Optimizing Medication Use for Accountable Care Success

A value-based care resource derived from an event sponsored by the GTMRx Institute & the Institute for Advancing Health Value

Event and Sponsor Background

In April of 2022, the GTMRx Institute and the Institute for Advancing Health Value co-hosted an executive roundtable, *Optimizing Medication Use for Accountable Care Success*. The primary objective of the event was to facilitate discussion between value-based care leaders about the importance of optimizing medication use through comprehensive medication management (CMM) in practice through clinical teams working within alternative payment models (APMs). GTMRx is a growing coalition of over 1,700 multi-stakeholder members from 1,000 companies focused on appropriate use of medications and gene therapies. The Institute for Advancing Health Value is a non-profit, peer-learning, member organization focused on accelerating the transition to value-based care. Together, these organizations recognized the importance of hosting an action-oriented discussion on the implementation of a more rational and comprehensive way to manage medications—within the context of value-based care efforts taking place across the U.S.

Value-Based Care and Comprehensive Medication Management

The goal of value-based care is to lower costs and improve care while ensuring a positive patient experience through the use of alternative payment models (APMs). While paying for value has been a long-time American experiment, it was given renewed emphasis after the passage of the Affordable Care Act and continues today through a multitude of private and public sector initiatives. Many of the care delivery organizations making serious strides and finding financial success within APMs have found that it is essential to identify and manage patients who have not achieved the clinical goals of medication therapy in order to decrease waste and increase value.

Efforts to optimize medication use have historically focused on discrete, medication therapy management (MTM) services, but comprehensive medication management (CMM) is a more comprehensive and team-based approach, focusing on the whole patient, rather than just the medications (MTM vs. CMM blog). The evidence supports that CMM leads to better care, lower costs and higher provider and patient satisfaction. It is defined as *"The standard of care that ensures each patient's 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" *(The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize-Patient Outcomes Resource Guide).*

Event Insights

The bulleted lists below represent the insights gained from the organizational spotlights, multi-stakeholder panels and in-depth breakout discussions. They are organized by main themes (or questions) that emerged organically from the discussions.

What does CMM and clinical pharmacy integration look like in practice?

- Numerous primary care and population health models are integrating CMM into practice to ensure that clinical goals of therapy are met, and medication misuse, overuse or underuse is addressed.
- Currently, CMM is deployed by a diverse cohort of organizations across the U.S. and can expand substantially within existing federal and state laws and regulations.
- Clinical pharmacists are critical team members as they are well-positioned to work in collaborative practice with physicians to help patients find affordable medications that are clinically appropriate.
- CMM has enabled teams to coordinate the variety of prescribers (e.g., primary care providers, specialty physicians, clinical pharmacists) involved in a patient's care and take the time to explain the disease, its effects and the role of medications.
- A growing number of new physicians are beginning clinical practice with the expectation of a collaborative care team with a clinical pharmacist playing a central role.
- As organizations take responsibility for the full cost of care, collaborative care approaches, inclusive of integrated clinical pharmacists, are becoming more common.
- CMM is frequently deployed for patients most in need of a comprehensive, whole-person approach—these are patients experiencing a number of medical conditions, taking a variety of medications and working with multiple providers.
- Risk stratification using clinical, claims and prescription data is an effective way to identify patients in need of CMM.
- One event participant reported having a ratio of roughly one clinical pharmacist per location, with the ratio of clinical pharmacists to patients ranging from 1:1,000 to 1:3,500.

What are the reported effects of CMM and pharmacy integration?

- CMM can lead to substantial reductions in emergency department visits, avoidable readmissions, daily medication regimens and overall number of medications.
- Research has shown the return on investment of CMM "to average around 3:1 to 5:1 and can be as high as 12:1, resulting in a reduction in the direct mean medical cost of between $1,200 and $1,872 per patient per year for each of the first 5 years for those patients with chronic diseases such as diabetes, cardiovascular health issues, asthma and depression" *(Pharmaceutical Care Practice: The Patient Centered Approach to Medication Management).*
- Integrating a clinical pharmacist into primary care practices to assist patients with complex medication management needs eases the pressure of primary care shortages and other staff-related bandwidth challenges.
- Physicians are typically very satisfied with the clinical pharmacist's contribution to the care team.
- Patients tend to be very pleased with CMM and have reported that they feel very comfortable asking the clinical pharmacist specific

medication questions that they might not ask otherwise.

- Patients appreciate additional time with a clinical pharmacist to discuss their lifestyle, goals, medications, questions, etc. and respond well to explanations on intended medication impacts, side effects, etc.

What are the barriers or challenges to CMM deployment and pharmacy integration?

- Widespread deployment of CMM will require establishing a shared and common definition.
- Broader awareness of the emerging role of clinical pharmacists in patient-care roles continues to be very low; and where there is some awareness, substantial skepticism remains.
- Ensuring reimbursement for CMM as a patient care service will greatly accelerate adoption.
- Because there is often no reimbursement for CMM, it must be considered a cost-reducer instead of a revenue generator. This means that organizations most prepared to implement it are those that can absorb the risk associated with the cost such as accountable care organizations, patient-centered medical homes and academic medical centers *(The Medication Therapy Management Pharmacist Reference Book)*.
- Payment models (mostly fee-for-service-based) have yet to account for the emerging role and increasing value of team-based care, particularly as it relates to integration of a clinical pharmacist on that team, and savings distribution models are relatedly underdeveloped.
- Payers and related entities can be resistant to change. Initial program set-up can take substantial time and effort to establish a business model and shared expectations around the value of CMM services when pharmacy benefits and medical benefits are not integrated.
- Health system and health plan administrators tend to focus on drug costs (i.e., the pill) and the near-term medication cost increases as part of an overall return on investment (e.g., reduced overall medical expenditures) vs. the opportunity to invest in a patient care service (i.e., CMM) that can create long term, sustainable savings.
- Team-based, interprofessional care, that includes a clinical pharmacist, will require a significant amount of time and resources from a team that might already be overwhelmed.
- Physicians take patient stewardship seriously and are not accustomed to asking for help from clinical pharmacists.
- Clinical pharmacists still require a degree of training to fully integrate into the multitude of value-based care approaches.
- Ensuring fidelity of practice for an entire team around a standard of care can be challenging.
- It is essential that all team members, including the clinical pharmacist, have access to clinical information, including diagnostic/lab results, at the point of care. This can be particularly challenging in situations with multiple EHRs.
- A person-centered, team-based approach requires additional team-members beyond a clinical pharmacist—nurses, social workers and community-based organization representatives are all important team members helpful in addressing social determinants of health.
- Patients may interpret changes to medication therapy as an indication that their physician or other primary care provider made a mistake.

What are the elements of success?

- CMM is best achieved when purchasers (e.g., employers, payers) understand that it is a medical service and must be integrated into advanced primary care delivery models. Since the service is not generally offered by pharmacy benefit managers, change in benefit plan design is necessary and essential to prevent a trial-and-error approach to medication use.

- Education on the cost, quality and benefits of CMM services is essential to get purchasers to recognize, contract for and pay for these services as part of the medical benefit.
- Physician and other provider champions of CMM are needed to help foster broader organizational buy-in and support.
- Health systems with multi-disciplinary team experience are typically more prepared to welcome the contributions of a clinical pharmacist.
- Evangelizing within a health system using actual local outcomes data from an internal pilot (as opposed to data from other organizations) can be more conducive to organizational buy-in.
- Proactively involving clinical pharmacists at the point of medication decision-making can establish a better clinical relationship. In situations where substance abuse issues can hinder a patient's ability to adhere to medication instructions, CMM can mitigate dangerous drug-drug interactions and address medication misuse and overuse.
- It may be necessary to change the workflow of prescribing so that the physician focuses on diagnosis, then—together with the patient—the physician and pharmacist discuss medication goals and options in real-time.
- Small practices can start with hospital and community pharmacist partners through collaborative practice agreements that establish EHR access, medication dosage review support, access to treatment plan, formal roles in adherence goals and bi-directional lines of communication.
- Patients with diabetes or hypertension (and other chronic conditions) will be assessed using referring diagnosis as trigger receiving a whole person evaluation when referred for CMM.
- Monitoring physician utilization of clinical pharmacy support can identify opportunities to increase buy-in.
- Working with community-based organizations (CBO) can enable a newer stakeholder to leverage trust from existing relationships between patients and the CBO.
- Patient partnerships, preferences and priorities must be considered. Patients may have different preferences for how to balance symptom relief and side-effects depending on their health and life goals.
- Organizations should avoid waiting for a larger cohort of patients to commence work. Start working with who you can and worry about scaling later.

Break-Out Session Summaries

During the event, various experts and key stakeholders separated into breakout rooms to discuss key issues related to CMM implementation including the current landscape, pain points, barriers and how to move forward. The summaries included below represent a synthesis of those discussions and are organized by topic area.

Population Health

Population health aims to improve the health status of a population through broad and targeted interventions. Gathering and analyzing data to understand the population's health status, needs and progress is a foundational step. There are many measures that can give useful information about the population, but measures that are prioritized by organizations involved in CMM include those related to: readmission rates, diabetes management, hypertension management, accessibility of care, and patient satisfaction *(Assessing the Impact of CMM on Achievement of the Quadruple Aim)*.

There are also many interventions that can be taken to improve the health of a population. Some examples include embedding clinical pharmacists in care settings throughout the clinical spectrum, post-discharge pharmacist consults, and identifying and engaging patients that will most benefit from CMM. While some medication therapy management (MTM) interventions focus on specific diseases, those attendees from

provider organizations most often offer whole person, comprehensive medication management programs.

Social Determinants of Health

Organizations engaged in CMM should try to understand and address the social factors that impact health. Many social determinants of health can impact a patient's ability to take medications as prescribed. Limited financial resources can create challenges with purchasing medications, access to sufficient and/or healthy food and transportation to doctor appointments and medical facilities. Additionally, a lack of reliable childcare can be a barrier to patient's being able to seek medical care and medication follow up.

Engaging in partnerships with community organizations is essential to addressing social determinants of health. Community organizations are especially helpful for educating patients because they have earned the patient's trust. They can also help to identify patients that would benefit most from CMM. CMM programs can help address and reduce health disparities.

Data Driven Transformation

Using clinical and claims data together is essential to insight that creates interventions that will drastically improve patient outcomes. It can help to identify patients with the greatest opportunity to benefit. Also, having robust data at the point of care is essential for making sound treatment decisions. When using a collaborative practice agreement, a clinical pharmacist can make medication changes in real-time, so it is essential that they can see the most recent lab data and other clinical information. Unfortunately, getting access to this kind of data in real-time can be challenging *(Four Formative Pillars: Top Health IT Capabilities that will Improve CMM)*.

Care teams working to find solutions to these challenges may need to change access to the needed information at the point of care to ensure that the workflow includes a clinical pharmacist in real-time, either virtually or in-person. In this way, the patient, pharmacist and physician can all discuss clinical goals, treatment options and medication changes needed to obtain clinical goals of therapy.

Change Management

Preparing your organization to take on risk and succeed under value-based care is essential but challenging. One challenge is executive buy-in to make the changes and investments that are necessary for new models of care (e.g., new staff required to implement new programs). Oftentimes, the complexity of value-based contracts, particularly around the issue of how savings will be distributed, can also be a challenge. Leaders may be reluctant to make an investment if it is not clear how those investments will pay-off or if the results will justify the intervention.

The staffing shortages that many clinical teams are experiencing pose another challenge. Integrating clinical pharmacists as members of the interprofessional team will ultimately allow all members to work at the top of their license. This enhances and expands access to primary care services, but it can be challenging to onboard new team members when the existing team is already overwhelmed. Change in practice during wide-spread staffing shortages may increase turnover, which interrupts the continuity needed to establish and succeed in a new care model. A shared philosophy of practice is essential for success.

Network Expansion and Clinical Integration

Clinical integration aims to provide patients with a comprehensive, seamless care journey. This requires looking at data to identify where there are gaps that need to be closed. For this, one organization created an aggregated risk score to identify patients that were most at risk for a medication related event, based on the medications they are taking along with certain other clinical factors. In one example, an organization first identifies where there are gaps to be closed, then assigns a care team member to follow-up with the patient, physician or other members of the care team to ensure medication therapy problems were adequately addressed. (See real-word examples of what CMM in practice looks like: *Medication Optimization Use Cases*.)

It is also important to track metrics that will indicate if an intervention has made an impact. Metrics that simply monitor medication adherence or whether

a comprehensive medication review has been completed may not be sufficient as they aren't directly related to patient outcomes. Alternatives could include medication therapy problem resolution, ED visits, inpatient admissions or other measures related to the patient's disease state.

Accountability and Relationship Management

Accountability and relationship management focuses on developing stewardship for patients' cost and quality outcomes. Ideally, this stewardship would follow the patient across their care journey, but this can be challenging when the patient is receiving care from multiple separate organizations. Fortunately, value-based care, especially "accountable care" approaches, can help to align incentives to provide a more involved and comprehensive care experience. Accountable care aligns interprofessional care teams and the people who entrust their care to them to help realize the best achievable health outcomes for all through comprehensive, high-value, affordable, longitudinal and person-centered care (Recommendation letter to the Health Care Payment Learning & Action Network (HCPLAN)).

There are several factors that can be used to identify patients that could benefit most from CMM. These include patients with multiple chronic conditions, patients taking multiple medications, patients taking complex medications that require specialized administration and patients transitioning between care settings *(Comprehensive Medication Management: FAQ for Employers)*. Interventions should not focus on a specific disease or medication but should instead take a whole-person perspective. This includes adjusting interventions to a patient's specific preferences and priorities. For example, patients will have different preferences about how to balance symptom relief with side effects depending on their own unique goals or genetic makeup (i.e., pharmacogenomics—*(PGx as an Essential Tool in the CMM Process)*.

Acknowledgements

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Sarah Fogler, Ph.D., Deputy Director, Patient Care Models Group, CMS Innovation Center


Pauline Lapin, MHS, Director of Seamless Care Models Group, CMS Innovation Center


Katherine Laurenzano, MD, Medical Director for Primary Care Monitoring and Oversight, Office of Primary Care, U.S. Department of Veterans Affairs


Erick Sokn, Pharm.D., MS, Pharmacy Director, Population Health, Cleveland Clinic


Amanda Brummel, Pharm.D., BCACP, Vice President of Clinical Ambulatory Pharmacy Services, MHealth Fairview


Katherine Czarnowski, Pharm.D., BCACP, Population Health Clinical Pharmacist, SoNE Health


Nicole Green, BSP, Director, Ambulatory Pharmacy, ThedaCare


Richard Bone, MD, Senior Medical Director of Population Health, Advocate Medical Group


Melissa Murer Corrigan, RPh, CAE, FAPhA, FASHP, Executive Director, Transformation Center, American Association of Colleges of Pharmacy


Paul Grundy, MD, MPH, FACOEM, FACPM, President, GTMRx Institute


Eric Weaver, DHA, MHA, Executive Director, Institute for Advancing Health Value


Katherine H. Capps, Co-founder and Executive Director, GTMRx Institute

GTMRx and Accountable Care Learning Center* Executive Roundtable Event Attendees

Wednesday, April 13, 2022 | 10:30 AM-1:30 PM EST | Virtual over Zoom

**The Accountable Care Learning Collaborative (ACLC) is now the Institute for Advancing Health Value*

Sarah Amering, Pharm.D., BCACP
Clinical Pharmacy Specialist, Ambulatory Care, University of Rochester Medical Center

Jeffery Barkoff, MBA
Area Vice President, Population Health, Tabula Rasa HealthCare

Michael Barr, MD, MBA, MACP, FRCP+
President & Founder, MEDIS, LLC, Executive Physician Advisor, GTMRx Institute

Caroline Bascle, MA
Senior Account Manager, Health2 Resources

Jill Bates, Pharm.D., MS, BCOP, FASHP
PHASER Pharmacy Program Manager, Department of Veterans Affairs

Jake Behnke, MS
Director, Marketing, Cureatr, Inc.

Rick Bone, MD
Senior Medical Director, Population Health, Advocate Aurora Health

Amie Brooks, Pharm.D., FCCP, BCACP
Director, Strategic Initiatives, American College of Clinical Pharmacy

Marissa Brooks, Pharm.D., MBA
Executive Fellow, Association Management & Leadership, American Society of Health-System Pharmacists

Amanda Brummel, Pharm.D., BCACP
Vice President, Clinical Ambulatory Pharmacy Services, MHealth Fairview

Marcia Buck, Pharm.D., FCCP, BCPPS, FPPA
Director, Clinical Practice Advancement, American College of Clinical Pharmacy

Tejay Cardon, MISM
Vice President, Product Portfolio, Enterprise Strategy & Solutions, Tabula Rasa HealthCare

Katherine H. Capps*
Executive Director & Co-Founder, GTMRx Institute

Collier Case
President & CEO, Mid-America Coalition on Health Care

Maria Castano, Pharm.D.
Director, Quality & Pharmacy Programs, Memorial Healthcare System

Lynette Chastain, Pharm.D., BCACP
Assistant Director, Pharmacy, NEA Baptist Memorial Hospital

Daniel Chipping, MBA, MHA
Senior Manager, Institute for Advancing Health Value

Christina Ciconte
Manager, Public Policy, ERISA Industry Committee

Melissa Murer Corrigan, RPh, CAE, FAPhA, FASHP
Executive Director, Transformation Center, American Association of Colleges of Pharmacy

Rebecca Cupp, RPh
Vice President, National Pharmacy Controls, Kaiser Permanente

Katherine Czarnowski, Pharm.D., BCACP
Population Health Clinical Pharmacist, SoNE Health

Lynn Deguzman, Pharm.D., BCGP
Clinical Operations Manager, Kaiser Permanente

Nilesh Desai, B.Pharm, MBA
Chief Pharmacy Officer, Baptist Health System

Anastasia Diafotis, MD*
Chief Scientific Officer, North America, Janssen Pharmaceuticals

Erica Dobson, Pharm.D., BCPS
Senior Director, EHR Applications, University of Rochester Medical Center

** Denotes GTMRx Board Member* *+ Denotes GTMRx Distinguished Fellow and Advisors* *GTMRx Institute as of 4/5/22*

Greg Downing, DO, Ph.D.
Strategic Advisory Board, Cureatr, Inc.

Molly Ekstrand, BPharm, BCACP, AE-C+
Associate Director, Account Medical Advisor, Boehringer Ingelheim Pharmaceuticals, USA

Julie England, MD
Medical Director of Medical Affairs, OneOme

Sarah Fogler, Ph.D.
Deputy Director, Patient Care Models Group, Centers for Medicare & Medicaid Services Innovaion Center

Nidhi Gandhi, Pharm.D.
Associate Director, Research Programs & Special Initiatives, American Association of Colleges of Pharamcy

Paul Grundy, MD, MPH, FACOEM, FACPM*
President, GTMRx Institute; Chief Transformation Officer, Innovacer

Sachin Gangupantula, FACHE, MBA, MS
Founder & Director of Operations, Valley Diabetes & Obesity

Ernest Grant, Ph.D., RN, FAAN
President, American Nurses Association

Nicole Green, BSP
Director, Ambulatory Pharmacy, ThedaCare

Julie Groppi, Pharm.D., FASHP
Assistant Chief Consultant, Clinical Pharmacy Practice & Policy, PBM Service, Department of Veterans Affairs

Curtis Haas, Pharm.D., FCPP
Chief Pharmacy Officer, University of Rochester Medical Center

Keri Hager, Pharm.D., BCACP
Associate Professor & Co-Associate Dean, Clinical Affairs, University of Minnesota College of Pharmacy

Jeff Hanson, MPH, MEd
Previous Director, Business Development, GTMRx Institute

David Harlow, BS, Pharm.D.
Sr. VP, Allied Health Operations, ECU Health

Elizabeth (Liz) Helms
President & CEO, California Chronic Care Coalition

James Hill
Vice President, Population Health, Prime Care Managers

April Hodges, RN, BSN, CMM
Senior Director, Medical Management, Genovista

Brian Isetts, Ph.D., BCPS, FAPhA, BPharm, RPh+
Professor, University of Minnesota College of Pharmacy

Pamala Jacobson, Pharm.D., FCPP
Professor & Associate Department Head, Department of Experimental & Clinical Pharmacology, College of Pharmacy, University of Minnesota

Tiffany Jenkins, Pharm.D., BCACP
Director, Population Health Pharmacy, Trinity Health Alliance of Michigan

Mitchell Kaminski, MD, MBA
Program Director, Population Health, Jefferson College of Population Health

Josh King
Office Coordinator, GTMRx Institute

Ira Klein, MD, MBA*
Vice President, Provider Relations, Tempus Inc.

Mary Ann Kliethermes, B.S. Pharm., Pharm.D., FAPhA, FCIOM
American Society of Health-System Pharmacist

Lawrence (Larry) LaMotte, MPP
Senior Policy Advisor, California Chronic Care Coalition

Pauline Lapin, MHS
Director, Seamless Care Models Group, Centers for Medicare & Medicaid Services Innovation Center

Bayli Larson, Pharm.D., MS, BCPS
Strategic Initiatives Associate, American Society of Health-System Pharmacists

Katherine Laurenzano, MD
Medical Director, Primary Care Monitoring & Oversight, Office of Primary Care, Department of Veteran Affairs

Jessica Lea, Pharm.D., MBA
CEO, Tria Health, LLC

Min Lee
Senior Product Manager, Cureatr

Brogan Madden
Healthcare & Program Management Intern, GTMRx Institute

Maria Maniscalco, Pharm.D.
Population Health Pharmacist, Holy Cross Health

Angela Mayo, Pharm.D., MBA
Assistant Director, Pharmacy Services, Vidant Medical Center

Shawn McFarland, Pharm.D., FCCP, BCACP
National Program Manager, Clinical Practice Integration & Model Advancement, PBM Service, Department of Veterans Affairs

John McGlew, MA
Director, Government Affairs, American College of Clinical Pharmacy

Sandra Morris, RN, MSN, CHC
Senior Advisor, GTMRx Institute

Heather Mosley, MBA
Clinical Practice Transformation Coordinator, Geisinger

Debora Menieur Nunez
Marketing & Communications Account Manager, Health2 Resources

Tim Peterson, MD, MBA, FACEP
Population Health Executive, University of Michigan; Executive Director, Physician Organization of Michigan Accountable Care Organization

Kathy Pham, Pharm.D., BCPPS
Director, Policy & Professional Affairs, American College of Clinical Pharmacy

Gabrielle Pierce, Pharm.D., MBA
Executive Fellow, Association Leadership & Management, American Society of Health-System Pharmacists

Hannah Post, Pharm.D., BCPS
Executive Fellow, Association Leadership & Management, American Society of Health-System Pharmacists

Daniel Rehrauer, Pharm.D.
Senior Manager, MTM Program, HealthPartners

Phil Robidoux
Director of National Sales, Cureatr

Chet Robson, DO, MHCDS, FAAFP+
Chief Medical Officer, imaware Health

Doug Scheckelhoff, MS, R.PH., FASHP
Sr. VP, Practice Advancement, American Society of Health-System Pharmacists

Teresa Schmidt, MA, PMP, CSPO
Vice President, Discern Health

Izzy Serji, MPH
Director, Project Management & Operations, GTMRx Institute

Julia Skapik, MD, MPH
Chief Medical Information Officer, National Association of Community Health Centers

Mistylynn Stephens
Area Director, ACO & MCO Business Development, AccentCare

Mindy Smith, BPharm, RPh, MHA
Sr. VP, Government & Professional Affairs, Tabula Rasa HealthCare

Lisa Smith, MD, FAPA
Psychiatry Section Chief, Department of Veteran Affairs, Eastern Colorado

Erik Sokn, Pharm.D., MS
Pharmacy Director, Population Health, Cleveland Clinic

Dele Solaru, Pharm.D., MBA
Chief Pharmacy Officer, US Office of Personnel Management

Todd Sorensen, Pharm.D.
Executive Director, Alliance for Integrated Medication Management

Saba Syed, Pharm.D., MS, BCACP, BCGP, EMBA
Director, Clinical Quality, Pharmacy, VillageMD

Andreea Temelie, Pharm.D., BCPP
Clinical Pharmacist, Psychiatry, University of Pittsburgh School of Medicine, Western Psychiatric Hospital

Tram Thai, Pharm.D., BCACP, AE-C
Clinical Pharmacy Specialist, Cureatr

Toyin Tofade, MS, Pharm.D., BCPC, CPCC, FFIP
Dean & Professor, Howard University College of Pharmacy

Eric Weaver, DHA, MHA
Executive Director, Institute for Advancing Health Value

C. Edwin Webb, Pharm.D., MPH*
Senior Policy Advisor, American College of Clinical Pharmacy

Joanne Williams, MD, MPH, MACM
Family Physician, Neighborhood Health Tennessee

Tatiana Wright, Pharm.D.
Clinical Pharmacy Specialist, Cureatr

Get the Medications Right Institute
8230 Old Courthouse Road, Ste. 420
Tysons Corner, VA 22182
703.394.5398 ■ www.gtmr.org

Institute for Advancing Health Value
at Western Governors University
4001 S 700 E Ste. 700
Salt Lake City, UT 84107

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