

MINUTES
HEALTH RESOURCES COMMISSION
January 21, 2005

Members Present/Phone: Walter Shaffer, MD Chair; Dan Kennedy, RPh; Lynn-Marie Crider, SEIU local 49; Paul Tiffany, Vice Chair; Steve DeLashmutt, MD, and Dean Haxby, PharmD

Members Absent: - James MacKay, MD; and Mark Yerby, MD

Staff Present: Kathleen Weaver, MD, HRC Director; Bruce Goldberg, MD, OHPR Administrator; Betty Wilton, HRC Project Coordinator

1. Call to Order and Roll Call

Meeting was called to order by Chair, Walter Shaffer, MD and roll call taken.

2. Approval of Minutes

Minutes were reviewed for comments. Dr. Haxby noted that on Page 3, names were identified, yet organizations they represented were not defined on the minutes, i.e. "Medical Liaison"

Action: The 11-19-04 Minutes were unanimously approved as amended.

2005 Meeting Dates

Reviewed and confirmed proposed schedule.

3. Drug Class Update

[A-046] a) Dr. Weaver reviewed the roster for TZD's and 5HT3

[A-088] **Action: Subcommittee Rosters for TZD's and 5HT3 were approved as presented.**

Concerns arose for the need for including a family practitioner, and/or emergency room doctor to be involved since these anti-nausea drugs are becoming more commonly used by primary care.

[A-123] b) Executive Summaries of drug classes.

Dr. Shaffer opened up discussion. Dr. DeLashmutt agreed this document was ideal, taking conclusions from the larger documents. Dr. Weaver noted that the full reports are available and should be referenced, though they are not listed here. This is a summary of drugs reviewed and points pertaining to it. The last update is listed and upcoming reports are listed for 2005. Dr. Weaver responded that she used the conclusion, but not the consensus points. Dr. DeLashmutt said he'd like to take this draft to his next medical staff meeting. This report is concise, helpful and consistent from report to report.

Discussion: Content is great, but what format would make this document useful? Email? Web? A laminated pocket booklet? We want it to be presentable and not lost in the shuffle of office papers. ACP may be interested in this draft to possibly use in a PDA downloaded from the internet. Also, the medical letter has drugs of choice. The Medical letter is a good route to funnel this information. We should explore options with these partners after we have polished up this draft. We could also use a companion newsletter to go along with pharmacist's letter.

Dr. Weaver agreed to find out more about the pharmacist's letter. The disclaimer notice may not be strong enough and should include a statement, "This summary is not intended as a substitute for reading the subcommittee reports."

[A-333] **Action: Motion Rescinded**

Motion was made to approve the progress of the draft, to begin to explore possibilities for distribution with previously mentioned organizations, and have test of draft with Dr. DeLashmutt's hospital staff. However, motion was rescinded in consideration that this is still a draft and not yet finalized.

4. Panel Discussions:

[A-430] **Document 5: Charge to HRC**

The HRC is charged to promote the practice of evidence-based medicine. Dr. Shaffer read and expounded upon the document. Dr. Weaver reviewed Evidence-Based Review document describing each organization's works.

(See documents).

Document 6: Panel Questions:

[A-790] Questions were looked over by the Commission and agreed the questions were adequate. Some additional thoughts and questions that arose were:

- Talk to the stakeholders to find out their needs.
- What is the overall perceived impact?
- Who is interested?
- Are we anticipating a financial impact?
- What would be useful to other organizations? What are their needs?
- This is a brainstorming stage! Our responsibility relates to the budget crisis in public funding and to ensure that we are using resources wisely.
- What are the foreseen costs?
- What are the variations in the technology adoption?

[B-001] -How do these goals in process affect the whole of those in need?

Panel 1:

[B-040] **Joanna Zamora, RN (Regence Technology Evaluation)**

The HRC may be helpful to Regence. There are about 300 medical policies that are all evidence-based policies. They rely heavily on the Blue-Cross/Blue Shield as the basis for the medical policies as well as internal assessments. These policies are updated annually. There are medical technologies that cannot be delayed for review because of administrative costs, even when there is a suspicion of over-utilization. For example, MRI, CAT, and PET scans are costly services.

1. We are looking to curb over-utilization of imaging.
Blue Cross, Regence, and the American College of Radiology are working together to look at guidelines from the ACR (1999) to review the 10 most utilized conditions for MRI and CAT scans and update those guidelines. The question now is how we will use them. Providers would rather us not do pre-authorization, but possibly develop guidelines for educational purposes. The HRC could be of help if they did imaging guidelines especially for cardiovascular conditions or for gastrointestinal conditions.

[B-082]

2. Also, guidelines for appropriateness of when back surgeries are necessary. Several minimally invasive back procedures are becoming very popular. The disc-decompression procedures use laser or a radio frequency probe technology that is put in the disc to burn the disc and then allow the disc to shrink down to decompress around the core. Another procedure called IDEC (IntraDiscal Electrothermal Coagulation Therapy) has a significant demand, but the evidence for it is poor.

[B-142]

3. Joanna Zamora requests that state-sponsored information to be spread to health providers. The State could lend a voice to what are good clinical trials and evidence. Our Commission could help by assessing the credibility of the literature about these procedures. CPT has new category codes representing new technologies that offer health plans a chance to start researching out the evidence before getting the plan receives requests for payment. Dr. Weaver remarked that the poor evidence for treatments may be related to the fact that they may offer only temporary relief. Though the device appears to be initially effective, if followed long enough, it might prove not to be in the long term. Three main problems found in these non-invasive procedures is failing to look at long term outcomes, failure to perform trials on sufficient numbers of patients, and failure to conduct the trials to compare the new care to standard care.

[B-172] *Bruce Goldberg, MD Administrator of OHP: The HRC has done great work, but many insurers don't use the evidence. While there is a need and interest, most insurers use their own internal information. Why are insurers doing this differently?*

Joanna - The drug and pharmacy process is separate (dealing with contracts and drug vendors). My section deals with new technology and not with pharmaceutical costs. We don't do cost-effectiveness analyses, but strictly the evidence based assessment. The Pharmacy side is complex because they deal with rebates. We determine the case based on our 5 technology assessment criteria. We may also use criteria and evidence from HRC, Pharmacy, but most likely the highly utilized and standard methods of other technology evaluators.

[B-208] *Dr. Goldberg Question: "What if the commission promoted utilization of under-utilized techniques, such as the use of fluoride?"*

Joanna- "Yes, if that's what the evidence says. Policies we hold are determined as a result of evidence based practices."

Dr. Weaver- "Competing insurers actually work together to gain the best evidence and then to make decisions. Credibility could be given to HRC for a neutral stand (with no cost benefit) to uphold the evidence."

[B-250] **Allison Knight, OMAP** –

Commissioner Question: Diagnostics are a large part of OMAP's costs. Are there ways to follow new guidelines of diagnostic procedures as they arise?

Yes, we can implement and enforce new guidelines. While we have more restrictions around drugs, there is less around procedures. We are interested in achieving positive results for our patients. The reality we face with is a budget crisis! We must make decisions based on evidence of effectiveness; some will be expensive and some won't. We do not intend to duplicate what the

HSC is doing, but link it into our process. If HRC can fill the need to gather in-depth studies and begin to inform us, then that would be helpful. We set policy for OMAP for fee-for-service this policy often is adopted by the managed care plans. It is important that the HRC exists and offers information publicly and reliably. Cost effectiveness is necessary to regard, but effective treatment is ultimately best. While our goal is efficacy, we are faced with the limitations of finances available and must work within that.

[B-285] **OMAPS Specific Needs**

1. Over-utilization of diagnostic imaging (MRI's and CT scans). OMAP may have numbers on that. We'd like good information on these topics.
2. Physical therapies – evidence of effectiveness is questionable.
3. Cost avoidance by using fluoride varnish.
4. Lithotripsy by ultra-sound
5. Radiation implants for oncology
6. Medical record technology – decrease adverse outcomes, promotion of patient safety. Best Practices?
7. Mental health – what are the effective practices?
8. OMAP specific needs to evaluate readmissions from hospital discharges, medical equipment and supplies.
9. Inappropriate ER utilization
10. Injectable drugs

[B-425] *Dean Haxby, PharmD*: A projected 20%- 40% increase of use of an injectable to prevent Respiratory Syncytial Virus (RSV) is expected in the next 5 years. Since it will be an area of fast growth, the evidence based trials will be invaluable. HRC finds that its focus will continue in what are new (such as injectables) rather than standard procedures (such as OMAP is reviewing now). While that is valid for them, HRC needs to advance along with the medical advancements. Evidenced based trials go beyond drugs onto surgical procedures and devices. OMAP looks at what evidence is available and uses it. Any investigational procedures are not covered. It is not uncommon for new technology to not have enough proof of its effectiveness.

[B-518] *Question – what would be your role in assessing new technology, in the evidence based perspective, if there is not enough evidence?*

We ask ourselves, “What kind of evidence is needed given what we do have? What are the unanswered questions? What study could be done? What would answer it?” The drug evaluation process is generating comparisons. By asking the questions, more pharmaceutical companies are coming to EPC for help, from that, more research is in progress.

[B-555] *Question – In regards to medical record evaluation, does OMAP see any cost advantage or health outcomes? What advantages and answers are trying to be arrived?*

We assist funding for federal health centers who are trying to extend the medical records technology and it is in the MMA for providers to use. Do it for the sake of providers to know what to look for, what to be aware of, and for their interest.

Public Testimony

[B-760] Kelly Wright (AMGEN) is a bio-technology company that buys and manufactures and markets a multitude of biologicals from a number of drug classes. The interest is to get OMAP, HSC, HRC involved in biologics in general and establishment of treatment guideline. It is encouraged that the process to establish guidelines will follow the best practices available by

HSC and EPC. We request your help to the work of undertaking this goal. Kudos to this Commission for your dedication to reliable reports. AMGEN manufactures a Hep C injectable [B862] therapy but does not market the product. This product has not yet been looked at by the commission. Biologicals cover two benefit categories: pharmacy benefits and medical benefits. As the EPC involves themselves in the injectables and the commission evaluates them, it is important to consider what perspectives are taken on the physicians' use of the therapies verses the pharmacy billed products. OMAP (and other Medicoids) are required to bill through the pharmacy benefit for long term injectables or long term medical therapies. So then, it will be important to take a holistic review. The Anti-TNF class goes beyond rheumatoid arthritis treatment and involves use in psoriatic arthritis, Crohn's Disease, and juvenile rheumatoid arthritis.

Panel 2-

David Candelaria, MD –

[B-930] He shared his work history and interest in HRC's advancement, then explained process of establishing guidelines for his office.

[2.A-007] Major factors of change are: experience, science, cost concerns, and marketing

[2.A-038] *Panel Question: What would be the HRC's role in this endeavor?*

He replied, "Don't reinvent the wheel. Define your perspective of your position and your perimeters. We need to ask ourselves, 'What should we use our money and resources towards?'"

Panel Question: How would the HRC further define the value of that medical technology?

Who are you trying to please? Realize how big of a job and commitment you are beginning to take on. So, define your audience and your perimeters.

[2.A-117] The therapeutic advances are adequate; physicians assessing evidence and offering an opinion. Adding public is ok, but may complicate the task. Our work is providing for OMAP, but hopefully is useful to physicians, insurers, and the public.

[2.A-170] *Panel Question: Could other organizations "buy-in" to the TAS network process?*

Dr. Candelaria, "Yes, this was how OHP was created. Yes, pharmacists, doctors, nurses, manufactures, and even your audience, the public, need to be a part of the process.

George Waldmann, MD Medicare

[2.A-204] *Panel Question: What are the needs and priority for evidenced-based information from your organization and the HRC's role in this endeavor?*

Dr. Waldman answered, "The process of Medicare (CMS) in Baltimore is to make national decisions for all the states. There are some local decisions allowable. Example: two different drugs for similar use are available and CMS chooses the cheaper one. The local carrier (Noridian) receives complaints and pressure for not using the latest and most expensive drug, though CMS is providing the most cost-effective drug. Many tasks the HRC is undertaking will face many similar political and public pressures. It is important to stick to evidence-based decisions, include all groups involved, and not just expert opinion.

Panel Question: How would the HRC further define the value of that medical technology?

Dr. Waldman replied that the high costs of health care are affecting our nation, Medicare, Medicaid, doctors, etc. The problem is less funds and high costs.

[2.A-444]

1. Imaging – problem is not only high costs and overly used, but its use with entrepreneurs. Imaging is accessible for a variety of public uses and has been marketed extensively. Consumers pay high prices for those diagnostic procedures, and perhaps they are less effective.

[2.A-510]

Dr. Weaver: “There are tests performed where the results falsely show a problem for a patient and that leads to more expensive tests. There are individual costs to the patient and also to the health providers. It’s a result of marketing medicines and technologies.”

2. *Panel Question. Is there any value in making guidelines for medical practice?*

Dr. Waldman “Standard diagnostic tests are performed (although a physician may find it unnecessary) in order to ensure and confirm a patient’s health? Yes, defensive medicine is a factor in practice. A picture is worth a thousand words!” This is done for liability. Yet, the response from a doctor depends on whether the patient had health insurance or not. Doctors were encouraged to pursue testing if the patient had health coverage.”

[2.A-697]

Decisions and Next Steps

Dr. Weaver stated that the Triptan Subcommittee meeting would be next week. When the HRC meets next, we could make a list of questions, criteria and prioritize the panels’ responses.

Dr. DeLashmutt responded that the ideas that arose from today’s meeting were great.

Action: Kathy will offer a summary of today’s ideas, email them, and have available for next meeting.

Dr. Weaver: Another idea to think about was that in the State of Maine they placed a cap on malpractice based on adoption of best office practices. This would be good for us to consider in relationship to patient safety and liability.

Dr. DeLashmutt said, “It is difficult to change practices. The perspective out there is ‘if you don’t you could be held liable and if you go to the protocol you’ll be safe.’ While the medical procedures are in place, there is a real need for guidelines that will hold weight. And if by following the guidelines the fear of malpractice can be taken away, then there can be a dramatic change in practice.

[2.B-803] **Action: Kathy will find out more about Maine’s policies.**

[2.B828] **Meeting Adjourned at 4:30 PM**

Documents:

1. Minutes 11-19-04
2. Meeting Dates 2005
3. Roster
4. Executive Summaries
5. Charge to HRC
6. Panel Questions

Key Questions:

- What are the needs and priority for evidenced-based information from your organization?
- What would be the HRC's role in this endeavor?
- How would the HRC further define the value of that medical technology?

Responses:

- Regence (Joanna Zamora)
 - Diagnostic Imaging
 - CT
 - MRI
 - PET
 - Minimally Invasive Back Surgery
 - Percutaneous discectomy
 - Laser discectomy
 - Intradiscal thermoablation
 - Other Minimally invasive new surgery codes (Check CPT 4 category "T" codes)
- OMAP (Allison Knight)
 - Diagnostic Imaging
 - MRI
 - CT
 - US- Lithotripsy
 - Physical Therapy Modalities
 - Ultrasound and others
 - Fluoride varnish for children
 - Injectable drugs
 - Radiation implants for oncology
 - Electronic health record adoption
 - Patient Safety
 - Integration of mental and physical health
 - Best practices
 - Prevention of readmissions for complications
 - Inappropriate ER Utilization
- TAS/Medical Director MVIPA (David Candelaria)
 - Don't reinvent the wheel
 - Define parameters
- Medicare Carrier Noridian / CMS
 - Diagnostic Imaging
 - Virtual Colonoscopy
 - Minimally invasive surgery for GERD
 - Injectables
 - Implantable cardiac defibrillators
 - Non-invasive coronary artery imaging
- Discussion
 - Fluoridation – Bruce Goldberg, MD
 - Safe Harbor for Malpractice – Steve DeLashmutt, MD
 - Injectables – Dean Haxby, MD

MINUTES
HEALTH RESOURCES COMMISSION
February 18, 2005

Members Present/Phone: Walter Shaffer, MD Chair; Dan Kennedy, RPh; Lynn-Marie Crider, SEIU local 49; Paul Tiffany, Vice Chair; Steve DeLashmutt, MD, Manny Berman; James MacKay, MD

Members Absent: - Mark Yerby, MD; Dean Haxby, PharmD,

Staff Present: Kathleen Weaver, MD, HRC Director; Bruce Goldberg, MD, Alison Little, HSC, OHPR Administrator; Betty Wilton, HRC Project Coordinator, Beth Zehr, HRC Assistant, Allison Knight, OMAP

1. Call to Order and Roll Call

[A-000] Meeting was called to order by Chair, Walter Shaffer, MD and roll call taken.

[A-014] Dr. Shaffer welcomed new commissioners Manny Berman and Dr. John Saultz who was unable to attend because of the short notice. New commissioner member Manny Berman shared his background, then other commission members introduced themselves to Mr. Berman.

[A-092] Betty Wilton's last HRC meeting and Beth Zehr's first meeting.

2. Approval of Minutes

[A-105] Changes to the minutes include the addition Summary Panel Discussion (bullet point summary of the minutes) became an attachment to the minutes.

[A-140] Correction in terms on page 4, change of lithotripsy of gallstones by ultrasound and radiation implants for oncology.

[A-173] **Action:** The 1-21-05 Minutes were unanimously approved as amended.

OMAP Update

[A-175] Allison Knight, OMAP announces changes to the hand out, "Practitioner Managed Prescription Drug Plan" (refer to handout). The list of prescription drugs take effect April 1st. The list can be found on the web and comment period is open until approximately March 22nd.

[A-227] The pharmacy is working on a new version of a pocket drug guide called OHP Plan Drug List (PDL). Copies are nearly completed and will be mailed to OMAP prescribers next month.

- OMAP's goal is to add PDL and OMAP to the ePocrates guide.
 - i. The contracts are underway with hopes to achieve goal in a few months.
 - ii. The PDL and ePocrates are good resources for prescribers for retrieving current information on
 - 1. half-tablet opportunities
 - 2. HRC executive summaries or guidelines.
 - 3. Estimating a number of those who actually make use of our site
 - 4. Refer to a PDL drug for substitution

3. Legislative Update

[A-320] Bruce Goldberg, MD

Dr. Goldberg does not foresee changes in the Oregon Health Plan in this legislative session.

The discussion topics of some upcoming bills in regards to public health are:

- 1) children's health, child obesity, school mandate of physical education, use of vending machines, information and prevention.
- 2) transparency in regards health care costs and quality information. Possibly some improvement for cost, quality, services, pharmaceutical, efficiency in delivery of services (electronic health infrastructure), regional health information, networking organizations, getting information to physician's offices.
- 3) Regulating costs around insurance rates and hospital rates.
- 4) State managing pharmaceutical costs (Public Hearing at the Capital 2-22-05 with the EPC, HRC, and 340b)
- 5) cigarette tax
- 6) expanding state's prescription drug plan starting March 1st,
- 7) not prohibiting mental health drug classes to be reviewed in an evidence based manner.

[A-436] *Question by Dr. Shaeffer: What is the state's role in the electronic information? Are they planning to make use of it?*

Dr. Goldberg: the state may not be in the position to invest the needed money. However, the state is gathering those interested groups to entertain discussion.

[A-612] *Question by Dan Kennedy: What is the status of the program that detected high utilization?*

Ask Allison. It is up and going with 17 drug classes reviewed in it.

Dr. Goldberg: projects that we're moving towards more transparency of costs and quality information around hospital data. Make information public and then add to it as we move forward that will impact consumers, insurers, doctors, etc.

[A-717] *Question by Dr. Delashmutt: Is there any talk about how litigation impacts the lawsuits? There is a lack of data recorded because one puts themselves at risk.*

Dr. Goldberg: agrees that the data is reported with this protection involved.

[A-738] *Question by Lynn-Marie Crider: Is there an actual bill that takes care of this?*

Yes, Senator Morrisette has set up a group policy discussion. While the Health Policy Commission is already making efforts to do this, the bill had been resolved to do the same.

Drug Class Update

[A-775] Kathy Weaver, MD – the revised Executive Summaries were reviewed (see actual document)

- 1) Possibly can use this information with ePocrates.
- 2) Not yet voted upon so work has not been done on the medical letter, American College of Physicians, ePocrates, etc.

[A-902] Dr. Shaeffer offered to vote on the approval of the Executive Summary or wait. If approved, it would be in the assumption that the Triptan report would be revised. Dr. Shaeffer reminded the Commission that HRC documents must be approved before being distributed. Discussion continued that Subcommittee drug class reviews do not need to be re-submitted to HRC since the policy and methods are set in place by HRC.

[A-1.000] Dr. DeLashmutt moved to approve the Triptan report. And the motion was amended to empower the staff to make revisions on the summary document as they are approved by the HRC. Thus, staff will correct the Executive Report for updating without HRC approval. Lynn-Marie Crider made a secondary amendment to have staff prepare and maintain a summary of most current information rather than approving each document.

[B-033] Action: Lynn-Marie moved that staff prepare and maintain a summary report of our drug class evaluations in the general format as been done and continue update reports as new evidence work is done. Dr. DeLashmutt seconded the motion and the Commission unanimously approved.

[B-044] Discussion continued on to the Triptan drug list for corrections and some editing to make drug list understandable.
Executive Summary should be listed on the website under the HRC provider's section.

Triptan Update #2

[B-100] Dr. Weaver represented the Triptan Subcommittee in place of Nicole O'Kane, PharmD. The Triptan Subcommittee was reconvened and held three meetings. As there was attrition of old members, three new members were added, two of them being neurologists, bringing a new perspective to the subcommittee.

New findings since the previous update were:

- Two head-to-head trials added
- EPC received dossiers from a three of the makers of the triptan drugs
- FDA had no new label changes
- No changes to the key questions
- Encapsulation was used in trials and resulted in decreased efficacy for all triptans except Eletriptan

The Triptan Subcommittee presented to HRC a revised list of drugs that they concluded were equally efficacious. None of the drugs appeared superior. But there was lack of evidence to recommend Frovatriptan.

[B-323] Mark Helfand, MD from EPC offered explanations to clarify some points. Subcommittee has attempted to display in Table 2 the comparative evidence of efficacy, yet to display where evidence of trial is absent. There was good evidence to answer Key Question 2. There is not enough evidence to answer Key Question 3, the new statement is "no comparison evidence" (see actual document).

[B-592] Dr. Weaver agreed that some drugs appear superior for 2 hour relief, but the patient may prefer long lasting relief. Mark Helfand, MD clarifies some drugs are meant to be immediate relief while others are long-lasting.

[B-700] The conclusion of Triptan report is that one superior Triptan drug brought to the formulary would be a mistake. Treatment for the patient needs to be individualized (page 17 point #2 of Triptan report). Other methods of treatment and drug form should be available. Triptans need handled as a special case.

[B-819] Suggestion was made to preface Table 2 with a note that the table is a "Partial" Summary of the Evidence. Then at the last of that table to state that there are holes in the evidence. Another suggestion was to have the table devised by Nicole O'Kane be inserted in place of the current Table 2 so that the lack of evidence for some time marks of relief are more

apparent. HRC agreed to have the Triptan subcommittee review these suggestions, but also agree that the summary is well done and needs no revision.

[B-899] No Public Comment was given when offered.

Kathy Weaver, MD will submit comments to the Triptan Subcommittee and the HRC will look forward to the revision for the next HRC meeting.

[2.A-020]. Document 3: Draft Key Questions for Triptan- adding mild migraines, cluster headaches to the draft. No public comments made.

Document 4: Draft Key Questions for 5HT3- the name will be changed to “newer anti-nausea drugs.” Drug use for pregnant women was considered. Dr. DeLashmutt requested to include older anti-nausea drugs to consider. Dr. Weaver reminded the HRC that are goals are comparing drugs, but not finding what these drugs are used for. Dr. DeLashmutt would like to see the comparison of the anti-nausea drugs for mild nausea. No public comments made.

[2.A-110] Document 5: Draft Key Questions for Estrogen- the DERP did not include our questions, however, the EPC will have another Estrogen Guideline Report for the Estrogen subcommittee to review.

[2.A-163] **Dr. Shaeffer moved to approve these three Key Question documents. It was unanimously approved.**

[2.A-190]

Panel Discussions-

1. Alison Little, MD - Health Services Commission

The Commission is charged to maintain and prioritize the OHP benefit packages and the Prioritized List.

Dr. Little shared a packet of information describing the methodology in prioritizing their plans using evidence based trials.

HSC would always like to use the best evidence. It would be helpful to have one more resource to turn to such as the HRC when the HSC needs in depth review of a topic.

2.A-284] Q. *Dr. Little-What items does the HRC want to receive from HSC? I'm supposing that the HRC would not want small or unique cases, but rather would prefer topics where guidelines might be established?*

Dr. Shaeffer: The HRC would entertain those items that involve the biggest impact on health and expenditures.

Dr. Weaver: Such as diagnostic imaging, less invasive surgical back surgeries

[2.A-335]

Dr. DeLashmutt asked if our procedures were compared with technology assessment and other medTAPs. The group answered that it would be interesting to see the differences and important to use the same process.

Dr. Goldberg: mentioned that previously only one medTAP was done per year. It's difficult to get answers using the HRC process in a timely manner. The EPC goes through an expensive, complex process to develop a systematic review. Should the HRC take on this task but there is other information from other review organizations such as Cochrane, NICE, and the Regence/Kaiser TEC readily available for us.

Dr. Little: The HSC is bound to decide the additions of new CPT codes (100-150 come up every year) to the Prioritized List. The commission has to offer decisions even before all their questions are answered as to whether this new technology has proven value.

Q. What would HRC like HSC to focus on?

HRC encouraged HSC to continue what they are doing, keep uncovering more evidence. Blue Cross is a strong resource to them.

Q. Do the Practice Guidelines for HSC come out of the evidence-based process Dr. Little has already described?

Dr. Little: not necessarily, some guidelines were in place before the evidence-based processes were adopted.

Dr. Weaver: The Prioritized List has difficulty defining severity of illness, as the diagnostic ICD-9 Codes are not specific to describe severity. Thus the HSC has developed guidelines to prioritize treatment choices

2. Rick Bennett- AARP

-National website will be up soon

-AARP News insert printed and distributed through newspapers around the state within the next month. Dr. Kennedy's photo is featured! Insert is meant to inform the public about what is available for prescription drugs.

- AARP members are asked to accept more responsibility in the form of cost sharing to finance diagnosis and treatment, even if they have medical insurance. So then, they should have more information available to make decisions about value, which is similar motivation for evaluating the pharmaceuticals.

-AARP website is shown on Consumer Reports – helpful to spreading the information.

-AARP has its own campaign to its members, and are sharing other reports and evidence that's available for them to use. But information resources are difficult to gain in order to make a good decision. These days patients are more responsible for their own health decisions. Any information to help the consumer make value decisions is what AARP is looking for.

[2.A-745]

For the next HRC Meeting March 18th, 2005 continuation of the panel discussion:

Dr. Weaver: requests a place in the panel for George Miller, Patient Safety

Dr. DeLashmutt: Grant Higginson

Lynn-Marie Crider: Jean Thorne

Dr. Shaeffer: Input from OMA for diagnostic imaging (John Moorehead?)

Dr. ?: see where the greatest impact is, an open ended question rather than just imaging.

Dr. Weaver: someone from the professional liability standpoint

Dr. DeLashmutt:

Electronic records escalating

Meeting Adjourned at 4:30 PM

Documents:

1. Minutes 01-21-05
2. Executive Summary Reports / Drug Class Evaluation
3. Triptan Update Report #2, February 2005
4. Key Questions for Triptan, 5HT3, and Estrogen
5. HSC Practice Guidelines
6. HSC Prioritization Process – Attachment A
7. Practitioner-Managed Prescription Drug Plan- Drug Table
8. Panel Questions

Key Questions:

- What are the needs and priority for evidenced-based information from your organization?
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 - Best practices
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- TAS/Medical Director MVIPA (David Candelaria)
 - Don't reinvent the wheel
 - Define parameters
- Medicare Carrier Noridian / CMS
 - Diagnostic Imaging
 - Virtual Colonoscopy
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Members Present/Phone: Walter Shaffer, MD Chair; Dan Kennedy, RPh; Lynn-Marie Crider, SEIU local 49; Steve DeLashmutt, MD, Manny Berman; James MacKay, MD; John Saultz, MD

Members Absent: - Mark Yerby, MD; Dean Haxby, PharmD; Paul Tiffany

Staff Present: Kathleen Weaver, MD, HRC Director; Bruce Goldberg, MD, OHPR Administrator; Beth Zehr, HRC Assistant, Allison Knight, Asst. Mgr. OMAP, Kathy Ketchum, R.Ph, MPA:HA, Rose-Ellen Hope, RPh

1. Call to Order and Roll Call

[A-000] Meeting was called to order by Chair, Walter Shaffer, MD and roll call taken.

[A-005] New commission member, John Saultz, MD shared his background, then the commissioners introduced themselves to Dr. Saultz.

2. Approval of Minutes

[A-059] **Action:** The 2-18-05 Minutes were unanimously approved.

3. OMAP Update

[A-088] Rose-Ellen Hope, RPh presented the 15 Drug Limit Report (see Document 7)House bill 3624 mandated a review of Medicaid patients receiving 15 or more unique prescription drugs in a six month period. There were 6,000 patients meeting these criteria. The Polypharmacy Review Program was implemented last June reviewing over 1,000 patients. The review found 81% are over the age of 50 including 19% who are over the age of 80. 17% reside in a long term care facility and 80% are dually eligible for Medicaid and Medicare. Recommendations are listed on document under Recommendation Statistics.

Feedback has been positive. Greatest problem now is the incorrect or lack of identification of prescribers on claims from pharmacies.

[A-148] Question from Dr. Weaver- Is it easy to identify the primary prescriber?

No, this is a problem. Drugs are prescribed by specialists and/or PCP's. The best route is to find the PCP through the pharmacy where only about half of the inquiries are answered.

Dr. Weaver-is part of the intervention to recommend that there be one person in charge of the patient's prescriptions?

No, not specifically. Not all the patients are required to have a PCP. Also, many patients have multiple chronic conditions and are changing physicians.

Dr. Weaver- 80% are dual eligible persons. Are some of those in nursing homes?

Less than 20% are in nursing homes, and within the other 80% the age ranges from the 30's on up. When the Medicare Modernization Act goes into effect Jan. 1st, all the dual eligible persons will go out of Medicaid. We wouldn't need to be reviewing those clients.

Dr. Weaver- any comment on the proposed legislation changing the standard from 15 to 17 drugs before review?

Rose-Ellen's personal opinion is that it will not change much.

[A-180] Dr. Goldberg- what percentage of scripts are you unable to identify the prescribers and is it any different in this group compared to the population as a whole?

OMAP has a unique identifier for each prescriber but is planning to change that. Residents at OHSU do not have these. Many physicians are not aware that they have an identifying number and are not using them. We provide updated lists for the pharmacists to use. This is an ongoing problem affecting about 20% of scripts; however the situation is improving from 30%.

Dr. DeLashmutt- is it possible to involve CMS?

Kathy Ketchum-no, but we realize that these patients are split between managed care companies. The responsibility goes to several different vendors.

Dr. DeLashmutt- What about Medicare patients without managed care coverage? Are their medicines covered by the federal act or by the state?

Kathy Ketchum- By the Federal Act, but I'll also direct that question on and investigate further.

Ruth Medak, MD- After MMA begins in January 2006, if dual-eligibles do not select a company, then they are assigned within 6 weeks. There will be more information through the QIO contract. In regards to nursing homes, it's potentially disruptive to them making arrangements with pharmacy vendors to oversee their medicine lists and interactions.

[A-227] Dr. Kennedy- How much money are we saving with our prior authorization program? We have saved \$500,000 total per month under the PA process for only four drug classes.

Dr. McKay - Do we know what the generic prescribing rate is for that population?

Kathy Ketchum – no, we don't necessarily from this specific population. But , we know that we had 60% generic prescribing rate for the fee-for-service program including the mental health drugs. Excluding the mental health drugs, the percentage would be approximately 68%-69% generic use rates.

Dr. Weaver-According to USP the national rate of generic use of medication is 47%, so Oregon is better in that regard! This is a time that patients may possibly be on duplicate medications. One proposal is for the FDA to make one name for all drugs and not have both a brand and generic name.

Dr. Saultz- thinks that we're getting close to significant increase in cost on prior authorization systems. It is more likely to have patients switching physicians and physicians are then requiring visits for a re-write in prescriptions. You need to look at the total costs including office visits, rather than just the medication costs. Medicaid seems to have more stability in the formularies compared to commercial plans.

[A-342] Kathy Ketchum presented the Oregon Health Plan Drug List Education Initiative (Document 8). Several items were done in April to increase education of the PDL. First, a survey was performed to determine what amount of knowledge the providers have of the PDL. From that, a 41% response rate was received. A profile was also sent showing the individual prescriber compared to the top percentile within OMAP in compliance rate with the PDL. Also, 7,500 Pocket Drug Guides were sent to the OHP prescribers. In July the first intervention of a change form to the prescriber was sent out as a cover letter describing the selling points from evidenced-based reports on Urinary Incontinence drugs. In this process, the prescriber then made changes, submitted them to the OSU College of Pharmacy who then notified the patient and then sent it on to the pharmacy for claims processing. 412 forms were sent out with the total target

population of 984 providers. Of those providers, 69% returned the forms and 58% said they would accept the preferred product. 46% of the 412 made it through the entire process. We avoided \$240,000 cost with just this one intervention.

The next targeted drugs were NSAID and COX-2 inhibitors (this was prior to Vioxx being removed from the market.) A much poorer response was noted with only 11% making it through the entire process. Still, there were some net savings. If OSU School of Pharmacy did this again we'd see better results. First, the safety issues about COX-2 Inhibitors are now widely known and secondly we now have a better target population to whom to send information.

In January we sent a follow-up survey resulting in a 38% response rate.. Of these 37% responded with supporting the use of the OHP Formulary on ePocrates and 85% of those using PDAs are already using ePocrates in their practice. This survey is biased to OHP prescribers since those were the ones being surveyed. Other interventions include dose consolidation with Mental Health drugs which was implemented in February. For the future, we anticipate taking this pilot project further for more interventions and more frequent interventions

Question from Dr. Weaver – Are there options for half tablets for Statins?

Kathy Ketchum – Yes, that is high priority. There is more gain from half tablets than switching products.

Kathy Ketchum shared the Pocket Drug Guide for 2005. These Pocket Drug Guides are in the process of being printed.

Dr. Schaeffer- Why would there be a difference of the accepted changes and verified changes if the provider's signature allows the change at the pharmacy?

Kathy Ketchum One idea we have is that the preferred product is not an accepted standard under the nursing home records. Those not accepted are most likely in long-term care situations. For example with Urinary Incontinence Drugs, the PDL drug may be considered by the Beer's List to potentially cause geriatric falls. In regards to the non-steroidal review, it might have reached the pharmacy and the pharmacy found that the patient had already failed on the drug listed on the change form or the patient refused to accept the change.

Dr. Weaver- Could it be a system problem by the time it gets to the pharmacy?

Possibly, but pharmacies receive prescriptions back and should have a good capture of that. We tried to make this program fit within the standard of the usual mode of communication.

Dr. Kennedy-Can the half tablet issue be overridden by the judgment of the pharmacist?

Yes. But that information should be passed back to the doctor.

Dr. Schaeffer-Is there an overall acceptance or is there any negative feedback you received?

Kathy- We've received very little negative feedback, primarily with the inaccurate prescriber identification piece. But we've received a hand-written thank you note! Over 60% response rate!

Dr. Kennedy-Is there anything in the works for the prescriber identification? There are multiple identifications now and the system isn't working well.

Yes, in the short term there is a cross-walk being built to populate the state's data base with DEA numbers. Now we have the state's identification for prescribers. Long-term solution is that HIPPA requires a unique provider identification by next year.

Dr. Schaeffer- Have you had negative feedback on using the DEA numbers?

Kathy, yes we have. Other states also have trouble with dummy DEA numbers.

Our tactic is simply to give the information to the pharmacies as best as we can.

We posted a provider number list on the OSPA website for any pharmacist to locate.

[A-588]

4. Panel Discussions-

Ruth Medak, MD - OMPRO

How can the HRC help OMPRO? Dr. Ruth Medak answers that there are ways that the evidence-based reviews can be used in the QIO Medicare mission for quality improvement.

- 1) While great evidence based reports are being produced, they don't always meet the needs found in the community. For some physicians, a big evidence-based review is potentially off-putting and they may not read it. They need something brief.
- 2) OMPRO needs a critical evaluation of evidence ("what" they do versus "what they think they do") and the efficacy of the systems improvement to change results (performance on quality measures or patient's outcome). This evaluation is needed in the practices, hospitals and for verification at OMPRO where we need evidence for systems changes in addition to evidence for efficacy and treatments. . It's not only "knowing" what works, but "doing" what works, and not just what has always worked in the past.

Question-Dr. Shaffer- What do you see as the HRC's role in this effort?

Dr. Medak- It would be worth looking at evidence that reviews the effects of system change.

If there were sufficient numbers of quality studies, it would be a valuable tool to have an evaluation of the evidence for various processes of change. [A-672] She suggests reformatting the report to separate the report in subsets so the hard work is not wasted (small brochure, bulleted points, highlighted, briefly stated, a website for more, etc.).

Dr. Medak-Dr. MacKay, would this be helpful to a doctor?

Dr. MacKay - The physicians need something brief, short and sweet, in order to have an impact.

Dr. Shaffer- HRC and EPC are both aware the reports are not read entirely.

The Evidence-based Report process is still needed, but the way we package this information could be improved. .

[A-777]

Dr. Weaver- Dr. Medak, in the area of liability, is there something we can do for the Oregon physicians on the basis of evidence? Possibly link some incentive to follow guidelines?

Dr. Medak- Yes, as long as they're kept up to date on a regular basis. It would be good to have a set of guidelines for basic things. Though it may improve care, it probably will not improve malpractice (which happens often at the point of changing guidelines). We need to integrate evidence into practice. This may happen best with electronic health records.

[A-863]

Dr. Saultz- There is a denominator problem in evidence-based trials and care. What are we really trying to get to change and who is trying to change whom? Probably the real change will happen when physician groups decide that the science of changing the clinical method is do-able by them and electronic records will empower them to do so. Our focus is to influence the

physicians' decision making, which is harder to do since they're besieged with "the latest and the greatest" information from a variety of resources.

Dr. Medak- what about the possibility to try to get health plans to agree on quality guidelines?

Dr. Saultz- Yes, that would be great. Unfortunately, the health insurance companies are competing for the customer. Change may not flow from the health plans, but rather from the physicians. The patients will ultimately demand improvement from the medical field..

Dr. Medak- But multiple guidelines create more chaos. For instance, the Oregon diabetes guidelines shows what can be accomplished when several major players get together to agree on basic standards. As we move towards electronic records, those who provide the information for it will soon be the source of what is the "best guideline."

[B-000]

Dr. MacKay- Physicians don't make up the guidelines, but the guidelines come from out there. It is good to bring it to their attention that there are gaps in care.

Dr. Medak- We should question and evaluate what we're delivering and what they think we're delivering. One of the best motivators is money- give bonuses for quality!

We're open to finding how we can better use the information you are providing. Let us know!

Kathy Ketchum – With guidelines from one health plan you're only feeding back a little piece of that provider's practice to the provider. Though OMAP compares them to the other OHP prescribers, it's still not an accurate picture.

Dr. Shaffer- The HRC needs think about what to project towards, perhaps systems improvement, electronic health records, reviewing the data, making recommendations, etc. What are we interested in pursuing?

[B-150] *Dr. Weaver – Dartmouth Atlas website has the capability to tailor information to the state of Oregon. A specialist in the Department of Family Medicine will be joining OHSU soon who may be able to discuss geographic variations in practice.*

Panel Discussions-

John Saultz, MD

The Dartmouth Atlas is an organization that researches patterns of medical care and information by demographic regions. Wennberg's paper (document 2) focuses on what the differences are and offers hypotheses on why it is so.

What is the state of evidence-based medicine and what might be the policy questions that arise?

- The Family Physicians Information Network. The goal of the project is to answer any evidence based question that a primary physician can come up with in the exam room in 60 seconds or less.
- The Family Physicians Information Network is building a data base of clinical questions. The questions are collected and prioritized.
 - Clinical Inquiry 2's are ones for which a guideline exists. An answer to the question is available. Most of the Clinical Inquiry 2s are done by community hospital residency programs..
 - Clinical Inquiry 1's require a medical librarian and an evidence-based review of the literature. Most of the Clinical Inquiry 1 is done by university faculty.
- OHSU is a sponsor department for this project and assists in level 1 reviews.

- The organization is partnered with a PDA technology company.

[B-220]

How do we get the right evidence where it needs to be? Is the evidence being provided to the physician or the patient?

A grant submitted from OHSU by David Hiccum proposes along with CERT (Center for Evaluation and Review for Therapeutics) to partner with Consumer Report magazine to issue information and interventions for the patient.

- Partnering with Kaiser since they are using the EPIC electronic record. Kaiser has a wealth of information of national populations of patients in varying practice patterns.
- Something to ponder: we need standard data architecture for the electronic records.

[B-366]

Dr. Goldberg - There is much work being done for electronic records. The need to ensure the same current information is made available. Another issue is identifying individuals in the system.

Dr. Saultz- an issue to consider is that in the past, medical research has been done in academic settings, yet clinical practice continues in community settings. This new model of care may not be possible until the researchers and physicians merge and work together.

Dr. Weaver planned for April's HRC meeting with panel discussions from George Miller (patient safety), and Jean Thorne (PEBB). Also, we could look at more Oregon specific practices; positive or negative.

[B-430] *Dr. Nicole O'Kane* shares on behalf of PEBB. They are looking into Pay for Performance. While they have the current information, they want to make something that works for small practices in addition to large net-works.

[B-538]

5. **OMAP update**

Allison Knight, Asst. Mgr. Program & Policy

- The Secretary of State's office issued an audit on the Medicaid Pharmacy Program to look at opportunities for savings. Their recommendation for saving is to implement prior authorization and add mental health drugs on the PDL. We're prohibited by state law to do those two steps now. The auditors studied a 15 month period and found they could have saved over \$11 million dollars if they could implement these two actions (This amount includes a switch to PDL drugs and supplemental rebates). The report is on the Secretary of State website at:
<http://www.sos.state.or.us/audits/audreports/fullreports/2005-08.pdf>
- OMAP is accepting offers on supplemental rebates for the Inhaled Corticosteroids through April 1st.
- Final stages of negotiations for our PDL on ePocrates.
- Question from last month – can we list PDL options to pharmacies if the patient's prescription is not found on the PDL? While OMAP has looked into that before, it was difficult for them to access the PDL.

[2A-000]

6. Report from Triptan Subcommittee

Nicole O’Kane, PharmD expounded on the Triptan Update Report #2 (Document 6) as presented at the March HRC meeting. She clarified the intent of the Triptan subcommittee and their conclusions that “(1) In comparing the effectiveness and duration of response of different triptans in reducing the severity and duration of symptoms in adult patients with moderate to severe migraine, almotriptan, eletriptan, naratriptan, rizatriptan, sumatriptan, and zolmatriptan were similarly efficacious. (2) For safety all those triptans listed above had similar side effects except evidence was not sufficient for almotriptan. (3) Based on clinical practice there is patient variability in response to triptan therapy. Therefore the triptan subcommittee strongly recommends that alternative triptans be available for clinicians to prescribe. Ready availability of alternate delivery forms is necessary for patients who are unable to tolerate the oral route.”

The Triptan Subcommittee revised the table on page 11 to better reflect their conclusion that rizatriptan was not superior to the other triptans listed as the HRC requested. Commissioners agreed that the Triptan Subcommittee produced what they wanted.

Dr. Saultz suggested that we include citations of the studies in the table on page 11 (like a footnote or bibliography).

Dr. Weaver noted that this update was more extensive than usual and brought this report more in line with the other reports. Also, two neurologists and an internist that were added to the subcommittee brought different perspectives and balance to the final decisions. The report was definitely strengthened by the people involved.

Public comments on Triptans were welcomed, no comments were offered.

[2A-136] **Action: The Commissioners unanimously approved the HRC Triptan Report.**

[2A-147]

7. Drug Class Updates

Kathy Weaver, MD

Roster and Approval of New Subcommittee Members (Document 3)

Action: Vote to approve the Roster.

[2A-220] **Commissioners accepted the new subcommittee members by consensus; pending on their Conflict of Interest forms and Orientations were complete.**

[2A-236]

8. Key Questions – AIIRA (Doc. 4) Newer Anti-emetics (Doc. 5)

When the committee met before, their recommendation was for the ARB’s to be compared to the ACEI’s. That was given back to the DERP and rejected. These KQ are essentially unchanged.

[2A-362] Public Comments were open. One response offered from Mark Winston, Bristol Meyers Squibb Company. He brought a letter from Don Moran of Sanofi Aventis (producing Avpro) announcing that he is offering public comment on AIIRA’s by March 24th.

[2A-400] Key Question to compare newer anti-emetics to the older and less expensive anti-emetics. The offer was refused because the trial would be so huge and the literature on compazine and phenergan is dated. There is a severity of nausea in chemo-therapy or

withpregnancy, so only the more potent drugs are being used for these indications . Name changed from 5HT3 to Newer Anti-emetics.

Dr. Weaver agreed to pursue the change in the Key Questions for Newer Anti-emetics with the DERP again.

Dr. Weaver was requested to find an ER doctor for the Newer Anti-emetic Subcommittee.

[2A-538] Public Comments were open. No comments were offered.

[2A-540]

Action: Motion to accept the Key Questions – AIIRA’s and the Newer Anti-emetics.

Commissioners unanimously approved.

[2A-559]

9. Legislative Update

Bruce Goldberg, MD

- HB 2480- Taking Hepatitis C drugs out of any sort of review management and evidence based reviews and re-categorize the drugs with mental health drugs which we cannot review.
- SB 505- Expanding the prescription drug pool to all individuals regardless of age. Also to relieve small businesses in their prices.
- HB 2025- Fluoride bill passed unanimously out of a committee. Bill will be voted on Monday, March 21st in the House.
- SB 1- Mental health parity was passed by the Senate. We will wait and see what happens.

10. Meeting Adjourned at 4:30 PM

Documents:

1. Minutes 02-18-05
2. “Is More Better?” by John E. Wennberg, MD, MPH
3. Key Questions for Angiotensin Receptor Blockers
4. Key Questions for Newer Antiemetics
5. Triptan Update Report #2, February 2005
6. OMAP Oregon Health Plan Drug List Education Initiative
7. OMAP Polypharmacy Review Program Report

MINUTES
HEALTH RESOURCES COMMISSION
APRIL 22, 2005

Members Present/Phone: Walter Shaffer, MD Chair; Paul Tiffany, Vice Chair; Dean Haxby, PharmD; Lynn-Marie Crider, SEIU local 49; John Saultz, MD

Members Absent: - Mark Yerby, MD; Dan Kennedy, RPh; James MacKay, MD; Steve DeLashmutt, MD; Manny Berman

Staff Present: Kathleen Weaver, MD, HRC Director; Bruce Goldberg, MD, OHPR Administrator; Beth Zehr, HRC Assistant; Allison Knight, Asst. Mgr. OMAP; Kathy Ketchum, R.Ph, MPA:HA

1. Call to Order and Roll Call

[A-000] Meeting was called to order by Chair, Walter Shaffer, MD and roll call taken.

2. Approval of Minutes

[A-020] **Action:** The 3-18-05 Minutes were unanimously approved.

3. Report on Dr. Steve Galson

[A-030] Dr. Shaffer highlighted Dr. Steve Galson's presentation on April 21, 2005. Galson is the Assistant Surgeon General U.S. Public Health Service Director for the Center of Drug Evaluation and Research of the Food and Drug Administration. In his presentation, Galson gave some insights into the FDA, noting that there are some problems with drug safety oversight and their plan to resolve them.

Problems that the FDA faces (much of which is out of their control):

- Black box warnings used on anti-depressants medications to show the increased suicidality (not actual suicides). American Psychiatric Association insisted that the FDA had gone too far and keeping patients away from using a much needed drug.
- There are limits to the evaluation of our studied drug classes.
- Difficult to elucidate side effects from reviews of evidence (such as finding the effects of COX-2 agents while cardiovascular problems are common).
- Time dependant events are hard to pick out from the short term studies
- Off-label events occur. The FDA does not regulate the practice of medicine!
- Untested populations: poly-pharmacy, elderly, other nationalities.
- Safety evaluations are required for drugs, but the methods haven't changed in over 50 years. No national program for long term outcomes of drugs.
- Once a drug is approved, the FDA has less clout. They advise, but cannot require a drug company to follow through with post marketing safety messages and studies.
- Advertising from drug companies is not regulated or pre-approved by the FDA. If needed to confront, it takes money, attorneys and time to do so, and may get resolved much later than when the advertisement stops.

FDA intends to bring change and will focus on:

- Communicating with prescribers
- FDA website communicating more with consumers and prescribers, providing accessible information.
- Drug safety initiatives with the Institute of Medicine.
- Regulating drug company advertisements.

FDA uses experts from the industry and may not be free of conflict of interest. Yet, the FDA will argue that they can't find un-conflicted experts. Congress may give more authority to the FDA. They are interested to know what the FDA can do better that would in turn help our efforts. A bigger issue is the need to place a stronger emphasis on well designed studies. Discussion continued among the commissioners with ideas and areas they see needing change with studies, drug companies, and also reviewed how the HRC process works.

4. OMAP Update

[A-275] Allison Knight, Assistant Manager of Policy and Program of OMAP

First update is that there is very little updates and OMAP is fairly quiet.

Knight announced the drug classes that OMAP is accepting supplemental rebates. The message has been given to manufacturers and their responses are due by July 1st. This would change the plan drug list for September 1st. Drug classes on the list are Alzheimer's, Anti-platelets, Beta-Blockers, Calcium Channel Blockers, Opioids, Oral Hypoglycemics, Proton Pump Inhibitors, Skeletal Muscle Relaxants, and Overactive Bladder drugs.

New Pocket Drug Guide lists were distributed among the commissioners and public.

[A-313] *Mr. Tiffany- How is this (PDL) being received?*

The Communications Department sent out the Pocket Drug Guide with their Oregon Health Plan checks to our prescribing doctors. We're targeting the practitioners.

Also, the information is issued in the college (OSU) DUR newsletter.

[A-325] Dr. Weaver included that she plans several presentations to physicians this year along with a slide show.

Website for the PDL is found on:

http://pharmacy.oregonstate.edu/drug_policy/prescriber_tools.html

or go to Google.com type in "Oregon DUR board" it will be the first selection of the search.

Click on the link, then click on "prescriber tools".

5. Legislative Update

Bruce Goldberg, MD

[A-355] It's not so quiet at the legislature. There are significant problems of health issues in the state. Some themes of discussion are:

- Oregon Health Plan has not had much legislative or policy activity. Possibly a move to eliminate premiums from those who are the lowest of income.
- Lower cost and increase quality of healthcare.
 - Bills to regulate hospital rates
 - Bills to insist on transparency of healthcare information, transparency of health insurance companies, certificate of need.

- SB 505- Expanding the prescription drug pool to all individuals regardless of age. Also to relieve small businesses in their prices. (status: on-going)
- SB 1- Mental health parity (status: passed by the Senate and is now in the House)
- HB 2025- Fluoride bill passed. This is the single greatest health issue for children. (status: unanimously passed out of the House. Senate hearing on Wednesday, April 27, 2005 with the environmental committee).
- Childhood obesity, nutrition, school vending machines. The problem has arisen in discussion, but not much consensus where the state will move towards.
- Professional liability issues.
- Electronic health records. The Senate understands the strategy to improve quality and decrease costs with a state-wide electronic connection among all communities. We can push forward on this topic.
- Budget issues. Revenue forecast in May. There will be a little additional revenue. Co-chairs agreed on amount to spend exceeded the amount they actually had on hand. State seems to be pulling out of its recession. Pressures between health care, public safety and education will continue to exist.
- Issues affecting us as a state will mostly be Medicaid reform. Fiscal crisis we're facing as a nation is Medicare. Decisions will be made in the next year and will likely have a large impact on our state.

[A-480]

Dr. Shaffer updates the HRC and the Panel Discussion members with the HRC process. Our main goal is to improve the health of the people of Oregon. We analyze evidence and promote evidence based medicine. To the panel members, we ask, "How can the HRC be of help to the organization?" and "What information is lacking that you need?"

[A-543]

6. Panel Discussions-

1) Jean Thorne, Public Employee Benefit Board (PEBB)

What PEBB does- Purchase healthcare and benefits for state employees. There are 45,000 members, which include some retirees, (with dependants, 115,000 members). PEBB is the largest health care purchaser in the state. The 8 member board (half management, half labor) is appointed by the Governor, confirmed by the Senate. Dr. Bruce Goldberg sits on the board.

In 2002, the board started to plan for the future to avoid rising costs with a vision for 2007. The focus is to look for better value of their money. One way is to create incentives around evidence based medicine. 1) Make new criteria for purchasing to ensure quality outcomes 2)Accountability 3) Response from the RFP 4) Carve outs for prescription drugs, rather than for specific diseases or conditions.

The board decided to be the selection committee. They started with reviewing medical plan proposals. The first phase was to score on 80% quality and 20% administrative components. Secondly, interviews are arranged with those medical companies. PEBB finds whether the medical proposals are involved in evidence based medicine. The board will decide by June 21, 2005 who they will have for 2006 for a three year contract. Contract will be renewed annually on the basis that the companies follow through with the plans they proposed in the contract.

Thorne encourages the HRC to continue in evidence-based reviews. This is one main cost effective method and gives better value for the money spent.

[A-863] *Dr. Goldberg* included that the goal is to deliver better care. Our hopes are that we not duplicate, but combine efforts.

Ms. Thorne – PEBB is taking the first step to look for better outcomes even when it's not been asked for yet. Bringing clinicians together to hear what they see are needed outcomes, then have purchasers decide how they want to use those outcomes. There are other purchasers waiting to be a part. They realize PEBB is leading the way to what may become the common way. PEBB is asking itself, "how can we use our leverage to be a catalyst for change?"

[B-000] *Dr. Weaver*-Would help if there were agreement on the criteria for pay for performance?

[B-011] Ms. Thorne is proposing the challenge to providers, what are they doing, what are they proposing to do with the evidence-based reviews. PEBB is not made up of medical professionals, but will push forward to the new.

[B-030] *Dr. Saultz* applauded Ms. Thorne and PEBB for moving on the right track. Insurance companies cannot change clinical practices. The evidence-based medicine is meant for the clinical encounter of physicians and patients, not insurance companies and employers. Then some better directions for PEBB may be to have a process of evaluating medical practices (not health plans) to decide whether they are where they need to be in regards to evidence-based practices. The companies are competing in the market for advantage. Any health plan is a small part of a doctor's overall practice. So then, grade the medical practices. Another way is to grade the patients to find whether they're being managed correctly. The efforts of PEBB could be better directed by influencing the patient and physician. The payment system is too crude.

[B-065] Ms. Thorne noted to HRC that PEBB not only works with insurance carriers. PEBB is not in the situation to contract with all medical practices, but with those who will support the evidence-based practices.

Panel Discussions-

Susan Allan, MD-

[B-101] Public health is struggling nationwide. The story here in Oregon is no different than what is seen elsewhere. Public Health and evidence-based medicine has an interesting similarity. The strength of Public Health is epidemiology which is evidence-based and works with populations. We start with an assessment of key issues and paired that to the greater concern within the community. Oregon is one of the least funded by state investment, and overwhelmingly driven by federal dollars. With that, the federal funds determine the state of Oregon interventions. Public Health staff then, work dedicatedly to choose what to focus on and also take what filters down from the federal decisions and put into a relevant Oregon framework

Examples

- State funding stopped tobacco prevention programs. While the programs were effective, the tobacco use increased when the programs were shortened, then discontinued.
- Breast feeding promotion. WIC program helps track what is happening.
- Tuberculosis may not be seen much in a doctor's practice, but it's a potential problem for public health.

[B-177] Public Health is faced with a difficulty in promoting activities for better health when dealing with populations along with the specific patient. Patient impact of following health guidelines may be slight. However, it may have a significant impact on the populations as a

whole. The challenge is to convert these health recommendations into a clinical action and a community action.

Public health is in the political arena and is asked to do things that may have poor or no evidence-based conclusions. It gives us a sense that we are asked to drop our very framework and core guidance for public health improvement; evidence-based medicine. Also, we are undertaking many topics of educating the public (abstinence, fluoridation). Family planning funding is under assault because it's thought to promote more abortions, though its intent is to see healthier babies and families. Even when holding solid evidence, it can be disregarded or changed.

[B-226] Dr. Saultz comments that resolving the issues are political and not limited to science and evidence-based practices. It may also be social issues with each patient; they are motivated by what they fear, not by evidence. The government oversees the public health system while the patient oversees their own health care encounter.

[B-283]

Panel Discussion

Robert Dannenhoffer- president of the Oregon Medical Association

OMA has 7,200 member physicians in which they support the physicians as they improve the health of Oregonians. Medicare has had a large affect on Oregonians; many have had a difficult time finding a physician who will accept OHP. Also, there are difficulties to recruit in rural areas. Medicare funding projections to 2019 are overly optimistic and thought to really not last beyond 2010.

[B-304] While we can't solve bigger problems, there are things we can do:

- OMA and HRC could work together better. OMA can receive the information of evidence-based drug class reviews and spread the news to their physicians. Physicians receive so much information, they want clear and unbiased information and rely on that from the OMA. OMA partnered with HRC can accomplish much together to empower the physician
- Pay for performance.
 - Skepticism of pay for performance because it's more complex than just the process (what does the patient want? patients don't always comply)
 - Physicians may not always clear about what is the best medicine due to the overwhelming amount of information.
 - Pay for performance does not offer more money in the system, just a shuffling of existing money. Some of the performance is outside the physician's control. Patient compliance is a big part of outcomes.
 - Patients who have the most needs may not find access to care as they will not have favorable "performance."
 - We recognize pay for performance is coming.
- Electronic Health Records
 - Paper based records are out of date; they're no better than they were 100 years ago. This needs to change if we are to improve communication.
 - High initial costs.
 - Will bring changes in the human interaction of doctor/patient visit.
 - HRC can be a resource to small practices to adopt electronic health records.

- Fluoride
 - Younger generations of physicians are more interested in the community health and public health initiatives. They see the need expand from one patient to the entire community.

[B-463] Discussion opens to others comments made concerning the state of Oregon. Susan Allan, MD remarked that Oregon is ahead on the discussion of public health compared to other states. It may possibly be because of the OHP and the state making health concerns public policies. Dr. Weaver commended the HRC subcommittees for being ambassadors for change and going back to their own communities and practices with the information they acquire. One of our most important objectives is to release the information and educate physicians; this should not only be routed to OHP. OMA has helped distribute information for AARP and can continue to educate patients in their own doctor's offices. Patient satisfaction is most important to a physician. It's important to make consumers wise. Electronic records discussion included the needs to develop important information at the beginning, costs to develop, training needed, and offering community help.

[2A-010]

7. Drug Class Updates Kathy Ketchum, RPh, MPA:HA

a) Additional Drug Classes

Kathy Ketchum asked HRC to consider which drug classes to request to review. There will be five new drug classes to reviewed this next year; we have a vote on which ones we'd like to have done. HRC's requests will be taken to the Governance Meeting in late May.

Another topic to consider before the Governance Meeting is whether to fully review the TZD Glitizone drug class (for diabetes). Normally the reviews are drug-to-drug comparison within a class. TZD is often prescribed for off label uses (for pre-diabetes, metabolic syndrome, polycystic ovary disease, obesity, preventing cardiovascular diseases, and hyperlipidemia).

b) Additional Subcommittees

HRC was also asked to authorize activating new subcommittees for the drug classes for Non-Sedative Hypnotics and Second Generation Antihistamines (lines 49 and 51 of Doc #4). EPC Reports have already been issued.

[2A-168]

Kathy Ketchum provided the HRC with the 2005 Top 100 drug classes arranged by price and use. Ketchum ultimately suggested the other drug classes that were options to consider:

- Beta Agonist Inhalers-line 17,
- Insulins –line 18,
- Hematinics-line 41,
- Sedative-Hypnotics –line 49,
- Antihistamines – line 51,
- General Bronchodilator Agents – line 68,
- Pulmonary Hypertension drugs-line 92.
- Growth Hormones – line 32

[2A-212]

Paul Tiffany moved to adopt the recommendations made by Kathy Ketchum of the new drug classes to review. Lynn-Marie Crider seconded the motion to further discuss the topic.

Discussion continued with the clarification that this same process of authorization from HRC has been done previously and resulted in drug classes reaching the PDL. Insulin drugs have been considered before, but were not included because it is a difficult drug class to. Some insulin drugs are used in combination with other drugs and this factor limits the review being done. Beta Agonist agents and Inhaled steroids were considered.

[2A-330]

Action: Acceptance of the five suggested drug classes for review shaded on Doc. #4 was unanimously approved.

Dr. Weaver presented the past HRC Minutes from July 16, 2004, item 3, wherein Non-Sedative Hypnotics was discussed and needed to pick up at the time of our first update. We have already paid for the EPC reports and they are now available. Dr. Weaver requested the HRC to activate new subcommittees for Non-Sedative Hypnotics and Antihistamines.

[2A-360] **Action: HRC approval and authorization for new subcommittees to begin for review of Non-Sedative Hypnotics and Antihistamines were unanimously approved.**

[2A-370]

8. HRC Policy- Conflict of Interest

Dr. Weaver announced April as the annual renewal of each HRC members' Conflict of Interest form. To simplify, there is one sheet to sign and date if there are no changes since the form was last completed.

Every subcommittee volunteer is also under this policy before their participation in the drug evaluations. Dr. Weaver shared the concern that there is not a written policy to renew their Conflict of Interest forms annually. Dr. Weaver asked the HRC to consider this because the volunteer subcommittees reconvene after several months to a year due to the EPC report and drug review schedules. Conflicts of interest may be present within that time.

Action: HRC unanimously approved to adopt a policy where each subcommittee volunteer is to complete a Conflict of Interest form, or update their previous form as the case may be, and be found free from a conflict of interest within one calendar year before their participation as a voting member in a subcommittee meeting. No other changes to the Conflict of Interest policy were made.

[2A-409]

9. Drug Class Updates- Dr. Kathy Weaver

a) Key Questions for HRC information:

- 1) Targeted Immune Modulators
- 2) Statins update #4- suggested including renal impairment.

Public Testimony was open, no comment was made.

[2A-470]

10. Report from Inhaled Corticosteroid Subcommittee (Document 7)

Dr. Weaver spoke on behalf of Dr. Earl VanVolkinburg –

The ICS subcommittee met for four meetings focusing on treatments for asthma and chronic obstructive pulmonary disease (COPD). A difficulty in review is the delivery devices and product formations differ affecting the outcomes. Another difficulty was a patient's compliance and dosage amounts.

Dr. Weaver highlighted areas of discussion: Key Question 2; the subcommittee had agreement. The ICS subcommittee was disagreed about Key Question 3 in the summary on Page 11 (whether to include the last two bullet points containing facts upholding Budesonide for pregnancy.) The HRC decided to move the comments referring to Budesonide which holds a category B rating, out of the summary box. The notes were moved to the paragraph in the section under pregnancy. It was agreed that HRC's decisions are not to re-evaluate FDA approvals, but evaluate the evidence of efficacy. This is in concordance with our other HRC reports.

Public comments on Inhaled Corticosteroid were welcomed, no comments were made.

[2A-753] **Action:** The Commissioners unanimously approved the HRC - ICS Report as amended with changes made to the Key Question 3 Summary box. (See final HRC ICS Report).

[2A-760]

Upcoming HRC meeting schedule has been changed.

HRC agreed to meet on Friday, May 20, 2005 and there will be no meeting for the month of June.

10. Meeting Adjourned at 4:30 PM

Documents:

1. Minutes 03-18-05
2. Conflict of Interest renewal sheet
3. Minutes of 07-16-04
4. OMAP FFS Top 100 Drug Expenses
5. Key Questions – Targeted Immune Modulators
6. Key Questions – Statins update 4
7. ICS Report from subcommittee

MINUTES
HEALTH RESOURCES COMMISSION
MAY 20, 2005

Members Present/Phone: Walter Shaffer, MD Chair; Paul Tiffany, Vice Chair
Lynn-Marie Crider, SEIU local 49; John Saultz, MD; Dan Kennedy, RPh; Steve DeLashmutt, MD;
Manny Berman

Members Absent: - Mark Yerby, MD; Dean Haxby, PharmD; James MacKay, MD

Staff Present: Kathleen Weaver, MD, HRC Director; Beth Zehr, HRC Assistant, Allison Knight,
Asst. Mgr. OMAP, Kathy Ketchum, R.Ph, MPA:HA,

1. Call to Order and Roll Call

[A-000] Meeting was called to order by Chair, Walter Shaffer, MD and roll call taken.

2. Approval of Minutes—Walter Shaffer

[A-014] Correction: Manny Berman not shown as being absent.

Action: The 4-22-05 Minutes (Document 1) were unanimously approved.

3. Drug Class Updates — Kathy Weaver, MD

[A-038] Statin Key Questions update #4 (Document 2)– These Key Questions were shared in April’s HRC meeting as well. Dr. Weaver wanted to make it known that the Center accepted changes at the last group phone call as the HRC suggested. Changes made were the correlation between the magnitude of the LDL-c lowering and risk reduction for cardiac outcomes and also correlation between LDL-c lowering and adverse effects. An addition was to include renal toxicity to the outcomes of adverse effects. No HRC approval was necessary. This was shared for information purposes showing that our input can make a difference to the outcomes. Changes are labeled “proposed” because they’ve been verbally accepted, but not yet reflected in the EPC documents.

[A-064] Dr. Saultz- in this document, the proposed changes are labeled 2A and 2B, both concerning LDL lowering. However, KQ2 original concerns HDL rising. Dr. Weaver thought the EPC would re-number the KQ to clarify. Dr. Saultz also suggested that Question 2A should be worded better to show a relationship between how much the LDL is lowered and how much the risk of cardiac outcomes changed. The correlate of Question 2A would be, "Does how much you raise the HDL, what is the evidence that it affects the risks for cardiac disease?"

Dr. Weaver will share the suggested change with the Evidence-based Practice Center.

[A-086] Dr. Shaffer noted that the word, “statin” does not appear in the document, and that is wanted. He suggested a change of the question to read, “Does the LDL lowering that you get from using statins correlate with cardiac outcomes?”

HRC did not need to formally adopt the Key Questions, but to have a consensus.

[A-132] Dan Kennedy, RPh gave an update from the Standing Update Committee. The SUC met on May 10, 2005 in a quorum meeting. The Skeletal Muscle Relaxants (Document 3) and Oral Hypoglycemics reports (Document 4) uncovered no new findings to have any affect on the summaries. Public Testimony was open, and no comments were made.

[A-194] Dr. Saultz commented that all the drugs listed for the Oral Hypoglycemic drug class are not all oral drugs. The title is inaccurate.

Discussion continued with ideas for a new name and though it's not entirely inclusive, no new suggested title was named. Dr. Weaver agreed to share that with the next Governance phone call.

[A-251] Dr. Saultz moved to accept the Oral Hypoglycemic HRC report and the Skeletal Muscle Relaxant HRC report. **OH and SMR HRC reports were unanimously approved.**

[A-262] Opioid report (Document 5) updates considered several new trials including high dose vs. low dose, and placebo vs. every other day dosing, and constipation results of the drugs. There is an idea of opioid rotation which is using different opioids on a rotational basis to decrease the amount of tolerances and increase the effectiveness in specific opioids. Updated data in Emergency Room use of opioids – increase in use, but no mention of which opioids used. Public comment from Dr. Rosenbloom offered his concern about methadone safety because in the general population it increases mortality. SUC considered the need to insert information on this update report indicating that safety in using methadone is a high concern. The questionable safety of methadone should be mentioned, but the SUC could not make a statement due to lack of evidence. SUC passed the report as issued to the HRC and none of the consensuses were changed.

[A-356] Dr. Weaver commented on an observational study on page 9 near the top. The SUC decided to keep the mention of over dosage of methadone leading to death. However, there is no accurate determination of number of patients using methadone and number of patients using oxycontin. OHP has an alternative to methadone and several other health care plans have conversion tables for alternative pain meds.

Dr. Saultz considered there is likely more safety data available in opioids other than in chronic pain patients. We must look elsewhere (look at methadone and its adverse effects, not at chronic pain patients and their use of methadone).

[A-431] Dr. DeLashmutt mentioned that some conversion tables are wrong for methadone. Other narcotics block methadone metabolism and should start a patient on small amounts of methadone. Kathy Ketchum, RPh, knew that the American Pain Society planned to correct their conversion table. Dr. Weaver stated that with the use of methadone, there is a disassociation between the dosage for pain relief and respiratory depression.

[A-474] Dr. Saultz was interested to find whether there is a difference across these medications as to whether there is an abuse potential. Lynn-Marie Crider also agreed that a clarification is needed for the potential abuse. But since there's no evidence, the HRC has no need to decide, but rather, make a statement that there is no firm evidence. Dr. Shaffer supported that issue and made a plan to make a word of caution about methadone, though it should not appear in the summary boxes. Dr. Weaver agreed to look at past Opioid reports for mentions of methadone and email it to the Commissioners.

[A-546] Public comment opened, no comment was made. It was projected by Dr. Weaver and Kathy Ketchum, RPh that the next Opioid update (#4) would most likely involve some new drugs and would need reviewed by the original subcommittee.

[A-575] Dr. Shaffer moved to approve the HRC Long-acting Opioid report and the report was unanimously approved.

4. OMAP Update – Allison Knight, Assistant Manager of Policy and Program of OMAP [A-590] OMAP started a new type of managed care organization on May 1st, 2005 called Physician Care Organization. This handles all the same services except for in-patient hospitalizations and Kaiser is the health plan on board, and this is a new model of managed care for OMAP. This is considered managed care and the clients seeing physicians within Kaiser on a fee-for-service basis are moving into Kaiser Physician Care Organization. It's a capitated arrangement. OMAP is looking to expand this in regions where there is not fully capitated health plans.

Update for proposed PDL list goes into effect July 1, 2005. Public comments are due to the department on June 17th. The changes are within the ICS class (pg. 6).

OMAP is moving away from sending less mail and relying more on email and web-based information. Program changes and notifications are on the website. Interested persons may sign up for which type of emails they'd like to receive. Those without computers will continue to receive regular mail. Client notices will be sent by mail, the emails are mainly for the providers.

[A-670] Dr. Saultz shared his perspective of the PCO program in the 1980's and liked that OMAP is trying this approach.

[A-724] Allison Knight updated the HRC on the ePocrates and announced that OMAP is moving forward, but have been delayed much longer than expected. Hopefully in the next month or so we should see the results. Dr. Weaver's experience in education in evidence-based medicine and the PDL has shown that the prescribers are requesting the accessibility on their palm pilots.

5. HRC Policy Issues

[A-807] Dr. Weaver referred to HRC statutes (Document 6) to review that HRC is required to meet at least once every two months. We have done that, but have come close to not having a quorum. The intent of the director and chair is to make HRC meetings scheduled in advance and worth the while of those who attend. Dr. Weaver is in the process of recruiting a business representative member for the HRC and will soon need to replace our public member, Paul Tiffany. Dr. Shaffer asked the commissioners to make the HRC a priority for every member. Since our schedules may conflict and our professions may be demanding, we have come close to not having a needed quorum. Dr. Shaffer also suggested the possibility that HRC is meeting more often than necessary. Now that the drug review process has become routine with the information being handed down to the HRC, it's possible that we as a group are engaging less and find we are less likely to feel that our attendance is needed.

[A-943] Dr. Weaver proposed an adjusted HRC schedule due to the timeliness of reports issued: No June Meeting

Next meeting will be Friday, July 22, 2005 at 1:30 p.m.

No August Meeting

Meet on Friday, September 23, 2005 at 1:30 p.m.

Aiming for once every other month for a while might help us to combine our work, utilize our time together, and soon to re-focus on what the future direction of the HRC. If a new project is supported by the HRC we may gear up again, but we suggest our meetings should accommodate the amount of work needing done.

[A-986] Dr. Saultz commented that it is unclear as to why the panel discussions are a part of the HRC agendas in the past months. The variety of the topic discussions has been nebulous to the purpose of the HRC. With agreement, Dr. Shaffer answered that the purpose is to get input as to what the HRC might do besides drug reviews. It is to inform our decision making. It is part of the process of what we could do to answer the questions and partner with relevant issues among our networking partners.

[B-043] Dan Kennedy, RPh inquired about any legislative moves to expand SB 819 to include mental health, cancer, or HIV drugs. It appears that the HRC is in search of a mission at this point and there are considerable savings if we were to take on these reviews.

Dr. Weaver spoke with Dr. Goldberg and found that there has been nothing new. The Medicare modernization act taking out those who are dually-eligible has taken away some of the savings that would have been available. Mental health drugs are worthwhile to pursue as there is up to 10 million dollars to be saved. We'll have to wait for the next biennium.

Allison Knight commented that an audit was done showing the possible savings if the mental health drugs were approved for the HRC to review by state law. This would also spare OMAP of doing prior authorization policies.

[B-078] Dr. Weaver said that the Mental Health drugs have been reviewed by the EPC and are now available. We would not be paying any additional money to access the reports. Dr. David Pallock with the Partnership for Psychiatric Medication Access (PPMA) does some change forms like splitting pills, better dosing, and no multiple mental health meds. While there is good work being done by organizations such as PPMA, still there are issues going in a different direction such as the bill that has passed the Senate to add Hepatitis C drugs to the list of drugs the HRC cannot formally review.

[B-092] Dr. Shaffer was curious as to what the HRC can do to advance the mental health drugs included and personally spoke with Dr. Goldberg in the past. Dr. Goldberg didn't think efforts to persuade the legislature was the HRC's role. There would need a political force behind the issues.

Dr. Weaver offered statistics of the other 28 states involved in a state Medicaid formulary, 14 of them have mental health drugs. Other states are moving in that direction as well. Since safety and efficacy are the core purposes for our Oregon formulary, then mental health drugs should be included into that criteria.

Kathy Ketchum, RPh suggested looking at the Medicare Modernization Act and seeing how new things fit into that besides prescription drugs. In 1990 over 90 in Medicare Modernization Act shifts the balance of purchasing for drugs into Medicare. That purchasing model is more than likely going to drive the policy. If we stick with prescription drugs, or for whatever the HRC chooses to do, then it should fit into the Medicare Modernization Act. Regulations provide for two drugs per class, mental health drugs offer more than two.

Dr. Weaver had considered drug reviews for mental health drugs within the HRC but not to release and process the information and reports as is done for all the other drug classes until finding that it would be very difficult to take that on politically. The HRC has been discouraged from doing that. In the past, the HRC has discussed the possibilities of including mental health drugs, injectables, combination drugs, and comparing different classes of drugs (rather than the comparative trials performed within a class, i.e. medicines for hypertension).

[B-144] Summary of responses from panelists this year shows some possible directions for the HRC to go. (Document 7)

Dr. Shaffer led how the HRC could prioritize this list to have the highest impact on Oregon health status:

- To save on costs or improve the value of health care expenditures
- Identify areas of information that is lacking
- Promote evidence-based medicine
- Look for areas to develop partnerships with stakeholders

[B-180] Electronic Records came up in HRC meetings frequently- some obstacles are the high costs and set up, the uncertainty of needed data, uncertainty of improving quality of health care and cost effectiveness, combining medical info with computer and technical info.

Dr. Saultz - HRC could help define the core attributes of an electronic record and provide guidance for the needed outcomes of an electronic record. If the state intends to give advantage to doctors who have an electronic record, then they should talk about what the make up of the electronic record should be. Otherwise, a low standard of records may be created and the outcomes less desirable.

[B-297] Another item to further discussion of interest: Emergency Room use, imaging policies, drug and alcohol abuse – punishment vs. treatment policies, Critical access hospitals program and proliferation of additional Federally Qualified Health Centers. Adding it through FQHC improves access, though true, is it good public policy to start more? Federal government puts money into FQHC then leaves them under-funded.

[B-340] Manny Berman brought up the thought that the ED study Oregon Safety Net group is doing a data study. Is this something we could partner with? Retrieve their information and come up with policies with that data?

Dr. Saultz agreed and remarked about the work of Rob Lowe in regards to Emergency Room utilization and community characteristics within Oregon.

Discussion continued around electronic records. It's important to know that there is a gap between the people who intend to use the information and those who are knowledgeable in storing the information properly in the record. Another approach may be an export command to link to other programs to export data. This is what Medicare and Medicaid are doing. Health care can be improved if there is a way to signal a patient's needs by the electronic health record and call them to come receive care. This is a proactive approach instead of treating a patient's complaint when they come to the doctor and hope to catch onto other medical needs. Then in the end, there are some doctors who will not want to use computers, new systems, the internet, or electronic records.

[B-515] A legislative bill has been in discussion to enact a committee to get some support for electronic health records. HRC should find what is their role, and not duplicate what other committees are already doing.

[B-528] Dr. Shaffer shared that the diagnostic imaging is more complicated than the families of prescription drugs. Though tough to assess, it is clearly worthwhile and appropriate for the HRC to review due to the high claims costs of imaging. The main problem is finding exactly what to study. There are several different types of imaging, different body parts of the machines, different clinical situations, different order of priority for use of imaging, and different ones prescribing the imaging.

Kathy Ketchum, RPh suggested that HRC collect data finding why the images are being performed before the policies around it are discussed.

[B-633] Dr. Weaver thought to investigate more information from the state of Maine where offices that followed certain guidelines then there were safe harbors for them. Dr. Weaver will look into any specifics they may have on imaging. Also, the article from Winnberg on geographic variations handed out in March's HRC may uncover information on imaging.

[B-714] Dan Kennedy, RPh agreed with researching the topic of alcohol and drug abuse treatments. Effective treatment to produce more productive members of society is needed. Allison Knight of OMAP strongly supports that and agrees with that need. On the other hand, treatment efficacy is questionable. Lynn-Marie Crider suggested to find whether it's effective, then find something different that may work.

Dr. Weaver explained that the probable next step for the HRC to take would be involving Bruce Goldberg, MD and Walter Shaffer, MD and Kathy Weaver, MD to meet, prioritize the projected goals, and start! The input from the HRC members is valuable and will begin the process of targeting these projects. A prioritized list will be brought to the July 22nd HRC meeting as well as researching for other resources that have begun the tasks that the HRC is also intending. Electronic records, drug treatment, imaging, and emergency room use are the four topics for the HRC to continue with. Start now for seeing results legislatively two years from now.

10. Meeting Adjourned at 3:30 PM

Documents:

1. Minutes 04-22-05
2. Key Questions – Statins Update #4
3. HRC – SMR Update #3
4. HRC – OH Update #2
5. HRC – OPIOIDS Update #3
6. HRC Statutes
7. Panelists Responses to HRC Questions
8. OMAP –PMPDP, email announcement, supplemental drug rebate letter

MINUTES
HEALTH RESOURCES COMMISSION
JULY 22, 2005

Members Present/Phone: Walter Shaffer, MD Chair; Paul Tiffany, Vice Chair
Dean Haxby, PharmD; John Saultz, MD; Dan Kennedy, RPh; Steve DeLashmutt, MD;
James MacKay, MD; Manny Berman

Members Absent: Mark Yerby, MD; Lynn-Marie Crider, SEIU local 49;

Staff Present: Kathleen Weaver, MD, HRC Director; Beth Zehr, HRC Assistant,
Allison Knight, Asst. Mgr. OMAP

1. Call to Order and Roll Call

[A-000] Meeting was called to order by Chair, Walter Shaffer, MD and roll call taken.

2. Approval of Minutes—Walter Shaffer, MD

[A-016] Correction: Dr. Shaffer noted that on page 5, under the section on Oregon health status, the first bullet point should read “to save on costs or improve the value of health care expenditures.”

Action: The 5-20-05 Minutes (Document 1) were unanimously approved as amended.

3. OMAP Update – Allison Knight, Assistant Manager of Policy and Program of OMAP

[A-032] ePocrates is still underway and is intended to be up and running by early September. During the month of August, ePocrates will be tested and will be promoted among doctors, providers and the OMA. Next HRC meeting will hold more news. ePocrates holds information for not only PDL drugs, but all drugs and it has no quantity limits or any prior authorization required.

Top 20 evidence-based review topics were handed out. Knight explained that the list of drugs are formed within OMAP, submitted for approval to the HRC, and then become Oregon’s elected drugs for review by the Evidence-based Practice Center at OHSU. Commissioners were made aware that they may suggest additions or deletions to the list. The top 20 list becomes only one vote among the 16 other states involved in the same contract. Interestingly, fellow state organizations have selected a few of the priority drug classes the same as ours.

[A-068] The contract for replacing the Medicaid information system has been awarded to EDS of Texas. The current system is 30 years old and in need of a more efficient system for processing claims. Work has been started, yet it is expected to be two years before the system is entirely implemented and able to process claims. Many interfaces of the application are web based. This way, more immediate answers will be available to providers.

[A-104] Discussion on the Top 20 list of prescription drugs continued. Dr. Weaver explained that the top six drugs that note a line number show where that drug class ranks on the Top 100 drug list by cost. As Rx prices change, our list may change. There is interest in reviewing combination drugs in comparison to a single use drug. Dr. Weaver briefly discussed each drug class on the Top 20 list. Kathy Ketchum, RPh, MPA:HA and Dr. Weaver devise developed this list together based on the frequency of drug use, then by issues of cost or safety. We can possibly have another five drug classes reviewed in this final year of our contract along with updates of the 25 drug classes already in process with EPC. Dr. Weaver will attend the Governance Meeting this September and receive answers about current discussions on long range plans. So then, there are four or five final drug class

reviews remaining. Discussion was made open to the Commissioners for feedback: Dr. MacKay suggested osteoporosis drugs will become more important especially with Medicare Part D. [A-220] Dean Haxby asked, "Is the goal to choose a class with the broadest applicability or to keep focus on OMAP's utilization?" Dr. Weaver noted that the 'dual eligible' will be gone. Allison Knight explained that if a drug was covered by Medicaid Part D, then OMAP does not cover it. There are a few classes that are carved out and covered by OMAP. Dr. Goldberg said that it is up to each state to decide. Oregon legislature is pending which would not have the state wrap around in addition to Medicare. Knight explained data is roughly sorted to compare the dual eligible. Part D benefit makes a huge impact for OMAP. Dr. Shaffer concluded that if we get OMAP's list of new responsibilities, will this be the main driver of what HRC is interested in reviewing, or is it the general use of the agents? Our priority is giving advice to OMAP with whatever issues arise.

4. Legislative Update – Bruce Goldberg, MD

[A-283] Dr. Goldberg summarized activities and discussions of legislature first, in regards to budget and secondly, on policy. Budget has not yet reached agreement between the House and Senate. Once established, it may take a few weeks to process and finalize. Policies in terms of healthcare have not seen substantive legislation.

- Mental health parity has passed out of the Senate and is waiting in the House.
- No progression on professional liability
- Cost and quality efforts at regulations, certificate of need, transparency, increasing bulk purchasing pool
- Public health – obesity in children, potential bill mandating increased physical education that would start 10 years from now
- Oregon Health Plan – no big changes. No funds are coming from general funds; however, money was added back for a dental benefit, a partial dental benefit.
- Bill passed to make Sudafed a prescription drug (due to methamphetamine issue)
- All health care workers are now required to wear name badges.
- Fluoridation of water passed out of the House, but unlikely to pass out of the Senate because the environmental community portrayed fluoride as a hazard.
- Bill for Hepatitis C treatment added to the list of diseases (such as cancer, mental health, and HIV) not reviewed by the state passed out of the Senate and House and then vetoed by the Governor.
- Bill to create a taskforce towards Electronic Health Records is still in discussion.

Little changes have occurred for the Oregon Health Plan. Reasons for that may be because of substantial changes in the previous years. The bigger issues facing us are the national issues (Medicare drug bill, public policy issues). Federal government's medical funding will have affect on each state.

5. Drug Class Updates – Kathy Weaver, MD

[A-460] Our aim among the HRC office staff is to send the reports to Commissioners two weeks before the HRC meetings. Six reports were presented to the Commissioners, five of the reports were updates reviewed by the Standing Update Committee. Each report was explained highlighting the new evidence and summaries: Beta Blockers #2, Calcium Channel Blockers #2, Over Active Bladder #2, ACEI #2, Proton Pump Inhibitor #3 and Alzheimer's drugs.

[A-485] **Beta Blockers #2 (Document #2)** – after review by Dr. Weaver, Commissioners made minor corrections. Public comment was made open. No public comment received.

Action: The HRC unanimously approved the Beta Blocker #2 HRC report.

[A-600] **Calcium Channel Blockers #2 (Document #3)** – after review by Dr. Weaver, she noted that the conclusion was the same as the previous HRC report update. Dr. Shaffer saw that bepridil was eliminated from our list of included drugs for this review and later in the report the drug is referred to in the HRC summary. Dr. Weaver replied that bepridil was voluntarily withdrawn from market by manufacturers (not the FDA). While the drug may not be available now, it may in the future. The Commissioners agreed to include bepridil in the report and indicate with an asterisk, with each appearance of the drug, that the drug was voluntarily withdrawn. Public testimony was made open, and no public comment was made.

Action: The HRC unanimously approved the Calcium Channel Blocker #2 HRC Report.

[A-870] **Over Active Bladder #2 (Document #4)** –reviewed by Dr. Weaver and informed the Commissioners that OAB will be reviewed again in six months due to many other drugs on the market for this drug class. HRC agreed to have the future OAB report #3 to be reviewed by the original OAB (formerly known as Urinary Incontinence) subcommittee instead of the Standing Update Committee. The Commissioners thought to delay approval of this report and wait for the next update in six months, however, because of some new evidences, the HRC decided to move forward with the report.

[B144] Public testimony was made open, no comments were made.

Action: The HRC unanimously approved the Over Active Bladder #2 HRC Report.

[B-196] **Alzheimer's original report (Document #7)** – Sean Karbowicz, PharmD and chair of the HRC Alzheimer's subcommittee presented the report to the Commissioners. There are difficulties in measuring outcomes of drug treatments in that treatments don't cure or reverse the disease, but merely slow the rate of decline. Three barriers to answer our questions are 1) the time to achieve clinical differences between clinical studies 2) while looking for clinical improvement in these studies, the improvement is no more than the slowing rate of decline in an Alzheimer's patient. 3) there are a variety of scales to measure Alzheimer's that are unrelated.

[B-294] Karbowicz reviewed answers to each Key Question and reviewed the subcommittee's final conclusions. The HRC made changes in the conclusion boxes to better clarify. Discussions continued on the difficulty to compare the drugs and their outcomes per patient. The HRC intends to make a consistent summary grounded in evidence-based medicine and the outcome is that there is insufficient evidence that any one Alzheimer's drug is superior to another.

[B-540] Public Testimony was made available. Dr. Ann Speiser of Ortho McNeil/Janssen commented that Galantamine (generic) - Reminyl (brand name) was changed to Razadyne. The next public comment was made by Calvin Harris of Forest Labs. He highlighted some points not covered. There is a definition of mild-to-moderate and from moderate-to-severe. Memantine or Namenda is the only drug indicated for moderate-to-severe Alzheimer's. This should be considered when reviewing this drug class. Namenda has proven effective in model therapy and combination therapy improving cognition, function and behavior.

Dr. Shaffer asked whether this information would change the summaries the Commissioners have arrived at. Harris replied that it should be noted that there are differences in range of Alzheimer's disease. Dr. MacKay asked if the reported trials are available that show the results of the measured outcomes of mild-to-moderate and moderate-to-severe ranges of Alzheimer's. Dr. MacKay asked if the Alzheimer's subcommittee had considered and differentiated these ranges of the state of

Alzheimer's. Karbowicz said that there were discussions on that and concluded that they don't have information on whether the FDA does have indications for drugs in correlation to the severity of the Alzheimer's in a patient. Also, there was difficulty to even conclude any superiority in sub-populations, so the evidence was not apparent.

[B-733] Public comment was made by Mr. Sharp, regional director of Forest Labs noting that one clinical scale was not reviewed; which is the severe impairment battery clinical scale. This latches to the previous public comment with Namenda being used for moderate-to-severe Alzheimer's disease. This scale shows improvement with using Namenda and patients were looked at on a severe level. Dr. Weaver stated the revised conclusions as requested by the HRC.

Action: HRC unanimously approved the Alzheimer's report as amended.

[B-802] **Draft Key Questions-Alzheimer's #1 (Document 9)** - Sean Karbowicz, PharmD reviewed the report with the Commissioners. The Alzheimer's subcommittee submitted to the Commissioners their request to have a trial that compared three different areas 1) a placebo to cholinesterase inhibitor 2) a placebo to Namenda 3) a placebo and any combination in order to discern if the combination is truly superior.

[B-847] Dean Haxby, PharmD said he would like to see the Key Question worded to include any combination of treatment studies. Monotherapy vs. Combination therapy would be our aim. Including the findings of adverse effects is necessary as well.

[B-870] Dr. Weaver added that there already was a request for the Key Questions to show under adverse effects where reducing behavioral symptoms also helped patients not to begin anti-psychotic medications. The Commissioners requested it not be limited to Anti-psychotic drugs but include all behavioral modification agents. Addressing outcomes decreasing caregiver burden is also of interest in these trials.

[B-945] Dr. Shaffer asked for clarification on discontinuation outcomes. Sean Karbowicz, PharmD answered that it intends to show a patient's ability to endure or function when the medications are stopped. Dr. Shaffer asked that this part of the Key Question be made clear.

[2A-000] Public comment was made open for the Alzheimer's Key Questions. Dr. Ann Speiser of Ortho/McNeil Janssen noticed that Key Question #2 was the same as the previous Key Questions. Seeing that there was no data found to answer that question, she agreed it would be best not to continue asking the same. The HRC had already put forward a replacement to do a comparator. Secondly, a possible direction to consider is that although the end point results of trials comparing Alzheimer's drugs to a placebo appear to be no different, still the shape of the curve may be quite different. There may be reduced costs, reduced assisted living, less care giver burden, etc. Is it possible to discover this evidence? The HRC process is a great resource and would agree to use it as best possible.

[2A-038] Dr. Weaver made the Commissioners aware that the idea for removal of Key Question #2 was discussed with the Drug Effectiveness Program. Dr. Shaffer noted that keeping Key Question #2 may actually help us to arrive at the conclusion of the time required for clinical response. While the question will not be eliminated from the report, it is the effort to find that answer, but no guarantee.

[2A-056] **Proton Pump Inhibitor's #3 (Document 6)** – Dan Kennedy, RPh reviewed the report with the Commissioners and concluded that there were no significant changes from the previous report. Dr. Weaver added the idea that next report may best be reviewed by the original subcommittee again (as update #3 was reviewed by the Standing Update Committee) because this drug class review is very specific. The Commissioners discussed some changes of formatting and clarification in summary boxes to stay consistent with other HRC reports.

[2A-182] Public Testimony was made open and no comments were made.

Action: The Commissioners unanimously approved the PPI #3 HRC report as amended.

[2A-190] **ACE-I Update #2 (Document 5)** – Dr. Weaver presented the report to the Commissioners. Public testimony was made open, no comment was made.

Action: The Commissioners unanimously approved the ACEI #2 HRC report.

[2A-224] **TZD Key Questions (Document 9)** – Dr. Weaver shared the Key Questions with the Commissioners simply for their information. It was thought to not review this drug class because often times, TZDs are not used for diabetes. PCPs use them as a 3rd or 4th line drug in treating diabetes, and the Diabetologists and cardiologists use TZDs for metabolic syndrome; preventative for developing diabetes. Key Questions 3, 4, 5, and 6 are targeting on preventing diabetes. There are only two brand name drugs in this drug class review. The question is whether these drugs even should be used for diabetes, which was the intended reason to go through with this drug class review. The subcommittee for this review will require a balance of diabetologists and PCP's.

Dr. MacKay inquired whether this review will look for the lipid effects. Dr. Weaver noticed it's within the content of the Key Questions and will look at clinical outcomes. Other Commissioners remarked how the TZDs are being promoted as a choice drug for several conditions, even without data to support it. Metformin is a basic used drug and it would be good to find a trial comparing it to TZDs.

6. HRC Retreat - Walter Shaffer, MD

[2A-313] HRC has entertained ideas for future projects needing done from a number of panelists this year, yet no project has been determined. While input was received, there has not yet been forward movement on any one direction. The Commissioners were asked what they'd like to do and a reminder was offered of some topics that have come to the top: Electronic Health Records, Diagnostic Imaging Studies, Drug and Alcohol Abuse Treatments, ER utilization – costs and problems, minimally evasive surgeries, and fluoridation. In efforts to arrive at an agreeable project, the HRC and other boards will come together to discuss the best options for the HRC (for instance, Electronic Health Records may be pursued by a task force pending on a bill in legislature now. Planning ahead will prevent the HRC from working towards goals already met by other organizations).

[2A-383] Dr. Goldberg contributed his perspective that the same endeavors for cost savings by reviewing prescription drugs can be applied to other projects. The review of evidence-based medicine has successfully impacted the state's costs of prescription drugs and now, there are other places the state is spending on health care that can benefit from the same principle of evidence-based medicine reviews. Dr. Goldberg's understanding of what the Governor and the legislature would like is to take what started around pharmaceuticals and bring it to health plans, public employees, and whatever can help them provide cost-effective care by evidence-based medicine. He suggested a collaborative effort for PEBB, OMAP, and OHPR to meet, dialogue, consider the topics already mentioned and offer their final ideas to the HRC.

[2A-450] Dr. Weaver added the Health Services Commission to those networking together so as to not overlap work and to gain the strength from them. Dr. Weaver explained the layout of a day retreat, hearing from the representatives of PEBB, OMAP, and HSC in the morning then allows the Commissioners to make decisions in the afternoon. Funding plans for any of our future projects will also need to be discussed.

Dr. Goldberg envisioned the first few steps be accomplished by the reps of PEBB, OMAP, and HSC before the retreat in October and provide the options to the Commissioners at that time. The Commissioners agreed that refining the options would be best done before the Retreat and is of interest to them that their work is contributing to their needs. Also, besides having a specific project, it should be significant. The Commissioners would like to see it be a significant pay off in savings and in public health in comparison to the testing, trials and work to find the evidence.

[2A-630] The next HRC meeting is scheduled for September 23, 2005 and there is no meeting in August. The HRC retreat meeting is tentatively planned for October 21, 2005. *(Two weeks after the HRC meeting it was determined by the HRC that Thursday, October 20, 2005 would become the Retreat date with a quorum).*

7. Meeting Adjourned at 4:30 PM

Documents:

1. Minutes 05-20-05
2. HRC Draft – Beta Blockers Update #2
3. HRC Draft – Calcium Channel Blockers Update #2
4. HRC Draft – Over Active Bladder Update #2
5. HRC Draft – ACE-I Update #2
6. HRC Draft – Proton Pump Inhibitors Update #3
7. HRC Draft – Alzheimer's original
8. Key Questions – Alzheimer's Update #1
9. Key Questions – TZD – Thiazolidinedione Antidiabetic Agents

MINUTES
HEALTH RESOURCES COMMISSION
PLANNING SESSION
OCTOBER 20, 2005

Members Present/Phone: Walter Shaffer, MD Chair; Paul Tiffany, Vice Chair
Dean Haxby, PharmD; Steve DeLashmutt, MD; Dan Kennedy, RPh; Lynn-Marie Crider;
James MacKay, MD; Mark Yerby, MD; Manny Berman; John Saultz, MD

Staff Present: Kathleen Weaver, MD, HRC Director; Beth Zehr, HRC Assistant,
Kathy Ketchum, RPh, MPA:HA, OMAP

1. Call to Order and Roll Call—Walter Shaffer, MD

[A-000] The meeting was called to order by Chair, Walter Shaffer, MD and roll call taken. Commissioners announced their profession and affiliation. Dr. Shaffer gave the charge to the Health Resources Commission. It was suggested that the following addition be incorporated: Dr. DeLashmutt commented that the charge should reflect “cost-effective” health care. It was discussed by the HRC that they assumed this was the intent.

Approval of Minutes—Walter Shaffer, MD

[A-112] Correction: Dr. DeLashmutt noted that on page 6, the section for TZD discussion appears to be unfinished. Dr. Weaver gave a brief explanation recalling the discussion at that time.

Action: The 7-22-05 Minutes (Document 1) were unanimously approved with the intention that the minutes will be completed.

Director’s Report – Kathleen Weaver, MD, director of the HRC

The AHRQ announced a new effective health care program to compare medical treatments and help put proven treatments into practice. Their process, similar to our current work is networked with 13 Evidence-based Practice Centers **DEcIDE**. Their program’s components are 1) Comparative Effectiveness Reports 2) Network of Research Centers 3) Making Findings Clear for Different Audiences – the Eisenberg Center. Discussion arose for whether the HRC should move along with AHRQ’s program next year.

2. HRC Project Planning Group Report – Alison Little, MD

HRC’s charge is to encourage the appropriate use of medical technology in Oregon by informing health care decision makers. Recognizing HRC as a resource, networking agencies came together to become the HRC Project Planning Group. This group was comprised of stakeholders interested in having input on the projects to be systematically studied by the HRC. A few of these members were actually “panel speakers” from past HRC meetings. Members of this brainstorming, advisory group were, Kathy Weaver, MD, Health Resources Commission, Bruce Goldberg, MD, Director of the Office for Oregon Health Policy and Research, Alison Little, MD, Medical Director of the Health Services Commission, Darren Coffman, Director of the Health Services Commission, Jean Thorne, Director of Public Employees Benefit Board, Tom Turek, MD, Medical Director of Oregon Medical Assistance Program, Jim Edge, Senior Deputy Administrator of Oregon Medical Assistance Program, Allison Knight, OMAP, Assistant Manager of Policy and Program. This group

worked together compiling their needs, interests, and costs to find the top priorities they'd ask the HRC to review. PEBB (primarily their Regence Plan) and OMAP Compared data from the top 20 procedures (CPT), top 20 diagnoses (ICD-9), for frequency, cost. The Project Planning group gave suggestions to HRC for the next possible steps to take in medical technology. The top need for cost-effective evaluation were: 1) Disc Surgery 2) Drug and Alcohol Treatments 3) Bone Marrow/Stem Cell Transplant 4) Depression 5) Prematurity. See attachment Prioritization of HRC Projects.

3. Prioritization of HRC Projects – Bruce Goldberg, MD

Dr. Goldberg commended the HRC Project Planning Group for efficiently completing their work to present today at our planning session. Dr. Goldberg represents the Governor of Oregon who says that he is interested in the ability of the state to provide for more uninsured patients and for the ability of the small businesses to provide full coverage for health care for their workers and dependents. While this regards health policy in general, the part that the HRC can play is in reviewing cost-effectiveness. There are waste and unnecessary costs in the system. There may be procedures that are less effective. Many are beginning to look at the HRC for a leadership role to evaluate not only pharmaceuticals, but the effectiveness of diagnostic and therapeutic procedures. The HRC has developed a respected evidence-based process that is proven and has had an impact on health care expenditures at the State and National level in conjunction with the DERP. The HRC decisions effect more than Medicaid and bring value to the whole population of Oregon.

Dr. Goldberg encouraged the Commission to choose items for review that are achievable and items that can be built upon in the years to come. Let's ask ourselves how the HRC can create a process for the state that the state can actually use. Examples are: how the state improves health care purchasing or how the state can expand access to the Oregon Health Plan. Plenty of other private organizations are looking for value in their health care and are eager to utilize HRC's findings.

Today we are at the point of choosing one or more HRC projects building on HRC's success with evidence-based prescription drug reviews. Now is an opportunity to move to a larger perspective of health care! Now is the time for the state to show leadership for health care and responsibility for health care dollars!

Dr. Shaffer asked whether there were differing views of priorities coming from the state. There was no specific priorities known, but Dr. Goldberg suggested the best options are those that will have an impact that is achievable, will provide a foundation, and can be built upon. Ideally, we will study today the answers to the questions not yet asked!

Commissioners were encouraged not to be bound by the listed items, but to use them as a directional guide.

Discussions –

- Before the HRC decides on a topic to review, shouldn't we first find whether there is actual evidence available to adequately complete our studies?
- Should the HRC choose items that are cost-effective to review?
- Should the HRC deter from items such as drug and alcohol treatment that have little head to head comparative evidence though the results have wide impact?
- Should the HRC select items more frequently used, or items most expensive, though not as frequent?
- Obesity arose in discussion as an item to include on the list. So little evidence is out there for treatments. Expensive and invasive measures are done without consideration of the evidence.

Effective treatment for **obesity** will have a significant impact by preventing other obesity-related conditions.

During the lunch break the commissioners decided to take votes on the items they'd like to review. Each Commissioner had two votes to cast (some of the topics that surfaced are listed at the end of these minutes). The HRC's voting results were:

Obesity treatments – 9 votes	}	Combined = 6 votes
Alcohol treatments – 2 votes		
Drug treatments – 4 votes		
Disc Surgery – 4 votes		

The HRC will continue plans at the next meeting, Friday, November 18, 2005. The best focus is to organize subcommittees as advisory groups to the HRC for projects that are feasible.

[2A-390]

5. Drug Class Updates – Kathleen Weaver, MD

HRC Report Statins Update #3 – (Document 3)

Dan Kennedy, RPh presented the Statins Report to the HRC. The original subcommittee was reconvened. New studies were reviewed, though there were not many new results. On page 13, in the summary box, the second sentence within the box, *“Also, therapy should be initiated at a lower dose in Asian patients.”* will be moved to appear in the paragraph above the box. Though included in the report, it will not need to be in the consensus box. Final decisions on page 17 were briefly reviewed. An issue arose at the subcommittee with public testimony by Mr. Palmer who was concerned with the exclusion of a recent good study that compared high and low doses of atorvastatin. Mark Helfand, MD of the EPC was asked to give his reasoning on this subject and responded that the EPC's priority was to consider head-to-head trials of different drugs as best evidence.

[2B-604] Class effect guidelines played a role in this Statins review. Class effect happens when new drugs are added to a drug class at a later date and there are intermediate outcomes such as LDL lowering, but no clinical outcomes. Is it practical to expect a new FDA approved drug in a class to prove long-term clinical outcomes? Or is it good enough to take accept the class effect for that drug in good faith that clinical outcomes are probable?

[2B-638] Discussion on “Class Effect” continued since an HRC policy for Class Effect was intended to be discussed later in the agenda. Whether the proposed new policy would be approved or not, the Statins subcommittee intended for the HRC to review this report under the current policy.

[2B-732] Public Testimony was taken. Henry Tang of Astra Zeneca offered testimony. Based on the experience with pravastatin and rosuvastatin with fibrates, side effects occurred more frequently from combining these two classes of cholesterol lowering drugs. A class labeling by the FDA for all Statins warns about weighing the risk/benefit ratio of further cholesterol lowering as this combination may increase risk of myopathy or rhabdomyolysis.

Placebo-controlled outcome data is needed for clinical outcomes such as MI or strokes, but it becomes difficult to obtain, especially since statins are becoming standard therapy and have already been proven. All statin studies show the benefit of reducing cholesterol and LDL. Why would we

believe that Rosuvastatin is any different? It has been on the market for two and a half years and is well prescribed. Why would AstraZeneca spend our resources on outcome studies?

[2B-868] Tony Ranno representative for Pfizer gave testimony – Long term clinical trials are time consuming and expensive, but remain our best measures for evidence. Pfizer looks for three things in a trial: 1) long term trials 2) risk/benefit ratios 3) studies with thousands of patients. Why consider any other drug that has no proof of outcomes? Please stay with your criteria for proof of efficacy.

[3A-030] The HRC moved to approve the Statins Report #3 with the understanding that the policy on Class Effect remains. In addition the Second sentence in the consensus statement on page 13 will be removed and placed in the text above the box.

Action: The HRC unanimously approved the Statins Report #3

[3A-040] Class Effect Policy – Document #9 - Kathleen Weaver, MD

Dr. Weaver reviewed the current policy and the proposed revision of the policy. Lynn Marie Crider suggested leaving the class effect policy as is because it states, “Clinical outcomes are the *most important* indicators of comparative effectiveness,” but it doesn’t preclude using intermediate outcomes depending on how strong the relationship between the intermediate and final clinical outcomes is. In the case of rosuvastatin, at best there is only a slight benefit from adding another statin to the five other statins already included in the PDL.

[3A-099] Dr. Weaver agreed that clinical outcomes are the preferred indicators, but there is always room for discussion and this was requested by the Statin Update subcommittee. Dan Kennedy said that in his experience with the subcommittees, this has been a frequent topic arising in most every meeting.

[3A-150] Dr Shaffer responded that while the HRC may be sympathetic to the difficulties this policy presents, it is more difficult to assess a drug’s effectiveness without definite clinical outcomes.

The HRC made no motion to change the Class Effect policy

[3A-172] Key Questions for Newer Sedative Hypnotics –NSH (Document 4)
Key Questions for Proton Pump Inhibitors Update #4 –PPI (Document 5)
Key Questions for Antiplatelets Update #1 –AP (Document 6)

Dr. Weaver shared the key questions as an informational piece to the HRC. Dr. DeLashmutt noticed there was category for Aggrenox (combination dipyridamole and aspirin) for the Antiplatelets, yet dipyridamole and aspirin were not considered separately. Dr. Weaver responded that the subcommittee agreed. Aspirin is one of the oldest treatments and the EPC didn’t want to compare it to the newer Antiplatelet drugs to it because of the volume of literature on ASA. The subcommittee felt it particularly important that dipyridamole and aspirin be considered as comparators and had recommended it at their final meeting. Dr. Weaver will take this recommendation to the November 3rd DERP conference call.

Demographic Roster for AH, NSH (Document 7)

Dr. Weaver reviewed the list of new members volunteering to serve on a subcommittee. Since many of them are new to the process of the HRC and its subcommittees, the required paper work has not yet been completed.

The HRC voted to approve the new members listed upon receiving their Conflict of Interest disclosures and Curriculum Vitae and having an orientation into the HRC Subcommittee.

[3A-402] **Action: The HRC unanimously approved the Demographic Roster.**

[3A-420]

6. ePocrates Demonstration – Kathy Ketchum, RPh, MPA:HA

Kathy Ketchum presented the use of ePocrates to the HRC and included how the Oregon Health Plan's formulary (PDL – Prescription Drug List) is shown in it. This accomplishment will impact prescribers and offer them the tools they need to prescribe appropriately for OHP patients.

7. HRC Policy Decisions – Kathy Weaver, MD

A. Dr. Weaver proposed a new Conflict of Interest Policy (see Document #8)

Two different recommendations were offered. The first was allowing members to be a part of the subcommittee, but prohibiting them to vote. The second recommendation reads, "A person cannot serve as a subcommittee member if they have direct, current financial relationships within the past year with pharmaceutical companies or their subsidiaries or organizations funded predominantly by the pharmaceutical industry. However, they may be invited by the subcommittee to give testimony on their area of expertise as long as they declare their conflict of interest prior to testifying."

Action: The HRC unanimously approved Recommendation #2 as stated in the document to become the new HRC policy.

B. A new HRC Class Effect policy was proposed (see Document #9). The HRC discussed this policy but chose not to vote and did not approve.

C. Finally, a recommendation was offered to the HRC for the Standing Update Committee (see Document #10). While the recommendation proposed was not voted upon, the HRC came to a different solution requesting that the HRC director write their recommendations and bring them back to the November 18, 2005 HRC meeting for approval.

7. Meeting Adjourned at 4:00 PM

Documents:

1. Minutes 07-22-05
2. Charge to the HRC
3. AHRQ Press Release
4. HRC Draft – Statins Update #3
5. Draft Key Questions – Newer Sedative Hypnotics Update #1
6. Draft Key Questions – Proton Pump Inhibitors Update #4
7. Draft Key Questions – Antiplatelets Update #1
8. Demographic Roster – Antihistamines and Newer Sedative Hypnotics subcommittees
9. Draft Conflict of Interest HRC policy revision
10. Draft Class Effect HRC policy revision
11. Draft Standing Update Committee HRC policy revision
12. ePocrates handouts

HRC Prioritization of New Projects 10/20/05

Priority for 2006-2007

- 1. Surgical vs. Non-surgical treatment of obesity**
- 2. Methamphetamine treatment (Alcohol/Drug)**
- 3. Lumbar disc and spondylosis surgical treatment**
- 4. Depression treatment**
- 5. Prevention of prematurity**

Lower priority for later consideration

- 6. Stem cell/Bone marrow transplants**
- 7. Surgical vs. Non-surgical treatment of GERD**
- 8. Diagnostic Imaging (MRI/CT/Cardiac/PET)**
- 9. Cardiac (PTCA/Stents/CABG/ICD)**
- 10. Epidural for chronic pain**
- 11. Electronic health records**
- 12. ER Utilization**
- 13. Fluoridation**

organization must serve under-served populations. With the Medicaid Part D program, there's no guarantee that those prices will be passed along.

[A-167] Dual eligibles will be gaining more because of the Medicare price differential. The advantage is there will be continuity of care and of medications prescribed even if patients go off one plan. Allison Knight concluded that while the Part D program is complex for patients, and the regulations are still unclear for providers and plans, there are opportunities for savings.

[A-210] Discussion continued about the confusion that patients and organizations are wading through. To counteract this, OMAP has trained volunteers to answer their questions and referral to a case worker is available. There is also a website: www.Medicare.gov which can also help patients that need to decide what to do if they currently have no, or low, drug costs, but wish to avoid a penalty for late enrollment.

[A-280] Knight agreed that the transition to Medicaid Part D will be a challenge. On a good note, many populations in the Oregon Health Plan are covered by managed care plans that already have Medicare advantage counterparts in their programs. Fortunately, this provides some continuity. Most dual eligibles have been automatically enrolled into the plans. As for the others, OMAP is seeing that individuals have been appropriately enrolled previously.

[A-313] The question arose as to how much OMAP projects to save with shifting costs to the federal government. Knight answered that though there is some cost savings there, we are actually refunding money back to the federal government. Dr. Jeanene Smith replied that this is the first federal program that requires the state to pay back; it's commonly called a "claw-back." The state of Oregon fills in the costs. Just how much savings or loss will occur has not yet determined.

[A-333] Dr. Smith added that those states that have had richer benefits for their duals are probably paying more than those who have had a skinny benefit for their duals. Those states will likely put in more money. If there are cost over-runs in Medicaid Part D, then it may cost the States even more.

Some states have elected to pay the co-pays through their general fund (since it is not allowable to use Medicaid money for that). Since Oregon isn't using that option, there will be co-pays patients will be responsible for.

[A-350] Dr. DeLashmutt asked what control Oregon will have on the plan if we're paying money back to the federal government. Knight responded that while there is little control, there is a set formulary and inflation factors that will be used for the years to come. If the federal government manages it well, the percentage of state payments will be lowered. It's projected that the cost will average \$420 per member per month and the costs are going up. The new Medicare Part D opens up prescriptions and care that has been restrained in the past. There's likely to be more prescribing.

[A-396] Dan Kennedy, RPh explained to the HRC about AWP, which is the current formula for drug pricing. The proposal is to now go to the AMP, Average Manufacturer's Price +. They are trying to get to the net price of a drug. AMP+ does not take into consideration the different types of pharmacies receiving the prescriptions. Essentially, community pharmacies may be asked to dispense medications for less than purchase price.

Federal legislation is looking at Oregon's Medicaid managed care provider tax that is used to fund OHP standard. If this mechanism of funding OHP Standard disappears, there is no other funding sourced to take its place. This would have a large negative impact on OHP.

[A-440] Ms Knight reported that supplemental rebates are posted on the OMAP website and they are taking offers for Triptans, Newer Sedative Hypnotics, Overactive Bladder, and Targeted Immune Modulators. The offers close January 4, 2006.

[A-468]

4. Drug Class Updates – Kathleen Weaver, MD

HRC Report Antiplatelets – (Document 3)

Ruth Medak, MD chair of the Antiplatelets subcommittee presented the Antiplatelets Report to the HRC. Dr. Medak began with making it clear the subcommittee answered the Key Questions that were posed. Perhaps the HRC would like to see further results or better conclusions on this report however, that can be done in the next update. In general, the conclusions on page 9 were difficult to arrive at due to: 1) very few studies conducted but lots of detail, 2) no head-to-head trials comparing the agents for acute coronary syndrome 3) the way the key questions were phrased, and 4) lack of evidence.

[B-626] The HRC requested having chronic angina included in the review next year. Dr. Weaver agreed to share that input for the update when the Key Questions for the next update are being reviewed by the DERP. Also, the HRC would like to include high-risk patients – those with a history of a major event, diabetes, known coronary disease, or chronic angina patients. An possible way to figure what classifies as a high risk patient is creating a scale of complexity.

[B-700] To conclude this discussion, it was agreed that the Antiplatelet subcommittee and Dr. Weaver will suggest a change of the key questions for the Antiplatelet Update #1. Secondly, a notice should be included in the report to state that there was limited evidence and therefore the recommendations are limited. Finally, what has not been seen is a comparison of Copidegril to aspirin. Though Oregon suggested to the DERP to have the EPC study this comparison once before, it was rejected. Acute coronary syndrome studies did not come to strong evidence-based results. To address that, the HRC agreed to add a note in the conclusions that the HRC did not study this question. Adding this note, doesn't change the conclusions, but clarifies the report for public use. HRC could not arrive at a consensus for coronary artery stents in relation to this report due to the lack of published evidence.

[B-852] Public Testimony was taken. Anne Tweedt responded with interest for her company, Bristol-Meyers, to have an opportunity to review this addition to the Antiplatelet report before the report is finalized.

[B-872] **Action: The HRC unanimously approved the Antiplatelet Report with specified amendments and the request to see the Antiplatelet report at January's HRC meeting.**

[B-880] Dr. Weaver reported to the HRC new volunteers added to HRC subcommittees for Newer Sedative Hypnotics and Antihistamines in Demographic Roster for AH, NSH (Document 3). Dr. Shaffer brought to light that in the past, there were often a couple of pharmacists on a subcommittee and thought it best to add another pharmacist for these subcommittees. For the future, it would be advantageous to have a community-based pharmacist and an academic-based pharmacist since they bring valuable perspectives. Dean Haxby offered to find other pharmacists that may be helpful for the Antihistamine subcommittee.

[B-972] For clarification, the Newer Sedative Hypnotics drug class review contains newer agents compared to each other and also compared to older agents. Drugs include Sonata, Ambien, Ambien CR, Imovane, Lunesta, Rozerem.

[B-1-010] **The HRC unanimously approved the Demographic Roster for Antihistamines and Newer Sedative Hypnotics on the understanding that another physician will be added.**

[B-1-022] Revised HRC policy Change for the Standing Update Committee (Document4).

Dr. Weaver presented a second draft to the HRC requesting a change of policy. See attached document. The current policy for the Standing Update Committee is to review annual update drug class reviews unless there are significant changes in the new report that would likely change the HRC consensus statements. In that case, the original subcommittee would be reconvened to review an updated report. The policy change submitted reads,

“The Standing Update Committee will review all updated reports and make recommendations to the HRC. If the evidence suggests a major change of such magnitude that the conclusions might be changed as determined by the Chair of the Standing Update Committee and the Director of the HRC, those original subcommittee members who wish to continue to serve will join the Standing Update Committee to review the new evidence and amend the original report. If there are less than two original subcommittee members who wish to serve, the HRC will be consulted about adding new members to the subcommittee.”

[B-1-070] **The HRC unanimously approved to adopt the new Standing Update Committee policy recommendation.**

Dr. Weaver included that she is drafting a new HRC policy in regards to conflicts of interest for our upcoming obesity study. The HRC policy draft will be submitted at the January HRC meeting.

[2A-009]

5. Next Steps for 2006 – Walter Shaffer, MD

HRC Schedule for 2006 – The Commissioners received a proposed schedule for 2006 and were asked to reserve the dates on their calendars. See attached document. The meeting for January was requested to change from the 20th to the 27th.

[2A-041]

Summary of decisions from October 2005 HRC meeting – document titled, “Weighing in on Bariatric Surgery” compiled by Dr. Weaver to begin review obesity management. See attached document with bibliography. A few procedures were described for treatment and surgery: malabsorptive and restrictive. The two most common procedures are adjustable gastric banding, Roux-en-Y gastric bypass (GBY) described in the attached document.

[2A-402] Dr. Weaver gave recommendations concerning this obesity review

1) the HRC may best handle this by drawing together a variety of medical professionals of different levels to write up key questions to see what the scope of our review should be.

2) if we do this review, answer how we will arrive at the cost-effectiveness to apply these studies.

[2A-420] Dr. Smith added several helpful points to consider along with the HRC’s decision to review obesity. 1) What is the HRC’s approach? Since this is not a covered benefit on the Medicaid plan there’s not a need to save money on behalf of OMAP and OHP.

2) There are no funds to receive these studies, so we must draw from readily available resources such as through OHSU. 3) The HRC would likely need to do a cost-benefit analysis and/or partner with others.

[2A-498] Discussion continued among the Commissioners agreeing that those who could potentially benefit from this review are the insurances and health plans. Usually, they would like a neutral source without bias.

[2A-535] Manny Berman suggested accumulating proposals for a cost-benefit review done for us. Then from there, take those proposals to the health plans and explore options of grants. Dan Kennedy noted that while health plans have vested interest, they wouldn’t have control of the systematic research conclusions. Dr. Weaver spoke on behalf of James MacKay, MD of Providence

Health Plans which needs of an objective look at the research. Those who fund these reviews would probably want to help draw up the key questions and probably would want to agree on the make-up of the subcommittee. Perhaps also, the cost-effectiveness question would be secondary in the scope of this review. The approximate cost of a systematic bariatric surgery review for PEBB was \$10,000-\$12,000.

Commissioners also questioned whether we aim to research nationally or state-wide. Currently, bariatric surgeries are not covered as a medical surgery by OHP and it appears below the funding line in the Prioritization List.

[2B-762] Dr. Smith proposed the scenario that if the Health Services Commission did move the bariatric surgeries above the line on the Prioritization List; they would need to know which procedures to add. Dr. Shaffer saw it appropriate for the HRC to find that information and provide it to the Health Services Commission. Dr Weaver agreed to return to the HRC with proposals and content of an ideal obesity subcommittee, what the subcommittee would do, some draft key questions, draft revised HRC policy, and revised conflicts of interest. As well as saving money by using finished reviews on bariatric surgery, the HRC could like use the subcommittee to develop criteria to determine what evidence can be used.

[2B-825] Dr. Weaver suggested that the HRC's obesity subcommittee be offered to PEBB for developing the clinical component to the EPC report. The HRC's work would benefit PEBB greatly if there were a possibility of having the report made public. Dr. Shaffer would like to see the possibility of cataloging the various guidelines for the bariatric surgery that are currently available.

[2B-865] The HRC agreed to make time to review the obesity management first and stay focused on it. While the HRC will eventually aim for the second and third choices for review (Drug/Alcohol Treatment and Disc Surgery), they will be developed later as staff time allows.

[2B-965] Dr. Weaver agreed to bring back an initial highlighted review of Drug/Alcohol Treatment and along with more details of the Obesity review.

6. Meeting Adjourned at 4:30 PM

Documents:

1. Minutes 10-20-05
2. HRC Draft Newer Antiplatelets Agents report
3. Demographic Roster – Antihistamines and Newer Sedative Hypnotics subcommittees
4. Revised HRC policy change for Standing Update Committee
5. HRC 2006 meeting schedule
6. "Weighing in on Bariatric Surgery" and Bibliography

**MINUTES
HEALTH RESOURCES COMMISSION**

NOVEMBER 18, 2005

Members Present/Phone: Walter Shaffer, MD Chair; Paul Tiffany, Vice Chair; Dean Haxby, PharmD; Steve DeLashmutt, MD; Dan Kennedy, RPh; Manny Berman.

Members Absent: Lynn-Marie Crider; John Saultz, MD; James MacKay, MD; and Mark Yerby, MD;

Staff Present: Jeanene Smith, MD, MPH Interim Administrator for OHPR, Kathleen Weaver, MD, HRC Director; Beth Zehr, HRC Assistant,

1. Call to Order and Roll Call—Walter Shaffer, MD

[A-000] The meeting was called to order by Chair, Walter Shaffer, MD and roll call taken.

2. Approval of Minutes—Walter Shaffer, MD

[A-033] Correction 1: Dr. Shaffer noted that in the first section with the charge of the Health Resources Commission should be re-phrased to say there was a discussion of the charge, and not to imply there was a change in the charge.

Correction 2: Dr. Shaffer noted that in section 2 at the top of page 2, the HRC Project Planning Group's list of projects was the HRC developed list and their list should be reported.

[A-077] Manny Berman opened the idea to include the full list of items for HRC review (brought up for vote on 10-20-05). This way, we will have it in the minutes for future reference. Dr. Weaver agreed to make an attachment of that list.

[A-080] **Action:** The 10-20-05 Minutes (Document 1) were unanimously approved with the revisions made as requested.

[A-088]

3. OMAP Update – Allison Knight, Assistant Manager of Program and Policy, OMAP

There have been changes in staffing at OMAP. Tom Turek, MD will leave by the end of November. Interviews for his position will be held soon.

OMAP awarded a contract to ODS Health Plans now that ODS is back and serves smaller counties such as Baker, Columbia, Wallowa, and Malheur.

[A-104] OMAP is also getting ready for the Medicaid Part D drug plan. OMAP intends to communicate well during this transition. Training of volunteers to help more than 40,000 dual eligibles has been conducted.

The October Emergency Board meeting brought up the issue of budget problems the department had from last session. The case load is higher than originally projected and it's impacting the budget. There is a huge increase in OHP Plus and the SCHIP program (Children's Health Initiative Program) that serves kids.

[A-150] Allison Knight described the beginning efforts of a pilot program with West Salem Clinic called the 340 B program that is underway in response to the Medicare Part D Act. The 340 B program insures the purchaser the lowest price to obtain prescription drugs. To be eligible, the