TESTIMONY OF THE

MAINE MEDICAL ASSOCIATION AND

THE MAINE CHAPTER OF THE AMERICAN ACADEMY OF PEDIATRICS

IN OPPOSITION TO

L.D. 148, AN ACT TO AMEND THE LAWS GOVERNING DRUGS AND VACCINES ADMINISTERED BY PHARMACISTS

Joint Standing Committee on Labor,
Commerce, Research & Economic Development
Room 208, Cross Office Building
Tuesday, February 19, 2013

Good afternoon Senator Patrick, Representative Herbig, and members of the committee. I am Gordon Smith, of East Winthrop, Maine testifying today on behalf of both the Maine Medical Association and the Maine Chapter of the American Academy of Pediatrics. The medical association represents the interests of more than 3800 physicians, medical students, and residents in training in the state and the chapter represents more than 200 pediatricians practicing in the state. We are disappointed in having to oppose L.D. 148 as we know it is well intended and we work very closely with pharmacists and their professional association on a variety of issues. In fact, bills on the issue of pharmacists' administering vaccines has been considered in the 124th and 125th legislatures and, earlier this session in L.D. 32. In each case, we think a reasonable compromise was reached. It is very premature to have the proposal come back so quickly before there has been time to fully examine the results of the existing law.

This committee recently considered L.D. 32, an *Act to Expand the Types of Vaccines That May Be Administered by Pharmacists.* Because these were adult vaccines, we did not ultimately

oppose this limited expansion. And in the hearing on the bill, we noted our enthusiastic support for pharmacists providing flu shots. But the bill you are considering today, L.D.148, is very different and let me tell you why.

First of all, as our pediatricians are very fond of saying, children are not just small adults. They are very different than we are, and until they reach adult status and their full growth potential, they are very vulnerable and deserving of society's protection. We have many laws that recognize this and I will not take the time today to note all of those for you.

Secondly, children 9 to 17, whom during those later years we consider adolescents, are among the most challenging patients and yet have some of highest health care needs. Prior legislatures have recognized this by passing several laws since the 1970's which encourage teenagers to see a physician by allowing them to self-consent to care for many different conditions and diseases. We have a difficult time thinking about a fifteen year old male or female approaching a pharmacist to discuss the difficult issues of Gardasil, for instance. A pediatric office or student health clinic would be a more appropriate venue to discuss the risks and benefits of the vaccine and spend time counseling the patient regarding related issues of reproductive health and safety.

And lastly, L.D. 148 threatens the need for all patients, but especially children, to have a medical home. We are very fortunate that the physicians of our state have embraced the need to transform healthcare by emphasizing prevention and primary care. We have seventy-six (76) primary care practices in the patient centered medical home pilot, in which most payers, MaineCare, and Medicare are participating. The most important characteristic of a patient centered medical home is consolidating care of the patient at one site, in one practice, with appropriate support through care management and community care teams. immunizing children

at a pharmacy represents a fragmentation of care and will result in fewer records transferred to the state's immunization information system, ImmPact maintained at the Centers for Disease Control and Prevention as pharmacies do not report to the registry as it is currently structured. Failure to record the shots in the registry could result in repeated shots, adding to health care costs and putting the child through the trauma of another shot, or two or three. Further, because pharmacies cannot report to ImmPact they cannot participate in the state's new universal Childhood Immunization Program. Under this program, the Maine Vaccine Board assesses a fee on payers based on the number of children they cover and then distributes vaccines to physicians, clinics and hospitals at no charge. It is unclear if payers would be willing to reimburse pharmacists for any of the vaccine administered to children outside of this new structure, or if families would be left footing the entire bill.

At one time, Maine had some of the highest immunization rates in the nation. Currently, we are below the national average. There are several reasons for this, but one way to improve the percentage of children who receive all of the recommended childhood vaccines is to link each child to a medical practice reporting to the ImmPact. At the practice level, the vaccines are provided through the new universal vaccine program so that the cost to the family is greatly reduced.

Let me also point out a technical objection to the bill. While it may seem reasonable to you because there will be a prescription from the child's physician or other health care provider, if the family does not report they have an existing relationship with a primary care provider, the immunization can be authorized through a standing protocol with any practitioner in the state. We learned during a previous debate of this issue that the intent was to have a corporate medical

director at central office serve as the practitioner for all the sites in the state. Perhaps that plan has changed this year. We certainly hope so as we do not believe that having a single physician; physician assistant or nurse practitioner employed by a chain pharmacy authorizing immunizations for children across the state is an appropriate standard of practice.

Finally, please also consider carefully the second section of the bill which would allow a pharmacy intern to administer the vaccine to the child. I think it probably goes without saying that if we are not comfortable with pharmacists giving childhood immunizations, we are certainly not comfortable with interns giving them.

Thank you for the opportunity to present our concerns regarding this proposal and I would be happy to answer any questions you may have.

Pharmacists (Position Paper)

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Introduction

The AAFP recognizes the evolving complexity and proliferation of pharmaceutical agents and the important role pharmacists play in the delivery of high-quality health care. The pharmacy professional and physician can and should work collaboratively so that their combined expertise is used to optimize the therapeutic effect of pharmaceutical agents in patient care. It is the intent of this document to define the nature of that relationship.

Background

The increased complexity of pharmaceutical applications is at least partially reflected in the pharmacy profession's decision to upgrade its educational standards. Until July 1, 2000, an individual who wished to become a pharmacist could enroll in a program of study that would lead to either a bachelor of science degree or a doctor of pharmacy degree. As of July 1, 2000, the doctor of pharmacy became the only degree accredited by the American Council for Pharmaceutical Education (ACPE). PharmD programs take six years to complete and usually involve two years of preprofessional coursework and four years of professional education.[1] For the purposes of this document, the terms pharmacist, PharmD, and pharmacy professional are interchangeable.

Expanded Scope of Practice

Like other health professionals, pharmacists are seeking to expand their influence and scope of practice. Expanded roles for pharmacists have been promoted via legislative and regulatory action. Currently, 46 states have collaborative drug therapy management (CDTM) legislation or regulations.[2] These laws allow physicians and pharmacists to enter into voluntary written agreements to manage the drug therapy of a patient or group of patients. The American Pharmacists Association outlined the activities that CDTM may include:

- Initiating, modifying, and monitoring a patient's drug therapy
- Ordering and performing laboratory and related tests
- Assessing patient response to therapy
- Counseling and educating patients about their medications
- Administering medications

Benefits of Collaborative Arrangements

At the core of integrated care models such as the patient-centered medical home (PCMH) and the accountable care organization is the concept of coordinated and team-based care. There is a growing body of evidence that medication management programs can make positive contributions to patient health. In many of these studies, pharmacists lead the medication management programs.

Additionally, pharmacists have an important role in providing direction to patients seeking advice on over-the-counter medications. For the patient seeking nonprescription medication, the pharmacist is positioned to determine the presence of allergies, as well ad adverse reactions between prescription and over-the-counter medications. However, the AAFP recommends that vaccine administration be provided in the medical home setting. When vaccines are administered elsewhere, the information should be transmitted back to the patient's primary care physician and their state registry when one exists so that there is a complete vaccination record.

Relationship with Physicians

Fragmentation of care is one of the challenges in the American health care system. The PCMH and other such efforts to improve collaboration and team-based care models should be encouraged, whereas the development of islands of health care service or further fragmentation of care should be discouraged. In a collaborative environment, the pharmacist is a logical member of a team and is qualified to deal with issues of medication use, medication efficacy, and patterns of medication use. Although the AAFP supports health professionals working together, current policy says that "...interests of patients are best served when their care is provided by a physician or through an integrated practice supervised directly by a physician."[3] This defines the family physician as the coordinator and the pharmacy professional as a member of an integrated team.

"The AAFP believes that only licensed doctors of medicine, osteopathy, dentistry, and podiatry should have the statutory authority to prescribe drugs for

human consumption."[4] The pharmacy professional is in the position to dispense the prescription written by the physician.

Conclusion

The AAFP supports arrangements where the pharmacist is part of an integrated, team-based approach to care. The AAFP believes that independent prescription authority for pharmacists will further fragment the American health care system and will undermine the national goals of integrated, accountable care and models such as the PCMH.

References

1. The Council on Credentialing in Pharmacy, "Credentialing in Pharmacy," September 2000.
2. American Pharmaceutical Association, "Pharmacists Finding Solutions Through Collaboration," www.aphanet.org.
3. The American Academy of Family Physicians, "Integrated Practice Arrangements" Policy.
4. The American Academy of Family Physicians, "Drugs, Prescribing" Policy.

(2002) (December 2011 Board)