STATE OF MARYLAND
DHMH
Maryland Department of Health and Mental Hygiene
Lawrence J. Hogan, Jr., Governor - Boyd K. Rutherford, Lt. Governor - Van T. Mitchell, Secretary

February 26, 2015

The Honorable Lawrence J. Hogan, Jr.
Office of the Governor
State House
Annapolis, Maryland 21401-1925

The Honorable Thomas V. Mike Miller, Jr.
President of Senate
State House, H-107
Annapolis, MD 21401 – 1991

The Honorable Michael Erin Busch
Speaker of House of Delegates
State House, H-101
Annapolis, MD 21401 - 1991

John M. Colmers, Chairman
Health Services Cost Review Commission
4160 Patterson Avenue
Baltimore, MD 21215

Re: Report of the SB 257 Task Force to Study Access to Pharmacy Services in Maryland

Dear Governor Hogan, President Miller, Speaker Busch, and Chairman Colmers:

The SB 257 Task Force to Study Access to Pharmacy Services in Maryland submits this letter in response to the report required by SB 257, Chapter 150, passed during the 2014 Legislative Session.

The Task Force was assigned to review barriers that may prevent Maryland hospital patients from obtaining their prescriptions following discharge. It met for three months to review the various problems associated with patient access to pharmacy services following discharge from hospitals. It considered several models of discharge planning presented by hospitals, closed health systems, chain drug stores wellness programs, the Behavioral Health Administration, the American Society of Consulting Pharmacists, and health insurance carriers and received additional verbal and written testimony regarding patients' discharge experiences during a public hearing.

Given the breadth of information received, the variations in perspectives and in the discharge systems employed by hospitals and other entities engaged in coordinating patient discharges, as well as other practical considerations required to adequately respond to SB 257 mandates, the Task Force was not able to draw definitive conclusions in the time available. The Task Force was also unable to recommend regulations for adoption. Nonetheless, based on its expanded understanding of the issues and barriers that confront Maryland's discharged hospital patients, the Task Force recommends that access to pharmacy services in Maryland be further studied by certain experts and hospital stakeholders over a longer timeframe.

A summary of Task Force deliberations and written comments submitted to the Task Force are attached with this letter. Key Task Force findings related to the eight review items listed in SB 257 included the following:

(1) Study the availability of pharmacy services for patients when they are discharged from the hospital;

Various models of hospital discharge planning were reviewed. The Task Force learned that the availability of services varied based on particular models and other factors. For example, physical access, transportation to pick up prescriptions, and limited pharmacy hours were noted as barriers to securing needed medications. Also, regional differences affected the availability of pharmacy services for some patients when they are discharged.

(2) Identify any barriers or obstacles facing patients when they are discharged from the hospital that may prevent them from filling prescription orders;

In addition to limited service availability in some areas, a general lack of communication of prescription information and poor education of patients were identified as barriers that have prevented some patients from filling orders. Patient motivation and biases were barriers identified by presenters during deliberations. Another barrier discussed included the variation in services offered by available discharge programs. For example, some hospitals' staff discuss the medications administered by the hospital physicians with their patients where others do not.

Cost and prescription coverage were also identified as barriers following hospital discharges. Maryland has a law regarding pre-authorizations. A Maryland Health Care Commission (MHCC) report recently showed that all carriers have met the State law related to insurance adjudication. Despite real time adjudication and the ability to acquire immediate adjudication, however, only 1% of physicians are using the pre-authorization forms. Reconciliation of old and new prescriptions was described as a barrier that has resulted in some patients being sent home with duplicate medication therapies prescribed. Physical access, transportation to pick up prescriptions and limited pharmacy hours were noted as barriers to securing needed medications. The Task Force acknowledged that region to region differences should also be taken into consideration when planning patient discharges.

(3) Compile information on best practices, programs, and community pharmacist services used around the State and nationally to provide and to facilitate access to pharmacy services, including community pharmacy medication therapy management services;

A variety of best practices were shared during the four Task Force meetings and Public hearing. A few best practices shared with the Task Force for patients discharged back to their homes in their communities included:

- Counseling patients about medications they no longer need to take and any new prescriptions before they are discharged;
- Initiating prior authorization by insurer process prior to discharge;
- Implementing pharmacy service plans for the patients within a few days after they are discharged;
- Faxing or e-prescribing patients' prescriptions to the patients' pharmacies at discharge;
- Determining Medicaid eligibility for patients prior to discharge;
- Performing follow-up care by phone – regarding refills and taking the drug properly.
- Sending the medications with the patient when they are discharged from the hospital.
- Having the Hospital/program perform follow-up care by phone – regarding refills and taking the drug properly.

Common best practices for patients discharged to long term care or acute care facilities included:

- Having a consulting pharmacist meet with the patient and family/caregiver to review medication list/ history, any changes in medications since the acute care stay, including Formulary changes, new medications, and any planned discharge orders;
- Preparing discharge prescriptions the day before planned discharges and checking insurance coverage for such prescriptions, securing prior authorization as needed or writing alternative, covered prescription before issuing the prescription to the patient;
- Having the pharmacy technician meet with all known discharges on the day of discharge, after discussing the medication regimen with nursing and the pharmacist staff;
- If a patient wishes, filling the prescriptions in-house and readied for delivery to the patient;
- If the prescriptions are filled in-house, delivering the filled orders to the responsible nurse on the floor. The pharmacist and nurse would coordinate delivery to the patient and appropriate review and discussion;
- If the patient chooses, having the prescriptions filled by their personal pharmacist following receipt of electronic prescriptions from the hospital;
- If the patient wishes to use their personal pharmacist, having the nurse and pharmacist discuss the written prescriptions with the patient and family;
- If payment for the prescriptions is a concern, best practices have included:
    - The Team coordinates with patient support services to facilitate drug availability
    - Use of alternative prescriptions by a prescriber
    - Facilities that are willing to absorb the cost of the drug, and/or
    - Seeking manufacturers or foundations to supplement patient co-pays or medication costs.

The Task Force identified Medication Therapy Management (MTM) as a potential tool to facilitate access to pharmacy services. However, it was felt that a work group would be required to research the true benefits of MTM for discharged patients. Numerous other best practices were discussed during meeting presentations and documented in the attached meeting deliberation summary. All of the best practices discussed would require additional details before the Task Force would be able to positively attest to the extent of their benefits versus the required resources, costs and other considerations.

(4) Explore transition of care and care coordination efforts by hospital staff and direct acute care pharmacists that connect patients with needed pharmacy services after discharge from the hospital;

The Task Force encourages a future review of patient care following discharge to gain a better understanding of follow-up actions that are taken related to patient medication care and coordination. It was learned that, sometimes the community pharmacist is not included in the planning and coordination of after care for discharged patients. Thus, the Task Force recommends further study on the community pharmacist' roles in care coordination. Additionally, bedside delivery, though more expensive, was discussed as a possible care coordination option. The Task Force suggest that this be reviewed in the future since it has been identified as a best practice.

(5) Consider geographic differences in the State relating to access to pharmacy services;

Time limitations interfered with the Task Force's ability to review geographic differences. The Task Force learned however that on average, all Marylanders are within 5 miles of a pharmacy. Local health departments

or similar entities are encouraged to performing surveys of geographic differences in accessible pharmacies across the State. Also, 24/7 pharmacies may be identified throughout the state through a survey.

(6) Receive public testimony from stakeholders and the public;

The Task Force hosted one public hearing in Annapolis. Two individuals, representing a pharmacist and a physician association, testified at the hearing. No patients or their families testified. Written testimony was also accepted, however, again only patient advocacy groups, pharmacy associations and businesses, educational institutions, and medical associations submitted written testimony.

(7) Recommend strategies to reduce disparities in access to pharmacy services;

Further study is required in order to address this mandate. To study this properly the Task Force identified the need to bring additional stakeholders to the table (e.g., Chesapeake Regional Information system (CRISP), Health Information Exchange (HIE) and hospitals from across the state).

(8) Recommend the adoption of regulations by the Department of Health and Mental Hygiene that are consistent with the efforts of the State to redesign the State's Medicare waiver.

As noted above, the Task Force was unable to develop and recommend the adoption of regulations consistent with State efforts to redesign the State's Medicare waiver because of the scope of review required under SB 257 in the allotted time.

Should you have questions or additional concerns, please feel free to contact Anna D. Jeffers, Legislation and Regulations Manager, Maryland Board of Pharmacy, at (410) 764-4794.

Sincerely,

Van T. Mitchell
Secretary

Enclosure

cc: The Honorable Edward J. Kasemeyer, Chair, Senate Budget and Taxation Committee
The Honorable Thomas M. Middleton, Chair, Senate Finance Committee
The Honorable Maggie McIntosh, Chair, House Appropriations Committee
The Honorable Peter A. Hammen, Chair, House Health and Government Operations Committee
Sarah Albert, Department of Legislative Services, MSAR #10119
Linda Bethman, Board Counsel, Maryland Board of Pharmacy
Shawn Cain, Chief of Staff, DHMH
Lenna Israbian-Jamgochian, President, Maryland Board of Pharmacy
Anna D. Jeffers, Legislation and Regulations Manager, Maryland Board of Pharmacy
Christi Megna, Assistant Director, Office of Governmental Affairs
Simon Powell, Department of Legislative Services
Sajal Roy, Chair, SB 257 Task Force to Study Access to Pharmacy Services in Maryland
Allison Taylor, Director, Office of Governmental Affairs
Katie Wunderlich, Governor's Legislative Office

SUMMARY OF DELIBERATIONS OF THE SB 257 TASK FORCE TO STUDY ACCESS TO PHARMACY SERVICES IN MARYLAND

MEMBERS OF THE SB 257 TASK FORCE TO STUDY ACCESS TO PHARMACY SERVICES IN MARYLAND

Sajal Roy, PharmD, Chair, Board Member, Maryland Board of Pharmacy
The Honorable Delores Kelley
The Honorable Bonnie Cullison
The Honorable Shawn Tarrant
Steve Bouyoukas, Maryland NACDS
Vivian Braxton, Consumer
Jacqueline Brown, Board of Physicians
Paul Celano, M.D., MD/DC Society of Clinical Oncology
Christina M. Francino, Mobility Unit of MTA
Dr. Carrie Herzke, Maryland Chapter of the Society of Hospital Medicine
Peter Kaufman, MD, MEDCHI
Bonnie Levin, PharmD, Maryland Hospital Association
Judy Lipinski, Federally Qualified Health Center
Marie Mackowick, PharmD, Maryland Behavioral Health Administration
Deborah Rivkin, Carefirst
Richard L. Rogers, DDS, Maryland State Dental Association
Dixit Shah, PharmD, Maryland Medicaid
Matthew Shimoda, MPhA
Sonia Stockton, Board of Dental Examiners
W. Maurice Swanson, DDS, Maryland Dental Society
Meghan Swarthout, PharmD, Maryland Society of Health System Pharmacists
Angelo Voxakis, EPIC
Leslie N. Wood, Pharmaceutical Research and Manufacturers of America
Donald K. Yee, Kaiser Permanente

Board of Pharmacy Staff

LaVerne G. Naesea, Executive Director
Anna D. Jeffers, Legislation and Regulations Manager

PURPOSE

The Task Force to Study Access to Pharmacy Services in Maryland was convened following the passage of SB 257, Chapter 150 during the 2014 Legislative Session. It was assigned to review barriers that may prevent Maryland hospital patients from obtaining their prescriptions following discharge. Specifically, the Task Force was mandated to:

(1) study the availability of pharmacy services for patients when they are discharged from the hospital;

(2) identify any barriers or obstacles facing patients when they are discharged from the hospital that may prevent them from filling prescription orders;

(3) compile information on best practices, programs, and community pharmacist services used around the State and nationally to provide and to facilitate access to pharmacy services, including community pharmacy medication therapy management services;

(4) explore transition of care and care coordination efforts by hospital staff and direct acute care pharmacists that connect patients with needed pharmacy services after discharge from the hospital;

(5) consider geographic differences in the State relating to access to pharmacy services;

(6) receive public testimony from stakeholders and the public;

(7) recommend strategies to reduce disparities in access to pharmacy services; and

(8) recommend the adoption of regulations by the Department of Health and Mental Hygiene that are consistent with the efforts of the State to redesign the State's Medicare waiver.

Summary of Task Force Meetings, Public Hearing Proceedings

Given the brief timeframe in which to accomplish the mandates of SB 257, the Task Force convened three times, held one public hearing, received written comments from the public and industry, and convened one final time to review their work and determine report recommendations. The following is a summary of the Task Force deliberations.

First Meeting - September 9, 2014

Sajal Roy, Task Force Chair and Member of the Maryland Board of Pharmacy opened the meeting and allow considerable time for introduction of Task Force members and orientation. Megan Swarthout, representing the MD Society of Health System Pharmacists, also provided an overview of the admission and discharge process at the hospital where she works. The overview provided an example of

Key elements of the process described at Ms. Swarthout's hospital included:

- Admission of the patient;

- Discharge coordination begun immediately with determining why the patient has been admitted and how the hospital can assist the patient in getting back home;
- Determining an accurate medication list so the hospital can begin processing the patient's care. This is also mandated by the Joint Commission. The staff begins with:
    - Home medication list,
    - Active medication list while admitted to the hospital; and
    - Discharge medication list;
- Determination of what pharmacy the patient uses;
- Educate the patient initially by counseling the patient on how to use the information provided;
- Clarify with the patient medications they no longer need to take to address problems with patients taking medications at home that they should no longer take;
- Initiating the prior authorization by insurer process. Sustainability is key so that the hospital can keep the patient on their medications; and
- Implement a service plan for the patients after they are discharged, within 7 to 14 days.

Second Meeting - September 23, 2014

Different models of care were presented that demonstrated that existing health care models are addressing barriers to medications and addressing patient support upon discharge from institutions were presented at the second meeting. The Task Force heard presentation from Audree Watkins, DHMH Eligibility, who discussed qualifying patients for MD Medicaid; John O'Brien and Jamie Reuter from the Walgreens WellTransitions; Marie Mackowick, MD Behavioral Health Administration; David Jones, representing the American Society of Consulting Pharmacists(ASCP), who discussed Acute Care Hospital discharge planning and Long Term Care patients; Meghan Swarthout, MD Society of Health System Pharmacists who also discussed discharge planning from Acute Care Hospitals; and Don Yee of Kaiser Permanente who presented a closed integrated health system perspective.

Behavioral Health – Medicaid Eligibility

Audree Watkins, DHMH Eligibility, presented concerns about patients attempting to qualify for MD Medicaid and suggested that delay in determining eligibility impact patients obtaining their medications. Ms. Watkins also suggested that hospitals start the discharge process earlier, pointing out that previously in a State facility, 6 months had been allowed to obtain the required information, and cases could be reactivated after a patient was released. However, under the Affordable Care Act, the window is now only 30 days. The DHMH Medicaid Eligibility Unit has corresponded with State facilities and to ask them to look at the discharge needs of patients two weeks before discharge. The facilities have indicated that this is not sufficient time and often eligibility is delayed. The DHMH Medicaid Eligibility Unit has been working with the facilities to have eligibility in place closer to discharge because it receives a lot of phone calls from families who do not know what to do about receiving patients' medications following discharge. Household composition and income can impact a patient's eligibility as well as several other new nuances and challenges. For example, some individuals who transition to new housing situations in the community must be considered along with all of the patient's income.

According to Marie Mackowick, MD Behavioral Health Administration, Many patients go into supervised housing. About 20% of the patients' families need assistance with registering the patients. The MD Behavioral Health Administration is moving toward the new Health Exchange, but might use paper applications because, at the present time, someone has to assist patients and caregivers in navigating the website. Behavioral Health and MD Medicaid have been working on how to better establish eligibility.

(Please note that with the implementation of the new Health Benefits Exchange (HBX), the landscape for applying for Medicaid has changed and with the new system, there has been significant improvement.)

Walgreens WellTransitions.

Walgreens presented information on its bedside delivery program called WellTransitions. It is part of the company's overall strategic health plan. Some key points from the presentation included:

- A pharmacy technician may explain the program to the patient once they get permission from the patient.
- The WellTransitions program performs follow-up care by phone – regarding refills and taking the drug properly.
- Most hospital stays are 1 to 3 days. The participation is determined by the hospital which is part of the care that patients receive if determined eligible. The WellTransitions Program works even if the patient does not use Walgreens. Unless the patient "opts out," they are in the WellTransitions program. The patient then can decide if they want to use Walgreens as their pharmacy. Bedside delivery is available and is "opt in."
- 3 or 5 hospitals in MD are participating. The American Hospital Association approves the WellTransitions Program.
- Walgreens can also secure prior authorizations. Their goal is to have the medications with the patient when they are discharged from the hospital. The WellTransitions Program also follows up with patients to find out how it is going, including asking about any side effects, and whether the patient needs directions on how to take the medications. Other services of the WellTransitions Program include:
    - Comprehensive patient review
    - Barriers to taking the meds
    - Do they have a follow-up visit with their doctor?
    - Did you get to the appointment?
    - They call the doctor to get this scheduled.

  For specialty medications there is a health system pharmacy on the campus of the hospital. It caters to employees and patients and can assist with prior authorization. It becomes more difficult once the patient is out in the community, but they begin the process as early as possible. A Blue Cross representative indicated that they are trying to have an electronic pre-authorization available. The goal is to make prior authorization an easier process. There is also the option to call the medical director of the carrier for emergency situations.

- Looking at the total population, those patients in the WellTransitions Program were 46% less to be readmitted in the first 30 days. There has also been large patient satisfaction.
- The funding for this program is a flat fee paid to the hospital. WellTransitions is a flat fee. The program can be customized for the hospital.

Behavioral Health Presentation.

Marie Mackowick, MD Behavioral Health Administration, discussed barriers or obstacles facing patients when they are discharged. Some key points from the discussion:

- The first barrier is obtaining entitlements. Patients can apply two weeks prior to discharge. Medicaid does have someone to handle the applications who can have the patient eligible within 3 days of discharge. Most patients qualify for Medicaid, but are not active at the time of discharge. This makes it difficult to get appointments and medications, etc. They advise them to go to a walk-in clinic. The expectation is that they will have their Medicaid in hand. Without all the information required to complete the application process, treatment will be delayed.
- The second barrier is the availability of mental health appointments. Typical the wait is 4 to 6 weeks.
- The third barrier is that some discharge medications that are not on the preferred drug list. Medications not on the preferred drug list require pre-authorization in the community.

Solutions that were suggested include:

- Pharmacist run clinics that would provide clinical backup for patients on complicated medications; and
- Establish a pharmacist run "transition of care" program similar to Walgreens and assist patients in managing their medications.

Long Term Care and Acute Care – transition of pharmacy services

David Jones, representing ASCP, presented the process for transition of care of pharmacy services in institutional and acute care settings into the community.

Transition of Care Process: Institutional:

1. At the time of admission, a Team member requests a copy of the Physicians Order Sheet (POS) or Medication Administration Record (MAR). This will serve as a resource for Medication Reconciliation by the Pharmacist and PA.
2. If a drug is not available on Formulary, the patient or a family member may be asked to bring in existing supply if needed.
3. Patient Care Conference: Team meets on day 1 to discuss anticipate length of stay.
4. Case manager/ social worker meet with patient and family/ caregiver to discuss options at discharge, including possible need for rehabilitation, additional sub-acute care, or return to previous living arrangements.

5. Utilization manager validates with insurance carrier the authorized length of stay
6. These Team meetings continue daily.
7. Pharmacist meets with patient and family/ caregiver to review medication list/ history. Discussion includes any changes in medications during acute care stay, including Formulary changes, new meds, and any planned discharge orders.
    a. Continuing supply of current medications is assessed, when needed. This would apply mostly to patients admitted from an assisted living facility, with plans to return there.
8. If the patient is going to return to an independent or assisted living facility, the discharge process will follow that for a discharge to community setting in most cases.
9. For patients with planned discharged to a rehabilitation center, to a sub-acute setting, to a skilled nursing center, no discharge prescriptions are written, with some specific exceptions. The discharge summary, dictated by the PA or other designated prescriber, will serve as the discharge orders. This will be transmitted to the appropriate facility. This summary includes procedures performed, past and present medications, and essential lab findings, among other information.
    a. Exceptions are limited and apply especially to Class-II controlled substances. These require that a separate written prescription accompany the patent's discharge paperwork.
10. Patients discharged to such centers will be covered by Medicare Part A for a designated number of days. Following that time, Medicare Part D will cover prescriptions in most cases. The contracted pharmacy for the facility is responsible for all such orders.
11. If there is concern that a specific drug may not be available or that may be too expensive for the facility, the pharmacist, nurse case manager, and social worker help determine options.
    a. The acute care center may cover the cost.
    b. An alternative medication may be appropriate. The prescriber will determine such options and appropriateness.
12. Initial drug needs for these patients can be met in a number of ways, as designated in the facility and pharmacy policy and procedures.
    a. Interim medication supplies, such as Pyxis, are available in all centers.
    b. The facility has a designated alternate or emergency pharmacy for needed drugs.
    c. The contracted pharmacy must have provisions for on-call supply and emergency delivery.
13. The pharmacist will contact the facility's Consultant Pharmacist and prove additional information about the patent's medication history during the admission. This addresses the need for that pharmacist's medication therapy management review within an appropriate time frame.
    a. Note: Consultant Pharmacists must review every patient's chart in a skilled setting at least once a moth. In an assisted living setting, such reviews are mandated only every 6 months.
    b. The Consultant Pharmacist may need to perform this review sooner than the next scheduled visit to the facility. Instances may include newly instituted

anticoagulation, complex antibiotic regimens, extensive pain management, and post-stroke therapy.

c. Note that the Consultant Pharmacist and attending physicians at the facility assume all responsibility for orders and review upon admission to the facility.

14. Follow up calls are coordinated for the day after discharge and three days later.

Acute Care to Community Settings:

1. For scheduled admissions, obtain patient's medication list as part of pre-admission process whenever possible. The Pharmacist reviews them at this time. If a drug is not available on Formulary, the patient may be asked to bring in existing supply.
2. For non-scheduled admissions, all following steps hold from Day1. Pharmacist performs Medication Reconciliation at time of admission and reviews any needed changes with PA (or physician)
3. Patient Care Conference: Team meets on day 1 to discuss anticipated length of stay.
4. Case manager/ social worker meet with patient and family/ caregiver to discuss living conditions, transportation needs, and insurance.
5. Utilization manager validates with insurance carrier the authorized length of stay
6. These Team meetings continue daily.
7. Pharmacist meets with patient and family/ caregiver to review medication list/ history. Discussion includes any changes in medications during acute care stay, including Formulary changes, new medications, and any planned discharge orders.
    a. Continuing supply of current medications is assessed,
8. Discharge prescriptions are written the day before planned discharge, but not shared with patient yet. Insurance coverage for such prescriptions can be checked at this time. Prior authorization can be obtained as needed or an alternative, covered prescription can be written.
9. On the day of discharge, a pharmacy technician meets with all known discharges for that day after discussion with nursing and the pharmacist. If the patient wishes, the prescriptions can be filled in-house and readied for delivery to the patient. If the patient wishes to have these filled by their personal pharmacist, the prescriptions can be sent to that pharmacy electronically, at the patient's discretion, to facilitate availability when the patient returns home.
10. If the prescriptions are filled in-house, the filled orders are delivered to the responsible nurse on the floor. The pharmacist and nurse coordinate delivery to the patient and appropriate review and discussion.
11. If the patient wishes to use their personal pharmacist, the written prescriptions are discussed with the patient and family by the prescriber, nurse and pharmacist.
12. If payment for the prescriptions is a concern, options include
    a. The Team coordinates with patient support services to facilitate drug availability.
    b. Alternative prescriptions may be written
    c. Drug costs may be absorbed by the center
    d. Manufacturer patient support resources may be used.
13. Follow up calls are coordinated for the day after discharge and one week later.

Closed System

Don Yee, Kaiser Permanente, presented a closed integrated health system. Key points:

- Closed systems have everyone within their system. Their objective is the same, to minimize re-admission of patients. Their advantage is they have the full medical record for all their patients.
- Closed systems do not have the barriers that everyone else has. The same person that follows them in the hospital follows them outside of the hospital. They have a team that follows the patient before and after discharge.
- Unfortunately, not everyone can join a closed system and there is no interoperability for the rest of the population.
- The first step in resolving barriers to medications is to look at this issue. Medication issues should be resolved while the patient is in the hospital when all the stakeholders are captive.

CareFirst has a similar health care transition program. CareFirst is not a closed system and provides broad services.

It was mentioned that a continuity of care form, if adopted, would be beneficial and would fit into all the healthcare systems.

Acute Care – Hospital

Meghan Swarthout, MD Society of Health System Pharmacists, presented for acute care. She presented a basic menu for patients in transitional care:

- Utilization of a Multidisciplinary Team.
- Progression of the patient once they leave the hospital. Counselling about discharge needs and medication history.
- At Admission there is discussion of transition of care within their stay
- Medication reconciliation at discharge
- Development of a medication calendar. They try to develop a sheet that works best for individual patients.
- Discharge counseling or patient education with follow-up phone calls that use the team members appropriately.
- Discharge prescription delivery services since most patients will not get their prescriptions filled.
- Utilization of a team to figure out pre-authorization issues.
- Home Pharmacists Visits – This system is labor intensive but funded through their Charitable Care Program
- Medication Therapy Management other outpatient pharmacy clinics are available. Some drugs need more monitoring so there are specialty clinics provided.

Challenges for Acute Care:

- Handing off information

- Staff training
- Interdisciplinary implementation
- Patient factors
    - Finance
    - Self –management

Third Meeting – October 14, 2014

The third meeting included additional presentations on models of care, including a presentation by John O'Brien and Jamie Reuter of CareFirst – Blue Cross/Blue Shield on "Pharmacy Initiatives to Improve Care Transitions."

CareFirst – Blue Cross/Blue Shield

Representatives from Blue Cross/Blue Shield discussed care coordination and the patient centered medical home, which is available to all their insured. All patients when admitted to the hospital have access to the Transition of Care Program. The goal of the program is to promote health and to have a "warm hand off" to the next level of care.

The transitions coordinator meets with the patient/care giver before and after discharge. They have a nurse stationed at most hospitals and each patient care coordinator works with only a handful of physicians. Those facilities that do not have a dedicated nurse provide telephonic support for members being discharged.

The CareFirst program can put patients in touch with a pharmacist or social worker if necessary. The CareFirst program also calls patients weekly once the patient goes home to go over medications and care. Medication reconciliation is an important part of their program. Since beginning the care coordination program they have seen robust reductions in re-admissions.

It was explained that self-funded individuals are different than fully insured individuals. Some self-funded may have picked a different Pharmacy Benefit Manager. All of their members may access to a suite of pharmacy services.

When a hospital is not participating with the Transition of Care Program. CareFirst uses telephonic communication and visits from a patient care coordinator. CareFirst has their coordinator also look for caregiver issues and contact social work services. The CareFirst program also calls weekly once the patient goes home to go over medications and care. Medication reconciliation is an important part of their program.

Additionally, CareFirst hires coordinators that are familiar with the area served. CareFirst has learned that a local health care coordinator is essential. It is one of their lessons learned and that their program is a work in progress. The coordinators are all nurses who work only in this function.

CareFirst explained that mental health is treated as a medical condition. Changes that will occur in 2015 embrace the additional services that are needed. CareFirst explained that it does offer special medication packaging when there is a complex medication schedule along with other pharmacy services. The point of having a Case Management System is that the patient has someone specific to call. Case Managers do weekly calls and set up a schedule to call. There is a higher illness burden and readmission rates for behavioral health patients. Medication Therapy Management, which is high touch, addresses gaps in care and medication adherence. The goal is to improve care coordination so that patients stay out of the hospital

CareFirst does not have a mail order requirement. For the home bound sometimes it makes sense to do mail order. There are discussions in advance for what is appropriate to be mail ordered. There is a phone number provided in case the medications are not in good shape. They do make sure the delivery of medications work when medications change or when the patient is discharged from the hospital. They also have a number of different avenues for delivery of mail order such as the doctor's office, etc.

Public Hearing Testimony – October 28, 2014

The Task Force had time to conduct one public hearing in Annapolis. Two individuals testified at the hearing. *Linda Smith, President of American Society of Consultant Pharmacists (ASCP) testified first, followed by Pam Kasemeyer of SMWPA, testified on behalf of various physician groups.* No patients or their families testified, however, written testimony was also accepted.

Testimony of Linda Smith, President of American Society of Consultant Pharmacists (ASCP)

Ms. Smith presented a summary of the issues seen by ASCP. The transition between facilities is an area that is problematic. The problem stems from how the different facilities are set up and the formularies that they use which can switch patients in the hospital to other drugs. Resuming all medications upon discharge might not coordinate with the old list of medications. A lot of discharges happen on the weekends and medications are not finalized or confusing. She believes that consultant pharmacists should be contacted immediately upon the transfer of the patient. The question is who will pay for it and who will contact the pharmacist to do this.

Acute care also needs to have current medication records and prescriptions if the medications are not available at the facility. She suggests that a 3 day follow up be performed to make sure that all information has been shared.

Ms. Smith testified that the accuracy of the medication list varies with the facility. Patients often get two or three different lists of medications, some from the pharmacy and some from the facility. It is often difficult to get the patient's physician to confirm the list and coordination is a major problem. The best list should be provided, so the facility will know exactly what they need for that individual. Follow-up depends on the facility.

Ms. Smith testified that the good practices she has seen vary among facilities. She said it would be difficult for her to speak to the good practices without surveying the members of her

organization. She usually does not see the good practices, but rather is called in when the situation goes bad. Ms. Smith testified that there are no standards for coordination of medications in the health care system. Each facility has its own protocol.

When patients' transition to their homes, prior authorizations will slow things down or the patient does not get their medications. Pharmacies do not take the responsibility to work this out with the physician. They will let a physician know that something needs prior authorization. On the weekend, however, the physician often will not see the request until after the weekend.

Ms. Smith testified that she has seen problems with patients leaving the hospital and trying to obtain their medications from mail order. Sometimes patients can take their prescriptions to a local pharmacy for a 7 day or 2 week supply. Then the patient needs a separate prescription for the rest from mail order, which can create a time lag. There are stipulations for those medications needed on an emergency basis. Ms. Smith testified that she often helps people negotiate their way through the health care system.

Ms. Smith testified that a good practice and a possible solution would be to have a consultant pharmacist look at the patient's medications upon transfer. She thinks the Massachusetts Transition of Care form is a good idea and Maryland should look at that. It may decrease the issues that occur upon transfer.

Ms. Smith testified that she thinks there should be a patient advocate, but that the advocate should be a pharmacist because of their training in prescription medications. Not anyone should be doing this. When patients go back to a facility, the caregivers are trying to get the patient settled. Any physician notes go to transcription and are delayed following the patient. So the next caregiver will not know what's going on.

Ms. Smith testified that the smaller facilities have similar problems, but less trained staff. Pharmacists do show up every 6 months. Some smaller facilities are beautifully documented. It can vary widely. She thinks that pharmacists could help. She has been concentrating on interactions. She can help to choose the best medications for that individual based on the diagnoses. There needs to be developed an interdisciplinary working relationship.

Testimony of Pam Kasemeyer, SMWPA, testified on behalf of various physician groups

Ms. Kasemeyer testified that she has been asked to raise the issue of automatic prescription refills by various physician groups. She sees it as a related issue to the work of the Task Force. There is good that can come out of automatic refills; however, there is a significant challenge with communication especially if a prescription has been changed or discontinued. Patients receive the wrong prescription refill or ones they should no longer be taking and become confused.

Ms. Kasemeyer wanted to get this issue on the Task Force's radar screen. Automatic refills become workload issues for physicians as well. The number of calls to physicians has increased from patients and pharmacies. She wants to put it on the table for discussion at another time at the request of the physician community. There is the potential of significant health issues.

It was suggested by Dr. Kaufman, a Task Force Member, that the physician could write "not to refill" on the prescription. There is currently not a note "to not allow auto refill." The other solution is prescription discontinuance. The physician could send a note to the pharmacy to do this. Some systems do not accept it. MD could regulate that all pharmacies in MD accept a prescription cancellation. The records should be sent to the primary care physician as soon as possible.

Written Comments and Testimony

The Task Force also accepted and reviewed written testimony from several stakeholders and interested parties that presented varying concerns related to discharged patients' barriers to medications and offering several approaches to resolve concerns. Comments were received from: The National Association of Chain Drug Store (NACDS); Asteres, Inc.; MEDCHI; and University of Maryland School of Pharmacy.

The written submissions have been included at the end of this summary.

Fourth Meeting – December 2, 2014

The fourth and final meeting focused on reviewing draft language for this report and led to a lengthy discussion of the findings of the Task Force. The Task Force members agreed that no valid recommendations could be made as the Task Force did not have the requisite time to process the volumes of information presented during the meetings.

The group reviewed each mandate listed in SB 257 that was assigned to the Task Force:

(1) study the availability of pharmacy services for patients when they are discharged from the hospital;

The Task Force accomplished this goal, in part, by looking at the different models of care.

(2) identify any barriers or obstacles facing patients when they are discharged from the hospital that may prevent them from filling prescription orders;

The Task Force discussed the need for communication of prescription information and education of patients. It discussed patient motivation, communication, and education, bias by patients, costs and coverage of medications when coming home from the hospital.

It was noted that Maryland already has a law about pre-authorization. Additionally the Maryland Health Care Commission (MHCC) did a report recently showing that every carrier has met the law. There is real time adjudication and Maryland already has something in place. However; only 1% of physicians are using the pre-authorization forms. It is possible in Maryland to get immediate adjudication. There is so much more that would have to be included.

It was suggested to just mention "cost and coverage" as a possible barrier and leave out pre-authorization.

Reconciliation was identified by the Task Force as a barrier based on the fact that some patients are sent home with duplicate medication therapies prescribed. Thus, the lack of sufficient patient communication is another barrier.

Physical access, transportation to pick up prescriptions and limited pharmacy hours were also noted as barriers to securing needed medications. The Task Force acknowledged that region to region differences should also be taken into consideration when planning patient discharges.

Another barrier discussed at the final meeting included the variation between available programs. For example, some hospitals discuss the medications prescribed or administered by the hospital where others do not.

Finally, it was determined that any recommendation made by the group should acknowledge costs for implementation.

(3) compile information on best practices, programs, and community pharmacist services used around the State and nationally to provide and to facilitate access to pharmacy services, including community pharmacy medication therapy management services;

The Task Force identified some best practices. One suggestion is that hospitals could fax the patient's prescriptions to their pharmacy or e-prescribe the prescriptions to the pharmacy. Medication Therapy Management (MTM) was mentioned, but it is another component in itself. The Task Force could recommend that a task force be set up to research MTM. MTM is not the same thing as Drug Therapy Management (DTM), which is a Board of Pharmacy program. An additional study would be the implications of MTM and DTM.

(4) explore transition of care and care coordination efforts by hospital staff and direct acute care pharmacists that connect patients with needed pharmacy services after discharge from the hospital;

It was discussed to encourage follow up upon discharge and determine what actions have been taken. As previously discussed, sometimes the community pharmacist is left out. The Task Force could recommend further study on care coordination.

Additionally more study could be done on bedside delivery although this could be expensive. The Task Force is only suggesting to look into this as it has been identified as a best practice. Sometimes a pharmacy can bring the medications to the patient if there is prior authorization. The pharmacy can call the physician in advance. Dr. Roy's hospital has a foundation to pay for co-pays.

(5) consider geographic differences in the State relating to access to pharmacy services;

The Task Force did not have time to look at geographic differences. It was recommend that the local health departments do a survey of geographic differences in access. It would be interesting to know where the 24/7 pharmacies are located. On average all Marylanders are within 5 miles of a pharmacy.

(6) receive public testimony from stakeholders and the public;

The Task Force did hold a public hearing but no public testified and those who did testify were not a representative group.

(7) recommend strategies to reduce disparities in access to pharmacy services; and

The Task Force agreed that this needs further study. To study this properly there needs to be more stakeholders at the table such as CRISP and HIE. All hospitals should participate, as well. Senator Kelley suggested that HGO and EHE might want to follow up on these issues. Linda Smith, ASCP, suggested looking at HIE information as patients go through this transition of care.

There are a number of different systems to study.

(8) recommend the adoption of regulations by the Department of Health and Mental Hygiene that are consistent with the efforts of the State to redesign the State's Medicare waiver.

There was no time for the Task Force to make a recommendation regarding adopting certain regulations.

It was agreed to mention automatic refills in the report. Even though it is outside of scope of the Task Force, it warrants further discussion.

APPENDIX
Written Testimony and Comments

NACDS

Via email to anna.jeffers@maryland.gov
Anna D. Jeffers, Esq.
Legislation and Regulations Manager
Maryland Board of Pharmacy
4201 Patterson Ave
Baltimore, MD 21215

RE: Comments for the Pharmacy Stakeholders and SB 257 Task Force to Study Access to Pharmacy Services in Maryland

Dear Ms. Jeffers:

On behalf of chain pharmacies operating in the State of Maryland, thank you for the opportunity to submit comments regarding the Pharmacy Stakeholders and SB 257 Task Force to Study Access to Pharmacy Services in Maryland. The meeting brochure provides that the discussion will center on problems that Maryland residents may have in obtaining prescriptions when discharged from a hospital that may affect their recovery after leaving the hospital.

Chain pharmacies and their pharmacists are fully committed to working to see that Maryland residents have the opportunity to access pharmacy services to help them receive prescriptions when discharged from hospitals. Community pharmacies are available in every community with most patients having access to community pharmacies within several miles of their homes.

Benefits of Electronic Prescriptions for discharged patients
Electronic prescriptions would be a valuable process in helping patients with their discharge prescription needs. Nearly all community pharmacies now accept electronic prescriptions. In addition, a number of hospitals are now adopting the capability to send electronic prescriptions. This capability would allow them to send discharge prescriptions to the patient's pharmacy of choice before they leave the hospital, and the prescriptions will be ready for the patient to pick-up when they arrive at the pharmacy. Many hospitals are developing this ability, and we encourage this trend.[1]

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[1] See http://surescripts.com/news-center/press-releases/!content/surescripts-connects-nearly-1-000-hospitals-drives-interoperability-and-health-information-exchange-nationwide

In addition to sending discharge prescriptions to the pharmacy, it would also be helpful to send a "discharge summary" of all the medications (with current dosage) that the patient should be taking. Often, discharge prescriptions include therapeutic duplicates of medications that the patient has already filled. The discharge summary would provide an additional mechanism to avoid confusion, allow the pharmacist to provide the best coordination of care possible, and ensure that the patient had the correct medications they needed while also ensuring that the pharmacy's records were updated with any discontinued medication.

Community pharmacies and their pharmacists are the most accessible health providers in the community and stand ready to help patients. Community pharmacists also are well positioned to provide discharge patients with help in managing their prescription medications through community pharmacist provided Medication Therapy Management (MTM) services.

Pharmacist Medication Therapy Management Services

Over the last decade, medication therapy management (MTM) services provided by community pharmacists have gained widespread public attention for achieving improved outcomes in patients with chronic health care issues, while at the same time reducing overall health care costs. In addition to more actively engaging patients in their own health care, implementation of pharmacist-provided MTM can provide significant cost savings to state Medicaid, state employee, and worker's compensation programs. MTM services provided by community pharmacists are an effective tool to increase medication adherence, improve quality and control overall health care costs, particularly in this period of reduced budgets and economic uncertainty.

MTM focuses on patients with chronic conditions that require maintenance medications, such as hypertension, high cholesterol, asthma, diabetes, Alzheimer's and Parkinson's disease, and mental health disorders. MTM services are usually targeted to those patients with disease states that are most prevalent in a specific population. Patients are targeted based on their medication history and compliance to the prescribed regimen and their frequency of hospitalizations, emergency room visits, and doctor's visits. In the community-based setting, MTM services are conducted by a licensed pharmacist in partnership with the patient and their primary care provider. MTM services include a broad range of activities designed to improve patient outcomes, identify complex medication-related problems, prevent medication errors, enhance communication between providers and patients, improve communication among providers, and enable patients to be more actively involved in their own medication self-management.

Community pharmacies are the face of neighborhood health care. The innovative programs of chain pharmacies deliver unsurpassed value - improving health and wellness and reducing health care costs. Through face-to-face counseling, the pharmacist-patient relationship helps people take medications correctly. This improved medication adherence means a higher quality of life, and the prevention of costly treatments. Innovative community pharmacy services - vaccinations, health education, screenings, disease management and more - also make up the health care delivery system of tomorrow.

The Benefit of Medication Therapy Management

Several states have implemented MTM programs and have seen notable program savings for the state and enrolled beneficiaries. For example, the North Carolina ChecKmeds program uses specially trained personal pharmacists in communities throughout North Carolina to provide MTM services to all Medicare Part D recipients ages 65 and older. The program has generated savings of approximately $66.7 million in overall health care costs for the state which included $35.1 million from avoided hospitalizations and $8.1 million in drug product cost savings.

Similar results were seen in programs implemented in both Ohio in Iowa. In Ohio, the CareSource Program is one of the country's largest Medicaid managed healthcare plans, serving approximately 900,000 Medicaid members in Ohio since it was implemented in 2012. All plan members are eligible for face-to-face MTM services from specially-trained local pharmacists to help them achieve safe and effective results from their medications while controlling costs. Members receive MTM coverage through a national network of more than 70,000 local pharmacists nationwide, including nearly 3,300 pharmacists in Ohio alone. In the first nine months of CareSource's face-to-face MTM program there have been over 60,000 MTM services delivered and the program is already operating with a return investment greater than $1.30 for every $1 spent.

In the Iowa MTM pilot program pharmacists are utilized to help patients manage their medications and improve patient adherence through education and continued monitoring. In the first twelve months of implementation, the state generated savings of approximately $4.3 million in avoided costs which consisted of $1.18 million from drug product costs savings and approximately $3.07 million from fewer hospitalizations, fewer emergency room visits, and fewer office visits.[2]

The Pharmacist's Role in Medication Therapy Management Services

Pharmacist-provided MTM services are one of the many ways of using a pharmacist's clinical skills to improve patient outcomes. Pharmacists already have the training and skills needed to provide MTM services and currently provide most of these services in their day-to-day activities. Through well-established relationships with the patient, pharmacists have gained the trust of their patients and have proven to be a reliable source of information to the patient regarding their health care needs. Accessible in virtually every community, pharmacists are medication experts with the ability to identify patient specific medication-related issues and communicate those issues to the patient and their provider. Pharmacists have the ability to educate the patient with the necessary information to improve patient compliance, outcomes and overall quality of care.

In order to be effective, MTM services should be provided in a setting that is convenient and comfortable for the patient. MTM services provided in a community setting allows the patient to interact with a knowledgeable health care professional that is familiar with their medication needs, and can answer questions about effectiveness, and appropriate dosing. Because most patients obtain their prescription drugs and services from their local pharmacy, the convenience of pharmacist-provided MTM services is not only logical, but is a cost effective way to increase patient access to MTM services.

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[2] North Carolina ChecKmeds Program, Ohio CareSource Program and the Iowa MTM Pilot program use Outcomes Pharmaceutical Health Care for the management of their MTM programs. All savings have been provided by Outcomes.

We ask that the stakeholder group incorporate community pharmacy-based MTM into the stakeholder group recommendations. We look forward to continued involvement with this valuable stakeholder group.

Sincerely,

Director, State Government Affairs
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Asteres

Increasing medication compliance and revenue providing discharge prescriptions

Numerous studies have identified that adverse medication events are at the very core of the readmission problem. This includes patient non adherence to prescribed drug therapy, which by itself leads to treatment failures and wasted resources. Patients often delay filling their prescriptions post-discharge. One study found that only 40% of patients filled their prescriptions on the day of discharge, 20% filled them 1 or 2 days later, 18% waited 3-9 days, and 22% had not filled their prescriptions by the time of the follow-up telephone call (median of 12 days). Patient-reported barriers included lack of transportation and *long wait times at the pharmacy*.

Hospitals are looking for ways to reduce readmissions by implementing Transitions of Care programs. A Transition of Care program has many components, and one that can be closely linked to ScriptCenter is making sure the patient has a convenient way to pick up their prescriptions from the hospital's outpatient pharmacy before they leave to go home.

What is ScriptCenter?

ScriptCenter is a prescription pickup kiosk that allows patients or caregivers the ability to pick up and pay for prescriptions anytime of the day or night without waiting in line. The kiosk has security, counseling, and tracking features to ensure the correct prescription is delivered to the correct patient EVERY TIME.

How it works?

1) Patient prescriptions are discussed and ordered through the outpatient pharmacy
2) Patients/caregivers are given a claim check
3) Patient/caregiver uses their claim check and birth date to pick up and pay for prescriptions – counseling is done prior to pick up or at the kiosk through an audio/visual link.

Meds to Beds Programs

To ensure patients are receiving their prescriptions post-discharge some hospitals are implementing a 'meds to beds' program. Challenges that hospitals face when implementing 'meds to beds' programs include barriers such as the logistics of getting the prescription to the patient at the exact time needed, as well as the challenge of collecting payment at the patient bedside. Many of these barriers can be solved by prescriptions being picked up and paid for in a convenient location on the way out of the hospital rather than always being delivered to the patient bedside. ScriptCenter offers a secure and convenient pickup point for patient discharge prescriptions.

The Agency for Healthcare Research and Quality (AHRQ) suggests that when patients understand their postdischarge medication instructions, they are 30% less likely to be readmitted or visit the ER. For this reason, 35% of the 5,000 hospitals in the U.S. have at least one pharmacy that serves discharge patients, according to the America Society of Health-System Pharmacists (ASHP).

www.asteres.com

MEDCHI

Anna D. Jeffers, Esq.
Legislation and Regulations
Manager Maryland Board of
Pharmacy 4201 Patterson Ave.
Baltimore, MD 21215

RE: Automatic Prescription Refills - Comments for the Pharmacy Stakeholders and SB 257 Task Force to Study Access to Pharmacy Services in Maryland

Dear Ms. Jeffers:

MedChi, the Maryland State Medical Society, the Maryland Chapter of the American Academy of Pediatrics, the Maryland Academy of Family Physicians, the American College of Physicians - Maryland Section, and the Mid-Atlantic Association of Community Health Centers jointly submit these comments to the Task Force to Study Access to Pharmacy Services in Maryland regarding automatic prescription refill programs and the issues related thereto.

While we understand that the Task Force was created to focus on problems that Maryland residents may have in obtaining prescriptions during the transition of care such as being discharged from a hospital, that may affect their continued treatment plan, the Task Force has broadened its discussion to encompass the identification of other barriers/delivery system issues relative to pharmacy services and requested comments from stakeholders accordingly. While each of our respective undersigned organizations may have additional comments on other issues being considered by the Task Force, this letter reflects the collective voice of the primary care physicians in the State on the specific issue of automatic refill programs.

The primary care community has seen a significant increase in automatic prescription renewal programs. While the primary care community recognizes that automatic refills programs are a well intended way to improve medication adherence by ensuring that patients receive their medications without intended disruption, however, these programs can also cause several problems for both the patients and their primary care providers. Problems can occur when physicians change the dose or frequency of which medications are used, or in some instances discontinue the medication entirely or switch to another drug in the same therapeutic class. Patients and/or their caretakers may not realize that the prescriptions are being automatically filled and think that the primary care physician has requested medication renewal. This can be particularly problematic for elderly patients who often are challenged to comply with their medication regime and can become easily confused. Furthermore, phone calls, faxes and other electronic requests to the primary care provider from both patients and pharmacies

regarding refill renewal requests have dramatically increased and add to the administrative burden of a primary care practice taking time away from patient care activities.

In an effort to better evaluate and understand both the positive and negative implications for patient access to pharmacy services and compliance with medication management associated with automatic prescription refill programs, a number of questions have been identified that we believe should be discussed and addressed. The list in not exhaustive as we anticipate that other stakeholders will have additional questions and issues relative to these programs should a more deliberative stakeholder assessment be undertaken. The questions that we initially identified included but are not limited to:

- What are the procedures followed by pharmacies who provide automatic renewals?
- Would it be appropriate to limit the number of refill requests made by a pharmacy for any given medication, on behalf of a patient, and then require that any further request be made directly by the patient or his representative?
- When the automatic renewals are dispensed, is the primary care and/or prescribing physician notified by the pharmacy?
- If each renewal request is sent to the primary care/prescribing physician, do these renewal requests cause increased work for the physician's office as each renewal request must be reviewed by the office prior to authorization being given?
- If the primary care/prescribing physician is not notified, what impact will this have on patient care?
- How is the patient informed that the automatic RX has been completed? How long do pharmacies keep the automatic RXs for pick up?
- How is payment for automatic renewals implemented by the pharmacy?
- What is the weight of benefit versus consequence for the practice of automatic prescription renewals?

We applaud Senator Kelly for her concern about access to pharmaceutical services. While we are not certain the current Task Force has representation from all relevant stakeholders necessary to comprehensively address automatic refill program issues, we encourage this Task Force to recommend a more formal stakeholder process for this issue in its final report. We are available to discuss this issue in further depth should the Task Force so desire.

Gene Ransom, Chief Executive Officer
MedChi, The Maryland State Medical Society

Susan Chaitovitz, M.D., FAAP, President
Maryland Chapter of the American
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Kisha Davis, M.D., President

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November 25, 2014

Anna D. Jeffers, Esq.
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Dear Ms. Jeffers:

Thank you for giving the University of Maryland School of Pharmacy the opportunity to provide comments regarding SB 257 Task Force to Study Access to Pharmacy Services in Maryland.

Medication Therapy Management (MTM) is the conduit for communication between the patient and pharmacist. The University of Maryland School of Pharmacy is committed to offering strategies to increase medication compliance, promote adherence, and encourage proper medication usage to improve clinical outcomes. This critical function provides: review of medication through patient charts and interviews; preparation of a personal medication record; consultations for interventions or referrals; and documentation of the visit and follow up as required.

Last year, the University of Maryland School of Pharmacy, in collaboration with the Department of Health and Mental Hygiene and the Institute for a Healthiest Maryland, conducted a roundtable of targeted public and private health care leaders which included: insurers, payers, self-insured employers, Maryland's Health Enterprise Zone (HEZ) leaders, Patient Centered Medical Home and Accountable Care Organizations, and non-pharmacist providers. The goal of the roundtable was to promote understanding and overcome barriers to the adoption of MTM services by linking MTM to the triple aim of better quality of care, improved health outcomes, and reduced unnecessary health care costs.

There was consensus that there is value in MTM to support health care reform, specifically with patients who are elderly, undergoing transitions of care, have chronic disease, are high-utilizers, have multiple medications, are impacted by health disparities, have high-risk conditions, and those who have poor medication adherence. Respondents also concurred that MTM adds value to clinical decision making and reduces health care costs. Barriers to implementation were

identified in payment systems, existing structures in health-systems, strict patient eligibility criteria, and financial challenges.

There are many examples of the benefits seen in implementing a MTM program, including our P^3 Program which works with Maryland businesses to provide care for employees with chronic diseases as part of their employee health benefits package. Specially-trained pharmacists coach employees at the worksite to improve adherence to medications and manage the patient's medications in collaboration with physicians with the ultimate goal of improving the employee's health. We have been able to demonstrate a significant improvement in clinical indicators, a reduction in overall costs, and employee/patient satisfaction with the program. Since implementation in 2010, one of our clients has seen a 33% reduction in unnecessary emergency room utilization and hospitalizations.

MTM has the potential to actively engage patients in their own health care and provide significant cost savings. To echo the *Surgeon General Report* published in 2011, we urge the committee to support the expansion of MTM programs and find solutions to overcome barriers of implementation. The University of Maryland School of Pharmacy is ready to assist in any way to ensure the success of the efforts of the taskforce. We look forward to continued involvement with the pharmacy stakeholder group.

Sincerely,

Natalie D. Eddington, PhD
Dean