Chairmen D'Agostino and Maroney, Ranking Members Witkos and Rutigliano and Distinguished Members of the General Law Committee:

My name is Vincent Do and I am a licensed pharmacist practicing in the ambulatory care setting within transplant at a large health system in the state of Connecticut. I am submitting this written testimony on behalf of my patients and myself in strong support of **RB 895 An Act Concerning Changes to Various Pharmacy Statutes**.

As a transplant pharmacist, I care for patients in the pre-transplant, peri-transplant, and post-transplant setting. Many of my patients post-transplant are overwhelmed with many of their new immunosuppressive medications but may now have to deal with potential worsening or new onset diabetes that could lead to hospitalizations and damage to their new kidney transplant. To remedy this, my transplant providers (physicians and APRNs) have worked closely with myself to develop a Collaborative Drug Therapy Management (CDTM) agreement to provide exemplary care for our patients. In this CDTM, I am able to initiate, modify, or discontinue various therapies that are agreed upon between the physician and the pharmacist. Since implementation of our CDTM, we have successfully reduced hospitalizations for our patients from 9 hospitalizations within 90 days post-transplant due to diabetes related reasons to 1 hospitalization within 90 days post-transplant.

Although our CDTM has provided improved patient care, it comes with major limitations that I believe that this bill will help improve. This bill as proposed **does not change pharmacist scope of practice.** It eliminates an outdated administrative burden for pharmacists, physicians, and APRNs engaging in this agreement that was created prior to the availability of shared electronic medical records. It also provides clarification that a written protocol within a CDTM agreement may include guideline-directed management.

Maintaining Pace with Technology and Improving Patient Care:

Although our CDTM has provided great patient care, it comes with major limitations due to the 30 day reporting requirement. Some examples are highlighted below:

- I often will be referred patients by my providers who have newly diagnoses diabetes post-transplant. Although I will meet with these patients closely in the beginning to establish our relationship and ensure comfortability with their new diagnosis, follow up visits may be appropriate to extend past the 30 days. For instance, I have patients who are referred to me with borderline diabetic A1c who are not on medication therapy but require monitoring. Based on guidelines, this can be done by performing an A1c every 3 months. However, due to the 30 day reporting requirement, I am required to reach out to this patient on at least a monthly basis and document in the EMR with unnecessary clinical information. This leads to ramifications that include patients who become disengaged in their care by the frequency of unnecessary visits as well as burdening physicians and APRNs with unnecessary communication on an unactionable item.
- One of the medications we manage post-transplant is an anti-viral agent call valganciclovir that is used to prevent infections from happening in the early post-transplant period. How much a patient takes of this medication depends on how well their kidneys are functioning. After kidney transplant, a patient's kidney function may fluctuate resulting in the pharmacist calling the patient to adjust the dose based on laboratory values that the patient receives at their routine physician office visit. A physician may refer a patient to the pharmacist for valganciclovir

management where we then calculate their kidney function for these dose adjustments. However, there are many instances where since the referral, the patient's dose may not change for over a month, but will potentially require dose adjustments in the future as their renal function improves. With the 30 day report out requirement, the pharmacist would have to call the patient with an unactionable purpose, document in the EMR that there has been no update which clutters the EMR, and further burden the physician and APRN with an unactionable item.

With this 30 day reporting requirement, I have encountered several patients who become disengaged in their care by potentially ignoring these routine calls or visits due to the sheer volume of unactionable and unnecessary visits. It creates strain in the pharmacist-patient relationship and also in the pharmacist-physician relationship. For this reason, I believe that removing the 30 day reporting requirement will strengthen the physician-pharmacist-patient relationship and improve overall patient care.

Guideline Directed Management and Patient Safety

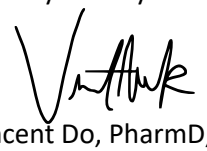
This bill also provides clarification that a written protocol within a CDTM agreement may include guideline-directed management. This is crucial as patient care does not always fit an algorithm and requires clinical decision making.

- A patient who is newly started on insulin may be prescribed 8 units of Lantus and 2 units of Humalog three times daily before meals. The patient may return next week with continued significantly elevated blood glucoses in the 300s. If a strict protocol were to be followed of a 10% increase, this would only allow the pharmacist to increase the patient's insulin to 9 units of Lantus and 3 units of Humalog three times daily before meals. This slow incremental increase would result in significant delay in getting this patient's blood glucose at goal. A slow attainment of goal contributes to patient stressors and demoralizes the patient to achieve control of their newly diagnosed disease state. However, if guideline directed management were allowed, this would reinforce that our goal is to have the patient's blood glucose to be between 80 to 130 mg/dL per guidelines allowing for clinical decision making to increase to what is necessary for a quicker achievement of patient goals and greater patient satisfaction.

With this clarification, pharmacists are able to practice within guideline-directed management and are able to use clinical decision making to improve patient care.

Pharmacists are highly educated medication experts who improve patient care and safety through engagement in CDTM agreements. This bill will further enhance patient care. For this reason, I request that you support this bill.

Thank you for your time,



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