Statement of the
American College of Clinical Pharmacy
To the Institute of Medicine
Committee on Identifying and Preventing Medication Errors

The American College of Clinical Pharmacy (ACCP) appreciates the opportunity afforded by the Institute of Medicine Committee on Identifying and Preventing Medication Errors to present its perspective on the important issue of improving the quality and safety of medication use in the United States. ACCP is a national professional and scientific society representing almost 10,000 clinical pharmacist practitioners, researchers, and educators. Our members have been the profession's leaders for almost three decades in providing professional services, consultation, cutting-edge clinical research, and educational leadership that improve the quality of medication use in the health care settings in which they practice.

As a founding organization of the Pharmacist Provider Coalition, ACCP has worked diligently with Congress, the Medicare Payment Advisory Commission, and other key policymakers over the past five years to firmly establish the policy position that pharmacists' professional services for assuring the effective and safe use of medications must be an integral part of the Medicare program, and indeed all systems of health care delivery. The recent enactment of the Medicare Modernization Act (MMA), which has provided the stimulus for the work of your Committee, has also provided an initial, although quite limited, endorsement of this policy principle through the requirement for medication therapy management programs (MTMP) as a component of the Part D drug benefit.

ACCP suggests that this recognition of the role of the pharmacist in improving the quality of medication use, although important, is insufficiently comprehensive to address the concerns that are under the Committee's review. Indeed, the occurrence of not only medications errors, but substantial amounts of medication misuse, inconsistency in application of established therapeutic guidelines, and the frequent failure to assure the cost-effectiveness of otherwise comparable therapies all represent important areas of concern in the contemporary use of medications that deserve greater scrutiny on the part of policymakers and thought leaders such as the IOM. A patient that does not receive the most appropriate medication for their condition, for whatever reason, has experienced just as much of a "medication error" as one who received the wrong medication due to a "sound-alike" name.

Consequently, ACCP encourages the Committee to examine the issue of "medication errors" in a broader context, and as a symptom of a larger and more significant problem:

- **That problem is the clear failure of the nation's current "system" of medication use to evolve in scope and sophistication comparable to the growth in the complexity and criticality of pharmacotherapy in contemporary patient care.**
- **The current "system" – involving disjointed processes for prescribing, dispensing, and monitoring of medications, combined with a lack of consistently-delivered, standards-based, and quality-focused practice activities that evaluate, manage, and deliver better medication use outcomes in individual patients – must be acknowledged to be fundamentally flawed.**
- **Substantial change in provider responsibilities, care processes, and the systems and procedures that constitute the current medication use process must occur if meaningful improvement in the quality of medication use, including the prevention of avoidable medication errors, is to be achieved.**

ACCP urges the Committee to engage in provocative and substantial "out of the box" thinking about the entire medication use system – not just medication errors – and to develop transformative recommendations that will foster a national commitment to create a re-engineered medication use system.

Specifically, ACCP urges the Committee to develop recommendations that would foster the following:

Promote Collaborative Drug Therapy Management –

Authority and responsibility for the medication use process within the health care system must be reorganized. The current system of disjointed medication-related decision making, with concomitant dispersion of responsibility and accountability for medication use outcomes across multiple disciplines and providers, can no longer be (if it ever was) expected to produce the optimal outcomes or quality of care that patients, payers, and the health care system as a whole should expect to derive from the use of medications.

ACCP has long supported the development and application in practice of collaborative drug therapy management (CDTM).[1] [2] CDTM utilizes the skills and abilities of qualified pharmacists, working within the context of defined protocols and practice structures, to assume professional responsibility for performing patient assessments, ordering tests related to the pharmacotherapy

[1] http://www.accp.com/position/pos2309.pdf. Position statement on collaborative drug therapy management by pharmacists. 2003. American College of Clinical Pharmacy.
[2] http://www.accp.com/position/pos19.pdf. Position statement on collaborative drug therapy management by pharmacists. 1997. American College of Clinical Pharmacy.

process, administering medications, and selecting, initiating, modifying, monitoring, and adjusting medication regimens. Forty one states now provide a regulatory framework for CDTM, and the model is being increasingly embraced by the health care community as the logical and appropriate structure within which the skills and abilities of pharmacists can most effectively be applied.

Clinical pharmacists, by virtue of their education, training, experience, and professional commitment, should be both recognized and expected to serve as the provider ultimately responsible and accountable for the appropriate, effective, and safe use of medications, delivered within a system of CDTM.

While this can and should be accomplished in full partnership with the patient's physician and other providers, there can be no comprehensive solution to the challenge of safer and more effective medication use until the responsibility for providing that care is fully and appropriately vested in a health care professional dedicated exclusively to and accountable for that goal as the focus of daily practice. ACCP believes that health care professional is the clinical pharmacist.

Support and Promote the Role of Pharmacotherapy Specialists

The Board of Pharmaceutical Specialties (BPS) recognized pharmacotherapy as a distinct specialty within pharmacy practice in 1988. Since that time, fewer than 3,000 pharmacists have been certified as pharmacotherapy specialists by BPS. The vast majority of these practitioners are actively engaged in practices that embrace CDTM or similar models of care. ACCP was the sponsoring organization for the petition to BPS seeking recognition of pharmacotherapy as a specialty area of pharmacy practice.

Clearly the concept of the pharmacotherapist was an idea ahead of its time in 1988. Two decades later, however, there can be little doubt that having a health professional whose practice activities focus specifically on pharmacotherapeutic care and services has become essential for many patients, particularly those with complex medication regimens generated by a system of multiple providers and prescribers.

The contemporary health care system requires or expects physical therapy to be provided by physical therapists, respiratory therapy to be provided by respiratory therapists, and psychotherapy to be provided by psychotherapists. We don't expect physicians or physician assistants or nurse practitioners to directly provide these services. Patients are referred to these providers by their primary caregivers because they recognize the capabilities and expertise of those practitioners and their own limitations in delivering those types of specialized care.

Why should we not expect pharmacotherapy to be provided by and be the responsibility of a health care professional with specific and comprehensive education, training, and expertise in that area of clinical care?

The obvious reasons, of course, encompass a complex mixture of historically established professional roles, disciplinary turf boundaries, patient expectations, regulatory limitations, and health system inertia. It's simply not the way that pharmacotherapy has historically been managed.

But perhaps the most important reason this expectation does not exist is that the idea has not been discussed or debated in any meaningful way in health policy circles outside of the pharmacy profession itself. IOM is in a position to both foster and lead a national discussion to challenge the medication use system status quo, and help guide the development of an improved system for the provision of pharmacotherapy that better meets patient and societal needs.

Restructuring the activities and responsibilities of the principal health professionals involved in the pharmacotherapy process -- primarily physicians, physician extenders, and pharmacists -- will be an essential element of system reform. It is certain to be a lively and contentious discussion, but one that is worthy of the leadership and vision of the IOM.

As long ago as 1967, Dr. Donald Francke noted in an editorial in the journal *Drug Intelligence* that "...today's drugs may be likened to ballistic missiles with atomic warheads, while we prescribe, dispense, and administer them as if they were bows and arrows." Unfortunately, that statement is barely less true four decades later. The opportunity to improve the situation must be embraced now with provocative discussions and innovative proposals.

Encourage payment policy reform that appropriately fosters quality outcomes from medication use.

In addition to the need for re-engineering of the system of medication use, fundamental reform of payment policies that promote safer and more effective pharmacotherapy are also essential.

In November 1990, the HHS inspector general noted in a report on "the clinical role of the community pharmacist" that "[O]ne of the most formidable barriers facing pharmacists…is the transaction-based reimbursement structure of [pharmacy]. The result typically is a focus on product and price rather than provision of clinical services for which there is no economic incentive." Fifteen years later, scant progress has been made in changing the economic paradigm under which the profession of pharmacy is practiced. When pharmacists are paid to fill prescriptions, prescriptions get filled. When pharmacists receive payment for services, they will (and do now in limited circumstances) indeed provide those

services. The system must be reformed to reward what it should value most – high quality medication use outcomes that are both effective and safe.

The Pharmacist Provider Coalition, established in 2000, has engaged in a substantial advocacy effort with Congress over the past five years to seek legislative changes in Medicare's payment policies such that qualified pharmacists would be recognized as providers under Part B of Medicare. Legislation introduced in both the 107th and 108th Congress has thus far failed to attract sufficient support for passage. Nevertheless, a favorable analysis of the issue by the Medicare Payment Advisory Commission in 2002, together with continuing support of several legislators, should provide encouragement to the Committee to consider developing recommendations that promote the reforms in payment policy that are needed to support practice activities of pharmacists that enhance the quality and outcomes of medication use.

The Bottom Line…….

Patients and the U.S. health care system need and deserve a new approach to the provision and management of pharmacotherapy – through a re-engineered medication use system managed by health professionals whose principal education, training, expertise, and interest can fully contribute to the appropriate use of medications. Not only will such reforms address the specific problem of identifying and preventing medication errors, they will help to enhance the quality, safety, and effectiveness of medication use in all patients.

ACCP urges the IOM Committee on Identifying and Preventing Medication Errors to explore these issues fully, and to make bold recommendations that look far beyond current practices and professional biases concerning the medication use process. ACCP looks forward to working with IOM and others in the months and years ahead to advance policy changes and system reforms that promote the highest quality of medication use.

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