



GTMR_x
Institute™

Get the medications right
www.gtmr.org

A \$528 billion problem: How employers can avoid medication overuse, underuse and misuse

GTMRx Learning Network Webinar

Agenda



- **Welcome and Introductions**

- **Learning Objectives**

- **Presenters:**

- Sandra G. Morris, RN, MSN, CHC
 - ❖ Senior Advisor, GTMRx Institute; President, About Quality Benefits Design; Former Senior Manager, US Benefits Design, Procter & Gamble
- Jan D. Hirsch, BS Pharm, PhD
 - ❖ Director and Founding Dean, School of Pharmacy & Pharmaceutical Sciences, University of California, Irvine

- **Question and Answer Session**

- *Please submit your questions via the Q&A box.*

Thank You to Today's Sponsor

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Thank you to the employer & coalitions members of the GTMRx Employer Task Force!



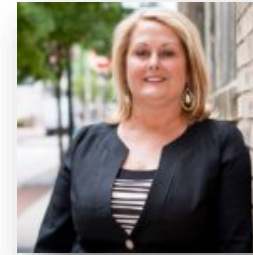
Jessica Brooks, MPM, PHR



Gerri Burruel



Marianne Fazen, Ph.D.



Gaye Fortner, BSN, MSN



Neil Goldfarb



Cheryl Larson



Troy Ross, MS



Chris Swerson



Karen van Caulil, Ph.D.



Jane Cheshire Gilbert, CPA

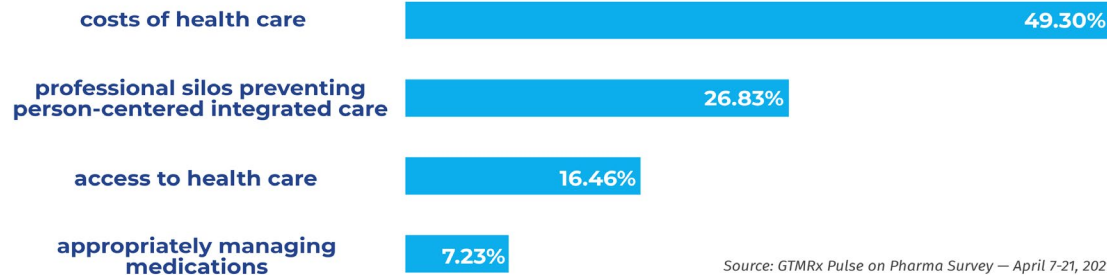


Pulse on Pharma Survey



New Data from GTMRx Reveals Some of the Biggest Hurdles in Health Care

In a recent survey, we asked: What do you believe is the biggest issue in health care right now?



Source: GTMRx Pulse on Pharma Survey — April 7-21, 2021



New Data from GTMRx Reveals Some of the Biggest Hurdles in Health Care

In a recent survey, we asked: What is the biggest issue with managing medications right now?



Source: GTMRx Pulse on Pharma Survey — April 7-21, 2021

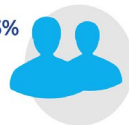
Pulse on Pharma Survey



New Data from GTMRx Reveals Some of the Biggest Hurdles in Health Care

What should be the first step in changing the way we manage medications?

33%



Physicians working in collaborative practice with pharmacists to help patients reach their clinical goals of therapy

31%



Access to clinical information at the point-of-care for all team members (to include the clinical pharmacist) working with the patient

27%



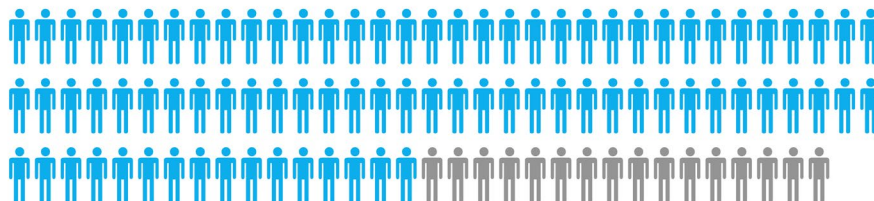
Payment for comprehensive medication management services

Source: GTMRx Pulse on Pharma Survey — April 7-21, 2021



New Data from GTMRx Reveals Some of the Biggest Hurdles in Health Care

84% of respondents in a recent survey believe that comprehensive medication management (CMM) can stem the opioid crisis



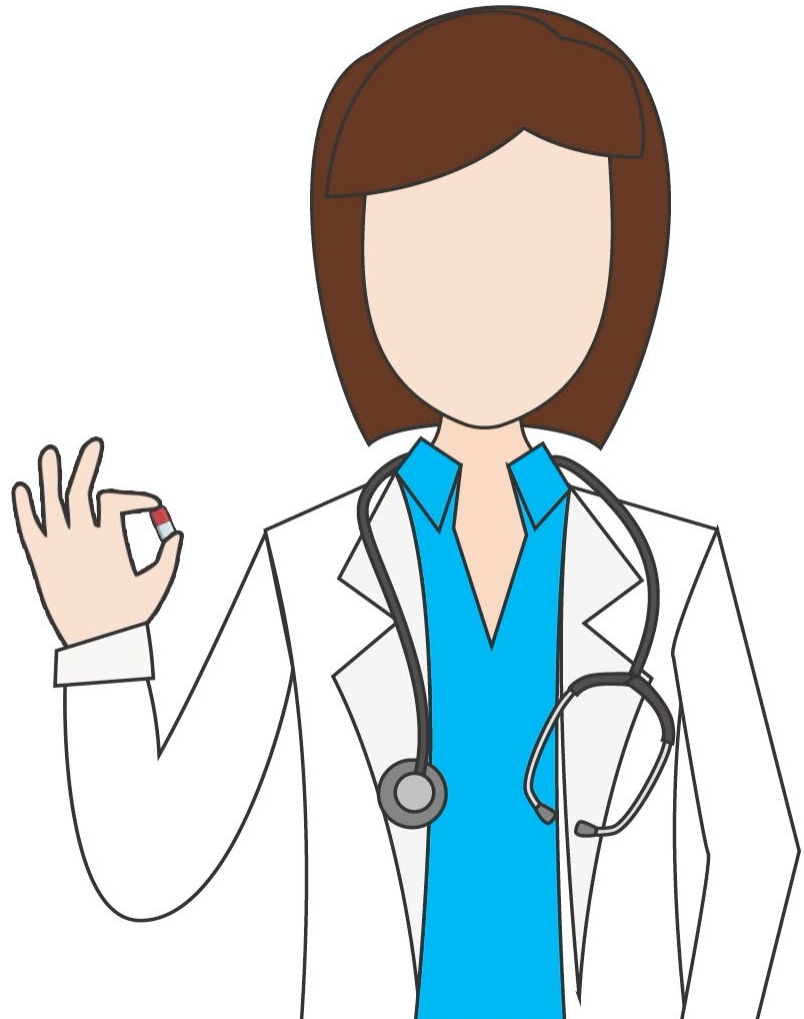
Source: GTMRx Pulse on Pharma Survey — April 7-21, 2021

Learn more...Explainer Video

One simple question

Is this the
right medication
for you?

GTMR_x
Institute™



Our Presenters



Sandra G. Morris, RN, MSN, CHC

Senior Advisor, **GTMRx Institute**

Formerly Senior Manager U.S. Benefits Design
Procter & Gamble



Jan Hirsch, BS Pharm, PhD

Founding Dean

School of Pharmacy & Pharmaceutical Sciences

University of California, Irvine

GTMRx Distinguished Fellow

Author: Cost of Prescription Drug–Related Morbidity and
Mortality

Call to Action: Why U.S. employers are best positioned to lead optimized medication use as a standard of care



Prescription drugs are 10% of US health spending, but 19% of employer spending with rebates.¹



Private insurance covers 47% of national prescription drug costs vs. 30% by Medicare.²



The current trial-and-error system of medication use drives losses in quality of life and employee productivity, as well as wasted spend on medications that do not work.³



Employers have a fiduciary responsibility to act prudently to avoid risk of health plan losses.⁴

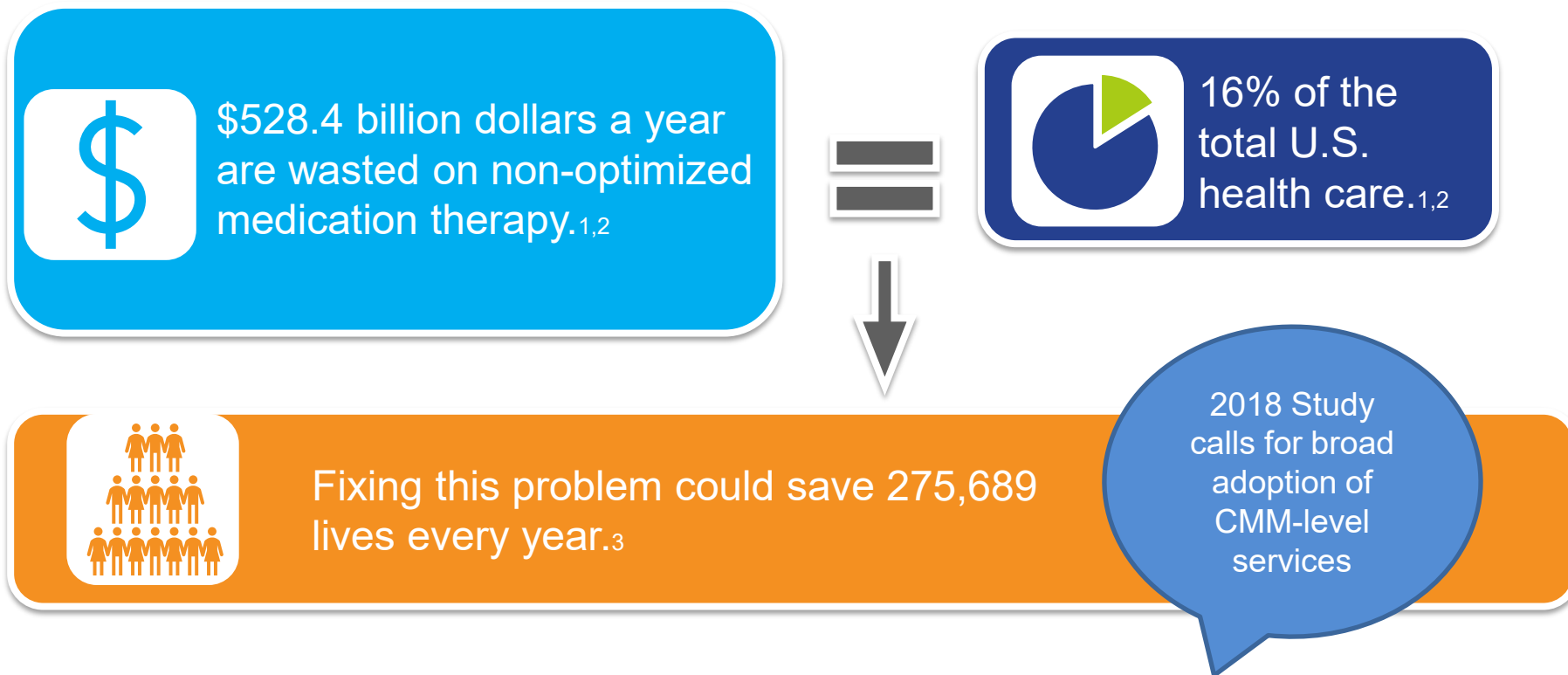
¹ "Prescription Drugs' Sizable Share of Health Spending." Kaiser Family Foundation. Dec. 2015. Accessed 24 April 2019. <https://www.kff.org/health-costs/perspective/prescription-drugs-sizable-share-of-health-spending/>

² "10 Essential Facts About Medicare and Prescription Drug Spending." Kaiser Family Foundation. Jan. 2019. Accessed 24 April 2019. <https://www.kff.org/infographic/10-essential-facts-about-medicare-and-prescription-drug-spending/>

³ "Health Plans & Benefits: Fiduciary Responsibilities." U.S. Department of Labor. Accessed 30 April 2019. www.dol.gov/general/topic/health-plans/fiduciaryresp.

⁴ "Health Plans & Benefits: Fiduciary Responsibilities." U.S. Department of Labor. Accessed 26 April 2019. www.dol.gov/general/topic/health-plans/fiduciaryresp.

Unnecessary loss of lives and waste of money can be prevented



1. Cutler DM, Everett W. Thinking outside the pillbox: medication adherence as a priority for health care reform. *N Engl J Med.* 2010;362(17):1553-1555 [PubMedGoogle ScholarCrossref](#)

2. Watanabe J, et al. Cost of Prescription Drug–Related Morbidity and Mortality. *Annals of Pharmacotherapy*, March 26, 2018. Accessed 3 April 2018.

<http://journals.sagepub.com/eprint/ic2iH2maTd15zfN5iUay/full>

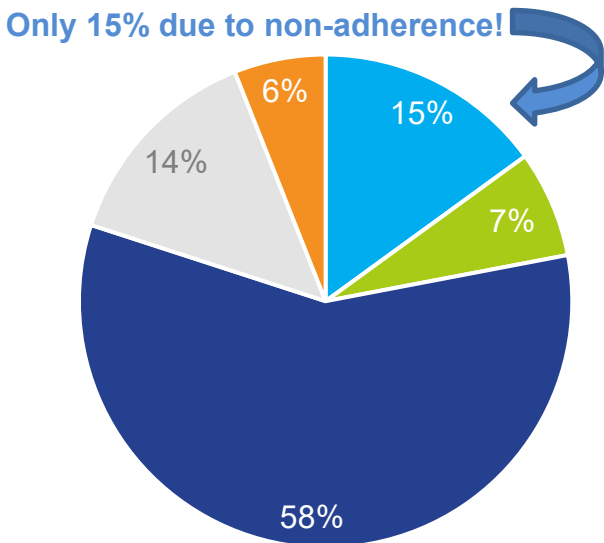
3. Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug–Related Morbidity and Mortality. *Annals of Pharmacotherapy*. 2018;52(9):829-837. doi:10.1177/1060028018765159

Are we managing *all* medication problems?

Between 50% - 75% of patients do not take their medications as prescribed.^{1,2}

Types of Medication Therapy Problems ⁴

Only 15% due to non-adherence!



- Non-Adherence
- Dose Too High
- Inadequate Therapy
- Adverse Reaction
- Unnecessary Therapy

Consequences of Medication Therapy Problems ³

- **\$528.4B in 2016** - cost of non-optimized medication therapy
 - \$174 billion **hospitalization** costs
 - \$271.6 billion **long-term care** admissions
 - \$37.2 billion **emergency department** visits
 - \$37.8 billion additional **provider visits**
 - \$7.8 billion **additional prescriptions**
- **275,689 deaths**— from non-optimized therapy
- **\$2,481-\$2,610**— average cost of an individual experiencing treatment failure or new medical problems after initial prescription use.

1. National Community Pharmacists Association. Take as directed: a prescription not followed. <http://www.ncpanet.org>.

2. World Health Organization. Adherence to long-term therapies: evidence for action. http://www.who.int/chp/knowledge/publications/adherence_introduction.pdf. Accessed August 3, 2012

3. Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug-Related Morbidity and Mortality. *Annals of Pharmacotherapy*. 2018;52(9):829-837. doi:10.1177/1060028018765159

4. Comprehensive medication management in team-based care. *American College of Clinical Pharmacy*.

Proposed Solution: Include medication specialists in the provision of team-based, patient-focused care

“We propose expansion of comprehensive medication management (CMM) programs by clinical pharmacists in collaborative practice with physicians and other prescribers as an effective and scalable approach to mitigate these avoidable costs and improve patient outcomes.”¹

Watanabe, McInnis, Hirsch

- The predicted US physician shortage, up to 122,000 by 2032, can be addressed with clinical pharmacist services²
- Physicians spend **26 seconds** on guideline-recommended components and **23 seconds** on all other aspects of a prescription when talking to patients about a new medication (in a mean office visit time of 15.9 mins).³
- Patients need varying intensities of support to achieve optimal use of new medications. There is a huge void of support in today’s medication use system.

1. Watanabe JH, McInnis T, Hirsch JD. Cost of Prescription Drug–Related Morbidity and Mortality. *Annals of Pharmacotherapy*. 2018;52(9):829-837. doi:10.1177/1060028018765159

2. <https://news.aamc.org/press-releases/article/2019-workforce-projections-update/>

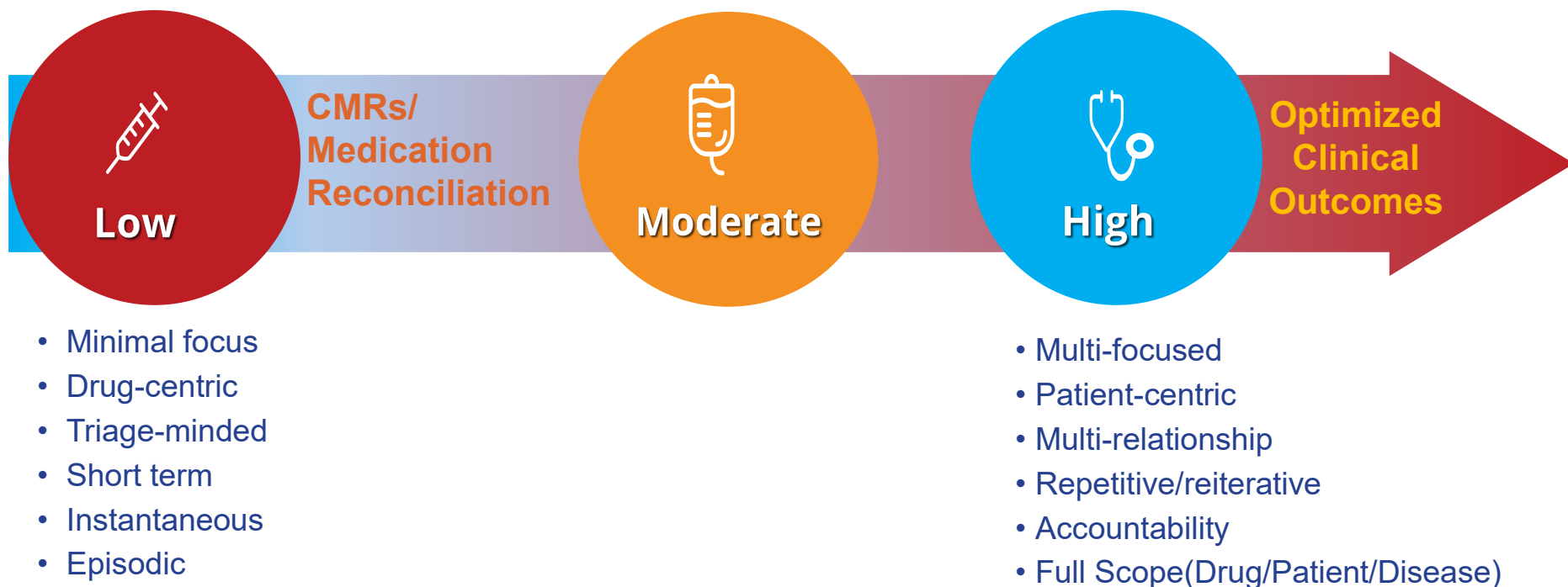
3. Tarn, D. M., Paterniti, D. A., Kravitz, R. L., Heritage, J., Liu, H., Kim, S., & Wenger, N. S. (2008). How much time does it take to prescribe a new medication? *Patient Education and Counseling*, 72(2), 311-319. <https://www.sciencedirect.com/science/article/pii/S073839910800116X?via%3Dihub>

Dispelling myths:

Your PBM is **NOT** already providing CMM

- **Prior Authorization (PA)** – a one-time process typically **not conducted by a pharmacist** involving completion of a list of questions to determine if a single medication is FDA indicated for use in treating the condition, step-therapy is indicated before use, the drug is covered under the patient's prescription plan and at what formulary level, etc.
- **Medication therapy management (MTM)** – a Medicare Part D covered program that **might be conducted by a pharmacist** and usually involves review/documentation of a drug list and a medication-related action plan.
- **Comprehensive medication management (CMM)** – a reiterative process involving a clinical pharmacist, the patient, physician, and other team members working together to ensure all medications are appropriate and safe for the patient, effective for treating the medical conditions, able to be taken, and achieve desired outcomes.

Progression of Clinical Pharmacy Service Intensity





What is Comprehensive Medication Management?

A systematic approach to medications where **physicians and pharmacists ensure** that medications (whether they are prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each **medication is appropriate for the patient, effective for the medical condition, safe** given the comorbidities and other medications being taken, and able to be taken by the patient as intended.¹

1. McInnis, Terry, et al., editors. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes*. 2nd ed., Patient-Centered Primary Care Collaborative. PCPCC Medication Management Task Force collaborative document.

All 10 steps of the care process must be in place for CMM!



#1

Identify patients that have not achieved clinical goals of therapy.



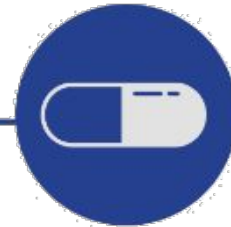
#2

Understand the patient's personal medication experience, history, preferences, & beliefs.



#3

Identify actual use patterns of all medications including OTCs, bioactive supplements & prescribed medications.



#4

Assess each medication for appropriateness, effectiveness, safety (including drug interactions) & adherence, focusing on achievement of the clinical goals for each therapy.



#5

Identify all drug-therapy problems.



#6

Develop a care plan addressing recommended steps including therapeutic changes needed to achieve optimal outcomes.



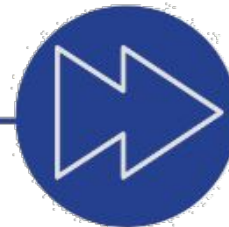
#7

Ensure patient agrees with & understands care plan which is communicated to the prescriber or provider for content & support.



#8

Document all steps & current clinical status vs. goals of therapy.



#9

Follow-up evaluations are critical to determine effects of changes, reassess actual outcomes & recommend further therapeutic changes to achieve desired clinical goals & outcomes.



#10

CMM is a reiterative process! Care is coordinated with other team members & personalized goals of therapy are understood by all team members.

Benefits of CMM for employers

- Improved clinical outcomes and employee health, especially in those with chronic conditions such as diabetes and cardiovascular disease ¹⁻⁵
- Decreased employee absenteeism ⁶
- Reduced health care utilization, including emergency department visits, hospitalizations and readmissions ^{2,5}
- A reduction in annual total health care costs of an average of \$1,000 per participating member/year ³⁻⁶
- A return on investment to average around 3:1 to 5:1 the first year ⁷

1. Theising KM, Fritschle TL. Implementation and clinical outcomes of an employer-sponsored, pharmacist-provided medication therapy management program. *Pharmacotherapy*. 2015 Nov;35(11): e159-63.

2. Iyer R, Coderre P, McKelvey T, et al. An employer-based, pharmacist intervention model for patients with type 2 diabetes. *Am J Health Syst Pharm*. 2010 Feb;67(4):312-6.

3. Johannigman MJ, Leifheit M, Bellman N, et al. Medication therapy management and condition care services in a community-based employer setting. *Am J Health Syst Pharm*. 2010 Aug;67(16):1362-7.

4. Bunting B, Nayyar D, Lee C. Reducing healthcare costs and improving clinical outcomes using an improved Asheville project model. *Innovations in Pharmacy*. 2015;6(4):227.

5. Rodriguez de Bittner M, Chirikov VV, Breuning I, et al. Clinical effectiveness, and cost savings in diabetes care, supported by pharmacist counselling. *J Am Pharm Assoc*. 2017;57(1):102-108.

6. Cranor C, Bunting B, Christensen D. The Asheville project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. *J Am Pharm Assoc*. 2003 Mar;43(2): 173-84.

7. Comprehensive medication management in team-based care. American College of Clinical Pharmacy. <https://www.accp.com/docs/positions/misc/CMM%20Brief.pdf>. Accessed August 26, 2020.

A look at the evidence



Different Models Using CMM and Types of Results



Employers & health system pharmacy



Employer & onsite pharmacist



Employers & community pharmacies

A look at the evidence



Different Models Using CMM and Types of Results



Employers & health system pharmacy



Employer & onsite pharmacist



Employers & community pharmacies



At Diabetes Goal

Improved 66% to 75%
Reduced cholesterol

Employer Savings/patient

\$253 medication
\$1,011 total cost

Patient Satisfaction

4.8 out of 5

Johannigman MJ, Leifheit M, Bellman N, et al. Medication therapy management and condition care services in a community-based employer setting. *Am J Health Syst Pharm.* 2010 Aug;67(16):1362-7.

A look at the evidence



Different Models and Types of Results



Employers & health system pharmacy



Employer & onsite pharmacist



Employers & community pharmacies



At Diabetes Goal

Improved 55% to 72%
Reduced blood pressure

Resource Utilization

30% lower hospitalizations
24% lower ED visits

Iyer R, Coderre P, McKelvey T, et al. An employer-based, pharmacist intervention model for patients with type 2 diabetes. Am J Health Syst Pharm. 2010 Feb;67(4):312-6.

A look at the evidence



Different Models and Types of Results



Employers & health system pharmacy



Employer & onsite pharmacist



Employers & community pharmacies



At Diabetes Goal

Improved 38% to 62%
Reduced cholesterol

Resource Utilization

Total medical costs decreased
MD, Hospital, ED, Labs decreased
Prescription costs increased

Patient Behaviors

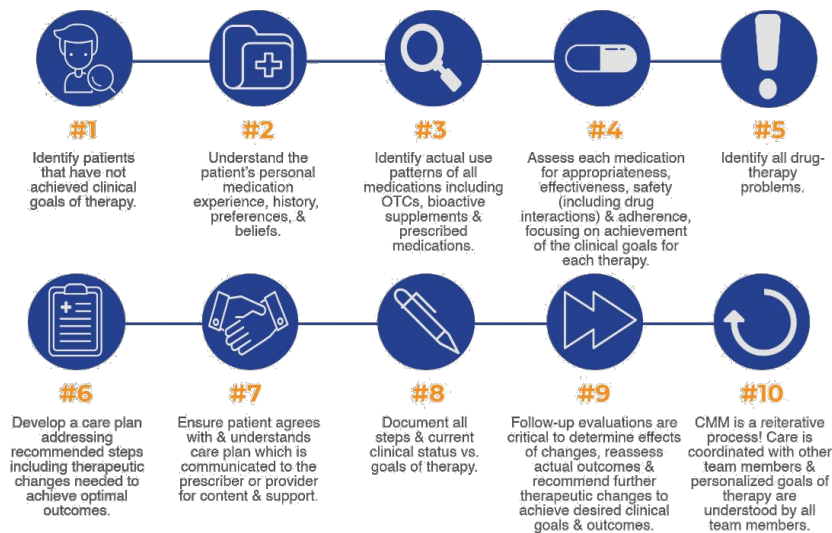
Sick Days: 12 to 6/year
(Employer Est. value: \$18K/year)
Increased recommended self care

Cranor C, Bunting B, Christensen D. The Asheville project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. J Am Pharm Assoc. 2003 Mar;43(2): 173-84.

A look at the evidence

How do the quality & cost changes occur?

Ten steps of the CMM Process



3 Case Examples



CMM Patient Case 1: 55-year-old female

Simplified from actual patient case notes



Diabetes

Available lab values

A1C 12.3 (goal < 7.0)

Fasting Glucose: 269mg/dL (goal 70-130)

Medications prescribed at referral:

1. Levemir® injection 42U BID
(patient only taking 40U BID)



2. Glipizide 10mg daily
3. Metformin 1000mg BID

Vitals at first visit:

- **BP: 129/69**
- **HR: 68**
- **Temp: 98.1**
- **Weight: 204lb**
- **Height: 5'3"**



Pt reported glucose at first visit were

- Fasting average: **165** (goal 70-130)
- After meal average: **347** (goal < 180)

CMM Patient Case 1: 55-year-old female



Medication changes from 9/2019 - 03/2021

- a) Glipizide switched to Jardiance (9/2019)
- b) Asked to use full 42U dose Levemir (9/2019)
- c) Increased Jardiance dose (11/2019)
- d) Added Humalog with meals (3/2020)
- e) Increased Levemir incrementally at *several visits* to final dose of 52U BID
- f) Increased Humalog incrementally at *several visits*

Final medication regimen on discharge from CMM clinic (4/30/2020):

- **Metformin 1000mg BID**
- **Jardiance™ 25mg daily**
- **Levemir™ 52U BID**
- **Humalog™ 17U TID AC**

Patient continued regular care with primary care physician & referred for 2 visits with dietician



CMM Patient Case 1: 55-year-old female



A1C progression:



12.3 (9/2019)

8.5 (11/2019)

8.7 (2/2020)

8.7 (5/2020)

9.3 (7/2020)

7.6 (10/2020)

6.7 (4/2021)



Take Away Points

- Patient not at goal referred
- Prescribed \neq Actual Use
- Consistent follow-up needed to assess
- Multiple medications needed
- Changes made over time
- Team-based care

Pt was discharged from pharmacy clinic April 2021.

CMM Patient Case 2: 44-year-old male

Simplified from actual patient case notes



Diabetes, High Blood Pressure & High Cholesterol

Available lab values

A1C 9.4 (goal < 7.0)

LDL cholesterol: 130 mg/dL (goal <100)

Medications prescribed at referral:

1. Metformin 1000mg BID
2. Linagliptin 5mg daily
3. Lisinopril 10mg daily
4. Atorvastatin 10mg daily



Vitals at first visit:

- **BP: 148/81** (goal < 130/80 with diabetes)
- **Weight: 220lb**
- **BMI: 32**

Pt reported concerns were

- Excessive daily & nightly urination
- Affecting work productivity
- Recent erectile dysfunction
- Not checking finger stick glucose
- Afraid of needles

CMM Patient Case 2: 44-year-old male



Poorly controlled diabetes

- Continue metformin (high efficacy, weight neutral)
- Stop linagliptin (low efficacy)
- Patient did not want to start SGLT2I due to high urination side effect
- Start semaglutide, titrate to effective dose in 4 weeks (high efficacy, weight reduction, oral)
- Start glucose monitoring with sensor and app – no finger stick
 - Improve adherence to checking glucose levels
 - Teach correlation between food and exercise on glucose values



Poorly controlled blood pressure

- Start amlodipine 5mg po daily
 - patient did not want to start diuretic
- Continue lisinopril
- Advised patient check BP daily
- Counseled on DASH diet

Poorly controlled LDL cholesterol

- Increase atorvastatin dose

Erectile dysfunction

- Expected to resolve with improved glycemic control; else refer to urology

Obesity

- Started semaglutide for diabetes and weight loss
- Counseled on healthy eating & exercise

DASH = Dietary Approaches to Stopping HTN diet

CMM Patient Case 2: 44-year-old male



Results

Time	A1C	BP	LDL	WT	BMI
Initial	9.4	148/81	130	220	32
2 mo	7.8	128/68	120	214	31
4 mo	7.1	129/75	106	211	30

- Diabetes: A1C close to goal <7%
- BP: at goal
- Cholesterol: Close to goal; patient did not want to increase medication dose
- Continued to lose weight
- Erectile dysfunction resolved

Take Away Points

- Patient not at multiple goals
- Patient involved in decision making
- Consistent follow-up needed to assess
- Changes made over time
- Team-based care

Patient continued regular care with primary care physician.

CMM Patient Case 3: 62-year-old female

Simplified from actual patient case notes



High Blood Pressure, Depression, Overactive Bladder & Pain

Medications prescribed at referral:

1. Metoprolol 25mg BID
2. Sertraline 200mg daily
3. Oxybutynin 5mg BID
4. Tramadol 50mg as needed for pain

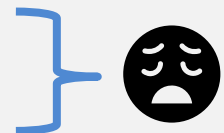


At first visit:

- BP: 120/86 at goal
- Depression diagnosis
- Overactive bladder diagnosis
- Pain diagnosis

Pt reported concerns were

- Recent falls
- Daytime Sleepiness
- Dizziness



CMM Patient Case 3: 62-year-old female

Simplified from actual patient case notes



High Blood Pressure, Depression, Overactive Bladder & Pain

Medications prescribed at referral:

1. Metoprolol 25mg BID
2. Sertraline 200mg daily 🙄
3. Oxybutynin 5mg BID 🙄
4. Tramadol 50mg as needed for pain 🙄



At first visit:

- BP: 120/86 at goal
- Depression diagnosis
- Overactive bladder diagnosis
- Pain diagnosis

Pt reported concerns were

- Recent falls
- Daytime Sleepiness
- Dizziness



CMM Patient Case 3: 62-year-old female



Patient discussion

1. Depression well controlled
2. Overactive bladder well controlled
3. Pain described as mild

Medication changes

First visit

- Decrease overactive bladder medication to 1 x per day
- Discontinue tramadol; switch to acetaminophen for pain

Two week follow-up visit

- Discontinue overactive bladder medication



CMM Patient Case 3: 62-year-old female



Medications at two weeks:

1. Metoprolol 25mg BID
2. Sertraline 200mg daily
3. Acetaminophen as needed pain
4. ~~Oxybutynin 5mg BID~~
5. ~~Tramadol 50mg as needed for pain~~

*Patient continued regular care
with primary care physician*

Take Away Points

- Do not have lab values for many conditions
- Patient involved in decision making – symptom reporting
- Follow-up needed to assess risk vs. benefit each medication
- Discontinue medications if possible
- Changes can occur quickly
- Team-based care

Patients Who Benefit Most from CMM

Significant evidence is accumulating to establish the positive impact that CMM has on patient outcomes.[†] Patients who benefit most include those:

- With one or more chronic conditions treated by multiple providers/multiple patients taking multiple medications
- With high ER/urgent care/hospital utilization
- With one or more complex medications requiring specialized administration and frequent outcomes assessments
- Transitioning between specialists and primary care providers visits, ER/Urgent Care visits, or discharge from a hospital/long-term care facility
- At risk for sub-optimal clinical outcomes due to medication therapy problems such as errors in self-administration, doses too high or low, adverse drug reactions, etc.

- Taking new medications requiring personalized education and on-going assessment of outcomes (inhalers, self-injectables, narrow therapeutic index, etc.)
- Showing absence of or erratic maintenance of intended therapy goals
- Problems understanding and following their medication regimen

McInnis T, Webb E, and Strand L. The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes, Patient Centered Primary Care Collaborative, June 2012

Comprehensive Medication Management FAQ for Employers. (GTMRx November 2020). Retrieved December 1, 2020, from <https://gtmr.org/wp-content/uploads/2020/11/Comprehensive-Medication-Management-FAQ-for-Employers-11252020.pdf>

[†] [https://www.amjmed.com/article/S0002-9343\(20\)31173-6/abstract](https://www.amjmed.com/article/S0002-9343(20)31173-6/abstract)



Metrics related to successful CMM implementation

Some Examples

Process of Care Measures

- Patients with > 1 chronic condition receive CMM services at least twice annually (>90%)
- Patient with > 1 chronic condition have a CMM encounter at each care transition (within 72hrs post hospital discharge or ER visit)
- Patients and medical providers grant access to the patient's EHR for the CMM team (from within or outside of the medical practice)

Outcome Success Measure for CMM

- Reduced utilization of health care services including ED visits, hospital admissions and readmissions ^{1,4} with resulting cost avoidance ^{7,8}
- Reduction in annual total health care costs per participant ²⁻⁵
- Decreased employee absenteeism ^{1,4}
- Positive return on investment ⁶

1. Iyer R, Coderre P, McKelvey T, et al. An employer-based, pharmacist intervention model for patients with type 2 diabetes. *Am J Health Syst Pharm*. 2010 Feb;67(4):312-6.
2. Johannigman MJ, Leifheit M, Bellman N, et al. Medication therapy management and condition care services in a community-based employer setting. *Am J Health Syst Pharm*. 2010 Aug;67(16):1362-7.
3. Bunting B, Nayyar D, Lee C. Reducing healthcare costs and improving clinical outcomes using an improved Asheville project model. *Innovations in Pharmacy*. 2015;6(4):227.
4. Rodriguez de Bittner M, Chirikov VV, Breuning I, et al. Clinical effectiveness, and cost savings in diabetes care, supported by pharmacist counselling. *J Am Pharm Assoc*. 2017;57(1):102-108.
5. Cranor C, Bunting B, Christensen D. The Asheville project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. *J Am Pharm Assoc*. 2003 Mar;43(2): 173-84.
6. Cipolle RJ, Strand L, and Morley P. *Pharmaceutical Care Practice: The Patient Centered Approach to Medication Management*. Third Edition. New York, NY: McGraw-Hill Medical; 2012.
7. Economic costs of diabetes in the U.S. in 2017. American Diabetes Association. *Diabetes Care* 2018 May;41(5):917-28.
8. Absenteeism due to functional limitations caused by seven common chronic diseases in U.S. workers. *J Occup Environ Med*. 215 Jul;57(7):779-84.

Available for download today!

Employer Toolkit



12+ months of employer expertise → Development of Employer Toolkit

- Toolkit for use as you work with:
 - Pharmacy Benefit Managers (PBMs)
 - Medical carriers
 - Benefit consultants
 - Solution providers (PGx, others)
 - Employees

Key areas of focus

- What is CMM
- How does CMM work
- What is the ROI
- What type of patients benefit the most from CMM
- How does CMM work & value-based payments
- Where does PGx fit in to CMM & PGx

Comprehensive Medication Management in Benefits Design: A Toolkit for Employers

Concerned about medication misuse, underuse or overuse in your pharmacy and medical program?

Everyone is different, not every medication is right for every person. Comprehensive medication management (CMM) is a well-established process of care that ensures that every medication an individual takes is appropriate and effective for them. CMM is not MTM.

CMM is different from medication therapy management (MTM), a broad term that has, over the years, come to include all sorts of activities related to pharmacy benefit management (PBM). MTM activities are not clearly defined or implemented in a standard way by PBMs and health plans. Be wary of programs that offer only single service activities (ex. adherence, medication reconciliation, comprehensive medication review) such as those found in Medicare Part D prescription drug plans; this is not CMM.

CMM is a well-defined process to optimize medication use that has delivered consistent results. This 10-step process of care is delivered in collaborative practice with a physician by a qualified member of the health care team (usually a clinical pharmacist) and designed specifically to ensure that all medications are optimized for that patient. It may also include tools such as pharmacogenomics (PGx) testing to target correct therapies.

This toolkit explores the benefits of CMM for individuals and for the employers who pay for benefits. Research published in March 2018 reveals the waste to the system when wrong drugs are prescribed, skipped or make people sicker, cause an estimated 275,689 deaths per year.¹ In financial terms, there's also a \$528 billion price tag attributed to non-optimized medication use.

Non-optimized medication use costs \$528.4 billion in waste attributed to:

- Long-Term Care Admissions
- Hospitalizations
- Emergency Department Visits
- Provider Visits
- Additional Prescriptions

Decreasing waste, improving quality and ensuring appropriate use of medications through health benefit design is a high priority for employers. As you plan your health benefit strategy (for pharmacy and medical), and as you seek to contract for programs that optimize medication use and manage medication therapy problems, use this toolkit to work with your:

1. Makarewicz L, et al. Cost of Prescription Drug-Related Mortality and Morbidity. *Annals of Pharmacotherapy*. March 20, 2018. Accessed 5 April 2018. <https://doi.org/10.1177/0898010118764946>

GTMR 1

GTMRx Employer Toolkit Resource Center

<https://gtmr.org/employer-toolkit-resources/>



EMPLOYER
TOOLKIT
DOCUMENT



FAQS FOR
EMPLOYERS



INFOGRAPHIC:
DRUG SPEND



USING PGX &
DIAGNOSTICS



CONTRACTING
FOR CMM



SHOW ME THE
EVIDENCE



USE CASES: CMM
IN PRACTICE



PAYMENT
METHODS
(COMING SOON)



CONSUMER
EDUCATION
TOOLS

Thank you to the employer & coalitions members of the GTMRx Employer Task Force!



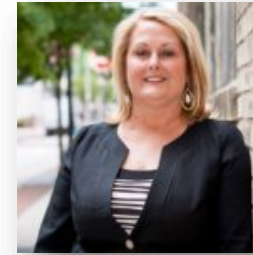
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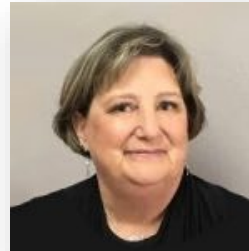
Neil Goldfarb



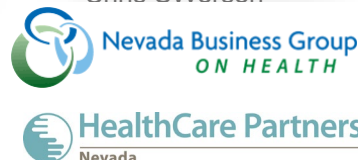
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Question & Answer Session



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University of California, Irvine
Author: Cost of Prescription Drug–
Related Morbidity and Mortality

What employers can do to lead the charge

- Learn from and share the tool kit.
- Use data analytics of benefits spend (e.g., readmissions, polypharmacy, emergency department visits, adverse medication events), to establish the need for company adoption of CMM as a health care benefit and advocacy for transformation of the current system of medication use.
- Engage with other employers, **primary care** and specialist physician organizations, medical and pharmaceutical service providers, community leadership organizations, health care insurance carriers and consumer groups to discuss community need to transform medication use through CMM.
- Use value-based contracting to incorporate shared savings with medical carriers and PBMs to incentivize delivery of team-based CMM services and **advanced primary care**.
- Ensure contracts with insurance carriers require real-time interoperability and sharing of patient records between care providers.
- Base contract performance guarantees on clinical outcome improvements and financial waste avoidance achieved through CMM. Promote employer health care coalition education and advocacy to build demand for CMM services.

Thank you!

Please complete the survey after this webinar.

You can access the toolkit and other related resources at:

<https://gtmr.org/employer-toolkit-resources/>

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