ANDROSCOGGIN
Home Healthcare
+ Hospice

Testimony in Support of

LD 223, Resolve, Directing the Department of Health and Human Services to Amend Its Rules Regarding Pharmacy Services

February 15, 2023

Senator Baldacci, Representative Meyer, and members of the Joint Standing Committee on Health and Human Services, my name is Kenneth Albert, and I am a resident of Lewiston. I serve as the President and Chief Executive Officer of Androscoggin Home Healthcare & Hospice. We navigate health care at home and in the community for nearly 4000 patients per day across Maine. We do so with a team of physicians, nurse practitioner, registered nurses, physical and occupational therapists, speech language pathologists, social workers and certified nursing assistants. I also have the privilege of serving as the Chairman of the Board of Directors for the National Association for Home Care & Hospice located in Washington D.C., which represents America's thirty-three thousand home health and hospice providers.

I'm here today to testify in support of LD 223, Resolve, Directing the Department of Health and Human Services to Amend Its Rules Regarding Pharmacy Services. I wish to thank Rep. Zager for sponsoring this important bill.

Home health care is absolutely integral to the health care delivery system in Maine and the United States. Since the inception of the home health benefit under Medicare in 1965 (Social Security Act), the partnerships have expanded to a point of undeniable integration and symbiosis between the home health sector and others, including primary and specialty medical care, acute hospital care, and facility based care. Health care at home provides safe transitions to home from hospital and skilled nursing facility admission. Further, we partner with every primary care provider in Maine to help manage our collective patients in the community.

What I want to make clear today is that our experience as providers of health care at home and the research on integration of pharmacist consultation in the plans of care are aligned.[1]

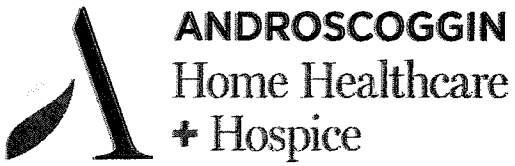
1. Primary outcome: Medication reconciliation programs have a direct impact on reducing hospital readmission rates within the 30-days post-discharge.

2. Secondary outcomes:

a. **Reducing overall healthcare costs;**
b. **Reducing the number of hospital and ED visits;**
c. **Reducing medication errors and adverse drug event; and**
d. **Improving patients' quality of life.**

Being discharged from the hospital can be dangerous. A classic study found that nearly 20% of patients experience adverse events within 3 weeks of discharge, nearly three-quarters of which could have been

[1] http://www.ichpnet.org/keeposted/article/44/08/educational_affairs_Impact_of



prevented or ameliorated.[2] Adverse drug events are the most common post-discharge complication. Nearly 20% of Medicare patients are rehospitalized within 30 days of discharge.[3] Sixteen percent (16%) of readmissions are medication-related, of which 40% are potentially preventable.[4] Minimizing post-discharge adverse events has become a priority for the US health care system – and for very good reason.

Research is also clear that medication review by a pharmacist in combination with medication reconciliation, patient education, professional education and transitional care, is associated with a lower risk of hospital readmissions compared to usual care.[5] This is especially true for patients with polypharmacy.

I am privileged to conduct home health appointments with members of my team periodically. Medication reconciliation is always part of the initial appointment. Doing so involves visualizing every single medication prescribed for the patient from multiple prescribing providers over months if not years. Then we compare and contrast with the medications the patient believes they should be taking. To do this we gather all the medications kept underneath beds; kitchen cabinets; bathroom closets; living room end-tables and other favorite storage places. You can imagine that all too frequently there is lack of alignment between what has been prescribed and what is being taken. Worse yet, and by no fault of anyone in particular, there is lack of comprehensive awareness among and between the prescribing providers regarding the accuracy of medication regimens.

We do this far more effectively within the hospice benefit, where hospice providers have professional relationships with consulting pharmacists. Pharmacist are employed by hospice providers in some situations, but Androscoggin, as an example, contracts with a large pharmacy provider to work with our medical and nursing teams. This service is employed for all of our patients, including MaineCare beneficiaries. The result is a well-managed pharmaceutical plan to address illnesses and symptoms that are both related and unrelated to the terminal diagnosis. My point: we know it works.

This bill directs the Department to provide reimbursement for the services of a Maine-licensed pharmacist to provide medication evaluation or consultation. As I have described for you today, the research and the clinical evidence is clear: This is a prudent investment on many levels.

Thank you for the opportunity to speak in support of this important legislation. I welcome any questions that you have.

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[2] https://psnet.ahrq.gov/issue/incidence-and-severity-adverse-events-affecting-patients-after-discharge-hospital
[3] http://www.ncbi.nlm.nih.gov/pubmed/19339721
[4] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8077030/
[5] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8247962/