Secretary Kathleen Sebelius

October 4, 2010

200 Independence Ave. SW
Washington, DC 20201

Dear Secretary Sebelius:

I wish to direct your attention to the present circumstances conditioning pharmaceutical services in the State of Iowa. Present demand for pharmaceutical service indicates current resource deficits and planning for future demand has not been rigorously pursued. The implications of the demographic trend of a rapidly aging population with respect to pharmaceutical service are not yet widely appreciated despite the promise of wide-ranging impact, particularly for rural Iowans who are most at risk from inadequate prescription medication care. I hope to provide you with a factual framework to guide upcoming decision-making. Finally, I wish to make a concrete recommendation regarding interim pharmacist services.

DEMOGRAPHICS

According to the U.S. Census's 2007 population estimates, Iowa holds fourth and fifth national rankings in terms of adults over 85 and 65, respectively. According to the 2000 census, nearly half (42%) of seniors Iowans live in counties with tiny (<8,000 people) or very small (<24,000) populations. According to the Iowa Department of Public Health (www.idph.state.ia.us; accessed Oct. 2010), 63 of Iowa's 99 counties registered service deficits stemming from a lack of professional caregivers. In contrast, in 1999, only 58 counties were so categorized. Accompanying this growth in service deficits has been a decrease in gerontological nurse practitioners—from 51 in 2001 to 35 in 2003. This fact adds an additional burden to pharmacists in that more advisory services will likely be required.

Given that an earlier study (Coward and Cutler 1989) concluded that seniors living in small towns or rural areas have less service options and less health care provider availability, it is obvious that a two-decade-and-growing less-than-ideal state of affairs has been allowed to continue and, perhaps, worsen. The University of Iowa's report titled the "Iowa Challenge in Aging" presented the following calculations: "As of August 2005, 10 entire Iowa counties and parts of 50 other counties had been designated as Medically Underserved Areas. In 2003, 63 of Iowa's 99 counties were designated as Governor's Health Professional Shortage Areas (HPSA) for primary health care (up from 58 in 1999). Similarly, 81 counties were identified as HPSAs for mental health (up from 48 in 1999), and 29 counties reported 4 or fewer pharmacies" (www.centeronaging.uiowa.edu/AboutUs/TheIowaChallengeinAging2.05.09%5B1%5D.pdf; accessed Sept. and Oct. 2010).

An aging population, of course, is not by itself alarming. However, when one considers that "over one-half of the rural elderly are in poor health," (Ibid.), the current network of pharmacist resources in these small rural communities renders rural and small town Iowans and their farms and businesses vulnerable to reduced access to health monitoring and reduced prescription medication care. In sum, decreases in the number of pharmacies in rural Iowa will result in restricted access to proper care for elderly taxpayers.

KEY FACTS

As the population ages there will be an increase in the number of prescription medications needed, particularly for the control of dementia, cardiopulmonary disease, carcinoma, weight & fatty lipid reduction, diabetes, and arthritis. But what is true of the general population is also true for the 254 ambulatory/independent and franchise pharmacy owners currently operating (according to the 2009 membership list for the Iowa Pharmacy Association) in the state, a high proportion of which include pharmacist-owned pharmacies in rural areas throughout the state.

Economy of scale factors suggest that large, big-box, and chain pharmacies are unsupportable in small and dispersed communities. This makes vital the role played by Iowan-owned independent or franchise pharmacies. As owners are aging along with the rest of the population, we must note that they are not being replaced by younger pharmacists. The trend, according to the Iowa Board of Nursing (2001) is that rural Iowa is losing competent health care professionals across the board.

We must therefore consider alternatives to local pharmacist resources. Remote medicine relying on video conferencing technology and mail order pharmacy represent the two most promising resources for medical and prescriptive care, respectively. Unfortunately, both offer limited values. Focusing on the latter, there is no doubting the fact mail order pharmacy has helped somewhat. Yet, access to acute prescription medication needs cannot be solved through mail order. Dispensing antibiotics, pain medications, and changes in doses for blood pressure medications, for example, require pharmacists to have personal knowledge of patient conditions.

There can be no doubt that there are sufficient numbers of Iowans who will be negatively impacted by reduced pharmacist access. Less pharmacies means that Iowans will likely deviate from taking their medications the way they were intended. Compliance is actually a serious and underappreciated issue. According to the International Society for Pharmacoeconomics and Outcomes Research, compliance is defined as "degree or extent of conformity to the recommendations about day-to-day treatment by the provider with respect to the timing, dosage, and frequency. It may be defined as 'the extent to which a patient acts in accordance with the prescribed interval and dose of a dosing regimen'" (http://www.ispor.org/sigs/medcompliance/medicationcomplianceandpersistence.asp; accessed Sept. 2010).

Common sense indicates and professional experience confirms that inadequate dosing leads to increased chances of adverse drug reactions. A typical example may be used to illustrate. Patient A is not being compliant with her blood pressure medication because she does not have access to a pharmacy close by. If she has questions or concerns she must travel a significant distance, a hardship under extreme Summer and harsh Winter conditions, thus inhibiting her from seeking information. Her doctor notices that she is not responding well to a blood pressure medication so he increases the dose based on the assumption that she is compliant. Patient's blood pressure drops and she ends up in the emergency room or dies on the way or soon after arriving.

Of course compliance problems are only one example where pharmacist clinical services are vital. Monitoring patients is vital to any successful treatment culture and the lack of pharmacist resources portends dire experience awaits many Iowans.

Is the current Healthcare Reform environment doing anything to forestall what should be an unacceptable condition for Iowans? The American Pharmacist Association (APhA) has produced some valuable guides, models, and programs. It has leveraged the "lessons learned"

from successful public and private sector programs and persuaded Congress to include several provisions that have the potential to optimize the benefits of pharmacist clinical services.

The following represent some of the most impactful initiatives (www.pharmacist.com/AM/Template.cfm?Section=Home2&TEMPLATE=/CM/ContentDisplay.cfm&CONTENTID=20621; accessed Sept. 2010).

Testing the Best Way to Deliver Medication Therapy Management (MTM) Services

- MTM Grant Program (Section 3503)
- Center for Medicare and Medicaid Innovation (Section 3021)

Improving Current Medicare Part D Medication Therapy Management (MTM) Programs

- Improvements to Medicare Part D MTM Programs (Section 10328)
- Medicare Advantage Bonus Payments (Section 3201)

Including Pharmacists and Pharmacist-Related Services in Integrated Care Models

- Community-Based Interdisciplinary Teams (Section 3502)
- Independence at Home Demonstration Program (Section 3024)

Including Pharmacists and/or Pharmacist-Related Services in Transitional Care Models

- Community-Based Care Transitions Program (Sections 3026)
- National Pilot Program on Payment Bundling (Section 3023)

Other Pharmacy-Related Provisions

- Fixes" the average manufacturer's price (AMP)-based reimbursement formula for generic medications in the Medicaid program (Section 2503)
- Exempts certain pharmacies from Medicare accreditation requirements to supply durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) and extends the deadline for obtaining accreditation until January 1, 2011 (Section 3109)
- Creates pharmacy benefit managers (PBM) transparency requirements (Section 6005)
- Establishes a National Health Care Workforce Commission that includes pharmacists in the definition of the health care workforce (Section 5101)
- Awards schools, including schools of pharmacy, grants to offer courses that focus on geriatrics, chronic care management, and long-term care (Section 5305);
- Makes pharmacists eligible for the Area Health Education Centers and interdisciplinary training grants (Section 5315)
- Advances research and treatment for pain care management (Section 4305);
- Establishes payment and approval pathway for biosimilars (Section 7002, 3139)
- Creates a Medicare coverage gap discount program (Section 3301)
- Addresses dispensing of outpatient prescription drugs in long-term care facilities in the Medicare program (Section 3310)

As laudable as these initiatives are, none directly address the needs of rural communities with significant proportions of independent living seniors.

CONCLUSION

Iowa legislators are faced with a sure and unavoidable challenge. In the context of limited resources occasioned by current economic constraints, the need to act now before the situation becomes critical may be compromised by financial exigencies. It is our view that inadequate response to this challenge will incur either equal or greater financial liabilities given the significance of rural Iowa farms and businesses to the state economy.

The general population is aging as are pharmacists. Legislators must ensure that operating a rural pharmacy is professionally rewarding and remunerative. They must ensure that younger pharmacists committed to professional excellence and small business independence are sufficiently encouraged to service non-urbanized areas. Ideally, Iowa legislators would set up an integrated program amalgamating federal and state standards, APhA recommendations, and county-level needs analyses to reduce pharmacist workload on the back-end in favor of more front-end, that is patient monitoring, time. Finally, if a service management process was implemented whereby interim pharmacy staffing would be remunerative to pharmacy owners, service hours could easily be extended in virtually every county. This last simple and practical solution may actually deliver the most impact for each investment dollar.

As you well appreciate, this is a critical time in our nation's history. This issue is not by itself determinative. But along with thousands of other opportunities to make life better for all of us, only limited imaginative and reasoning powers prevent us from progressing. I suggest policies reflecting the opposite.

With great respect,

Felix Gallagher, Pharm.D.
President
PharmServ Staffing