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ASHP Comments on Comparative Effectiveness Research
to the Federal Coordinating Council for Comparative Effectiveness
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Good afternoon. My name is Cynthia Reilly and I am the Director of the Practice Development Division at the American Society of Health-System Pharmacists. ASHP represents 35,000 pharmacists, pharmacy students, and pharmacy technicians who practice in hospitals and health systems. Pharmacists' expertise in medication use ensures that drug therapies are used safely, effectively, and in a cost-conscious manner. I appreciate the opportunity to present the Society's perspective on comparative effectiveness research, or CER, to the distinguished members of the Federal Coordinating Council for Comparative Effectiveness Research.

ASHP is a member of the Alliance for Better Health Care, which advocated for inclusion of comparative effectiveness research funding within the American Recovery and Reinvestment Act of 2009. The Society is also publisher of *AHFS DI*, a comprehensive, independent reference on the clinical use of medications, which is recognized through federal legislation under Medicare Part B, Medicaid, and Medicare Part D as an official compendium. For over 50 years, *AHFS DI* has followed sound and high-quality editorial processes to synthesize complex evidence for dissemination and use by a broad range of stakeholders, including prescribers, pharmacists, individuals who make health-policy and coverage decision, patients, and others. ASHP believes there is significant need to compare the effectiveness and safety of specific drug therapies within pharmacologic classes, drug therapies within different classes, and drug therapies with other treatment modalities. *AHFS DI* can serve as a foundation for medication information to support CER and ASHP looks forward to participating in this research.

Today, ASHP requests that the Council consider three CER recommendations related to health care delivery systems that represent critical information needs to improve patient outcomes:

- Optimal practice models for delivery of patient care,
- Strategies for using IT-enabled decision support for delivery of CER, and
- Best practices for disseminating and implementing CER.

As described by the Dartmouth Atlas, the quality and cost of care is inconsistent across geographic regions, with much of this inconsistency attributed to variation in the care setting and the health care professional that provides the service. Under Medicare Part D, pharmacists provide medication therapy management services that include formulating medication treatment plans; monitoring and evaluating patients' response to therapy; performing medication reviews to identify, resolve, and prevent medication-related problems; and coordinating and integrating MTM services within the broader health care services provided to patients. Pharmacists also participate in chronic disease management and prevention activities under collaborative practice agreements with physicians. MTM programs and published research have demonstrated that pharmacist management of disease and drug therapy significantly improves patient outcomes, while reducing overall health care costs. However, there is limited research that directly compares this practice model to models in which care is provided by other health care professionals or interdisciplinary teams. ASHP believes such research would demonstrate best practices and strongly recommends models of care as a research priority for CER.

A critical element of CER is ensuring that research findings reach the point of care where clinicians, together with patients, can use the information to make informed treatment decisions. Electronic health records and other technologies are expected to provide point-of-care information; however use of these technologies is currently limited, as described in a recent *New England Journal of Medicine* study that found less than 2% of hospitals have fully implemented an electronic health record with clinical documentation, test and imaging results, CPOE, and decision support. Decision support technology has great potential to deliver CER findings, but strategies for creating and integrating these programs within other technologies, as well as barriers to implementation, are not well-studied. ASHP encourages the Council to support research that compares approaches for using clinical decision support and other technologies in the translation and implementation of CER.

In addition to technology, other effective dissemination and translation techniques are needed to ensure that CER findings are used to make informed decisions that improve patient outcomes. However, there are significant challenges in these activities. It has been estimated that there is a 17-year lag time between evidence generation and its widespread implementation. Many strategies have been used to enhance the rate and extent of adoption of evidence-based best practices, including clinical guidelines, continuing education for health care professionals, patient education tools, and most recently, academic detailing. However, these approaches are not well studied and results are variable. ASHP would encourage the Council to support research that compares the benefits and limitations of each approach in order to determine the strategy, or combination of strategies, that facilitates use of CER by each audience, including clinicians, patients, and payers.

Finally, based on ASHP experience as a drug information publisher, we encourage the Council to consider that, similar to drug information, CER research and dissemination efforts are not single events, but rather an ongoing process that requires sustainable and ongoing effort to ensure the currency and usefulness of the information as evidence evolves.

ASHP appreciates this opportunity to provide recommendations for CER. Along with our members, we look forward to collaborating with the Council and others to ensure that CER is not only useful, but also disseminated to clinicians, payers, and patients and subsequently translated into practice.