Testimony for SB 265 – Jennifer L. Rodis, PharmD, BCPS, FAPhA

Good morning Chair Blessing, Vice Chair Reineke, Ranking Member Clyde, and members of the committee. Thank you for the opportunity to share with you my experience and perspective on Senate Bill 265, as well as my enthusiastic support.

I am a pharmacist, a faculty member, and an Assistant Dean at The Ohio State University College of Pharmacy. I graduated as a pharmacist looking for opportunities to practice at the top of my license in 2002, and found myself seeking advanced residency training with Ohio State, a leader in advancing pharmacist-provided care, in order to find the types of practice sites that met and could grow my skills. That was 16 years ago. As an educator of pharmacy students and pharmacist practitioner for the majority of my career, I am disappointed and shocked that the job market for our graduates does not provide the opportunities to apply their skills and expertise at the level to which could make major impacts on patient health and well-being in our state. Our students complete a post-baccalaureate Doctor of Pharmacy degree, with three years of intense in-class, team-based learning on the science and therapeutics of medicines and disease; they engage in three years of patient care simulations in our patient care laboratory refining their communication and application skills, and they learn interprofessionally with physicians, nurses, physical and occupational therapists, nurse practitioners, social workers, and many other disciplines on and off-campus through immersive in-class and experiential training. The final year of the PharmD degree involves monthly rotations in a variety of practice settings.

When our students leave campus, they are equipped with the knowledge and skills to optimize medications, communicate as a valuable member of a healthcare team, and manage acute and chronic diseases. However, the lack of provider status in Ohio means that our brightest students are leaving our state for opportunities elsewhere. This means that the world class education we are providing to our students at Ohio State and that is being provided at our six other colleges of pharmacy in Ohio is being wasted. The innovation and creativity of pharmacies and pharmacists to find new ways of providing interprofessional care that align with the capabilities of pharmacists and the needs of our shifting population and health care environment is being stunted by the lack of provider status.

For the past five years, I have led a statewide project funded by the Centers for Disease Control and Prevention (CDC) in collaboration with the Ohio Department of Health, Ohio Pharmacists Association, and the Ohio Association of Community Health Centers aimed at improving chronic disease with a focus on Diabetes and Hypertension. This project concentrated on our vulnerable, underserved citizens of the state who have the worst health outcomes. With the primary care provider shortage only getting worse and the disparities in health outcomes in chronic disease for minorities and low-income persons in Ohio, the Ohio Department of Health looked to leverage our most accessible and underutilized health care practitioners, pharmacists, in the fight against chronic disease. For this project, patients with uncontrolled blood pressure and/or diabetes were connected to care provided by pharmacists. Starting with three best-practice models and growing up to ten sites across the state, we were able to provide patients with pharmacist care at Federally-Qualified Health Centers or FQHCs. These FQHCs are funded by the federal government via Health Resources and Services Administration (HRSA) and provide safety-net care to those who are underinsured or who lack any insurance coverage at all.

1 Collin S. Many happy returns: Ohio-based Medicaid plan pays pharmacists for MTM, saves money. Pharmacy Today. Volume 20, Issue 5, 50-51

2 Jonathan H. Watanabe, Terry McInnis, Jan D. Hirsch. **Cost of Prescription Drug–Related Morbidity and Mortality**. *Annals of Pharmacotherapy*, 2018; 106002801876515 DOI: 10.1177/1060028018765159

Through creative mechanisms to engage pharmacists, including working around our lack of provider status in order to get electronic health record access and funding to support the work, this project has shown that, for patients with previously uncontrolled, out of range blood pressure, pharmacists providing medication management brought 68 percent of these patients to goal. For patients with uncontrolled, out of range blood sugar due to diabetes, pharmacist-provided medication management brought 50 percent to goal.

Dozens of other studies locally and across the country show similar improvements in health outcomes when pharmacists are added to the team. From a health outcomes perspective, what we've shown is impactful. From a cost savings perspective, pharmacists as providers of care like this could be transformative. Here in Ohio, our own Caresource found that, for every $1 spent on pharmacist care, $4.40 was saved.[1] Most recently, researchers in California estimated that illness and death resulting from non-optimized medication therapy costs $528.4 billion annually, equivalent to 16 percent of the total US health care expenditures in 2016.[2]

While what I've shared I believe to be notable and positive, I'd like to share not only the successes, but the challenges that were faced in this project. Many more than the ten FQHC sites approached us, interested in being involved. FQHCs across the state want to bring pharmacists to their team to improve their patients' care and health; however, we ran into road blocks due to pharmacists' lack of provider status. These included the inability to grant access to the electronic health record, which is a necessity for comprehensive medication management. Another major limitation was the inability for pharmacists to bill as providers, especially when off-site of the clinic. In many cases, community-based pharmacies and pharmacists are the front line of our health care safety net. Pharmacies are located in many counties where we lack primary care offices and care providers. These pharmacists are the front-line health care practitioners who possess the scope of practice to provide public health access, acute care services, and chronic disease management, but are limited to do so because of the lack of recognition as providers. Other states are ahead of us on this recognition. Look to California, North Carolina, Washington, and Utah as examples of states giving their citizens access to pharmacist care through recognition of pharmacists as providers.

According to the Health Policy Institute of Ohio (HPIO), Ohio ranks 46 out of 50 states and the District of Columbia (D.C.) on health value, landing in the bottom quartile. This means that Ohioans are living less healthy lives and spending more on health care than people in most other states. Ohio's State Health Improvement Plan highlights "access to quality healthcare and comprehensive primary care" as one of their key goals. By empowering pharmacists through recognizing them as Providers through Senate Bill 265, Ohio can move the needle to improve our health care value and the health of the citizens of our state.

I would like to thank Senator Matt Dolan for his leadership on SB 265, and I thank the committee for your consideration of this important legislation. I'd be happy to answer any questions you may have.

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