ARIZONA STATE LEGISLATURE
Forty-ninth Legislature – First Regular Session

SENATE HEALTHCARE AND MEDICAL LIABILITY REFORM AND HOUSE OF REPRESENTATIVES HEALTH AND HUMAN SERVICES COMMITTEE OF REFERENCE FOR THE SUNSET REVIEWS OF: COMMISSION FOR THE DEAF AND THE HARD OF HEARING STATE BOARD OF PSYCHOLOGIST EXAMINERS ADVISORY COUNCIL ON AGING BOARD OF HOMEOPATHIC AND INTEGRATED MEDICAL EXAMINERS THE PERFORMANCE AUDITS OF: DEPARTMENT OF HEALTH SERVICES MARICOPA INTEGRATED HEALTH SYSTEM AND THE SUNRISE APPLICATIONS OF: ARIZONA OPTOMETRIC ASSOCIATION THE ARIZONA ATHLETIC TRAINERS' ASSOCIATION

Minutes of Interim Meeting
Monday, November 9, 2009
Senate Hearing Room 1 -- 12:00 p.m.

Chairman Barto called the meeting to order at 12:12 p.m. and attendance was noted by the secretary.

Members Present

Senator John Nelson, Co-Chair
Senator Amanda Aguirre
Senator Barbara Leff
Senator Linda Lopez
Senator Thayer Verschoor

Representative Nancy Barto, Co-Chair
Representative David Bradley
Representative Steve Court
Representative Doris Goodale
Representative Phil Lopes
(replacing Representative Ed Ableser)

Members Absent

None

Commission for the Deaf and the Hard of Hearing

Ingrid Garvey, Legislative Research Analyst, Health and Human Services Committee, explained that the purpose of the Arizona Commission for the Deaf and the Hard of Hearing (ACDHH) is to improve the quality of life for deaf and hard of hearing Arizona residents by serving as an information and referral source for them, their families, other consumers, legislators, government agencies, public and private sectors and the general public. After the last sunset review, the ACDHH was continued for 10 years.

Carmen Green, Deputy Director, Commission for the Deaf and the Hard of Hearing, related accomplishments and challenges of the ACDHH. The major challenge is the fact that the agency is 100 percent funded by a tax on landlines but that revenue is declining because of the popularity of cell phones. She raised the possibility of decreasing the tax on landlines and adding a tax to cell phones. In response to questions, she explained that the Text Telephone (TTY)/ Telecommunications Device for the Deaf (TDD) is a teletypewriter used by individuals who are deaf or hard of hearing to communicate by phone. Access is provided through the Relay Center by dialing 711.

Lynn Wakefield, Business Manager, Commission for the Deaf and the Hard of Hearing, informed the Members that revenue derived from the tax on landlines during the last fiscal year amounted to $6.3 million; this fiscal year it is projected at just over $6 million. The relay service is provided through a contract with Hamilton Relay for $1 million, but the ACDHH is entirely funded by the tax.

Thomas Posedly, representing self, stated that over 30 years ago he was the first Chairperson on the Board of Directors for the Arizona Council for the Deaf, which was the first council for the state. Arizona has approximately 600,000 diverse people with hearing loss at various levels. ACDHH is one of many hundreds of state boards and commissions that communicate and serve the deaf and hard of hearing and deaf-blind Arizonans, but it is the only commission in the state that educates hearing people at the state level on how to communicate with deaf individuals. He encouraged support of ACDHH in order to continue its wonderful services.

Donna Kruck, Director of Advocacy Programs, Arizona Bridge to Independent Living (ABIL), stated that as a community organization that works to improve independence of people with disabilities, she can attest to the fact that the ACDHH is a vital community resource. The relay system is fabulous and provides the freedom for people with hearing loss to communicate and for others to communicate with them. Such strides have been made in the last few years that a video relay is now available in order to see someone sign, which has freed individuals to participate in the community more and be employed more. She encouraged the Members to extend the ACDHH.

Co-Chairman Barto announced the names of those who signed up in support of continuation of the ACDHH but did not speak:
Larry Devenny, Treasurer, Arizona Association of the Deaf, Incorporated
Tony Dirienzi, Arizona Statewide Independent Living Council
Siobhan McCurdy, representing self

Ms. Green answered questions concerning SB1348 passed in 2007, which requires state-licensed audiologists and hearing aid dispensers to educate consumers with hearing aids and cochlear implants about telecoil devices that provide easier access to sounds from telephones and other electronic equipment.

Co-Chairman Nelson moved that the Committee of Reference recommend to the full Legislature that the Arizona Commission for the Deaf and the Hard of Hearing be continued for 10 years. The motion carried.

Co-Chairman Barto thanked everyone for attending the hearing. She stated that it is an honor to not only keep boards and commissions that do such worthy work accountable, but to recognize and learn what the ACDHH does for the community. She added that it has been wonderful to read about improvements that have been made over the years for the deaf and the hard of hearing in Arizona.

Department of Health Services

Shan Hays, Performance Audit Manager, Office of the Auditor General, reviewed the performance audits and sunset review on the Department of Health Services (DHS) (Attachment 1, pages 1-11). In response to questions, she indicated that the Auditor General's Office is statutorily mandated to conduct sunset reviews and DHS was up for review with a due date of October 1, 2009. Numerous audits were conducted on DHS in the past so the auditors looked for areas that were not previously audited. The Division of Licensing Services is an important function of DHS and three reports were issued concerning timeliness of complaint investigations, inspection effectiveness and enforcement actions so those areas were not reviewed again. One of the items generally looked at in an audit is how an agency is funded, and in this case, the auditors found that the licensing fees have not been changed for some time so further research was done to determine if a change is needed.

Senator Leff opined that the licensing fees were low and she is glad the auditors reviewed the structure and made suggestions, but she is not sure the recommendations were implemented as suggested in the report.

In response to a question, Ms. Hays conveyed that she is not aware of other states that fully pay for the cost of child care licensing with fees, at least not any of the eight western states that were reviewed.

Representative Court asked if the fees set in statute can be changed. Ms. Hays answered that budget legislation for 2010 took the fees out of statute and required the director to set the fees by rule. The rule-making process was suspended so it can be done quickly.

Senator Leff stated that the recommendation for developing appropriate fees is to move slowly and conduct a full assessment, which may not be possible by January 1, 2010. Ms. Hays reviewed the five recommendations for developing the fees (Attachment 1, page 9), noting that one possibility is to implement new fees gradually if there will be a substantial increase.

Will Humble, Interim Director, Department of Health Services (DHS), advised that language relating to the fees was in the budget reconciliation bill which was delayed until early September 2009. The provisions became law at the end of September 2009, directing DHS to develop a fee schedule to fully support funding of DHS' inspection activities before January 1, 2010. There was time to figure out how resources are spent for inspection activities, but there was not enough time to conduct a full assessment, although an accelerated version is being done in which the public input phase was just finished with a final hearing in Tucson the previous week.

Co-Chairman Nelson assumed that when the process began someone was aware that the fees were not increased in 20 years and there would suddenly be a major hit to child care facilities.

Mr. Humble responded that child care licensing fees captured less than five percent of the licensing costs. He is taking the following approach to implement the provisions of the bill:

- Ensure that one industry is not subsidizing another.
- Develop a responsible distribution of expenses.
- Find additional resources to mitigate costs passed on to the industry, especially for child care. The First Things First Board was asked to invest in the program to help mitigate some of the fees; however, the request was denied, so the next option is to look internally at tobacco tax and federal funds.

Mr. Humble related that child care facilities are on three-year licensing cycles, but inspections are conducted every year. Inspections during the first two years are more expedited and focus on health and safety. The inspection conducted during the third/renewal year is more comprehensive. Hospitals and nursing homes are licensed and inspected annually. He said he considered conducting inspections for child care facilities once every three years, but DHS is obligated by statute to conduct annual inspections.

Co-Chairman Nelson surmised that if the statute says *inspection*, DHS can define the level of inspection, to which Mr. Humble agreed. He said he worked with the licensing staff in all of the programs to make sure the focus is on critical health and safety functions.

Co-Chairman Nelson asked if DHS is prevented by statute from assessing the direct cost for a complaint inspection to the receiving organization rather than spreading the cost throughout the entire group of licensees. He opined that those that do not receive complaints should not be paying for those that do receive complaints. Mr. Humble answered that the fines DHS assesses through the enforcement process do not capture additional operational costs of facilities that are not well run. He added that additional time is needed to conduct a more detailed analysis, but he is trying to do what can be done now so the inspection program is still solvent on January 1, 2010. In response to another question, Mr. Humble reviewed DHS budget cuts.

Senator Lopez commented that there may have been a different outcome if the fee increases had been made and subsidies were provided for child care for low-income, working parents.

Mr. Humble clarified that he proposed that First Things First develop a scholarship for about $2 million for facilities nearing renewal between January and June 2010 in exchange, for example, for joining the quality improvement program or changing the staffing ratio, etc. The other proposal can be seen in the Board's minutes and has to do with a loan program, but the Board went into executive session and passed a resolution suggesting that he look elsewhere.

When asked about the possibility of gradually implementing fees, Mr. Humble stated that he has mainly focused on obtaining resources. With the three-year renewal cycle, some facilities recently paid for a three-year license that will be held until 2012. A one-year licensing cycle would be much easier. He said he asked the Attorney General's Office if it would be legitimate to cancel someone's pre-existing $150 three-year license in order to pay the new fee and smooth out the cycle, but DHS does not have that authority.

Duane Huffman, Chief Legislative Liaison, Department of Health Services (DHS), related that a rough estimate of the impact on child care facilities could have been given prior to the

legislation, but not on specific proposals because there were none at the time. DHS works closely with the Executive Branch and this was in the Executive budget. DHS was under the impression that legislative staff provided an explanation to legislators, and the Joint Legislative Budget Committee puts together the budget.

Senator Leff apologized because the legislation passed with no knowledge about the impact and stated that she appreciates DHS working with the Legislature.

Mr. Humble noted that many good comments were made in writing and at the hearings, especially at the meeting in Tucson.

Senator Leff opined that it is necessary to consider a different way of doing things during a budget crisis, so perhaps changing the way the system works will be part of the mix. Mr. Humble replied that discussions are needed about the statutory mandates in Title 36.

Senator Leff requested that agency personnel talk to any Members about the implications of any budget proposal instead of only talking to Appropriations Committee Members. She suggested that the outcome probably would have been different on this issue had that happened.

Representative Lopes suggested looking at whether or not child care should be subsidized by government.

Mr. Humble responded to questions concerning inspection staff.

Mary Wiley, Assistant Director, Division of Licensing Services, Department of Health Services (DHS), related that total complaints for licensing for one year were 3,112.

Senator Verschoor indicated that with 100 inspectors investigating 7,000 facilities and 3,000 complaints every year, a review of some mandates in statute is needed.

Ms. Hays continued the audit presentation (Attachment 1, pages 12-23). She responded to questions concerning performance measures in Regional Behavioral Health Authority (RBHA) contracts and substance abuse treatment.

Mr. Humble thanked the auditors and commented on their level of professionalism. He said he was very happy with the results and the process DHS went through with the team.

Senator Verschoor mentioned that the Governor has a committee on behavioral health. One of the items brought up in the audit is that most of the funding for drug and alcohol abuse is under Title 19. He questioned which recommendations will be considered from the Governor's committee.

Dr. Laura Nelson, Acting Deputy Director, Behavioral Health Services, Department of Health Services (DHS), related that the majority of meetings held by the Governor's committee focused primarily on the *Arnold v. Sarn* lawsuit and the Seriously Mentally Ill (SMI) population, so substance abuse may not have been addressed to a great extent. The Governor recently proposed that the general mental health and substance abuse Title 19 populations be moved under the

Arizona Health Care Cost Containment System (AHCCCS) in the future, which will be considered by the Legislature.

In relation to budgeting for substance abuse, Dr. Nelson explained that the audit focused only on individuals enrolled in the substance abuse program, but many adults with SMI also struggle with substance abuse problems. Resources for adults with SMI are much more available than for individuals solely enrolled for substance abuse treatment, so individuals in the program strictly for substance abuse treatment are much less likely to have access to a case manager to coordinate services and less likely to be able to tap into housing support or supported employment. DHS did obtain a large federal block grant that provides substance abuse services for individuals who do not qualify for Medicaid, including adults with SMI. DHS has about $35 million to support substance abuse services, and a slight increase of about $5 million was received for the current year, which has helped offset some reductions in non-Medicaid substance abuse general fund dollars.

In response to a question, Dr. Nelson noted that while it is not addressed in the report, the majority of adults probably began having trouble with substance abuse during their adolescent years, so DHS engages in fairly aggressive activities relating to adolescent substance abuse services.

Senator Verschoor indicated studies have shown that individuals are more likely to become addicted to drugs or alcohol for the rest of their life if the abuse began at a young age, so focusing on treatment for juveniles before they become really addicted may prevent many adults from having addiction problems.

Co-Chairman Nelson asked if data indicates that someone will not be able to stop substance abuse unless they have the desire to do so. Dr. Nelson replied that individuals who are court-ordered into treatment by a judge are more motivated to complete the program than others. Much of the training and best practice approaches focus on motivation interviewing to help individuals become ready to take that step. The reference from the auditors about tapping into self-help community programs is a wonderful recommendation and DHS is moving with that.

Co-Chairman Barto asked if there is a plan to address evidence-based practices and look at outcomes more proactively in new contracts with RBHAs. Dr. Nelson responded that DHS is attempting to move much more in that direction. The Greater Arizona contract out for bid now has performance-based incentives. Performance incentives related to substance abuse have not been included yet because the plan next year is to begin gathering information and review data recommended in the performance audit to obtain baseline information. She pointed out that many of the performance measures built into contracts stem from DHS' contractual obligations with AHCCCS.

In response to a question, Dr. Nelson indicated that some provider inspections are required by the Centers for Medicare and Medicaid Services (CMS) if Medicaid dollars are received. There are also provider monitoring activities to review quality of services and licensing reviews.

Senator Verschoor said providers indicate that 25 percent of their time, budget and paperwork is spent dealing with inspections. Dr. Nelson replied that there is a state level paperwork reduction

and efficiency committee with representatives from around the state, including providers, RBHAs and family members. Each RBHA is also required to have a regional efficiency committee.

Co-Chairman Nelson asked if there is any duplication of effort at various levels that could be consolidated into a single report. Dr. Nelson answered that there may be situations not brought to DHS' attention. Recommendations are encouraged from families, providers, etc.

Mr. Humble advised that DHS is moving ahead in a number of areas:

- Most of the changes relating to information technology (IT) infrastructure and security were implemented.
- DHS is still in the process of developing licensing fees, which will probably continue over the next six months.
- The conclusions regarding substance abuse in the behavioral health system are consistent with the direction DHS has been moving on performance-based measures that are objective, measurable and outcome-based and whittling down criteria that are measured by processes with no outcome at the end. This is a very complex and complicated environment especially because of the *Arnold v. Sarn* lawsuit.

Senator Verschoor stated that the court monitor indicated that many items are not necessary and cost extra that are not about *Arnold v. Sarn*, but for which the lawsuit is used to justify.

Co-Chairman Barto agreed, noting that there is much work ahead to define some of the problems and determine why the system is so process-focused.

Bruce Liggett, Executive Director, Arizona Child Care Association, testified that private licensed child care facilities are frustrated by the proposal relating to licensing fees (position statement, Attachment 2). Many improvements could be made in the licensing process, which should be done before charging private businesses and non-profits for regulation. He asked the Committee to do what it can to intervene and work with child care facilities on a fair increase. He clarified that he supports continuation of DHS but opposes the fee proposal as stated in the Auditor General's report. In response to a question, he stated that the bill relating to the fees moved quickly last Session. His testimony would have been that the impact is not known; however, not much testimony was heard at the hearings.

Co-Chairman Barto announced the names of those who signed up in support of continuing DHS but did not speak:
Kathleen Pagels, Executive Director, Arizona Health Care Association
Bob Ramsey, President, PMT Ambulance
Mitch Menlove, Arizona Healthcare Association; Arizona Ambulance Association
Emily Jenkins, President/Chief Executive Officer, Arizona Council of Human Service Providers
Charlie Smith, Chief, LifeStar EMS
Pete Wertheim, Chief Legislative Liaison, IASIS Healthcare; Health Choice Arizona
Matt Jewett, Research Associate, Children's Action Alliance
Dana Naimark, President/Chief Executive Officer, Children's Action Alliance
Barbara Fanning, Legislative Liaison, Arizona Hospital and Healthcare Association
Laura Hahn, Executive Vice President, Arizona Academy of Family Physicians

Jason Bezozo, System Director, Government Relations, Banner Health
Susan Cannata, Attorney, Maricopa Consumers, Advocates and Providers

Co-Chairman Nelson moved that the Committee of Reference recommend to the full Legislature that the Arizona Department of Health Services be continued for 10 years. The motion carried.

Maricopa Integrated Health System

Dot Reinhard, Office of the Auditor General, reviewed the special audit on the Maricopa County Special Health Care District (Attachment 3).

Betsey Bayless, Chief Executive Officer, Maricopa Integrated Health System (MIHS), thanked the auditors for their professionalism and thorough cooperative approach. She explained that the audit was requested at the end of the last Legislative Session when legislators were trying to finish the budget and there was criticism of the system relating to Disproportionate Share Hospital (DSH) payments. MIHS did not request the audit.

She conveyed that MIHS is a very large system with a major general hospital, two psychiatric hospitals and 10 residency programs so it is a very important part of health care in Maricopa County and statewide. MIHS has begun to implement the measures suggested:

- There is ongoing refinement of strategic business and finance plans, and the MIHS strategic finance plan was delivered to the Special District Board in June 2009.
- A detailed analysis of the relationship with MedPro was conducted in the context of strategic financial operational and business objectives and strategic staffing needs from which a set of clearly defined partnership guidelines and criteria were developed that will frame MIHS' relationship with MedPro or any other group in the future. An independent fair market value analysis of physician compensation was performed to ensure the contract is valued properly, and a risk-sharing element was added that rewards higher performance with higher payment and reduced performance with less payment.

Ms. Bayless added that MIHS is very proud of the work that has been done in the past few years. Improvements can always be made, and MIHS is working to improve for the benefit of patients and taxpayers of Maricopa County.

Co-Chairman Barto announced the names of those who signed up in favor of MIHS but did not speak:
Helena Whitney, Director, Government Relations/Legislative Affairs, MIHS
Barbara Fanning, Legislative Liaison, Arizona Hospital and Healthcare Association

Representative Goodale noted that an item discussed in another COR is the cost and time it takes to perform these audits, which is especially important in this case where legislators are not sure why the audit was performed.

Debbie Davenport, Auditor General, stated that she does not have the cost to audit MIHS; however, these kinds of audits are very expensive. The statute was specific in the six areas that were to be audited and there are areas where she is not sure much value was added. In fact, the

Auditor General's Office asked the Joint Legislative Audit Committee at the end of Session to remove some sunset reviews from the audit schedule to make room for this audit.

Representative Lopes remarked that aside from the cost, the excellent in-depth, high-quality work performed by the auditors is obvious.

(No action was required for MIHS)

State Board of Psychologist Examiners

Ingrid Garvey, Majority Research Analyst, Health and Human Services Committee, advised that the mission of the State Board of Psychologist Examiners (Board) is to protect the health, safety and welfare of Arizona citizens by regulating the psychology profession. After the last sunset review, the Arizona State Board of Psychologist Examiners was continued for 10 years.

Cindy Olvey, Executive Director, Arizona Board of Psychologist Examiners, stated that the Board regulates psychologists, and beginning January 2011, will also regulate behavior analysts. The Board issues licenses to individuals qualified to practice psychology, conducts investigations, hears complaints in response to allegations of unprofessional conduct, takes disciplinary action against individuals who violate laws governing psychologists and provides consumer information to the public. The Board currently licenses 1,836 psychologists, including 1,503 on active status and 333 on inactive status. The Board receives about 50 complaints per year and 90 applications for licensure. The Board is composed of three public members and six psychologists; two are university faculty and three are in practice. She related that agency funds were swept for FY 2009; $300,000 was returned as backfill in FY 2010 to be used only for FY 2010, so in the upcoming budget the Board is requesting $109,000 to carry through until the next renewal cycle in April 2011.

She added that the last sunset audit was conducted in 1999 when the main issue addressed was an oral examination the Board administered for licensing. The primary concern was that the examination was scored by psychologists trained to administer the examination but scores were inconsistent and varied according to who administered the examination; therefore, the Board voted to discontinue the oral examination. The Board currently requires applicants to take and pass the national examination. The Board is authorized to administer an additional examination but does not do so at this time.

Faren Akins, psychologist, representing self, stated that he attended every Board meeting over the last six years. He never had to appear in front of the Board on a licensing complaint, but if he did, he is confident that the matter would be heard fairly and impartially. He stated that he is a licensed attorney who represents mental health people who have Board complaints, and the Board always does a good job in protecting the public and respecting members of the profession who appear before the Board. He asked the Committee to consider renewing the Board for an additional 10 years.

Dianne Fitzgerald-Verbonitz, Executive Director, Arizona Psychological Association, testified that she attended virtually all of the Board meetings for the past 10 years and works closely with the executive directors. The Association is appreciative of how acceptable and transparent the

Board has been. The members are very thoughtful in deliberations and making decisions. While she may not always agree with the Board on an issue, they work respectfully with each other, agree to disagree and move forward. She expressed support for a 10-year continuation.

Co-Chairman Barto announced the names of those who signed up in support of continuation of the Board but did not speak:
Libby Howell, psychologist, Arizona Psychological Association; representing self

Co-Chairman Nelson moved that the Committee of Reference recommend to the full Legislature that the State Board of Psychologist Examiners be continued for 10 years. The motion carried.

Advisory Council on Aging

Ingrid Garvey, Majority Research Analyst, Health and Human Services Committee, stated that the mission of the Governor's Advisory Council on Aging (Council) is to enhance quality of life for older Arizonans. The Council advises policymakers and state agencies and works with local communities, private enterprises and older adults across Arizona to accomplish its mission. The Council monitors and develops programs and policies that affect older adults but does not provide direct services. After the last sunset review, the Council was continued for 10 years.

Kathy De Lisa, Acting Executive Director, Governor's Advisory Council on Aging; Governor's Office on Aging, advised that in FY 2009 the Council received about 63.7 percent federal funding, which is Title 3, from the Older Americans Act. The remainder of funding is derived from the general fund, which in FY 2009 was $91,786. Since the director and policy advisor positions will not be filled, the projected budget for FY 2010 is between $180,000 and $220,000, which is received through the Department of Economic Security so she is not sure of the exact amount. In response to a question, she indicated that the federal dollars are not contingent upon receiving general fund dollars.

Co-Chairman Barto announced the names of those who signed up in favor of continuation of the Council but did not speak:
Kathleen Pagels, Executive Director, Arizona Health Care Association
Mitch Menlove, Arizona Healthcare Association

Mr. Court moved that the Committee of Reference recommend to the full Legislature that the Governor's Council on Aging be continued for 10 years. The motion carried.

Board of Homeopathic and Integrated Medical Examiners

Ingrid Garvey, Majority Research Analyst, Health and Human Services Committee, explained that the mission of the Board of Homeopathic and Integrated Medical Examiners (Board) is to protect the public health, safety and welfare by regulating allopathic and osteopathic physicians who apply for a homeopathic medical license, and registering homeopathic medical assistants that work under the supervision of licensed homeopathic physicians that practice within the State of Arizona. After the last sunset review, the Board was continued for two years.

Dr. Todd Rowe, President, Board of Homeopathic and Integrated Medical Examiners, advised that in 2006 the Board underwent a full performance audit, which was completed in 2007. As part of the process, the Board sought legislation to amend statutes to provide the ability to make changes in enabling legislation to address the Auditor General recommendations. This was accomplished during the 40th Legislative Session and the new statutes became effective October 1, 2008. The principal changes implemented were continuing education requirements, alignment of licensing requirements with the Arizona Medical and Osteopathic Boards as it applies to practitioners with previous actions against their licenses and requirements for informed consent. He asked the Members to vote for a 10-year continuation of the Board, which has shown great progress since implementation of the performance audit recommendations in 2007. In response to a question, he explained that green medicine is medicine that is environmentally friendly and cost effective.

Chris Springer, Executive Director, Board of Homeopathic and Integrated Medical Examiners, related that Arizona is one of three states that regulate physicians with a medical doctor (M.D.) or doctor of osteopathic medicine (D.O.) license that practice integrative medicine. The law recognizes and requires that perspective applicants have a M.D. or D.O. license in good standing from one of the 50 states and complete 300 hours of coursework in alternative modalities (acupuncture, nutrition, neuromuscular medicine, chelation therapy, homeopathy and orthomolecular medicine). Licensees also practice pharmaceutical medicine and minor surgery. She addressed the performance audit:

- Regarding considering the best method of regulation, all parts of the finding are implemented, except one that is no longer applicable.
    - Passage of SB1123, which continued the Board for two years.
    - Passage of SB1236, which strengthened the inform consent requirements, changed the Board's name, strengthened licensing requirements to align with all other medical boards and implemented a continuing education requirement.
    - The Board worked closely with both medical boards to ensure that one board's actions do not negate actions of the other. In addition to meetings between staff members, an effective ad hoc process was instituted to determine complaint jurisdiction for matters involving dual licensed physicians.
- Regarding complaint processing, all of the findings are implemented.
    - The complaint process now includes a log to track the status of all working cases, outside medical investigators who review and report on the technical aspects of each case and front end receipt of complaint information necessary to determine lead investigation status for matters involving dual licensees.
- Relating to ensuring competency in the authorized therapies by improving the examination and instituting a continuing education requirement, three of the six findings are completely implemented, one is no longer applicable and two are in process.
    - Concerning those in process, on October 21, 2009 the Board was granted an exemption by the Governor's Office to proceed on developing rules for continuing education, amending examination rules to align with new statutes and certifying competencies in the authorized modalities.
    - Ongoing validation of the comprehensive written examination should be completed by June 2010.

- The Board asked for a rule-making exemption that has not yet been approved involving dispensing of drugs, remedies and natural substances.
- Concerning outreach to the public, the website is updated to include disciplinary history, agendas, minutes and pending rulemaking, and in September 2009 the Board approved additional enhancements to direct the public to resources about the alternative modalities authorized by statute. Efforts have been taken to inform licensees of the statutory changes regarding continuing education and informed consent. Changes in the complaint procedures made the process more timely and ensures that there is a method to track each allegation.

Representative Lopes noted that complaints improved from an average of 134 days to 100 days and asked how the 100 days compare to other professional licensing boards. Ms. Garvey indicated that she will provide the information.

Dr. Bruce Shelton, President, Arizona Homeopathic and Integrative Medical Association, stated that he is in awe of the work the Board has done to comply with the audit. It is a very fair Board. He urged the Members to approve a 10-year renewal.

Co-Chairman Barto announced the names of those who signed up in favor of a 10-year continuation of the Board but did not speak:
Stan Kalson, representing self
Bridget Cepuch, representing self
Don Farris, representing self
Patrick Hesselmann, HMA, representing self
Linda Heming, CHOICE
Alan Kennedy, Arizona Board of Homeopathic and Integrative Medicine Examiners
Mario Fontes, HMA, representing self
Terry Lee, dentist, representing self
Victoria Bowmann, Ph.D, representing self
Russell Olinsky, environmental specialist, representing self
Ann Harris, representing self
Larry Goldstein, R.PH, representing self
Judy Staab, representing self
Doug Staab, representing self
Abram Ber, M.D., representing self
Shalom Siegel, representing self
Audrey Shelton, representing self
Lisa Platt, representing self
Martha M Grout, MD(H), representing self
Amanda Weaver, Executive Director, Arizona Osteopathic Medical Association
Joseph Abate, Arizona Homeopathic and Integrative Medical Association

Co-Chairman Barto applauded the work of the Board, stating that it has made much progress in the past two years.

Mr. Court moved that the Committee of Reference recommend to the full Legislature that the Board of Homeopathic and Integrated Medical Examiners be continued for 10 years. The motion carried.

Arizona Optometric Association

Ingrid Garvey, Majority Research Analyst, Health and Human Services Committee, explained that the Arizona Optometric Association is requesting that licensed optometrists have the authority to prescribe, dispense and administer oral antiviral medications and allow for the prescribing of a specific class of drugs rather than named drugs.

Don Isaacson, lobbyist, Arizona Optometric Association, explained that the application before the Committee adds oral antivirals to the authority of an optometrist in Arizona to prescribe, dispense and administer oral pharmaceuticals and replaces three specific macrolides listed in statute with oral prescribing authority with the term *macrolides*. As schools began adding a medical component in pharmaceutical training for optometry students in the late 1960s and early 1970s, the practice of optometry expanded in each state. There have been four separate expansions in Arizona in the last 20 years and now the profession is seeking two additional expansions. He noted that medical doctors and ophthalmologists opposed expansion of optometry for the last 20 years, but each of the 50 states now authorize optometrists to administer oral pharmaceuticals and 43 states authorize optometrists to administer oral antivirals. The term *macrolides* would replace three specific macrolides in statute so names do not have to be added as new drugs are developed within that category.

He stated that the treatment of viral infections of the eye is within the scope of practice of optometry, and for the last two years optometrists have had the authority to use antiviral topical medications. The treatment of viral infections with oral pharmaceuticals is also within the scope of practice of optometry, and D.O.s (doctors of optometry) receive sufficient pharmaceutical and clinical training for the use of oral antivirals. If this bill passes, a patient in the care of an optometrist in a rural area where there is no ophthalmologist will receive better, faster and more effective treatment for a viral infection than is possible today. He added that this is not a turf battle and provided a list of states with oral antiviral authority by optometrists (Attachment 5).

Senator Leff expressed concern about what will be treated if this authority is given to optometrists and noted that there are many side effects associated with oral antivirals.

Dr. Robert Pinkard, optometrist, representing self, stated that the purpose is to primarily treat shingles of the eye. There is clear evidence to show that treatment with oral antivirals within the first 24 to 72 hours prevents postherpetic neuralgia. Optometrists work with primary care physicians (PCP) and internists as do ophthalmologists.

Senator Leff said she is concerned because the patient does not have to be sent to their PCP. Dr. Pinkard agreed and stated that it is also not a requirement for ophthalmologists. This is a very limited scope that is in the best interest of the patient. There are a number of communities in Arizona where care is not available by an ophthalmologist on a regular basis, so an expansion is needed. Treatment would be limited to disorders and diseases of the eye.

Senator Leff said she understands there are no other macrolides or any in the pipeline. Dr. Pinkard stated he is not aware of any in the pipeline but macrolides have been around for some time. The intent is to avoid having to return to make a change in the statute every time a new drug becomes available.

Co-Chairman Barto stated that a letter from the Arizona Ophthalmological Society and the Arizona Medical Association (ARMA) says treatment with oral antiviral medications is rarely indicated (Attachment 5). Dr. Pinkard stated that he may see a dozen or so cases of shingles in a year, but he does not know if that would be considered rare. It is an uncommon finding, but with the aging population in Arizona, he believes more of it will be seen.

Co-Chairman Barto asked if the optometrist association keeps records of how often the medications are used. Dr. Pinkard replied that he does not believe so but pharmacy records could probably be investigated, although there would be no optometrists on that record. He pointed out that he does some work at the Veteran's Administration where he has the authority to treat anything related to the eye in any way through non-surgical means.

In response to a question, Dr. Pinkard replied that to his knowledge there has never been a reversal of any authority granted to any optometric association or board related to medical treatment in other states. The only item he is aware of had to do with laser authority in one of the states, but he is not certain about that instance.

Dr. Pamela Potter, Chair of Pharmacology, Midwestern University, informed the Members that optometry and dentistry students receive 70 hours of general pharmacology as opposed to 110 hours that medical students and podiatrists receive. After that, optometrists receive another 30 hours about drugs relating specifically to the eye and another 20 to 24 hours in therapeutics, so the total training is about 120 hours. In response to a question, she indicated that optometrists also need to learn about drugs they cannot prescribe in order to be aware of drug interactions that may occur if patients are taking other medications. The scope of what the optometry students need to know goes far beyond the eye and involves complete general pharmacology training. She pointed out that a new macrolide is being developed, which is currently in clinical trials.

Dr. Pinkard advised that optometrists can leave the doctoral program and go right into practice. There are optometric residencies, and depending on the institution, students begin clinical practice in the second or third year and escalate as the years go on in terms of clinical exposure. By the time most optometry students finish, they will see about 3,500 patients. Optometrists are not required to do a residency per se but optometrists who want to specialize can do residencies in contact lenses, secondary ophthalmic disease, children's vision, etc. Optometrists are required to complete 32 hours of continuing education every two years and new drugs are frequently the topics of the educational symposiums. Many of the drugs fall into the same class and have the same side effects. He said he has an electronic gadget to check interactions and communicates with PCPs or internists if there is any systemic approach on his part. The intent is not to expand to write prescriptions every day for oral antivirals; optometrists would just like to have the ability.

Senator Leff commented that patients have problems with oral antivirals and she is concerned because optometrists do not perform a thorough medical examination. Dr. Pinkard stated that he

practiced with ophthalmologists for the last 30 years and has yet to see one listen to a patient's heart before prescribing an oral antiviral medication. It is imperative to know what drugs the patient is using and have some idea of the patient's medical status. If there is any concern, an optometrist communicates with the PCP or internist.

Co-Chairman Nelson said he had cataract surgery over the summer. No one at the ophthalmologist's office listened to his heart, but someone did at the surgicenter, so it is a function of what is needed at the point in time. He assumed that all professionals in the medical field conduct whatever office procedures are critical to the patient's welfare.

Mr. Isaacson stated that if an optometrist sees a patient in a rural area who requires an oral antiviral that the optometrist cannot prescribe, the patient has to schedule a consult with a general practice physician or someone in another town, which delays treatment. An optometrist who graduates from Midwestern University can go to other states and utilize training from the university, except in Arizona where optometrists are limited.

Representative Lopes remarked that he does not believe adding this authority, and therefore, increasing availability of that service in rural areas is enough of an argument to make this happen. Senator Aguirre stated that she welcomes this because for many years there was only one ophthalmologist in Yuma who traveled from Phoenix to Yuma. Now there are two, but both travel from Phoenix to Yuma, so it is a problem for the entire county.

Mr. Isaacson reiterated the fact that there has never been a reversal of this authority anywhere.

Dr. Ronald Barnett, ophthalmologist, representing self, testified that for the last 20 years he worked closely with optometrists who are qualified by education, training and experience to use pharmaceutical agents, and use of these two classes is very appropriate. Expanding medical care to rural areas is irrelevant because if an optometrist is not capable of prescribing these agents in Phoenix, Tucson or Flagstaff, they are not capable of prescribing them in Clifton, Globe or ShowLow. If a patient has shingles of the face and blisters are forming by the time the patient reaches the optometrist's office, then the disease is in the advanced stage. It is well demonstrated that if a limited number of oral antivirals are prescribed at that point, there is less chance of developing painful complications. In response to questions, he stated that optometrists in general are just as capable of using these medications as ophthalmologists and would consult with the patient's PCP just as an ophthalmologist would, if they believe it is necessary.

Mr. Isaacson revealed that he provided the Members with a copy of the statute that governs optometric pharmaceutical privileges (Attachment 6). When a sunrise application is filed, the actual language does not need to be filed, but he assumes that authority would go in statute, noting that the language states that "*If the patient's condition is other than blepharitis and does not improve during the first seventy-two hours of treatment by means of an oral antibiotic, the licensee shall consult with the patient's primary care physician or other family physician for the purpose of referral of the patient to a physician who specializes in ophthalmology, infectious diseases, internal medicine or neurology.*"

Jeff Gray, Legislative Liaison, Arizona Ophthalmological Society, commented that oral antivirals are not administered by ophthalmologists on a regular basis, and in talking with others,

it is rare, so this is not a turf battle as to who gets to see these patients; it is about patient care. He provided a letter from the Arizona Chapter American Academy of Pediatrics opposing the sunrise application (Attachment 7). He added that viral infections of the eye are common, but treatment with oral antiviral medications is rarely indicated. Neither PCPs nor ophthalmologists commonly prescribe oral antiviral medications for eye infections, but if so, ophthalmologists coordinate with the PCP, or pediatrician in the case of a child, according to the Wills Eye Manual. He submitted that there is no need to expand this to all macrolides because one type on the market will more than likely be pulled so the three currently in statute are those that are common today. There may be one in testing, but there will be no new macrolides on the market for the next decade.

Mr. Gray acknowledged that 43 states allow this, but submitted that some states may have restrictions, such as not allowing oral antivirals to be given to children under six or the patient has to be referred to a physician within so many hours. In states that do not allow this such as Texas, Massachusetts and Maryland, there are tens of millions of people, but there is no reduction in the quality of care individuals receive. In relation to reduced standard of care in rural areas by not allowing this to go forward, if an optometrist sees a patient that needs an oral antiviral, there is most likely a medical doctor in the community. In response to a question, he stated that he is not aware of any cases in states where the decision to allow optometrists to administer oral antivirals was reversed.

Dr. Daniel Briceland, Arizona Ophthalmology Society, Sun City, testified that he has a geriatric practice and sees maybe three cases of shingles per year, and of those usually two are already on medication from their PCP, internist, etc., so he uses what an optometrist would use, which is prophylactic antibiotics or drops. Co-management of the disease with a family practitioner or internal medicine doctor is necessary because of the severe pain a person can experience; in fact, he had two patients who, in the last six years, did not sleep for days and had to take antidepressants. This is a systemic disease with systemic manifestations; it is not an eye disease. This authority is not needed because PCPs are just a phone call away, and it is not an access issue because there are plenty of family physicians in ShowLow and throughout the state. As far as macrolides, there is no reason to "put the cart before the horse" until something comes out on the market.

In response to a query whether ophthalmologists are better at administering these drugs than optometrists, Dr. Briceland replied that ophthalmologists have four more years of training and experience in dealing with systemic diseases.

In response to a question, Mr. Isaacson stated that dental pharmaceutical practice is unrestricted, which means it is the same as M.D.s, podiatrists and D.O.s. He does not know if dentists use oral antivirals.

Mindy Rasmussen, Executive Director, Arizona Pharmacy Alliance; pharmacist, stated that an opposition letter submitted is about concern of patient care (Attachment 8). Shingles is a systemic disease, and not just an eye disease, so total quality of care by a PCP is needed. In response to a question, she clarified that opposition to the sunrise application has nothing to do with the training or competency of optometrists, but the need. There are two issues: 1) there are no other antibiotic macrolides on the market other than Ketek (telithromycin), which will

probably be pulled off the market because of liver toxicity; and 2) the fact that shingles is a systemic disease and not just treatment of the eye.

When asked if this authority has been a problem or a safety issue in the 43 other states, Ms. Rasmussen responded that she can only cite "what ifs." For example, "what if" a patient is treated for shingles, does not have coordinated care and the patient becomes blind. She does not have any knowledge that any "what ifs" occurred, but there is probably some information available.

Mr. Gray stated that not involving the physician in that particular scenario goes against the standard of care according to the Wills Eye Manual. If the physician is going to be involved, the sunrise application is not necessary because it allows optometrists to prescribe without a physician.

Representative Goodale mentioned that if she developed shingles it could be two or three weeks before she is able to obtain an appointment with her family physician in Kingman, which is somewhat remote. She would prefer that an optometrist be allowed to provide whatever treatment is necessary in the meantime, and the optometrist could consult with the PCP.

Discussion followed about modifying the proposed language to state *in conjunction with a qualified medical doctor.*

Amanda Weaver, Executive Director, Arizona Osteopathic Medical Association, expressed opposition to the sunrise application due to quality of care and cost concerns. She stated there is a difference between education and training, and the importance of training in residency programs cannot be stressed enough because that is where significant emphasis is placed on systemic medications. Also, the language in the sunrise application is too broad. There has not been a chance for stakeholders to meet and address concerns that were raised. There is a problem in some rural areas in getting in to see family physicians, but something of that nature would not be a wellness exam, so hopefully, the patient would not have to wait two or three weeks; however, because there are not as many ophthalmologists in rural areas, family physicians treat diseases of the eye. She added that oral antivirals are fairly expensive, and if there is an increase in prescribing, there could possibly be a cost with AHCCCS.

In response to a question, Dr. Pinkard related that there is implication of kidney disease with oral antivirals, but in the absence of decreased kidney function there would be no reason not to start someone on these drugs and monitor with the PCP. He indicated that optometrists understand their responsibilities and potential side effects of these medications and communicate with PCPs and internists all the time, as do ophthalmologists.

Dr. Briceland stated that when he calls internists, they call right back and call in prescriptions to the pharmacy, so there is usually no delay in treatment. He believes these cases should go through the family physician who is more familiar with treating shingles.

Mr. Isaacson spoke about the amount of hours optometry students are taught at Midwestern University and 22 other colleges and universities around the country in a professional pharmacological program, which is more than the basic medical degree that no article, testimony,

etc., anywhere has deemed insufficient. He added that every increment of improvement to the optometry statutes in Arizona has resulted in extended care and 43 states have been the experiment for Arizona.

In relation to residency requirements for ophthalmologists, Dr. Briceland related that the residency begins with a full year of internal medicine or general surgery when students are on call. After the first year of learning all about medical and surgical problems, students go into ophthalmology where they are in clinic five days per week and see significant medical problems, which goes on for three more years. For a fellowship in retina, it is two more years. The experience in terms of hours in patient visits, writing prescriptions, etc., is vast and much broader than that of optometrists.

Eden Rolland, Research Analyst, Senate Healthcare and Medical Liability Reform Committee, said she would need to consult, but she was told in the past that if the sunrise application is not voted on positively, legislation is not precluded from going forward.

A brief discussion followed about legislation. Mr. Isaacson related that the statute does not require language to be presented, but he would stipulate that the restrictions that apply to all other pharmaceuticals about patient consultation within 72 hours, etc., would apply to this. That is what he always meant, and he will work with the Co-Chairmen, understanding that if agreement cannot be reached, there will not be a bill.

Co-Chairman Nelson moved that the Committee of Reference recommend a bill be drafted for consideration by the full Legislature containing the items submitted in the sunrise application by the Arizona Optometrists Association. The motion carried by a roll call vote of 6-2-0-2 (Attachment 9).

The Arizona Athletic Trainers' Association

Ingrid Garvey, Majority Research Analyst, Health and Human Services Committee, explained that The Arizona Athletic Trainers' Association (Association) is seeking an expansion in the scope of practice with three changes:

- Removing an inconsistency in the original statute which varies the scope of athletic trainer practice based on the setting of practice and establishes a uniform scope of athletic training practice across all settings.
- Clarifying that licensed athletic trainers may treat persons who engage in games, sports, recreational activities or physical fitness activities whether or not there is a competitive aspect to the activity.
- Correcting an oversight in the original statute which failed to specifically authorize athletic trainers to treat athletic illnesses.

Susan Cannata, Attorney, Arizona Athletic Trainers' Association, stated that the Association worked with stakeholders and held several meetings with physician and nurse organizations where substantial progress was made. She is committed to working with any interested parties in crafting the actual statute in a way that reflects the current training of athletic trainers and best protects the health and safety of Arizonans.

Dr. John Parsons, President-Elect, Arizona Athletic Trainers' Association, stated that one of the three primary components of the expansion in scope of practice is to permit athletic trainers to engage patients with athletic illness, which athletic trainers have been doing for decades. About two years ago the University of Arizona determined that because there was not explicit reference to illness athletic trainers could not engage patients with illness, so there is concern that members who do this are particularly susceptible to negligence claims in the case of a civil suit. Athletic trainers work under the direction of a physician, which would not change. He related that illnesses athletic trainers commonly engage in are heat stroke, asthma and diabetes.

He stated that the other two changes relate to the existing definition of *athletic injury*, which is currently injuries suffered as a result of competition. Whether someone is engaged in training for a sanctioned marathon or a recreational runner, athletic trainers are prepared to deal with their injuries. Secondly, the Association seeks to ensure that scope of practice pertains to all athletic trainers in all practice settings. Currently, about 20 percent of the members practice in outpatient orthopedic and musculoskeletal rehabilitation settings to which the current provision does not apply.

Senator Leff raised the issue of refining the term *disease management.* Dr. Parsons responded that conversations were engaged in with medical and nursing colleagues. Since athletic trainers work under the direction of a physician, he anticipates working with them to find a compatible definition that suits patients' needs and physicians' concerns. He clarified that although the specialty is not identified in statute, athletic trainers generally work under the direction of a PCP or an orthopedic physician.

Dr. Eric Sauers, Director, Athletic Training Education Program; Arizona Athletic Trainers' Association, offered to answer questions about athletic training education.

James Roush, President, Arizona Physical Therapy Association; athletic trainer/physical therapist; representing self, stated that he is in favor of the application, but he is concerned about the area of recreational physical fitness activities, which involves a different gamut of client. He opined that this is a turf battle and it is all about finances. He does not know who the client will be. If it is a member of a competitive team, he has no problem with that, but if athletic trainers start working with older clients with more systemic problems, he wonders if those clients will be defined as athletes and included under this act. He acknowledged that as a physical therapist, he does not have to operate under the supervision of a physician, except for Medicare patients, but he does as an athletic trainer.

Senator Leff surmised that someone who has knee replacement surgery will not be referred to an athletic trainer, but to a physical therapist until they are well. If the person then wants to go skiing, an athletic trainer would be consulted to ensure that the knee is protected while the person is skiing.

Al D'appollonio, physical therapist, Arizona Physical Therapy Association, stated that he has concerns about the sunrise application, but he is willing to work on an agreeable bill. In Senator Leff's example, a physician could employ an athletic trainer and refer all patients to that person. There is nothing to prevent that from occurring. He said he has a few questions about the education level regarding pathology compared to physical therapists and athletic trainers, but

someone will be brought in to discuss that. As far as recreational injury, there are many different scenarios that could be covered under this term.

Co-Chairman Barto announced the names of those who signed up as neutral on the sunrise application but did not speak:
Michael Nesbitt, Arizona Athletic Trainers' Association
Laura Hahn, Executive Vice President, Arizona Academy of Family Physicians

Co-Chairman Barto announced the names of those who signed up in support of the sunrise application but did not speak:
Richard Ball, Arizona Athletic Training Association
Tamara Valovich Mcleod, Associate Professor, Athletic Training, Arizona Athletic Trainers' Association
Alison Snyder, Athletic Training Educator, Arizona Athletic Trainers' Association
Debbie Craig, professor of athletic training, representing self
John Neel, Owner, FITLIFE Health Systems; Arizona Athletic Trainers' Association
Randall Cohen, athletic trainer, Arizona Athletic Trainers' Association

Co-Chairman Nelson moved that the Committee of Reference recommend that a bill be drafted for consideration by the full Legislature containing the items submitted in the sunrise application for The Arizona Athletic Trainers' Association. The motion carried.

Without objection, the meeting adjourned at 6:55 p.m.

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Linda Taylor, Committee Secretary
November 19, 2009

(Original minutes, attachments and audio on file in the Chief Clerk's Office; video archives available at http://www.azleg.gov)