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Comprehensive Medication Management: Implications for the Patient and Pharmacist

Abstract

Since 1979, state pharmacy practice laws have begun to allow pharmacists to provide advanced levels of care in collaboration with prescribers. These might be termed medication therapy management, collaborative practice, comprehensive medication management and other variations. Invariably, pharmacists working closely with prescribers and patients in care of chronic disease have achieved dramatic results including improvement in surrogate markers, decreased rates of secondary large organ disease, decreased mortality, decreased hospitalizations, and as a result decreased spending.¹⁻²⁸

This paper will discuss the profound impact of advanced practice models on patient care and the health care system, the current status of New York's collaborative drug therapy management law, the comprehensive medication management proposal in Governor Cuomo's fiscal year 2018 Budget bill, and its potential impact on morbidity and mortality when applied to chronic disease.

Disciplines

Pharmacy and Pharmaceutical Sciences

Comments

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Comprehensive Medication Management: Implications for the Patient and Pharmacist

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Since 1979, state pharmacy practice laws have begun to allow pharmacists to provide advanced levels of care in collaboration with prescribers. These might be termed medication therapy management, collaborative practice, comprehensive medication management and other variations. Invariably, pharmacists working closely with prescribers and patients in care of chronic disease have achieved dramatic results including improvement in surrogate markers, decreased rates of secondary large organ disease, decreased mortality, decreased hospitalizations, and as a result decreased spending.¹⁻²⁸

This paper will discuss the profound impact of advanced practice models on patient care and the health care system, the current status of New York's collaborative drug therapy management law, the comprehensive medication management proposal in Governor Cuomo's fiscal year 2018 Budget bill, and its potential impact on morbidity and mortality when applied to chronic disease.

The role of the pharmacist has continued to evolve in New York State over the past decade. Mirroring other states, the pharmacy practice law has evolved to allow pharmacists to collaborate with physician colleagues in collaborative drug therapy management ("CDTM"). This started in 2011 with the creation of a "demonstration program" to assess the ability of pharmacists in New York to improve outcomes for patients in select settings (NYS Laws of 2011, ch. 21; Education Law §§6801, 6801-a). This pilot project was narrowly limited to pharmacists who had a doctor of pharmacy degree or Master of Science in clinical pharmacy with at least one year of residency training and one additional year of practice or two years of residency training. It also permitted pharmacists with the Bachelor of Science in pharmacy degree and at least three years of experience, with at least one year of clinical work (all within the past seven years). It was further limited to pharmacists in a "teaching hospital," defined as a healthcare entity licensed under Article 28 of the Public Health Law which receives funding for graduate medical education. The demonstration program notably excluded nursing homes and community pharmacies.

This pilot project, with data from participating pharmacists presented to the State Education Department, was an undisputed success. The report demonstrated the ability of the pharmacist to improve health outcomes and decrease morbidity and presumed mortality and health care costs in

anticoagulation, diabetes, heart failure, human immunodeficiency virus (HIV), oncology, and asthma.²⁹ It also noted improved patient and practitioner satisfaction. This data led to the State Education Department recommend to the state legislature to continue this practice in New York State. Pharmacists in New York advocated for expansion of this to areas of practice where pharmacists can have an even bigger impact, including all healthcare settings, adding community pharmacies and nursing homes.

What ultimately passed only slightly modified the required qualifications in both credentials and practice site (New York State Laws of 2015, ch. 238). Currently, pharmacists in New York with a doctor of pharmacy can participate if: they have practiced for two or more years and 1 year of clinical experience providing clinical services within the past 3 years (may include a residency) (NYS Education Law, section 6801-a((2)(b)) AND they have board certification acceptable to the state Board of Pharmacy or completion of an accredited or accreditation-pending postgraduate pharmacy residency program (8 NY Administrative Code, section 63.10(c)(3)(iii)). If pharmacists possess a bachelor of science in pharmacy, the required years of experience increase to 3 years, with at least one year providing direct patient clinical care in the past three years. The pharmacist's practice setting was expanded to include any teaching or general hospital, including any diagnostic center, treatment center, or hospital-based outpatient department based on section 2801 of the public health law. It also allows for pharmacists to practice CDTM in a nursing home with an on-site pharmacy.

Note well that the law does not include the overwhelming majority of pharmacists in New York State practice, and are most accessible: the community pharmacy. In the 2017-2018 fiscal year, the Governor added into his initial draft budget a provision adding a new section 280-c to the Public Health Law entitled Comprehensive Medication Management ("CMM") that would allow pharmacists to participate in a more active way in patient care through a collaborative relationship with a patient's primary care physician. This was based on the knowledge that community pharmacists have a demonstrated skill set that, similar to their institutional colleagues, can decrease morbidity and mortality, and dramatically decrease costs. The CMM proposal would enable qualified pharmacists, to engage in a voluntary collaborative agreement with a physician already providing care for a pa-

tient who “has not met clinical goals of therapy, and is at risk for hospitalization”. This created an entirely voluntary agreement where existing therapeutic relationships between physicians and community pharmacists were able to be codified to allow pharmacists to assist with the pharmacotherapy management of patients through titration and modification of medication regimens. Additional requirements included the need for the pharmacist to be able to document any changes in the medical record. It is clear that only allowed pharmacists who had a strong preexisting relationship with a physician and proximity to his or her clinical site (based on need for EMR access) would be able to participate. Unfortunately, this provision was not ultimately enacted into the final budget bill.

It is tempting to think that only residency trained or clinically experienced hospital-based pharmacists can have a significant impact on patient care. However, there is ample published evidence that front-line community pharmacists can also have a positive impact on patient care.¹⁻²⁶ A prime example of this are the Asheville Project studies conducted over the last 20 years.³⁻⁶ These studies looked at the impact of using certificate trained community pharmacists to provide face-to-face medication therapy management on a regular basis for individuals with chronic diseases such as diabetes, hypertension, hyperlipidemia, and asthma. In every published study they found significant clinical improvement. In addition, they observed decreased costs for the health care system attributed to the interventions by the pharmacist. These were, for the most part, not residency trained or hospital based pharmacists, just highly motivated community pharmacists who were willing to receive some additional training to be up to date on published guidelines for these chronic conditions.

CMM will allow for pharmacists to participate in the care of patients that are high risk and living in underserved areas where primary care is lacking. Current CDTM regulations limit participating pharmacists to areas where there is already a high level of healthcare resources (cities, large health systems). Indeed, as of May 2017, there are only 122 pharmacists certified to engage in CDTM, with few applications pending. This is a highly talented pool of pharmacists, but the numbers are not on trajectory to serve the overwhelming majority of New Yorkers. CMM, however, can invite pharmacists in rural New York or in areas otherwise limited by current CDTM requirements to help participate in the care of patients. Current law unjustly distributes the benefit of pharmacists to the lucky patients that go to healthcare facilities that are deemed appropriate. However, the skillset of a pharmacist does not change just because he or she is practicing in a different facility (e.g. community pharmacy). Implementation of CMM would afford all New Yorkers full access to the clinical skill set of a pharmacist practicing at the top of his or her license in arguably the most accessible healthcare location: the community pharmacy.

Enabling qualified pharmacists to provide CMM in all practice areas is also an issue of public protection. Comprehensive medication management, CDTM, or whatever else we might choose to call it, is proven to decrease morbidity and mortality in the context of chronic disease. If we are a patient-centered profession, we have an ethical imperative to advocate for pharmacists to provide this level of care.

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