

Senate Finance Committee

Description of Policy Options

Transforming the Health Care Delivery System:  
Proposals to Improve Patient Care and Reduce Health  
Care Costs

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ASHP Comments



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The American Society of Health-System Pharmacists (ASHP) is pleased to provide comments to the Senate Finance Committee's description of policy options for transforming the health care delivery system.

As the national professional association representing over 35,000 pharmacists who practice in hospitals and health systems, ASHP can offer unique and vital feedback on this important health care issue. Pharmacists in hospitals and health systems are experts in medication use who serve on interdisciplinary patient-care teams. They work with physicians, nurses, and other health care professionals to ensure that medicines are used safely, effectively, and in a cost-conscious manner. For more than 60 years, ASHP has helped pharmacists who practice in hospitals and health systems improve medication use and enhance patient outcomes. This includes working with patients to help them access the medications they need and to use them safely and effectively.

## **Section I: Payment Reform – Options to Improve the Quality and Integrity of Medicare Payment Systems**

### **Linking Payment to Quality Outcomes**

#### Establishment of a Hospital Value-Based Program (VBP)

ASHP supports establishment of a Hospital Value-Based Program that expands the existing payment system from one based solely on reporting to one in which payment is based on the quality of care provided. A majority of the 42 measures established under the RHQDAPU program are medication-related. Pharmacists are core members of multidisciplinary teams involved in reporting and quality improvement that address these measures. These efforts have resulted in dramatic improvement in the quality of care provided, but the proposed option that provides for pay-for-performance and expansion of quality measures would further improve patient outcomes.

In 2013, when the Secretary has the authority to issue new measures for the proposed VBP program, ASHP encourages consideration of composite or bundled measures. These measures, which represent a group of interventions that, when executed together, result in better outcomes than when implemented individually, have demonstrated significantly improved patient outcomes compared to the current individual measure approach. Measures that evaluate care provided across multiple care settings, such as those currently under development by the National Quality Forum's (NQF) project on care coordination, should also be considered. In selecting new measures, ASHP strongly recommends that the Secretary include only NQF-endorsed measures, which are developed through an evidence-based, multidisciplinary, and transparent process.

Finally, ASHP would like to see how these performance incentives are structured. We believe that intent of the VBP program is not to reduce overall revenues for those

hospitals that meet the performance measures, and we look forward to continued dialogue with the Committee and other stakeholders on this proposal.

### Physician Quality Reporting Initiative (PQRI) Improvements and Requirements

ASHP suggests adding pharmacists to the list of professionals eligible to participate in PQRI. We support a PQRI initiative that is structured in such a way to allow for non-physician providers, including pharmacists, to participate in the program. ASHP believes this is an opportunity to recognize the multidisciplinary care spectrum by aligning payment incentives that foster quality through a team-based approach. Further, ASHP supports the use of National Quality Forum (NQF) endorsed measures to develop clinical metrics.

### Payment for Transitional Care Activities

ASHP is pleased to see that a potential policy option within health care reform would be to support transitional care management for chronically ill patients. As the medication therapy experts, pharmacists are well-positioned to provide medication-related services to chronically ill patients who are transitioning from the hospital back into the community. Too often, patients who are discharged from a hospital end up needing additional care either through emergency department visits or re-hospitalization due to a lack of education, follow up care, and medication reconciliation. ASHP believes this is a critical point in our health care system where too many patients lack care services that keep them in the community and out of the hospital. Therefore, ASHP urges the Committee to include pharmacists as “qualified non-physician professionals” who would provide transitional care services.

According to a study funded by the Agency for Healthcare Research and Quality published in the *Annals of Internal Medicine*<sup>1</sup>, patients who received discharge services from pharmacists and nurses were less likely to be re-hospitalized within 30 days of discharge. Further, Congress has in the past recognized the need for medication-related services within the chronically ill patient population. The Medicare Modernization Act of 2003 created the Medicare Part D outpatient prescription drug benefit for Medicare beneficiaries without prescription drug coverage. The law also created a medication therapy management program for certain qualified beneficiaries who are chronically ill. While the law does not specify that pharmacists alone provide this service, many, if not most Part D prescription drug plans utilize the services of pharmacists to help these Medicare beneficiaries manage their medications. Clearly, there is a need for pharmacists, working as members of the care team, to provide medication-related services such as medication reviews, counseling, and appropriate follow up to chronically ill patients at risk for re-hospitalization.

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<sup>1</sup> Jack BW, Chetty VK, Anthony D, Greenwald JL et al. A Reengineered Hospital Discharge Program to Decrease Rehospitalization. *Ann Intern Med.* 2009;150:178-187.

## **Section II: Long-Term Payment Reforms – Options to Foster Care Coordination and Provider Collaboration**

### Chronic Care Management

ASHP supports the establishment of a Chronic Care Management Innovation Center (CMIC) to facilitate patient-centered chronic care management among health professionals. Much of the care provided in hospitals is a team-based approach among health professionals that seeks to optimize patient outcomes. Hospital and health-system based pharmacists are typically integral members of those teams because of their medication therapy expertise. ASHP believes that CMIC-tested models should include pharmacists, regardless of what form the care delivery model takes, i.e., medical home or transitional care teams, or another integrated approach. Eleven state Medicaid programs and the Veterans' Administration currently utilize the medication expertise of pharmacists to care for chronically ill patients.

Some estimates say medication-related problems cost the U.S. health care system \$200 billion a year. As medication use increases both in number and complexity, the need to manage patients' medication use, especially those with chronic diseases who are taking multiple medications, is critical. In some cases, patients are seeing multiple prescribers, who may not be aware of all the medications the patients are taking. As a result, the patient's pharmacist may be the only member of the caregiving team aware of the full medication regimen of the patient, and is in the best position to manage and coordinate medication therapy with other caregivers.

In the hospital setting, residency-trained pharmacists commonly perform rounds with the attending physician and are able to make medication recommendations to the patient's caregivers. Further, with their expertise in medication use and pharmacotherapy, pharmacists are able to reduce adverse drug events and improve patient outcomes. Enabling this type of care coordination among health care providers in the community through approaches that integrate pharmacists into the care delivery team is a critical element to achieve true care coordination. As health information technology links patients and providers, it should also be linking providers in a way that fosters input from all members of the multidisciplinary patient care team.

### Hospital Readmissions and Bundling

As noted in the section on payment for transitional care activities, ASHP strongly urges the Committee to provide incentives for hospitals to utilize the services of pharmacists to provide appropriate care and follow up to patients who are discharged from the hospital. Given pharmacists' medication therapy expertise and recent data that show a reduction in hospital readmissions, we support a policy that would provide incentives for hospitals to utilize the services of pharmacists for patients being discharged from hospitals. Again,

recognition of pharmacist services by Medicare would permit pharmacists to be fully utilized in preventing readmissions.

#### Medicare Shared Savings Program (i.e. Accountable Care Organizations)

ASHP supports the use of integrated care models that achieve coordination and efficiencies among various providers. Further, we agree with the Committee that accountable care organizations should go beyond the Medicare Physician Group Practice Demonstration program to include additional providers. We believe that accountable care organizations should be structured to allow for an expanded role for non-physician providers including pharmacists to achieve better care coordination, especially with respect to safe, effective medication use.

### **Section III: Health Care Infrastructure Investments – Tools to Support Delivery System Reform**

#### Health IT

ASHP supported the inclusion of a provision within the American Recovery and Reinvestment Act of 2009 that provides resources for capital investment for hospital and health-system adoption of health information technology to enhance medication safety. Pharmacist participation in the development of interoperable health information technology systems, including electronic health records and e-prescribing, is essential to ensuring safe and effective medication use.

The Society has a policy that supports the use of health information technology for medication management within hospitals and health-systems. The policy encourages hospital and health-system administrators to provide dedicated resources for pharmacy departments to design, implement, and maintain electronic health records and business technology and services. Furthermore, the policy encourages pharmacists to take a leadership role in the strategic planning and implementation of these systems.

ASHP believes that the development of health information technology will enable pharmacists to make real-time medication assessments for patients who are not on-site. Additionally, interoperable electronic health records will enable care coordination among various health professions as systems and providers are able to communicate with one another and prevent duplicative prescribing and drug to drug interactions. Consistent with the goal of the pharmacist as a member of the multidisciplinary care team, ASHP urges the Committee to consider including pharmacists as eligible recipients of health IT incentives that promote care coordination and effective chronic care management, such as grants to establish health IT systems.

Further, while the Committee is exploring the possibility of expanding eligibility for EHR Medicare incentive payments to health professionals who practice outside of a physician office, ASHP believes that pharmacists should be included among those professionals under consideration for potential incentives. The potential for medication

therapy management services to be included in the EHR, we believe, would be useful to ensure continuity of care among the patient's various caregivers. This may prove especially useful in rural areas where access to care is limited.

### Improving Quality Measurement

ASHP has a longstanding policy supporting health care quality standards. According to policy 0502:

To advocate that health care quality improvement programs adopt standard quality measures that are developed with the involvement of pharmacists, are evidence-based, and promote the demonstrated role of pharmacists in improving patient outcomes.

Therefore, while we are supportive of developing national priorities and strategies for health care quality improvement by the Health and Human Services Secretary, ASHP believes at least one hospital or health-system based pharmacist should be part of the multi-stakeholder group that would be created by legislation to provide guidance to the Secretary of HHS.

Further, ASHP would ask the Committee in its health care reform proposal to direct the Secretary of HHS to draw upon existing guidelines and practices developed by health quality entities such as the National Quality Forum (NQF). For example, NQF recently released its consensus report entitled: Safe Practices for Better Health Care 2009 Update. One area of particular interest to ASHP was the extensive discussion of medication-related problems and the role pharmacists can play in addressing those problems. According to the report: "Senior administrative management and governance leaders must recognize the critical role that pharmacists can play in reducing patient safety risks, optimizing the safe function of medication management systems, and aligning pharmacy services with national initiatives that measure and reward quality performance. [Denham, 2008b; Denham, 2005a; Denham, 2005b] Pharmacy leaders should be included as part of the organizations' leadership team and involved with integral system decisions. Also, pharmacists should take an active role in medication management programs as part of the overall care team. There should be explicit organizational policies and procedures, prepared in accordance with applicable state and federal laws, about the role of pharmacists in medication management systems."

Safe and appropriate medication use must be addressed in health care reform legislation. Medication-related problems not only add preventable costs to our health care system, but also result in undue pain and suffering to the patient. Pharmacist participation in establishing quality measures will help address medication use problems that currently exist in our care system.

### Comparative Effectiveness Research

ASHP has in the past and continues to support the development of comparative effectiveness research. ASHP commented in support of the comparative effectiveness funding provided in the American Recovery and Reinvestment Act of 2009. While we neither support nor oppose the creation of a non-profit corporation that would focus solely on comparative effectiveness research, ASHP strongly urges that all health professions, including pharmacists, be involved in development of comparative effectiveness research, whether it be a newly created entity, or one already in existence. Should an independent institute be established, at least one pharmacist should serve on its multi-stakeholder board.

### Workforce

ASHP is pleased to see the Finance Committee is exploring policy options to address health care workforce issues. Securing an adequate supply of well-educated and well-trained pharmacists is a crucial element of health care reform as Congress looks to expand coverage and access to health care services for the millions of people who are currently without it. One of ASHP's longstanding goals is to foster development of training programs, such as first and second year residency programs. We expect that completion of a residency will be a requirement for pharmacists providing direct patient care services.

ASHP has commented extensively in support of the restoration of funding for postgraduate year-two (PGY2) specialized pharmacy residency programs. PGY2 programs provide pharmacists with essential clinical training needed for providing high quality patient care to critically ill patients on complex medication regimens. Further, they promote a team based approach to care where the clinical pharmacist is a member of the multidisciplinary patient care team. The programs have emerged out of a clear need for the medication expertise of pharmacists who wish to perform a clinical role in the hospital and health-system. These programs have grown considerably in recent years and funding has been provided through the Veterans' Administration program, Department of Defense, and until 2004, Medicare.

ASHP believes these programs are essential to providing the highest-quality care possible, while minimizing the risk of adverse drug events due to medication-related problems. These programs increase the resident's depth of knowledge, skills, attitudes, and abilities to raise the resident's level of expertise in medication therapy management and clinical leadership in the area of focus. In those practice areas where board certification exists, graduates are prepared to pursue such certification.

According to the ASHP Long-Range Vision for the Pharmacy Work Force in Hospitals and Health Systems<sup>2</sup>, PGY2 specialized pharmacy residency programs foster development of pharmacists to care for highly-specialized and complex patients, capable

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<sup>2</sup> ASHP Long-Range Vision for the Pharmacy Work Force in Hospitals and Health Systems. Am J Health-Syst. Pharm. 2007; 64:1320-30

of effectively interacting with specialized physicians and nurses and conducting collaborative research. Similar to residencies in medicine, pharmacy residencies are intense, structured, “learn by doing” experiences that involve close work with preceptors and mentors. Further, ASHP believes that future roles involving specialized clinical activities, informatics and top management activities, pharmacists will be required to have completed an ASHP-accredited second-year residency. As the health care delivery system, particularly in hospitals and health-systems, evolves, licensure alone will be insufficient for practice.

In order to foster the growth of these programs, ASHP has adopted several policy positions that ultimately seek to make completion of a residency (both first and second year), a requirement for the clinical pharmacist in a hospital. The intent of the policy positions are to foster the growth of residency programs to reflect changes in care delivery and an increasing reliance on the multidisciplinary patient care team.

ASHP Policies and Guidelines:

#### **0701: REQUIREMENT FOR RESIDENCY**

*Source: House of Delegates Resolution*

To support the position that by the year 2020, the completion of an ASHP-accredited postgraduate-year-one residency should be a requirement for all new college of pharmacy graduates who will be providing direct patient care.

#### **0704: RESIDENCY PROGRAMS**

*Source: Council on Education and Workforce Development*

To strongly advocate that all pharmacy residency programs become ASHP-accredited as a means of ensuring and conveying program quality.

#### **0325: PUBLIC FUNDING FOR PHARMACY RESIDENCY TRAINING**

*Source: Council on Legal and Public Affairs*

To support legislation and regulation that ensures public funding for accredited pharmacy residency programs consistent with the needs of the public and the profession; further,

To oppose legislation or regulation involving reimbursement levels for graduate medical education that adversely affects pharmacy residencies at a rate disproportionate to other residency programs.

#### **9911: PHARMACY RESIDENCY TRAINING**

*Source: Council on Educational Affairs*

To continue efforts to increase the number of pharmacy residency training programs and positions available; further,

To expand efforts to make pharmacy students aware early in their education of the career choices available to them and the importance health-system employers attach to the completion of a residency.

#### **0005: RESIDENCY TRAINING FOR PHARMACISTS WHO PROVIDE DIRECT PATIENT CARE**

Source: Council on Educational Affairs

To recognize that optimal direct patient care by a pharmacist requires the development of clinical judgment, which can be acquired only through experience and reflection on that experience; further, To establish as a goal that pharmacists who provide direct patient care should have completed an ASHP-accredited residency or have attained comparable skills through practice experience.

## ASHP 2015 Initiative

Health-System Pharmacy 2015 is ASHP's landmark initiative to significantly improve the practice of pharmacy in health systems. The initiative includes a series of profession-wide goals and objectives that include target percentages, which were chosen based on member input, reflect substantial, realistically achievable improvements by the year 2015. The following goal 4 and objective 4.7 is relevant to the residency issue:

Goal 4: Increase the extent to which pharmacy departments in health systems have a significant role in improving the safety of medication use.

Objective 4.7: 90% of pharmacists entering hospital and health-system practice will have completed an ASHP-accredited residency.

A clinical pharmacist who completes two years of residency training also can reduce hospital expenditures by applying the skills he or she has learned. In a study published by the *American Journal of Health-System Pharmacy*<sup>3</sup>, an intensive care unit clinical pharmacist saved a hospital as much as \$280,000 over a 4.5-month period by preventing potential adverse drug events. The pharmacist, who had completed both a general residency and a specialized residency in critical care pharmacy practice, conducted patient care rounds, chart reviews, and other interventions.

ASHP supports including pharmacists within the health care professions that participate in the National Health Service Corps (NHSC). This program allows participating health care professionals to reduce their student loan balance, participate in scholarship programs, and experience student resident/rotations in community health settings in exchange for practicing in rural or underserved areas. Currently, pharmacists are not included among the health care professionals who are eligible to participate in the NHSC. Similar to other health professions, pharmacy is also experiencing a workforce shortage, which is particularly evident in rural areas. Congress can help alleviate this burden by allowing pharmacists to participate in the loan forgiveness program under the NHSC.

Given the additional funding made available to the Health Resources and Services Administration (HRSA) under the American Recovery and Reinvestment Act of 2009 specifically for loan forgiveness under the NHSC, ASHP believes that this is an appropriate time for pharmacists to be eligible for the program. Additionally, a recently published report by the Health Workforce Information Center titled “The Adequacy of

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<sup>3</sup> Kopp BJ, Mrson M, Erstad BL, and Duby JJ Cost Implications of and potential adverse events prevented by interventions of a critical care pharmacist. *Am J Health-Syst Pharm.* 2007; 64:2483-2487.

Pharmacist Supply: 2004 to 2030,” shows that there is still a shortage of pharmacists nationwide, (<http://www.healthworkforceinfo.org/topics/resources.php?id=118>).

Finally, the fragmentation of various departments, bureaus and government agencies have hindered development of any kind of coordinated effort to address health care workforce challenges. Many times this has resulted in health professions competing against each other for scarce resources devoted to workforce development. ASHP is pleased to see the Finance Committee is considering the formation of a national health workforce commission, however, we believe it is essential that all health professions be represented on the commission, including pharmacists. As the nation’s third largest health profession, ASHP believes pharmacists must have a presence on the proposed national health workforce commission.

#### TANF Health Professions Competitive Grants

ASHP would be supportive of utilizing block grants for disadvantaged parents for the purpose of obtaining accredited education and training in the health care field. These grants could help alleviate the shortage of pharmacists and technicians by allowing individuals to receive the accredited education and training they need through financial aid and child care services.

#### **Section V: Public Program Integrity – Options to Combat Fraud, Waste and Abuse**

ASHP supports efforts to combat fraud and abuse in both Medicare and Medicaid. Fraud and abuse of the health care system result in unnecessary costs to the American taxpayer and increase overall health care costs to the health care system as a whole. ASHP is willing to work with elected officials, both state and federal to combat criminals who seek to take advantage of public programs. Although committed to fighting fraud, we want to work with officials to ensure that efforts to combat fraud and abuse are not overly burdensome on caregivers to the extent that patient care suffers. ASHP believes that this should be a collaborative effort between the public and private sectors.