

# Improving Medication Use and Lowering Health Care Costs

## ***Our Nation's Medication Use Problem***

Medications are the first line of defense and have been proven to be our most important weapon in the fight against all disease, including chronic diseases like diabetes and coronary heart disease. Unfortunately, improper medication use has been estimated to cost our nation \$177 billion annually in total direct and indirect healthcare costs.<sup>1</sup> In addition, due to personal financial issues more patients are going without their medications and foregoing necessary treatment. Now, more than ever, patients need an accessible expert who can help them manage all aspects of their medication therapy.

## ***Successful Medication Therapy Management Programs***

Public and private sector payers/employers that provide their beneficiaries assistance in managing their medication therapy have seen lowered costs, increased productivity, and improved health outcomes:

- ***Asheville Project.*** The City of Asheville, a self-insured employer, implemented a voluntary health benefit in 1996 for employees with diabetes. Employees were provided intensive education and teamed with community pharmacists who made sure they were using their medications effectively and also got coaching on important lifestyle changes. Employees, retirees, and dependents soon began experiencing improved A1C levels, lower total health care costs, and fewer sick days. Due to its success, the Project was expanded to include cardiovascular disease, asthma and depression.
- ***Diabetes Ten Cities Challenge (DTCC).*** Employer groups in ten communities were invited to establish a value-based health benefit for employees and dependents. Using incentives, employers encourage people to manage their diabetes with the help of pharmacist coaches, physicians, and community health resources. The data show average total health care costs were reduced annually by \$1,079 per patient compared to projected costs if the DTCC had not been implemented. There also were improvements in key clinical measures — including A1C (blood glucose), cholesterol and blood pressure — and increases in preventive care measures, including the number of people with current influenza vaccinations, eye exams and foot exams.<sup>2</sup>

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## ***APhA's Delivery Reform Recommendations: How to Achieve Quality and Cost Goals***

To better ensure quality and cost goals are met, we strongly recommend explicitly including pharmacists in several areas of health care reform as follows:

- **Include Pharmacists as Part of Integrated Care Models.** Legislative proposals should include pharmacists as part of an integrated and collaborative care system that promotes effective use of medications. The system must take advantage of the specialized knowledge and skills of all professionals working as part of the medical home or accountable care organization. The incorporation of pharmacists' clinical services is necessary given the nearly universal role of medications in the care of patients with both chronic and acute disease.
- **Include Pharmacists in Payments for Transitional Care Activities.** Pharmacists are medication experts and one of the most readily accessible providers. Medication use is a top reason for hospital readmissions. Pharmacists on the transitional care team can play a major role in preventing these events, as patients are discharged from the hospital.
- **Ensure Health IT Interoperability.** Medications are a primary form of therapy. To better ensure medication use is optimized, all members of the health care team, including prescribers and pharmacists, must have access to an interoperable HIT system that provides access to patient health information; allows for an exchange of information; and ensures that the patient's health record is complete by ensuring that the results of all interventions, including pharmacist interventions, are reflected in the patient's health record. Also, to better ensure broad pharmacy participation in electronic health records, legislative proposals should provide pharmacies and pharmacists financial assistance to adapt and adopt HIT systems. Otherwise, silos will continue to exist among primary care providers.
- **Provide Medication Therapy Management Services.** Legislative proposals should require any health plan that is offered to provide a comprehensive pharmacy benefit that covers both medications and pharmacist services that ensure that the use of those medications are fully optimized and achieve therapeutic outcomes.
- **Conduct a Medication Therapy Pilot.** As CMS and/or AHRQ are given additional authority and direction to conduct demonstration/pilot projects, legislative proposals should ensure that the clinical/coach role of the pharmacist is an element of at least one project.

1 Accessed May..." with "Ernst FR, Grizzle AJ. Drug-related morbidity and mortality: updating the cost-of-illness model. J Am Pharm Assoc. 2001;41:192-9

2 Diabetes Ten City Challenge: Final economic and clinical Results. J Am Pharm Assoc. 2009;49:e52-e60.

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## **Others Agree on the Need to Manage Medication Therapy**

**Agency for Healthcare Research and Quality (AHRQ):** "...Pharmacists were most likely to prevent the errors from reaching the patients (40 percent of intercepted medication errors), while physicians and patients were almost equally likely to intercept the medication error (19 percent and 17 percent of intercepted errors, respectively)."<sup>1</sup>

**Centers for Medicare and Medicaid Services (CMS):** "... we believe that MTMP [medication therapy management programs] must evolve and become a cornerstone of the Medicare Prescription Drug Benefit."<sup>2</sup> More recently, CMS stated that in their ongoing attempt "to maximize access to MTM", that the Agency wants to "raise the level of the MTM interventions offered to positively impact medication use."<sup>3</sup>

**George Halverson, Chairman and CEO of Kaiser Foundation Health Plan, Inc. and Kaiser Foundation Hospitals:** "We did a study in Colorado. We did team follow-up care for heart patients. Again,... pulled information out [of] the electronic medical record into a care registry and then, had teams of nurses, caregivers, and pharmacists actually, because pharmacists are the most underutilized resource in health care, use[d] pharmacists to help advise if patients were not taking the drug, what the right drug would be, and the result of that was 73% reduction in deaths for heart disease and coronary heart disease for the entire heart population that we have in Colorado."<sup>4</sup>

**Institute of Medicine (IOM):** "...because of the immense variety and complexity of medications now available...the pharmacist has become an essential resource...and thus access to his or her expertise must be possible at all times."<sup>5</sup>

**Kendall Powell, Chairman and CEO of General Mills:** "No one understands these medications. They are too complex. We have white collar, professional, highly educated people at General Mills who do not know how to follow their meds. And so what we're doing now – again on this prevention tact – is we're sitting them down with a pharmacist. For as long as they need to, to understand what they're taking, why, the consequences of withdrawal, all the interactions. And again it makes a huge difference in the management of chronic disease."<sup>6</sup>

**Medicare Payment Advisory Commission (MedPAC):** "...a Medicare medical home would be responsible for monitoring its patients' medications. Medical homes should conduct periodic reviews of a patient's regular medications in addition to reviews immediately after an acute event, such as a hospitalization... Ideally, these medication reviews would be coordinated with a pharmacist."<sup>7</sup>

### **Endnotes**

1 AHRQ February 2009 Research accessed May 4, 2009 at [http://www.bighperformancepharmacy.com/pdf/case\\_studies/263.pdf](http://www.bighperformancepharmacy.com/pdf/case_studies/263.pdf)

2 Final CMS Rules Published in Federal Register on January 28, 2005 (70 FR 4280)

3 CMS 2010 Call Letter

4 HIMSS09 Keynote Address, accessed May 18, 2009 at <http://www.himssconference.org/general/videos.aspx>

5 Institute of Medicine. To Err Is Human: Building a Safer Health System. Washington, D.C.: National Academy Press; 2000.

6 During a breakout session of the White House Forum on Health Reform on March 5, 2009.

7 Medicare Payment Advisory Commission. Report to the Congress: Medicare Coverage of Nonphysician Practitioners. 2002. Available on-line at: [http://www.medpac.gov/publications/congressional\\_reports/jun02\\_NonPhysCoverage.pdf](http://www.medpac.gov/publications/congressional_reports/jun02_NonPhysCoverage.pdf).

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