November 11, 2022

Robert Otto Valdez, PhD, MHSA
Director
Agency for Healthcare Research and Quality
5600 Fishers Lane
Rockville, MD 20857

Re: Request for Information on Person-Centered Care Planning for Multiple Chronic Conditions

Dear Dr. Valdez:

On behalf of the American Association of Psychiatric Pharmacists (AAPP), we appreciate the opportunity to submit comments in response to the Request for Information from the Agency for Healthcare Research and Quality (AHRQ) on Person-Centered Care Planning for Multiple Chronic Conditions (MCC).

AAPP is a professional association of nearly 3,000 members who envision a world where all individuals living with mental illness receive safe, appropriate, and effective treatment. Members are pharmacists with expertise in psychiatry, substance use disorders (SUDs), psychopharmacology, and neurology, and most are Board Certified Psychiatric Pharmacists (BCPPs). With a significant shortage of mental health care professionals, psychiatric pharmacists are important workforce members who can improve outcomes for patients with psychiatric disorders and SUDs.

Pharmacists today graduate with a Doctor of Pharmacy (PharmD) degree, requiring six to eight years of higher education, and they have more training specific to medication use than any other healthcare professionals. Psychiatric pharmacy, a specialty within clinical pharmacy, is composed of post-PharmD residency-trained and board certified healthcare practitioners who have specialized training in providing direct patient care and medication management for persons with psychiatric disorders and SUDs.

Psychiatric pharmacists are ideally positioned to be important components of care coordination for people with MCC. They are integrated into healthcare teams in both primary care and mental health settings. They provide support and expertise to physicians and behavioral health providers. They are trained to optimize medications for patients with psychiatric disorders, SUDs, and non-psychiatric medical conditions. Psychiatric pharmacists can be especially invaluable in settings where patients are prescribed medications for both mental and physical illnesses concurrently, drawing on their core knowledge regarding all medications.

Comprehensive Medication Management

Psychiatric pharmacists collaborate with patients and other members of the healthcare team by using a process of care known as comprehensive medication management (CMM) (https://www.optimizingmeds.org/comprehensive-medication-management/).

8055 O Street, Ste S113 ■ Lincoln, NE 68510
www.aapp.org ■ info@aapp.org
402-476-1677 (phone)

CMM is a standardized, systematic process that includes an individualized care plan that achieves the intended goals of therapy with appropriate follow-up to determine actual patient outcomes. A research team led by McClurg, Sorensen, and Carrol[1] have developed a standardized framework for CMM that stakeholders can use to ensure consistency and fidelity and to the patient care process. Separately, the Pharmacy Quality Alliance has developed a framework to allow for the development of measures around CMM.[1]

CMM is an evidence-based care process provided by psychiatric pharmacists that includes:

- Assessing all of a patient's medications– prescription, nonprescription, vitamins, and supplements for both psychiatric and other medical illnesses;
- Assessing each medication to ensure that it is appropriate, effective, safe, and can be taken as intended; identifying and addressing medication-related problems, including medication interactions and adverse effects;
- Developing individualized care plans with therapy goals and personalized interventions;
- Prescribing medications and ordering laboratory or other diagnostic tests when permitted by state regulations;
- Following up with appointments at regular intervals to evaluate response, adverse effects, progress toward treatment goals, and to adjust medications as needed;
- Educating patients and families about medications and lifestyle modifications; and
- Referring to other providers and specialists for services such as diagnostic clarification, psychotherapy, and dietary counseling.

CMM services benefit patients:

- Needing complex care coordination among multiple providers;
- With multiple chronic conditions or at risk for developing MCCs;
- With complex medication regimens;
- Who are not meeting treatment goals; who have serious medication adverse effects;
- Transitioning between health care settings;
- Taking specialty medications like clozapine or long-acting injectable antipsychotic medications;
- Who would benefit from genetic testing to optimize their medication regimen;
- With tobacco, alcohol, opioid, or other SUDs who may benefit from medication treatment; and
- Who have conditions that complicate psychiatric medication treatment such as pregnancy, advanced age, concomitant medical illness; and those receiving antipsychotic medications as children.

An Issue Brief from the Alliance for Addiction Payment Reform on "Coordinated and Comprehensive Medication Management in Substance Use Disorder Treatment and Recovery" highlights the positive impact of including pharmacist-provided CMM including the development of specific, patient-centered treatment goals.

[1] CMM in Primary Care Research Team. The patient care process for delivering comprehensive medication management (CMM): optimizing medication use in patient-centered, team-based care setting. July 2018. Available at http://www.accp.com/cmm_care_process.

Iturralde and colleagues[2] describe and are evaluating a model of care implemented at six medical facility service areas within Kaiser Permanente Northern California in which clinical pharmacists lead a collaborative care team, providing patient assessment and education, medication adjustments, and care coordination for a large panel of patients with severe and persistent mental illness to improve access to high quality care. They anticipate that this model will also improve screening for the high preventive care needs for people with severe persistent mental illnesses (SPMI).

In addition, McFarland and colleagues[3] review the increasing number of publications that support the impact of CMM, including improved outcomes, healthcare costs, patient experience, and provider well-being.

Although the CMM model is well accepted in some government funded health systems such as Veterans Affairs and federally qualified health centers, it has not gained widespread acceptance. The primary cause for this lag is the lack of recognition of psychiatric pharmacists as qualified healthcare providers by CMS and failure of Medicare to reimburse practices for CMM as a covered service.

RFI Questions:
Please find below AAPPs responses to the questions in the RFI.

*What **terms**, strategies, and models of care are used to describe and deliver care planning for the **whole person** (not just for individual health conditions) that records: (1) roles and **tasks among care team members**, including the individual, their family and caregivers; (2) plans for coordinating care within and across organizations and settings; (3) strategies for supporting and empowering patients to manage their own health; (4) plans for engaging in shared decision making?*

- CMM by definition is whole person care, assessing all of a patient's conditions and medications with the purpose of meeting individualized, patient-centered treatment goals.

- CMM is a task that is uniquely suited to the education, training, and skill set of a pharmacist as part of the healthcare team.

- The process of CMM includes the patient as an essential part of the assessment and requires their agreement with the care plan.

- Pharmacists coordinate with other members of the team through a clear delineation of responsibilities and through collaborative practice agreements with a physician or non-physician provider.

- CMM includes consideration of factors such as social determinants of health, somatic and psychiatric conditions, substance use disorders (SUDs), acute and chronic conditions, transitions

[2] Iturralde E, et al. Closing the care gap for people with severe and persistent mental illness: collaborative care, telehealth, and clinical pharmacy. NEJM Catalyst Innovations in Care Delivery. May 2022. Vol. 3 No. 5. Available at https://catalyst.nejm.org/doi/full/10.1056/CAT.21.0417
[3] McFarland MS, et al. Assessing the impact of comprehensive medication management on achievement of the quadruple aim. Am J Med 2021;134:456-461. Accessed at https://pubmed.ncbi.nlm.nih.gov/33472055/

between care settings, continuous follow-up to assess response to treatment, and reassessment after a new diagnosis or hospital admission.

- Care is delivered in a multitude of care settings, some of which are unique to patients with psychiatric disorders, for example inpatient, outpatient, residential, partial hospitalization, and group homes.

- Pharmacists providing CMM are trained in providing patient and family education, motivational interviewing, shared decision making, and counseling on medication taking behaviors.

- The CMM assessment and care plan are documented in the patient's shared medical record

*What **key components** are necessary to fully deliver on the promise of person-centered care planning?*

- Key components of CMM are clearly described, published, and supported in the literature.[1]

- CMM should be provided to all patients with MCC, those with complex medication regimens, and those at risk for developing MCC, to ensure that all conditions are addressed and treated to goal.

*How is comprehensive, longitudinal, person-centered care planning for people at risk for or living with MCC **currently being done** in health systems, primary care, and other ambulatory practices? What are **examples of innovative models** of care, approaches, promising strategies and solutions that could support clinicians and practices in routinely engaging in comprehensive, longitudinal, person-centered care planning to improve the care of people at risk for or living with MCC?*

- CMM is currently being done following established guidelines and implementation science strategies in a number of health systems, encouraging fidelity to the evidence-based model studied by the CMM in primary care research team.

- There are numerous health-systems that have successfully integrated pharmacist-provided CMM as an innovative model of care to improve outcomes for patients with MCC, such as Fairview Health System in Minnesota. In addition, the Veterans' Health Administration[4] has embraced CMM provided by clinical pharmacist practitioners as its standard of care throughout the system.

The largest study evaluating CMM was done by Sorenson and colleagues on the CMM in Primary Care Research Team[1] using an implementation science approach to establish key factors necessary for fidelity to an evidence-based model. From there they developed implementation guidelines, studied implementation in several sites, and have developed a number of tools to assist practices in assessing and improving the CMM process in their own practice settings.

[4] VA's Clinical Pharmacy Practice Office. Accessed at: https://www.pbm.va.gov/PBM/CPPO/Clinical_Pharmacy_Practice_Office_Home.asp

Thought leaders in this field include the leadership at the Get the Medications Right Institute, American College of Clinical Pharmacists, AAPP,[5,6] and the CMM in Primary Care Research Team.[1]

*What are **best practices** for designing, implementing, and evaluating person-centered care planning for people at risk for or living with MCC? What implementation challenges are clinicians and systems likely to face?*

- Best practices for providing CMM have been described above. In addition, AAPP has been engaged in research specifically designed to develop a best practice model for psychiatric pharmacists in outpatient settings. CMM is a core component of this best practice model in recognition of its impact on patient outcomes. Some of the initial work has been published[5,6] and additional research is ongoing.

*What are suggested **strategies** for effective implementation of person-centered care planning at multiple levels (e.g., **policy**, system, practice, clinical team, people with MCC)?*

- As described above the biggest barrier to widespread implementation of CMM by health systems is lack of CMS recognition and payment for CMM provided by psychiatric pharmacists. We ask the administration to urge Congress to take action to promote policies that encourage inclusion of pharmacists on the team, and to promote pharmacist-provided CMM as a covered benefit of Medicare.

*Which **payment models** might enable and sustain person-centered care planning?*
*What quality of care measurements (e.g., **metrics**, indicators) exist or are emerging for assessing **process, implementation, and outcomes** associated with person-centered care planning?*

- A transition away from fee-for-service toward value-based payment models that reward quality over quantity will encourage health systems to engage members of the team that are focused on meeting goals of treatment. This includes pharmacist-provided CMM.[7]

- Metrics that assess the value of various members of the team are key, although it is sometimes difficult to attribute improved outcomes to a single team member vs the entire team. PQA, HEDIS, and others have developed measures that focus on improving medication-related outcomes, including identifying and resolving medication related problems. In addition, AAPP is currently studying the development of a core outcome set that can be used as a compass for future research

[5] Silvia, R. J., Lee, K. C., Payne, G. H., Ho, J., Cobb, C., Ansara, E. D., & Ross, C. A. (2022). Best practice model for outpatient psychiatric pharmacy practice, part 1: Development of initial attribute statements. *Mental Health Clinician*, *12*(2), 57-64. Accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9009820/

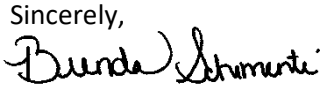
[6] Lee, K. C., Silvia, R. J., Payne, G. H., Moore, T. D., Ansara, E. D., & Ross, C. A. (2022). Best practice model for outpatient psychiatric pharmacy practice, part 2: confirmation of the attribute statements. Mental Health Clinician, 12(2), 65-76. Accessed at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9009822/

[7] Barr, M, Hass, C, McFarland, M et. al. Comprehensive Medication Management: A Missing Ingredient In Value-Based Payment Models. *Health Affairs Forefront*. September 9, 2022.DOI: 10.1377/forefront.20220907.835484. Accessed at https://www.healthaffairs.org/content/forefront/comprehensive-medication-management-missing-ingredient-value-based-payment-models

involving care provided by pharmacists. Implementation science research has been done on CMM[8] (Livet), to assess fidelity to the model and how to spread it to other settings. They have developed a platform[9] to allow practices to implement and improve practice with fidelity to the model

In summary, AAPP would like to thank AHRQ for its efforts to identify innovative models of care planning to improve outcomes for people with or at risk for MCC using a person-centered approach. We believe that CMM is an essential piece of a team approach to care to improve outcomes and we encourage AHRQ to help facilitate its implementation. If you have any questions, please do not hesitate to contact me or our Health Policy Consultant, Laura Hanen at lahanen@venable.com.

Sincerely,



Brenda K. Schimenti
Executive Director

[8] Livet, M, Blanchard, C, Sorensen, TD, Roth McClurg, M. An implementation system for medication optimization: Operationalizing comprehensive medication management delivery in primary care. J Am Coll Clin Pharm. 2018; 1: 14– 20. https://doi.org/10.1002/jac5.1037.
[9] https://www.optimizingmeds.org/cmm-implementation-system/