

**HOUSE . . . . . No. 1955**

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**The Commonwealth of Massachusetts**

PRESENTED BY:

***Gloria L. Fox***

*To the Honorable Senate and House of Representatives of the Commonwealth of Massachusetts in General Court assembled:*

The undersigned legislators and/or citizens respectfully petition for the adoption of the accompanying bill:

An Act to establish a model program for pharmacists as public health partners.

PETITION OF:

NAME:	DISTRICT/ADDRESS:	DATE ADDED:
<i>Gloria L. Fox</i>	<i>7th Suffolk</i>	<i>1/18/2013</i>
<i>Cheryl A. Coakley-Rivera</i>	<i>10th Hampden</i>	<i>1/18/2013</i>

**HOUSE . . . . . No. 1955**

By Ms. Fox of Boston, a petition (accompanied by bill, House, No. 1955) of Gloria L. Fox and Cheryl A. Coakley-Rivera for legislation to establish a pilot program for pharmacists as public health partners. Public Health.

**The Commonwealth of Massachusetts**

**In the Year Two Thousand Thirteen**

An Act to establish a model program for pharmacists as public health partners.

*Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:*

1 Model program for pharmacists as public health partners, and for the Department of  
2 Public Health to review the Center for Disease Control program guide for Partnering with  
3 Pharmacists in the Prevention and Control of Chronic Diseases to decide which model will work  
4 best for the a program in the Commonwealth. A pilot project in a specific region or with a  
5 specific large employer may be an option to consider. Be sure to build in a rigorous evaluation  
6 for the project at the beginning of the planning stage.

7 In the United States, health care extenders such as pharmacists, community health  
8 workers (CHWs), and patient navigators help us meet our national health goals by conducting  
9 activities and interventions that promote health and prevent diseases and disability. Health care  
10 extenders work closely with patients and providers to control chronic illness through education  
11 and counseling, communication with providers, and, in some cases, medication titration. Funded  
12 programs can play a role in reducing high blood pressure and high cholesterol by supporting  
13 high-level policy and systems changes that promote collaborative medication therapy  
14 management initiatives, train-ing or certification of health care extenders to reach disparate  
15 populations, or the use of health care extenders in multidisciplinary clinical teams.

16 Health Care Systems Change Interventions

17 • Support policy development for pharmacist-led comprehensive medication therapy  
18 management

19 • Promote systems changes in health care settings that utilize health care extenders for  
20 care improvement

21 New ways to expand team-based health care are needed to protect the health of people of  
22 the Commonwealth. Many chronic diseases, which are increasing with the aging population, are  
23 preventable or manageable. The role of the pharmacist has expanded beyond just dispensing  
24 medications and is evolving into active participation in chronic disease management as a part of  
25 team-based care. Programs addressing chronic diseases in state health departments and  
26 communities can build team relationships through public and private partnerships.

27 As defined by the American Pharmacists Association, medication therapy management  
28 (MTM) is a term used to describe a broad range of health care services provided by pharmacists,  
29 the medication experts on the health care team.

30 In *The Patient-Centered Medical Home: Integrating Comprehensive Medication*  
31 *Management to Optimize Patient Outcomes*, the Patient-Centered Primary Care Collaborative  
32 defines comprehensive medication management as the standard of care that ensures each  
33 patient’s medications—whether they are prescription, nonprescription, alternative, traditional,  
34 vitamins, or nutritional supplements—are individually assessed to determine that each  
35 medication is appropriate for the patient, effective for the medical condition, safe given the  
36 comorbidities and other medications being taken, and able to be taken by the patient as intended.  
37 Within this system, each medication is assessed for the medical condition or indication for which  
38 it is taken. To produce clinically useful data, the indication must be electronically linked with the  
39 product, dose, duration, manner in which the medication is taken, therapy goals, clinical  
40 parameters that determine progress toward these goals, and actual outcomes. The clinical status  
41 of the patient must be determined for each drug and each condition (e.g., current blood pressure  
42 level and cholesterol levels for patients with high blood pressure and high cholesterol). Without  
43 knowledge of the current clinical status of a patient, the indication, appropriateness, and  
44 effectiveness of most medications cannot be determined.

45 Comprehensive medication management includes an individualized care plan that  
46 achieves the intended goals of therapy with appropriate follow-up to help the pharmacist  
47 determine actual patient outcomes. The pharmacist evaluates the outcome parameters against the  
48 patient’s individualized therapy goals and re-evaluates the patient to identify any new  
49 medication-related problems that might interfere with the safe and effective use of medications  
50 in the patient’s care plan. These follow-up evaluations occur in a time frame that is clinically  
51 appropriate for the specific patient as well as his or her medical conditions and drug therapy  
52 plan. Evaluation time frames vary with each patient and are triggered when major transitions—  
53 such as hospitalization—occur or at the request of the patient’s providers/prescribers.

#### 54 Team-Based Care

55 According to the proposed definition from a working group of the Institute of Medicine,  
56 team-based health care is the provision of health services to individuals, families, and/or their  
57 communities by at least two health providers who work collaboratively with patients and their

58 caregivers—to the extent preferred by each patient—to accomplish shared goals within and  
59 across settings.

#### 60 Role of the Pharmacist in Team-Based Care

61 The role of pharmacists in providing patient care services is compatible and synergistic  
62 with the patient-centered medical home model and other innovative models of team-based care.  
63 Pharmacists extend the health care team to the local community, providing patients with the  
64 resources and care they need. In addition, pharmacists are some of the most accessible health  
65 care professionals and have a broader knowledge

66 A PROGRAM GUIDE FOR PUBLIC HEALTH Partnering with Pharmacists in the  
67 Prevention and Control of Chronic Diseases pharmacists know the medicines (prescription and  
68 over-the-counter) more than any other member of the health care team. Research shows real  
69 value in pharmacists' management of diabetes and heart disease. For the millions of Americans  
70 with uncontrolled diabetes, the risk for heart disease, stroke, kidney failure, blindness, and  
71 amputation are significant. Engaging pharmacists as members of the health care system can  
72 significantly improve treatment of diabetes, better control high blood pressure, improve  
73 management of cholesterol, and reduce overall health care costs. nated, high-quality, and patient-  
74 centered care.

75 Partner with an organization or group that understands this area well. First, look within  
76 our state health department to determine if another program is conducting a similar project. It  
77 might be more appropriate to add a focus area to an existing project rather than develop a new  
78 one. An ideal partner in any pharmacist-based intervention program should be a program or  
79 organization that already has something similar.