar.

Page 1, line 3, after "families" insert "; and to provide an appropriation"

Page 1, line 13, replace "and" with an underscored comma and after "pharmacists" insert ", and certified diabetes educators"

Page 1, line 15, after "pharmacists" insert "and certified diabetes educators"

Page 1, line 21, replace "prescriptives" with "prescriptive"

Page 2, after line 4, insert:

"**SECTION 2. APPROPRIATION.** The funds provided in this section, or so much of the funds as may be necessary, are appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from other funds derived from federal funds and other income, to the following departments for the purpose of defraying the cost of additional health insurance premiums necessary to pay the cost of the provisions of section 1 of this Act, for the biennium beginning July 1, 2007, and ending June 30, 2009, as follows:

DEPARTMENT	GENERAL	OTHER
Governor	$864	$0
Secretary of state	1,243	53
Office of management and budget	5,119	1,241
Information technology department	941	14,045
State auditor	1,826	805
State treasurer	288	0
Attorney general	7,232	1,470
Tax commissioner	6,384	0
Office of administrative hearings	0	384
Legislative assembly	6,000	0
Legislative council	1,584	0
Judicial branch	16,039	425
Commission on legal counsel for indigents	1,392	0
Retirement and investment office	0	816
Public employees retirement system	0	1,584
Department of public instruction	1,413	3,303
Land department	0	900
State library	1,233	195
School for the deaf	2,212	113
North Dakota vision services - school for the blind	996	300
Department of career and technical education	1,224	96
State department of health	4,896	11,016
Veterans' home	1,304	3,062
Indian affairs commission	192	0
Department of veterans' affairs	288	0
Department of human services	63,181	36,931

Protection and advocacy project	259	1,061
Job service North Dakota	66	14,718
Insurance commissioner	0	2,232
Industrial commission	2,382	276
Labor commissioner	377	151
Public service commission	1,326	690
Aeronautics commission	0	288
Department of financial institutions	0	1,296
Securities department	432	0
Bank of North Dakota	0	8,472
Housing finance agency	0	2,064
North Dakota mill and elevator association	0	6,288
Workforce safety and insurance	0	10,711
Highway patrol	6,241	3,215
Department of corrections and rehabilitation	32,051	1,875
Adjutant general	3,897	7,239
Department of commerce	2,564	940
Agriculture commissioner	1,708	1,508
Seed department	0	1,440
Upper great plains transportation institute	224	1,859
Branch research centers	3,369	1,203
North Dakota state university extension service	7,052	5,325
Northern crops institute	302	236
Main research center	11,415	5,293
Agronomy seed farm	0	144
Racing commission	17	79
Historical society	2,560	320
Council on the arts	240	0
Game and fish department	0	7,440
Parks and recreation department	2,302	122
State water commission	3,663	369
Department of transportation	0	50,520
Total	$208,298	$214,113"

Renumber accordingly

2007 SENATE APPROPRIATIONS

HB 1433

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1433

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 03-19-07

Recorder Job Number: 5297

Committee Clerk Signature Alecia Dilzer

Minutes:

Chairman Holmberg opened the hearing on HB 1433 at 3:30 pm on March 19, 2007 regarding diabetes treatment management services for state employees and their families. Senator Christmann handed out a written testimony left on his desk from Kristen Larson (1) regarding this bill. Senator Holmberg stated the committee should have the 1st engrossment with Senate amendments and that is what we can operate under.

Representative Robin Weisz, District 14 stated the bill has to do with a collaborative drug therapy program that is available to individuals with medical and hospital benefits covered through PERS and the purpose of the program is to improve the health of individuals with diabetes and manage health care expenditures. He stated the reason the bill is before this committee is the fact that chronic diseases have a huge cost on our PERS plan and there is a project called the Ashville Project and it offers by doing this type of program on average a savings of $4.00 for every $1.00 we invest in the program. That was direct savings for their health insurance plan. Plus it cuts the number of people who take sick days.

Chairman Holmberg had questions addressed to Allen Knudson, Legislative Council regarding the general fund and passage of this bill.

Allen Knudson, Legislative Council stated that if you give this bill a favorable recommendation it would reflect in the budget status so it would reduce the general fund ending balance like $208,000.

Senator Judy Lee, District 13, West Fargo sponsor of the bill gave oral testimony in support of HB 1433. She talked about the modest amendments done in the Human Services Committee. She stated they did amend in the area of the Certified Diabetic Educator because we learned that they are very positive and favorable to the pharmacist's role in managing and these people are specially trained people and will serve well on a medical treatment team along with several nursing levels people. The remainder is the spreading of the appropriation. It is no additional dollars but just spread out in PERS concerning the diabetes education program.

Chairman Holmberg directed the question to Allen stating he always struggles in understanding how they're adding this money in to these budgets in order to pay for this program and earlier this session we have had bills, 1003 dealing with Higher Ed and 1020 dealing with Extension Service, and I can never fathom this.

Allen Knudson shared the difference between the Higher Education Institution's appropriation and the Extension Services Appropriation.

Senator Mathern had questions regarding the fiscal note and why it was needed and had questions regarding Blue Cross.

Senator Lee shared the reasons for the different fiscal notes.

Laura Glatt, University System requested further amendments to increasing funding in the bill. Written Testimony (2) was distributed at this time.

Senator Krauter had questions directed to Allen regarding the salary package.

Chairman Holmberg closed the hearing on HB 1433.

2007 SENATE STANDING COMMITTEE MINUTES

Bill/Resolution No. 1433

Senate Appropriations Committee

☐ Check here for Conference Committee

Hearing Date: 03-22-07

Recorder Job Number: 5460

Committee Clerk Signature

Minutes:

Chairman Holmberg opened the hearing on HB 1433.

Senator Grindberg moved a do pass on HB 1433, Senator Fischer seconded. Discussion followed.

Senator Grindberg indicated this is something campuses can deal with on their own with their flexibility; the numbers are not that great.

Chairman Holmberg referred to the purple sheet that was distributed and discussed the amounts on each campus.

A roll call vote was taken on HB 1433 resulting in 13 yes, 1 no and 0 absent. The motion carried and Senator Dever will carry the bill.

Date:
Roll Call Vote #:

2007 SENATE STANDING COMMITTEE ROLL CALL VOTES
BILL/RESOLUTION NO. 1433

Senate Appropriations Committee

☐ Check here for Conference Committee

Legislative Council Amendment Number

Action Taken DP

Motion Made By Grindberg Seconded By Fischer

Senators	Yes	No	Senators	Yes	No
	✓				
Senator Ray Holmberg, Chrm	✓		Senator Aaron Krauter	✓	
Senator Bill Bowman, V Chrm	✓		Senator Elroy N. Lindaas	✓	
Senator Tony Grindberg, V Chrm	✓		Senator Tim Mathern	✓	
Senator Randel Christmann	✓		Senator Larry J. Robinson	✓	
Senator Tom Fischer	✓		Senator Tom Seymour	.	✓
Senator Ralph L. Kilzer	✓		Senator Harvey Tallackson	✓	
Senator Karen K. Krebsbach	✓				
Senator Rich Wardner	✓				

Total (Yes) 13 No 1

Absent

Floor Assignment Sen Dever / Hum Serv

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

REPORT OF STANDING COMMITTEE

HB 1433, as engrossed and amended: Appropriations Committee (Sen. Holmberg, Chairman) recommends **DO PASS** (13 YEAS, 1 NAY, 0 ABSENT AND NOT VOTING). Engrossed HB 1433, as amended, was placed on the Fourteenth order on the calendar.

2007 HOUSE HUMAN SERVICES

CONFERENCE COMMITTEE

HB 1433

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1433

House Human Services Committee

☑ Check here for Conference Committee

Hearing Date: April 13, 2007

Recorder Job Number: 5996

Committee Clerk Signature Judy Dehoch

Minutes:

Chairman Weisz: calls the meeting to order for HB 1433, and asks the senate to explain their changes.

Senator Dever: The first parts of our amendments are just to include the certified diabetes educators are involved in the process along with pharmacists. The prescriptive was just a grammatical thing. The section 2 was the program is funded through a $2.00 a month addition to the premium per employee and section 2 amendment was simply to spread that through the agencies so we would not have to deal with that in appropriations on an individual bases with each agency. It doesn't change the number of dollars in the program it just allocates that to the agencies.

Representative Potter: Do you know how they decided in the number of employees presumably per agency?

Senator Dever: That would be my understanding.

Chairman Weisz: How much is general funds and how much is special funds?

Senator Lee: It depends on the social funding for the agency. I think it is important for the house to know the senate didn't make any changes fiscally. There is no change with the policy you originally passed.

Chairman Weisz: Any questions from the committee? There has been some question about the $6,000.00 change, but I think everyone is aware of where it came from.

Senator Lee: The other thing I think is important about including other professionals is that there is significantly less expensive and we may see some budget savings. Nurses can fulfill these rolls as well. The pharmacist will have an important roll to play, but there are other professionals that also can play a roll and may not as much per hour. In the long run it is a budget consideration as well.

Representative Potter: I would make a move that the house accede to the senate amendments, seconded by **Representative Klein.** The roll was taken with 6 yeas, 0 nays, and 0 absent. **Representative Weisz** will carry the bill to the floor.

2007 HOUSE STANDING COMMITTEE MINUTES

Bill/Resolution No. HB 1433

House Human Services Committee

☒ Check here for Conference Committee

Hearing Date: April 20, 2007

Recorder Job Number: 6233 & 6235

Committee Clerk Signature Judy Schock

Minutes:

Chairman Weisz: We will call the committee to order on HB 1433. Let the record show all members are present. The only hang up we have in front of us is the dollars. The house has no concern or question on the fiscal note as far as the difference. I will go over what has happened so far. It left the house with no general appropriated funds, and the senate put on general funds appropriated. The 208,000 did not show up when it left the house.

Senator Dever: With all members now, we are happy with the amendments.

Chairman Weisz: There is resistance in the house thinking we are adding 200,000 to the bottom line.

Representative Klein: When we had it in appropriations, we were under the impression that it was going to come out of the existing budget.

Chairman Weisz: I visited with other members and that was their perception it was coming out of budget. The language in the original 1433 is not clear. The dilemma we have today is we can't change what already happened. Either we reamend the bill and take out the additional 200,000 or we send it out the way it is and see if it flies or not. Obviously it is not a problem in the senate. I believe it is an extremely worthy program. I don't want to loose this program. I think it is important one way or another to get this done.

Representative Klein: The way we had testimony this thing on a payback from other places where they implemented it.

Senator Dever: 1432 is kind of a companion bill applying to other agencies using money from grants and things like that.

Chairman Weisz: The problem we have is is verifying saving in this biennium. We don't have a lot of data. I am convinced it will pay back dividends. The only way this will not turn out is if they don't get the participation.

Committee has discussion on participation and it isn't going to take off at a bang, but as they get into it and start understanding and seeing benefits it will go. Where it will work is that the co pays are set aside and diabetic supplies will be no charge, and the saving in health care in a long run would be tremendous.

Chairman Weisz: Either we change the language back or accede and see if it survives. Committee agrees it is a valuable program.

Senator Lee: There is disappointment that the house appropriation does not see the cost savings and see it as an investment in cost savings and wellness. I would wonder if maybe you would be willing ask Sparb if there are things already being done and because there is a start on that is it possible to get along on less that $2.00 a month and could we consider funding a part of it and not the rest of it? Is there something that is already started with some of the more modest things that are being done or any cost saving fact that we are not starting from zero?

Sparb Collins, Executive Director with PERS: The two dollars came as a result of testimony that was given over at the house about what it may be and it was kind of an estimate. As such it is just an estimate. If you provided something less that, that estimate may be as valid as the 2 dollar estimate. It is not a product of specific plan designed in place. The

program will be developed from the dollar amount. We also are talking this won't be in effective until the second year. Yes, it can be designed around the dollar amount that you provide.

Chairman Weisz: In House Human Services, we based it on 800 looking at 4-600 for the pharmacists. One option we have if we assume we will get a big enough data base. That is an important key. Hoping we have a big enough data base to expand.

Senator Lee: If we look at 1 ½ bucks instead of 2 bucks not only would it be easier to consider at least a portion of it. Could we reduce the amount? Would it make a significant difference?

Chairman Weisz: W estimated based on what they paid at the actual project and some of the testimony what it took. You aren't going to get people on the program for $100.00. That was not enough of an incentive. The information I got from others the actual project it appeared you are going the minimum is 200 bucks for an incentive but more likely 400. the pharmacists in the other projects appeared from 300 and odd dollars to like 600 and some dollars. We came up with roughly 1,000 dollars. You add them all together it comes to 864,000. I think until they put it together we won't know exactly. We took it based on the projects that are in place now. The 800 is not cast in stone. I

Senator Heckaman: If we could cut down the number of people, and do it as a pilot project in certain agencies for a year. I know that is difficult because you may not be able to generate enough funds, but you could increase the dollars per month at the 2 1/2 .

Chairman Weisz: you wouldn't know who has the diabetic issues.

Representative Kline: If we would have had this 2 months ago 200,000 dollars, now you talk 5,000 the sky is falling. If we take this back I think the chances of getting it approved is slim to none. That is where I am at. I

Senator Dever: It seems to me that the number of dollars is not the issue, it is how it is appropriated. Seems to me the expectation was it would be absorbed by agencies and the house human services would not have seen a need to occur it to appropriations.

Senator Lee: I don't think it matters how it happened. It is a misunderstanding we all wish it wasn't there. What can we do top make this work? I want it to go forward? Collectively the buck stops at our desks. We made a mistake in the legislation and now someone has to pay for it. We all know the outcome is good. We can share the solution. Do we wait a year to start it and that cuts the amount of money, but I am not crazy in doing that.

The committee discusses, If we cut it back as close as we can get and get some out of general, but I am not sure. We need to compromise. As legislatively we say you got to pay because we made a mistake. That is like saying I hit your car and now you have to pay it. I just thin it is a bummer. I know everyone is really trying how to keep this budget where they want it. Is the appropriation committee not approving? In the second biennium it will be a general fund appropriation and that they can build it in there budget. It is a one shot deal for us. Another option is we go through a close out at the end of the biennium with BC/BS that there is a gain, and funded out of the gain. What happens to the gain?

Mr. Collins: We are not projecting a very substantial gain this time it was not applied to the premiums in previous bienniums. The biennium before we had 14 million dollars and that was applied to all the premiums of the premium reduction. That was applied to all the premiums of premium reduction and that is probably why it is 20% this time. This is a couple hundred thousand dollars. At this point you could do something.

The committee discusses just choosing some of them is not good they should all be able to take part or none of them. It is going to cost the state money down the line to wait to do the program. It all costs money. We will never do all of them starting out. The sooner we start the

sooner it starts saving us more money. If there is a potential of some money remaining and you don't know that, but if the state provided some general funds support for this up to that amount would come back into the general fund again, rather than it being applied to premiums, than the state gets the money back. It doesn't go into the agencies pocket.

Chairman Weisz: We will adjourn and meet again later today. We will again call the committee to order. I have some suggested language, and goes through that. We are working off of 0200.

The committee discusses the language.

Representative Kilzer the senate recedes from the senate and amends the bill as follows, seconded by **Senator Lee**. The roll was taken with 6 yeas, 0 nays, and 0 absent. **Chairman Weisz** will carry the bill to the floor.

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number 1433 (, as (re)engrossed): Date: 4/13/07

Your Conference Committee House Human Services

attend	For the Senate:	YES	NO	attend	For the House:	YES	NO
✓	Senators Dever	✓		✓	Chairman Weiss	✓	
✓	Sen Lee	✓		✓	Rep. Klein	✓	
✓	Sen Heckaman	✓		✓	Rep. Potter	✓	

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from)

the (Senate/House) amendments on (SJ/HJ) page(s) 1404 -- 1408-14-09

___, and place _____ on the Seventh order.

___, adopt (further) amendments as follows, and place _____ on the Seventh order:

___, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: 4/13/07
CARRIER: Rep Weiss

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: Rep Potter

SECONDED BY: Rep Klein

VOTE COUNT 6 **YES** 0 **NO** 0 **ABSENT**

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE

HB 1433, as engrossed: Your conference committee (Sens. Dever, J. Lee, Heckaman and Reps. Weisz, Klein, Potter) recommends that the **HOUSE ACCEDE** to the Senate amendments on HJ pages 1408-1409 and place HB 1433 on the Seventh order.

Engrossed HB 1433 was placed on the Seventh order of business on the calendar.

REPORT OF CONFERENCE COMMITTEE
(ACCEDE/RECEDE)

Bill Number HB 1433 (, as (re)engrossed): Date: 4/20/07

Your Conference Committee House Human Services

For the Senate:	YES / NO		For the House:	YES / NO	
Sen. Dever	✓		Chairman Weisz	✓	
Sen Lee	✓		Rep Klein	✓	
Sen Heckaman	✓		Rep ~~Schneider~~ Potter	✓	

recommends that the (SENATE/HOUSE) (ACCEDE to) (RECEDE from) the (Senate/House) amendments on (SJ/HJ) page(s) 0200 as follows.

____, ~~and~~ place _____ on the Seventh order.

____, adopt (~~further~~) amendments as follows, and place _____ on the Seventh order:

____, having been unable to agree, recommends that the committee be discharged and a new committee be appointed.

((Re)Engrossed) _____ was placed on the Seventh order of business on the calendar.

DATE: 4/20

CARRIER: Weisz

LC NO. of amendment
LC NO. of engrossment
Emergency clause added or deleted
Statement of purpose of amendment

MOTION MADE BY: Rep Kelzer

SECONDED BY: Sen. Lee

VOTE COUNT 6 **YES** 0 **NO** 0 **ABSENT**

Revised 4/1/05

REPORT OF CONFERENCE COMMITTEE

HB 1433, as engrossed: Your conference committee (Sens. Dever, J. Lee, Heckaman and Reps. Weisz, Klein, Potter) recommends that the **SENATE RECEDE** from the Senate amendments on HJ pages 807-808, adopt amendments as follows, and place HB 1433 on the Seventh order:

That the Senate recede from its amendments as printed on pages 1408 and 1409 of the House Journal and pages 807 and 808 of the Senate Journal and that Engrossed House Bill No. 1433 be amended as follows:

Page 1, line 13, replace "and" with an underscored comma and after "pharmacists" insert ", and certified diabetes educators"

Page 1, line 15, after "pharmacists" insert "and certified diabetes educators"

Page 1, line 21, replace "prescriptives" with "prescriptive"

Page 2, line 3, replace "by implementing" with "from any available funds in the uniform group insurance program and if necessary the fund may add up to"

Page 2, line 4, after the underscored period insert "A state agency shall pay any additional premium from the agency's existing appropriation."

Renumber accordingly

Engrossed HB 1433 was placed on the Seventh order of business on the calendar.

2007 TESTIMONY

HB 1433

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

CITY CENTER PLAZA • 418 E. BROADWAY AVE., SUITE 12 • BISMARCK, NORTH DAKOTA 58501 • PHONE (701) 328-6500 • FAX (701) 328-6505
www.ndbomex.com

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.

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

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**

(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:

<u>Structure</u>

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.

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For more information, contact ECI Communications:
Jayme Soulati, Vice President, Media Relations, 937-312-1363
Julie Weil, Senior Vice President for Public Relations, 262-569-1100
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

#1

PROPOSED AMENDMENT TO HOUSE BILL 1433

Page 1, line 3 after "families" insert ", and to provide an appropriation"

Page 2 after line 4 insert the following:

SECTION 2. APPROPRIATION. The funds provided in this section, or so much of the funds as may be necessary, are appropriated out of any moneys in the general fund in the state treasury, not otherwise appropriated, and from other funds derived from federal funds and other income, to the following departments for the purpose of defraying the cost of additional health insurance premiums necessary to pay the cost of the provisions of this bill, for the biennium beginning July 1, 2007 and ending June 30, 2009 as follows:

Department	General	Other
101 Office of the Governor	$864	$0
108 Office of the Secretary of State	$1,243	$53
110 Office of Management and Budget	$5,119	$1,241
112 Information Technology Department	$941	$14,045
117 Office of the State Auditor	$1,826	$805
120 Office of the State Treasurer	$288	$0
125 Office of the Attorney General	$7,232	$1,470
127 Office of the Sate Tax Commissioner	$6,384	$0
140 Office of Administrative Hearings	$0	$384
150 Legislative Assembly	$6,000	$0
160 Legislative Council	$1,584	$0
180 Judicial Branch	$16,039	$425
188 Legal Counsel of Indigents	$1,392	$0
190 Retirement and Investment Office	$0	$816
192 Public Employees Retirement System	$0	$1,584
201 Department of Public Instruction	$1,413	$3,303
226 State Land Department	$0	$900
250 State Library	$1,233	$195
252 School for the Deaf	$2,212	$113
253 N.D. Vision Services	$996	$300
270 Dept of Career and Technical Ed	$1,224	$96
301 North Dakota Department of Health	$4,896	$11,016
313 Veterans Home	$1,304	$3,062
316 Indian Affairs Commission	$192	$0
321 Department of Veterans Affairs	$288	$0
325 Department of Human Services	$63,181	$36,931
360 Protection and Advocacy Project	$259	$1,061
380 Job Service North Dakota	$66	$14,718
401 Office of the Insurance Commissioner	$0	$2,232
405 Industrial Commission	$2,382	$276
406 Office of the Labor Commissioner	$377	$151
408 Public Service Commission	$1,326	$690
412 Aeronautics Commission	$0	$288
413 Department of Financial Institutions	$0	$1,296
414 Office of the Securities Commissioner	$432	$0
471 Bank of North Dakota	$0	$8,472
473 North Dakota Housing Finance Agency	$0	$2,064
475 North Dakota Mill & Elevator Association	$0	$6,288
485 Workforce Safety & Insurance	$0	$10,711
504 Highway Patrol	$6,241	$3,215
530 Department of Corrections and Rehabilitation	$32,051	$1,875
540 Adjutant General	$3,897	$7,239
601 Department of Commerce	$2,564	$940
602 Department of Agriculture	$1,708	$1,508
616 State Seed Department	$0	$1,440
627 Upper Great Plains Transportation Institute	$224	$1,859
628 Branch Research Centers	$3,369	$1,203
630 NDSU Extension Service	$7,052	$5,325
638 Northern Crops Institute	$302	$236
640 NDSU Main Research Center	$11,415	$5,293
649 Agronomy Seed Farm	$0	$144
670 Racing Commission	$17	$79
701 State Historical Society	$2,560	$320
709 Council on the Arts	$240	$0
720 Game & Fish Department	$0	$7,440
750 Department of Parks & Recreation	$2,302	$122
770 State Water Commission	$3,663	$369
801 Department Of Transportation	$0	$50,520
Total	$208,298	$214,113

Renumber accordingly

EMPLOYEE BENEFITS PROGRAMS COMMITTEE
REPORT TO THE 60TH LEGISLATIVE ASSEMBLY
REGARDING HOUSE BILL NO. 1433

Date: February 2, 2007

Sponsor: Representative Clara Sue Price

Proposal: The bill, as amended by the House Human Services Committee, requires the Public Employees Retirement System to establish a collaborative drug therapy program to improve the health of individuals with diabetes and to manage health care expenditures.

Actuarial Analysis: The actuarial analysis indicates the bill, as amended, will require a $2 per month per contract increase in health insurance premiums which, based on 18,000 active contracts in the uniform group insurance program, will result in additional premium costs of $864,000 for the 2007-09 biennium, approximately 50 percent of which is paid from the general fund.

Committee Report: Favorable recommendation.

#3

03/13/07
SENATE HEALTH AND
HUMAN SERVICES COMMITTEE

HB 1433

THANK YOU, I AM REPRESENTING NDPSC AS VP AND NDPHA AS ECONOMIC ADV. COMMITTEE CHAIRMAN AS WELL AS THE OWNER OF SOUTHPOINTE PHAMACY IN FARGO.

1. THE INITIAL GROUND WORK WAS LAID 1.5 YEARS AGO. WITH PERS. THE NDPHA/NDPSC IS POISED AND READY.

2. NDPHA HAS PROPOSED THIS TYPE OF CARE BEFORE: ND MEDICAID AND ASTHMA. NOT FUNDED. THIS TYPE OF EDUCATION IS VERY SIMILAR TO CMS'S MTMS PROGRAM.

3. NDPHA AND NDSU COLLEGE OF PHARMACY AND RELATED HEALTH SCIENCES IS READY TO PROVIDE SUPPORT TO DEVELOP A STATEWIDE NETWORK OF CAPABLE PROVIDERS. PROVIDERS WILL INCLUDE R.PH'S AND CDE'S.

4. THERE HAVE BEEN INITIAL CONVERSATIONS WITH OTHER PROVIDERS OF DIABETES EDUCATION AND THERE SEEMS TO BE AGREEMENT ON THE NECESSITY FOR A PROGRAM LIKE THIS AS WELL AS A RECOGNIZED SHORTAGE OF PROVDERS CURRENTLY.

5. THIS PROGRAM REQUIRES AN INVESTMENT THAT IF WE ARE AT LEAST AS ½ AS EFFECTIVE AS THE ASHEVILLE, N.C. PROJECT WE SHOULD SEE A SUBSTANTIAL RETURN ON INVESTMENT AS WELL AS A WONDERFUL IMPROVEMENT IN THE WELLNESS OF THE RECIPIENTS. **SEE ASHEVILLE PROJECT DATA.**

6. THIS PROGRAM WILL BE DONE IN CONCERT WITH THE PHYSICIAN'S INVOLVEMENT. ALWAYS HONORING THE PHYSICIAN-PATIENT-PHARMACIST/CDE TRIAD.

7. CDE'S WILL BE ABLE TO CONTINUE THEIR CURRENT PROGRAMS AND I BELIEVE THAT IT WILL NOT COUNT AGAINST THE $1000 CAPS ON CDE PRACTICE OR THE 4 SESSION LIMIT THAT BCBS ND HAS IN PLACE FOR DIETICIANS.

8. WITH AN APPROPRIATION OF $300,000 WE ARE LOOKING AT A PILOT TYPE OF PROJECT. THE APPROXIMATE COST BASED ON 3 INITIAL VISITS AND FOLLOW-UP IS $600.00 PER PERSON. WITH ADMINISTRATIVE, REPORTING AND CLININCAL COSTS, WE WILL ONLY BE ABLE TO SEE 300-400 PATIENTS. IT IS MY UNDERSTANDING THAT THERE ARE ~ 2500-3000 DIABETICS IN PERS.

RESPECTFULLY SUBMITTED

DAVID OLIG, R.PH.

Chicago Tribune

News

Pharmacists score a healthy win as diabetes coaches; Model effort reports success and savings in treating disease

By Ian Urbina, New York Times News Service.
969 words
30 December 2006
Chicago Tribune
Chicago Final
12
English

ASHEVILLE, N.C.

In an office behind the Hershey's candy rack at a Kerr Drug here, Stuart Rohrbaugh shifts in his chair as his pharmacist stares at a dangerously high blood sugar reading from last month.

"I think that was the day a buddy of mine brought over his home-brew beer," stammers Rohrbaugh, whose **diabetes** was diagnosed six years ago.

Silently, the pharmacist lifts her eyes, sending Rohrbaugh's gaze to the floor.

"I know, I know," he says.

Rohrbaugh, 37, learned relatively late in life that he has Type 1 **diabetes**, a malfunction of the immune system that usually surfaces in childhood. There are hundreds in **Asheville** with that type, and even more with the more prevalent Type 2, which often hits as a consequence of obesity or age.

And so in this town of 75,000, Rohrbaugh and the others face the formidable challenge of either managing their **diabetes** or suffering its potential ravages: blindness, organ failure, stroke.

In trying to meet that challenge, the kind of polite browbeating that Rohrbaugh faced at his local pharmacy seems to be paying off.

For 10 years, the city of **Asheville** has given free **diabetes** medicines and supplies to municipal workers who have the disease if they agree to monthly counseling from specially trained pharmacists. The results, city officials say, have been dramatic: Within months of enrolling in the program, almost twice as many have their blood sugar levels under control. In addition, the city's health plan has saved more than $2,000 in medical costs per patient each year.

There are at least 21 million people with **diabetes** in the United States, and health officials have begun to despair of combating the disease because it involves getting people to alter their daily behavior, such as their eating and exercise habits.

But amid this gloom, **Asheville**'s public health experiment is an example, however modest, of the kind of house-to-house, block-to-block battle that can win results and save lives in the face of a disease that has resisted quick-fix solutions.

Indeed, in recent years, about 40 other employers across the country have adopted versions of the program.

Spend $1, save $4

"We get a four-to-one return on investment," said Barry Bunting, pharmacy director at Mission Hospitals, which runs the program in **Asheville** for about 450 city and hospital employees. For every $1 spent on medicines or counseling about diet, exercise and lifestyle, he said, the city saves $4 by preventing emergency room visits, dialysis, amputations or other common complications of **diabetes**.

During the first five years of the program, participants took an average of six sick days from work a year, half the number of previous years. Within three years of enrolling in the program, patients had halved their chances of going blind or needing dialysis or an amputation, a founder of the program said.

"When you have to answer to someone each month, you think twice before eating what you shouldn't," said George Ledford, 69, who joined the program five years ago.

The fifth deadliest disease in the nation, **diabetes** costs more than $130 billion per year in medical expenses and lost productivity in the workplace. While there is no cure, patients can delay or prevent complications by using medications properly and adjusting their diet and exercise routines.

But the efforts to help people change their lifestyles are complicated by a health-care system in which insurers typically do not reimburse doctors for the kinds of counseling and monitoring that might keep patients on track.

So the **Asheville** experiment has enlisted pharmacists in its model. They serve as coach, clinician and cheerleader for patients, and they earn a fee for each session.

"Once you have a sense of what motivates them, you set little goals each visit and then build on them," said Dana Arrington, a clinical pharmacist at Kerr Drug who sees at least one **diabetes** patient a day.

Avoiding relapse

While diabetics have often shown significant improvements in controlling their blood sugar soon after taking **diabetes** education classes, they typically relapse within three months, according to a study released in March 2003 by the Journal of the American Pharmacists Association. The report was co-written by Carole Cranor, a pharmacoeconomist who was then at the University of North Carolina, Chapel Hill.

What makes the **Asheville** Project unusual, the study found, is that at the end of the first year of the program, half the participants had their blood sugar under control. That number increased to two-thirds of the original group at the end of the program's third year.

"**Asheville** had unusually long-term successes because of the distinct role played by pharmacists, who have at least five years of academic training and who are more rooted and accessible in communities than doctors," said Cranor, now a clinical pharmacist at Dorothea Dix Hospital in Raleigh, N.C.

Aside from **Asheville**'s successes, the popularity of the program is being driven by pharmaceutical companies.

GlaxoSmithKline and Sanofi-Aventis, which make **diabetes** drugs, have jointly given about $1 million in the past five years to the American Pharmacists Association Foundation, a non-profit research group, to help promote and replicate the program, said Dan Garrett, one of the founders of the **Asheville** Project and a director at the foundation.

Diabetics frequently fail to take medications consistently, studies show, so drugmakers stand to profit from better patient compliance. None of the employers that adopt the program are obligated to buy from these companies, though.

The frequency of consultations is the reason the **Asheville** Project has shown such long-term benefits, Garrett said.

Document TRIB000020061230e2cu0002v

Regarding the Collaborative Care Bills HB 1432 & 1433:

Chairman Lee and members of the Senate Human Services Committee: 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.

Our model has been duplicated in over 40 sites across the country, from Hawaii to Maryland, with equal or better outcomes.

The current U.S. healthcare system "invests" heavily in fixing people when they break. We have an acute care system, a "sick" care system, not a "health" care system. 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.

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?

(1)

Mar 14, 2007

Senator Tony Grindberg
600 East Boulevard Avenue
State Capitol
Bismarck, ND 58505-0360

Dear Senator Grindberg,

I urge you to support HB 1433, legislation that would improve the health of people with diabetes and reduce the cost of diabetes care in North Dakota.

HB 1433 is intended to reproduce the Asheville Project for state employees. The Asheville Project model was a very successful effort to offer a free, comprehensive disease management program which includes diabetes supplies, medications, counseling, and education at no cost to the patient. These benefits were offered in exchange for the patient's full participation and cooperation with the program. As a result, hospitalization costs decreased so dramatically that they more than offset the preventive care increases for an overall reduction in diabetes care costs. In the first year alone, total mean health costs dropped by $1,828 per patient.

Thank you for your time, and I hope that you will stand up for state employees and their families living with diabetes and support HB 1433.

Sincerely,

Ms. Krista Larson
1781 39th St S Apt 302
Fargo, ND 58103-7178

(2)

HB1433 First Engrossment with Senate Amendments
Senate Appropriations, March 19, 2007
Laura Glatt, ND University System

HB1433, as amended by the Senate Human Services Committee, provides $208,298 in state general funds and $214,113 in other funds for the implementation of a collaborative drug therapy program under the uniform group health insurance program administered by PERS.

Since the provisions of this bill would apply to all state entities, including the colleges and universities, I would ask you to consider amending the bill further to provide funding for the $2.00 per month per contract premium cost as follows:

Campus	State General Fund Share Only
BSC	$6,876
LRSC	$1,800
WSC	$2,340
UND	$32,256
UND SOMHS	$5,875
NDSU	$25,402
NDSCS	$8,316
DSU	$5,746
MASU	$2,755
MISU	$9,329
VCSU	$4,334
MISU-BC	$1,512
TOTAL	$106,541

As you know, Engrossed HB1003 does not currently fully fund the state-share of parity costs (e.g. salary increases, health insurance increases, utilities, etc.). In addition, the bill also limits tuition rate increases to no more than 5% per year. Together, these two actions mean there will not be adequate funding available in HB1003 to fully fund parity costs, much less fund the additional costs associated with HB1433. Many campuses have and will have to continue to reallocate funds from other areas of the budget. This is extremely difficult to do, while trying to maintain access, at a reasonable cost, quality and responsiveness to the students and State of ND.

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POLICY Briefing
FACTS AND FIGURES ON IMPORTANT PHARMACEUTICAL ISSUES

Winter 2004

Better Health & Lower Costs: Diabetes & the Asheville Project

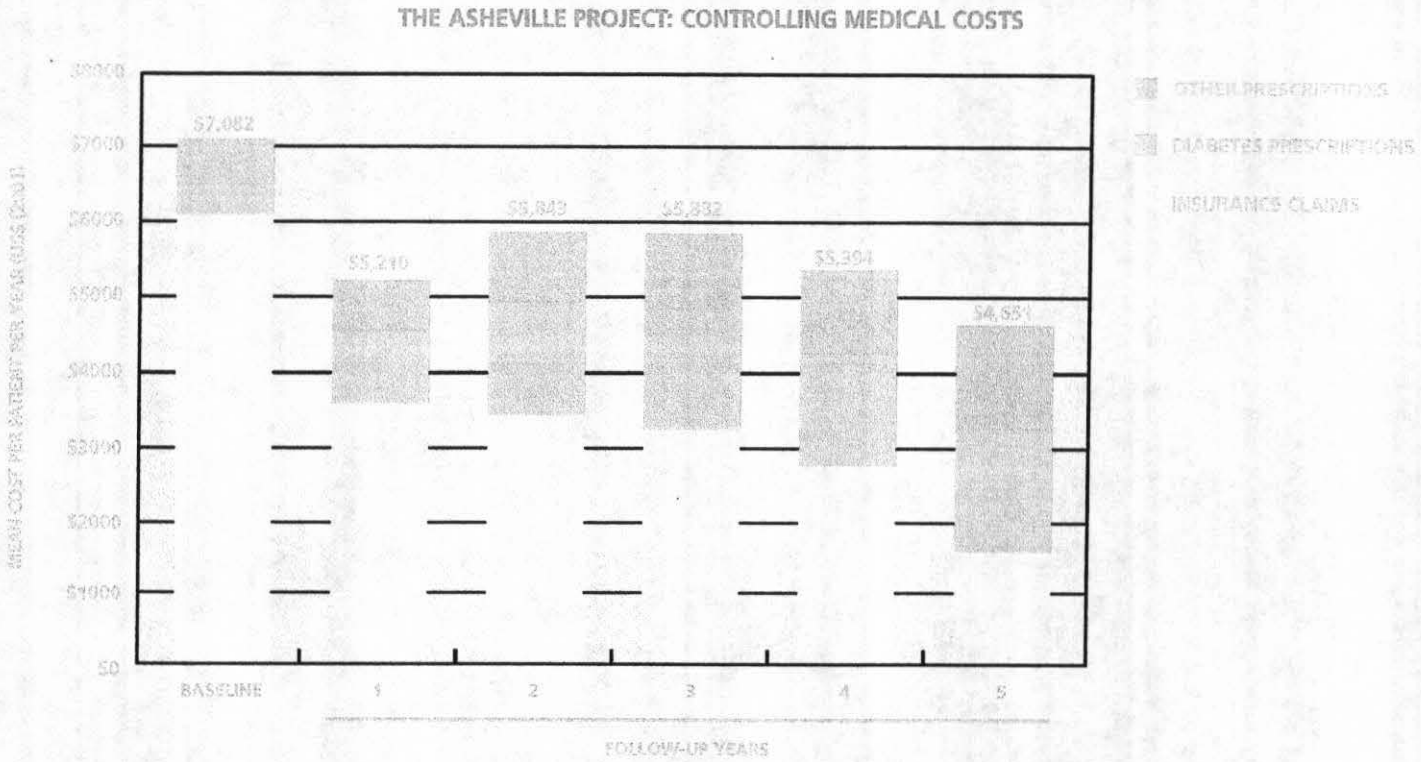
Facing rising healthcare costs and productivity losses, the city of Asheville, North Carolina decided to take a different approach to better manage its bottom line by helping employees better manage their health. The focus was on employees suffering from diabetes and other chronic diseases. In March 1997, the city launched "the Asheville Project," a pharmaceutical care program, in partnership with the North Carolina Center for Pharmaceutical Care (NCCPC).

Specifically, the city and NCCPC agreed to implement a pharmaceutical care demonstration project that could be expanded and used in other settings or diseases, and that would provide measurable clinical and financial benefit to the payers, the City of Asheville and Mission-St. Joseph's Health System.

Under the program, NCCPC trained community pharmacists in diabetes management and offered pharmaceutical care services for city employees with diabetes. The city waived employee co-payments on prescription medicines and medical supplies and offered employees other incentives to participate in the program. Employees agreed to go through a diabetes education program and to meet regularly with a specially trained pharmacist. The pharmacist monitored the patient's condition, educated the patient on medications, and acted as a partner in managing all aspects of the disease.

Five years into the program, project leaders found that both patients and the payers achieved significant results:

- Total annual prescription costs increased over five years from $762 to $2,958 per patient due to shifting of costs from inpatient and outpatient services to prescriptions.
- Annual average insurance claims decreased by $2,704 per patient in the first follow-up year and by $6,502 per patient in the fifth follow-up year.
- Payers realized significant reductions in overall, annual direct medical costs – with savings ranging from $1,622 to $3,356 per patient.
- Patients' A1c (glycosylated hemoglobin) concentrations, the primary clinical measure, decreased (improved) at every follow-up for more than half of the patients, and the number of patients with optimal A1c levels increased over time as well.
- Employees reported a greater quality of life and greater success in managing their diabetes; absenteeism was cut by more than half – from 12.6 days to 6.2 days a year. The result was increased productivity valued at $18,000 per year for the city.



Source: Cranor CW, Bunting BA, Christensen DB. "The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program." J. Am. Pharm. Assoc. 2003; 43(2):149 -59.

The success of the Asheville Project demonstrates the benefits and value of looking at healthcare spending as a whole and encouraging the appropriate use of medicines. Rather than trying to cut expenses and manage employee health and well being by a "budget line" approach, the City of Asheville managers used the right medicines, patient education, and other resources to achieve dramatic improvements in employee health and productivity while decreasing diabetes-related healthcare spending for the city.

Sources: Cranor CW, Christensen DB. "The Asheville Project: Factors Associated with Outcomes of a Community Pharmacy Diabetes Care Program." J. Am. Pharm. Assoc. 2003; 43(2):160-72; Cranor CW, Bunting BA, Christensen DB. "The Asheville Project: Long-Term Clinical and Economic Outcomes of a Community Pharmacy Diabetes Care Program." J. Am. Pharm. Assoc. 2003; 43(2):173-84; Cranor CW, Christensen DB. "The Asheville Project: Short-Term Outcomes of a Community Pharmacy Diabetes Care Program." J. Am. Pharm. Assoc. 2003; 43(2):149-59; Garrett DG, Martin LA. "The Asheville Project: Participants' Perceptions of the Factors Contributing to the Success of a Patient Self-Management Diabetes Program." J. Am. Pharm. Assoc. 2003; 43(2):185-90; Posey ML. "Proving That Pharmaceutical Care Makes a Difference in Community Pharmacy." J. Am. Pharm. Assoc. 2003; 43(2):136-39.

POLICY Briefing

FACTS AND FIGURES ON IMPORTANT PHARMACEUTICAL ISSUES

September 2006

The Avoidable Costs and Consequences of Diabetes

2006

20.8 million people have diabetes

Diabetic complications will cause:

- 12,000-24,000 new cases of blindness
- 44,400 new cases of kidney failure
- 86,000 new amputations

>> Costing the US $132 billion

2025

50 million people have diabetes

Diabetic complications will cause:

- 70,000 new cases of blindness
- 119,000 new cases of kidney failure
- 239,000 new amputations

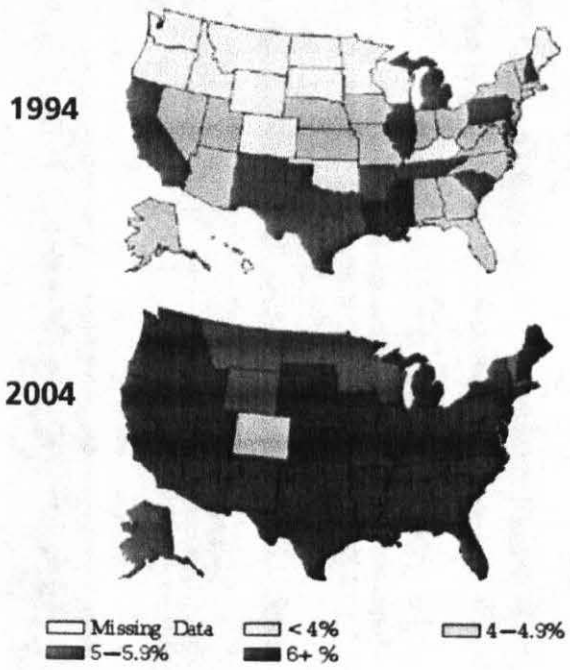
>> Costing the US $351 billion

Sources: Institute for Alternative Futures, "The Diabetes Epidemic: The Case for Changing Diabetes" (Nov. 2005); National Diabetes Statistics, National Diabetes Information Clearinghouse, National Institute of Diabetes and Digestive and Kidney Diseases (2005); American Diabetes Association, Complications of Diabetes

Complications Are Preventable[1]

- Improving blood sugar control prevents complications. Every percentage point drop in test results for blood sugar control (A1C levels) reduces the risk of microvascular complications (eye, kidney, and nerve diseases) by 40%.
- Blood pressure control reduces the risk of heart disease or stroke among persons with diabetes 33-50%, and the risk of eye, kidney, and nerve disease by about 33%.
- Detecting and treating diabetic eye disease with laser therapy can reduce the development of severe vision loss by an estimated 60%.
- Comprehensive foot care programs can reduce amputation rates by up to 85%.
- Detecting and treating early kidney disease by controlling diabetes and lowering blood pressure can slow the decline in kidney function by 30-70%.

Age-Adjusted Prevalence of Diagnosed Diabetes per 100 Adult Population, by State[2]



[1] "National Diabetes Statistics," National Diabetes Information Clearinghouse, National Institute of Diabetes and Digestive and Kidney Diseases, NIH (2005)

[2] CDC, Diabetes Disease Prevalence (2005)

Understanding the Complications

Diabetes & Blindness[3]

Diabetic retinopathy is a leading cause of blindness in American adults, and about half of Americans with diabetes have at least early signs of diabetic retinopathy. It is caused by changes in the blood vessels of the retina. In some people with diabetic retinopathy, retinal blood vessels may swell and leak fluid. In other people, abnormal new blood vessels grow on the surface of the retina. These changes may result in vision loss or blindness. People with proliferative retinopathy can reduce their risk of blindness by 95 percent with timely treatment and appropriate follow-up care.

Diabetes & Kidney Disease[4]

About 30 percent of patients with Type 1 (juvenile onset) diabetes and 10 to 40 percent of those with Type 2 (adult onset) diabetes eventually will suffer from kidney failure. Diabetes injures the small blood vessels in the body. When the blood vessels in the kidneys are injured, the kidneys cannot clean blood properly. The body retains more water and salt than it should, and waste materials build up in the blood. Damage to nerves from diabetes can make emptying the bladder difficult. The resulting pressure in the bladder can back up and injure the kidneys. Also, urine retention can lead to infections.

Treating one patient with end-stage renal disease costs Medicare almost $55K a year, or 7.5 times more than the average Medicare beneficiary.

Congressional Budget Office

Kidney failure occurs when the kidneys are no longer able to support a reasonably healthy state, and dialysis or transplantation is needed. It usually takes five to seven years between the onset of diabetic kidney injury and kidney failure.

Diabetes & Limb Loss[5]

Sixty to seventy percent of diabetics have mild to severe forms of nervous system damage or neuropathy. Results can include numbness or pain in the feet or hands, difficulty with digestion, and other problems. Almost 30 percent of diabetics over 40 have impaired sensation in the feet. Severe neuropathy can contribute to diabetic foot complications, and is a major contributor to lower-extremity amputations. More than 60 percent lower limb amputations not caused by trauma occur among people with diabetes.

"Statistics are not 'inevitability.' They are not 'fortune-telling,' but merely measures of past performance, not absolute predictors of the future. If you have diabetes, the best way to minimize the risk of any of its complications is to 'do as the doctor ordered,' to tightly control your blood glucose. It works--and we have the statistics to prove it."

National Federation of the Blind, *"Voice of the Diabetic" (2003).*

[3] National Eye Institute, Diabetes Eye Disease FAQs

[4] National Kidney Foundation, "Diabetes and Kidney Disease"

[5] "National Diabetes Statistics," National Diabetes Information Clearinghouse, National Institute of Diabetes and Digestive and Kidney Diseases, NIH (2005)