

Exhibit No. 2Date 2-2-2009Bill No. SB 174

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SB0174 Clinical Pharmacist Provider

This bill is neither a change to nor an expansion of current pharmacy practice.

SB0174 is an attempt to bring Montana in compliance with federal legislation affecting CMS.

The Collaborative Drug Therapy Management (CDTM) act was passed by the 2001 Legislature

- Refers to the practice where physicians authorize pharmacists to engage in specific medication management activities
- Maximizes the expertise of the pharmacist and the physician to achieve optimal patient care
- Has shown a reduction in delays to modifying drug regimens, reduction in unnecessary physician office visits, increased patient compliance and adherence to drug therapy plans, and increased likelihood that drug therapy problems will be averted¹

The Institute of Medicine reported that there were over 100,000 serious medication errors resulting in 7,000 deaths per year in the United States.^{2,3}

Clinical Pharmacists specialize in reducing medication errors and proactively improving medication therapies in clinical settings.

Clinical Pharmacist Run Anticoagulation Clinics

The American College of Chest Physicians Consensus Conference on Antithrombotic Therapy recommends patients receiving long-term anticoagulation should be managed in specialized anticoagulation clinics.⁴

- Three of the four studies examined by this group were taken from clinical pharmacist run anticoagulation clinics.
- Studies found a 50-90% reduction in major complications and a healthcare savings of \$4000/patient/year.⁵
- Western Montana Clinic Ambulatory Anticoagulation Management Clinical (WMC-AAMC) recorded data showing that an average annual increase in patient population since 1998 of 23% yearly and a decrease in hemorrhagic and thromboembolic events when compared to literature values.⁶

Clinical Pharmacy Services in Pain

Clinical pharmacists with prescribing authority in pain management produced the following results

- The use of a pharmacist clinician as a medication-safety expert to screen, triage, and process medication-refill requests, prevented an average of 10 near-miss medication misadventures daily.⁸

- The pharmacist was given the authority to bill the patients an average of \$25 per visit. This generated \$107,550 for the hospital. The pharmacist cost the hospital \$98,851. This was a 9% return on investment.
- Cost-savings data demonstrated a savings of \$455,238 to the health plans served by the clinic. When the cost to the health plan for pharmacy service is subtracted from the cost savings to the health plan ($\$455,238 \times 0.8 - \$107,550 \times 0.8$), the health plan saved \$278,150.
- Cost savings data demonstrated a savings of \$124,557 over 2 years in OxyContin use alone, ER visits were reduced by 72.7%, PCP visits reduced 59.6%, 51% of patients were identified as having aberrant drug-taking behaviors and 38% of these patients self-discharged from the structured program, 13% required referral for addiction, and 4% were weaned from opioids.⁹
- A pharmacist run acute pain service at St. Patrick Hospital in Missoula, MT demonstrated a cost savings of \$5713 per patient the first year and continued to demonstrate a cost savings of \$1458 per patient over the next 3 years.¹⁰

By defining a Clinical Pharmacist Provider, this should allow us to proactively meet the proposed legislation and negotiate with other third party payers to be reimbursed for clinical services provided by pharmacists.

References

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