

June 25, 2009

The Honorable George Miller  
Chairman  
House Committee on Education and Workforce  
Washington, DC 20515

The Honorable Henry Waxman  
Chairman  
House Committee on Energy and Commerce  
Washington, DC 20515

The Honorable Charles Rangel  
Chairman  
House Committee on Ways and Means  
Washington, DC 20515

Dear Chairmen Miller, Waxman, and Rangel:

The American Association of Colleges of Pharmacy (AACCP) is pleased with the overall intent of the legislative discussion draft released by your three committees last week. Your combined commitment to increasing all Americans' access to high quality healthcare is certainly commendable. The legislation's focus on opportunities for preventing unnecessary illness and keeping our citizens well is an approach that has been too long in coming. Our intent is to work with you and the Committees to make sure this opportunity becomes a reality.

The issue of how we will pay for reorganizing our healthcare delivery system is certainly important, but it is beyond the scope of our organization's mission. We are fully prepared to assist you in creating a reorganized system that makes the best use of the research, teaching, and service mission of pharmacy faculty. Pharmacy faculty can be of particular assistance, especially in the areas of quality improvement and measurement, wellness and prevention, workforce preparation, and the necessary research that establishes the evidence-base to improve the quality of care patients receive.

### **Affordable Healthcare Choices**

**We encourage you, in both public and private plans, to make any and all efforts to ensure that patients have access to team-based, patient-centered care as discussed in the 2003 report of the Institute of Medicine, "Health Professions Education: A Bridge to Quality."** Quality improvement is predicated on the needs of the patient to be addressed by a community of care. This approach to care delivery also reflects another IOM report from 1994 on primary care that was authored due to the growing complexity of and interdependencies within healthcare delivery.

How care delivery is organized is just as important as what care is included in an essential benefits package, whether in a public or private plan.

**Therefore, we strongly encourage you to create opportunities for care to be delivered in a collaborative manner, making best use of the knowledge and skills of all health professionals (acting within their individual scopes of practice) focused on the needs of the patient, not the payment expectations of the providers.**

This approach will go a long way toward increasing access to the primary type of care, including medication therapy management, that all patients need, especially the chronically ill and elderly. This team-based approach has been successfully employed in several state Medicaid programs including Community Care of North Carolina and integrated healthcare systems such as InterMountain Health in Colorado and Geisinger Health in Pennsylvania.

Academic pharmacy is actively engaged with the types of delivery system examples above, as well as a host of others including those within family physician offices, ambulatory clinics associated with academic health centers, and increasingly with federally qualified health centers through a patient safety collaborative administered by the Health Resources and Services Administration. The research of pharmacy faculty forms a significant evidence-base supporting collaborative, team-based approaches to care as the standard of care. This evidence-base readily leads to the development of quality measures for plan and provider incentive strategies, important elements in moving toward a reorganization of care systems.

### **Medicare and Medicaid Improvements**

Medicare beneficiaries and Medicaid eligibles form a significant population that benefits from strong care coordination. Regardless of whether the difficulties of accessing care are due to frailty or ability to pay, efficient and effective management of both clinical and community-based services is essential to help improve outcomes and reduce overall costs.

**We strongly support provisions within the discussion draft that direct care to be delivered in a much more comprehensive and coordinated fashion.**

**We ask that these provisions more stridently state the need for care coordination, especially at transitions of care and for the chronically ill taking multiple medications, to include medication therapy management services.**

With medications contributing a significant cost to any health plan, including Medicare and Medicaid, the integration of clinical pharmacy services, including medication therapy management, across the continuum of care is integral to improving medication-associated outcomes and controlling costs.

**We recommend that your proposed medical home pilot be expanded to be the standard of care for both Medicare and Medicaid patients.**

This coordinated, team-based approach has the ability to focus care on the needs of a disease-specific patient population as well as a general community/service area. This is due to the recognition that including the appropriate community-of-care-providers focused on the needs of the patient population being served improves health outcomes and can reduce costs associated with care delivery. Academic pharmacy is actively engaged with these policy concepts. Faculty are currently working with hospitals to

reduce readmissions due to medication-related problems that should have been addressed at discharge. Pharmacy faculty work with family physicians, their patients, and their patients' caregivers to improve the management of prescribed medications, which improves medication-related outcomes and prevents medication-related problems that may lead to emergency room visits or hospital admissions.

**This team-delivered care can be accomplished within a variety of contexts including those that utilize telehealth which makes your interest in increasing the access to telehealth all the more important to remain in final legislation.**

Elderly and chronically ill populations account for a significant cost to any health plan or delivery system and assistance with the management of their medication use has been shown to improve health outcomes, reduce unnecessary care across the continuum of care, and reduce the overall cost of care delivery.

**AACP supports the establishment of a Center for Comparative Effectiveness. We recommend that the national research agenda include the comparison of practice patterns.**

This is important in developing the evidence-base associated with support for team-based, patient-centered approaches to care delivery. For example, team-based, patient-centered care is important in improving the management of the chronically ill and patients at transitions of care. The results of this type of research are much more amenable to the development of quality measures to assist providers in the delivery of evidence-based care.

**We ask you to clearly state that the results of comparative effectiveness research should not necessarily be focused on payment issues that have the potential to reduce provider participation in research networks required for this type of work.**

**Inclusion of all the stakeholders in the development of this national research agenda will be important. Therefore, legislative language should clearly state that all health professionals, not just physicians, are expected to have a seat on the Commission.**

**We strongly support the expansion of prevention and wellness programs and services into the Medicare and Medicaid programs.**

The Committees should stress the importance of increasing access to all public health interventions across a wide-range of health professionals, including pharmacists. Expanded access to prevention and wellness programs and services through a wide-range of health professionals increases the chances that a patient will make the behavioral change necessary to become more responsible for their individual health and that of their community.

### **Public Health and Workforce Development**

Increasing access to high quality care at an affordable price will require a substantial reorganization of our healthcare delivery system. As we know, the United States spends more and receives less compared to other industrialized nations when it comes to many common population health measures. The final Division of the discussion draft does little to support the reorganization of health professions education toward the creation of professionals prepared to collaborate and provide culturally competent, team-based, patient-centered care, supported by informatics.

**The Committees could do much more toward this end by reauthorizing the Public Health Service Act Title VII health professions programs and requiring all the programs to be interprofessional in nature to the extent possible.**

Until the federal financial support for health professions education is focused on meeting the IOM recommendations stated in its 2003 report, “Health Professions Education: A Bridge to Quality,” efforts to move toward an interprofessional health professions education model will languish since federal policy may give the impression that it is not of high importance.

The Institute of Medicine defined primary care back in 1978, revised the definition in 1984 and again in 1994. The rationale for the 1994 revision was to create a definition “that recognizes two important trends: the greater complexity of health care delivery and the greater interdependence of health professionals.”  
[http://www.nap.edu/openbook.php?record\\_id=9153&page=5](http://www.nap.edu/openbook.php?record_id=9153&page=5)

The 1994 IOM definition reflects primary care as a concept incorporating the “main, chief, or principle” aspects of healthcare delivery and moves beyond the “first-contact” concept that suggests an initial interaction and then triage to the appropriate level of care.  
[http://www.nap.edu/openbook.php?record\\_id=9153&page=9](http://www.nap.edu/openbook.php?record_id=9153&page=9)

“Primary care is the provision of integrated, accessible health care services by clinicians who are accountable for addressing a large majority of personal health care needs, developing a sustained partnership with patients, and practicing in the context of family and community.” IOM 1994  
[http://www.nap.edu/openbook.php?record\\_id=9153&page=15#p20003779ddd0000023](http://www.nap.edu/openbook.php?record_id=9153&page=15#p20003779ddd0000023)

Over several decades, the United States Congress, recognizing the benefit to both individuals and communities of increased access to primary care, passed key legislation that authorized programs intended to increase access to primary care. The need to provide rural and underserved communities access to primary care was the rationale for establishing the National Health Service Corps. Increasing the supply of primary care providers created programs authorized under Title VII of the Public Health Service Act. Both of these federal programs are focused on who is eligible to provide primary care. The legislative language makes primary care the responsibility of certain healthcare professionals. Both of these programs were established prior to the wide-spread appreciation, supported by IOM primary care definition revisions, of the multidimensional aspect of primary care.

The effectiveness of these programs is further questioned in light of the 2003 IOM report that indicates that healthcare professionals competent in team-based, patient-centered practice may be one opportunity to close the quality chasm. The National Health Service Corps program, with its placement of those healthcare professionals deemed primary care providers through statute, makes no attempt to recognize the multidimensional aspect of primary care. It focuses solely on a healthcare professional. The negative aspects of this focus can and frequently does leave the designated provider isolated both from providers of his or her own profession, but more importantly, from those providers with whom he or she might establish a team-based, patient-centered approach to primary care delivery in keeping with the IOM’s current definition of primary care.

There are Title VII programs that, at least legislatively, recognize that the complexity of our healthcare system creates significant need for healthcare professionals to be educated through interprofessional approaches that establish team-based care as an acceptable and appropriate expectation upon graduation.

American Association of Colleges of Pharmacy

The area health education centers (AHEC), geriatric education center (GEC), and HIV education center programs all address an area of national significance - primary, geriatric and HIV care, respectively - the quality of which is improved by increasing the competence of health professions students to practice as teams focused on the needs of the patients for which they provide care. What is of concern is that the currently operating programs that Congress established to address past issues of national significance are not being readily considered as opportunities, through reauthorization and recommitment, for addressing new (or incompletely addressed) issues that impact the ability or willingness of our nation's health professionals to provide recommended care more than 50% of the time that is evidence-based, culturally appropriate, and that recognizes both individual and community determinants of the patients health status.

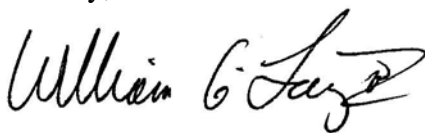
**Therefore, the Committees should first consider how existing health professions education programs, such as those authorized within Title VII, could, through reauthorization and recommitment, more readily address the development of team-based approaches to care, as well as test the assumptions of the benefits of this approach to quality, cost, and access.**

**One recommendation would be for all Title VII programs, to the extent possible, support interprofessional education of health professionals that is focused on team-based, patient-centered approaches to care.**

The focus of that care could easily address healthcare issues that remain important to the nation as a whole, such as primary, geriatric, and HIV care, as well as addressing new issues such as chronic illness, medication therapy management, and wellness and prevention. Such an approach would reduce the opportunity for duplication of programmatic intent, increase buy-in to change from existing stakeholders, and build a team-based approach to policy development between current program and new proposal stakeholders.

Academic pharmacy is a rich resource that has provided much of the medication-related evidence-base used to support many of the provisions within the proposals offered by your Committees, as well as those in the Affordable Health Choices Act. Pharmacy faculty remain committed to working with your Committees to ensure that new evidence is readily transmitted to policy-makers and healthcare professionals so that our nation's healthcare system continues to meet the needs of the patients it serves. Please do not hesitate to contact me to discuss how AACP and its members can be of assistance.

Sincerely,

A handwritten signature in black ink that reads "William G. Lang IV". The signature is written in a cursive, flowing style.

William G. Lang IV, MPH  
VP Policy and Advocacy  
American Association of Colleges of Pharmacy  
(703) 739-2330 x1038  
[wlang@aacp.org](mailto:wlang@aacp.org)