

June 22, 2015

The Honorable Orrin Hatch  
Chairman  
Committee on Finance  
United States Senate

The Honorable Ron Wyden  
Ranking Member  
Committee on Finance  
United States Senate

The Honorable Johnny Isakson  
Senator  
Committee on Finance  
United States Senate

The Honorable Mark Warner  
Senator  
Committee on Finance  
United States Senate

**RE: Finance Committee Working Group Request for Information on Ways to Improve Outcomes for Medicare Patients with Chronic Conditions**

Submitted electronically to: [chronic\\_care@finance.senate.gov](mailto:chronic_care@finance.senate.gov)

Dear Chairman Hatch, Ranking Member Wyden, Senator Isakson, and Senator Warner:

Thank-you for the opportunity to comment and for your commitment to meaningful bipartisan legislation. I had the privilege of co-leading the medication management task-force of the Patient-Centered Primary Care Collaborative (PCPCC) when a broad stakeholder group established the need and developed a guide to integrate a systematic approach to medication management to optimize patient outcomes within the patient-centered medical home. Comprehensive medication management (CMM) <sup>1</sup> was defined to provide a framework for a “whole-patient approach” to medication management. Appendix A included guidelines for practice and documentation consistent with PCMH and ACO integration.

“Comprehensive medication management is defined as the standard of care that ensures each patient’s medications (whether they are prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended. Comprehensive medication management includes an individualized care plan that achieves the intended goals of therapy with appropriate follow-up to determine actual patient outcomes. This all occurs because the patient understands, agrees with, and actively participates in the treatment regimen, thus optimizing each patient’s medication experience and clinical outcomes.”

The need is clear for patients with chronic disease who frequently see multiple providers or transition between sites of care. As a physician, bringing clinical pharmacists into the “team” that are both capable and willing to collaboratively deliver this level of service represents the most transformational paradigm shift in healthcare.

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<sup>1</sup> T. McInnis, E. Webb, and L. Strand. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes*, <http://www.pcpcc.org/guide/patient-health-through-medication-management> June 2012- page 5 definition

**Recommendation: Introduce legislation that provides for Comprehensive Medication (CMM) as a key service for all Medicare fee-for-service beneficiaries through Part B, Medicare Advantage plans, and as an essential element in all advanced payment models.**

Failure to enact policy to integrate, enable a service model, and remove existing legislative and payment barriers to provide a patient-centered, systematic approach to medication management consistent with comprehensive medication management (CMM) will continue to propagate a failed and unsustainable system of uncoordinated medication use resulting in poor outcomes and runaway healthcare costs. The integration of comprehensive medication management (CMM) services as the solution for coordinating and optimizing the medications of patients with chronic disease should be considered **the** top priority in transforming our healthcare system into one that is sustainable financially and quality driven.

Why? As you recounted the fact that 93% of Medicare cost is related to chronic disease, you must also consider that 90% of the means by which we treat and control chronic disease is with medications. Therefore absent a systematic approach to medication management we will fail to significantly improve outcomes or lower cost.

In testimony that you heard on July 15th, 2014 on “Chronic Illness: Addressing Patients’ Unmet Needs,” 3 of your 5 witnesses clearly articulated that the top concern was the lack of a systematic approach to the coordination of medications.

1) **Stephanie Dempsey, a patient advocate** spoke of her prolonged efforts to resolve her worsening seizure disorder caused by a medication prescribed by another specialist to treat her lupus.

2) **Chet Burrell, President and CEO of Care First** spoke of patients in the 65+ year old range having 20+ medications saying- “ A key challenge is that the specialists who treat chronic conditions typically operate in unrelated practices with little or no communication among them. This fragmentation often leads to breakdowns even when each specialist is effectively diagnosing and treating his/her portion of the patient’s needs. Thus, even if each of the specialists is providing outstanding care, the net effect is an uncoordinated jumble of medications and confusing instructions with no one to sort it out.”

3) **William Bornstein MD**, chief quality and medical officer at Atlanta-based Emory Healthcare stated: “The challenge is, how do we make sure all the care is coordinated to make sure we have a patient-centered approach,” he said of chronic disease patients, noting that many have a dozen specialists that they see annually. When Bornstein treats people with diabetes, he said specialists working with his patients should be planning around the effects of multiple medications. “How often does that happen? In my experience, almost never,” he said.

A 3-year CMMI Innovation grant, ending this year was awarded to the University of Southern California (USC) School of Pharmacy collaborating with AltaMed Health services to provide comprehensive medication management (CMM) for patients with poor chronic disease control in primary care teams (Patient Centered Medical Home-

PCMH and Programs for the All inclusive Care of the Elderly-PACE clinics).<sup>2</sup> In 10 clinics with over 6000 patients this grant shows strong preliminary results which builds upon overwhelming previous evidence substantiating that high-risk patients have many medication related problems (ave. 10 per patient), which when resolved result in vastly improved quality, lower acute care utilization, and extremely high patient and physician and provider satisfaction.

The Veteran's Administration has over 3000 clinical pharmacist collaboratively practicing within the patient aligned care teams (PACT), the VA's version of the medical home. ROI's from the VA have been reported to be as high as 28:1 and in other settings range from 17:1 to 1.29:1.<sup>3</sup> Taught and outlined in major texts (Pharmaceutical Care-The Patient Centered Approach)<sup>4</sup>, this approach is beginning to work for patients worldwide, but continues to not be a funded service under Part B fee-for-service for Medicare.

It is time to make radical changes in our system, including the introduction of pharmacist in ambulatory care settings working collaboratively with physicians as providers of this key service separate and distinct from any product dispensing activity or role.

We currently have a physician workforce shortage, most acutely felt in primary care. By clinical pharmacists working collaboratively with physicians and other providers as part of the patient-centered medical home and other comprehensive primary care teams, we can significantly shift a portion of these medication experts numbering over 275,000 and representing the 3rd largest healthcare workforce to deliver CMM services as separate and distinct from a dispensing role. This represents an opportunity to significantly increase access to care. Please make this your top priority.

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"However beautiful the strategy, you should occasionally look at the results."

Winston Churchill

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<sup>2</sup> <http://www.careinnovations.org/knowledge-center/facilitating-care-integration/integrating-primary-care-and-pharmacy-care/innovator-highlight-integration-of-pharmacy-teams-into-primary-care>. USC and AltaMED Webinar and download of slides- <http://www.careinnovations.org/knowledge-center/care-integration-webinar-4-integrating-pharmacy-care-and-primary-care>

<sup>3</sup> ASHP- 2014 Midyear Presentation- Morreale A. "Adventure into the Unknown: How VA & Federal Pharmacy is Leading the Profession"

<sup>4</sup> Pharmaceutical Care Practice: The patient-centered approach to medication management. Cipolle RJ, Strand LM, Morley PC. McGraw Hill, NY, 2012