From brown-bag “medication check-ups” at the pharmacy to full-fledged targeted beneficiary programs, drug therapy management (DTM) has entered the scene with potential to become a major component of the managed care continuum. DTM is now defined as “a distinct service or group of services that optimize therapeutic outcomes for individual consumers as a result of appropriate drug therapy.” Its growing prominence is aligned with the increasing role of pharmaceuticals in the treatment of chronic disease and management of health issues. As more individuals use one or more medications every day, the need to ensure their safe and effective use increases as well.

Prescription drugs play a key role in the current health care environment, representing 14.3 percent of total health care spending in 2004—a huge increase over the estimated 4.9 percent of the health care dollar prescription drugs accounted for in the early 1980s. In any given week, four out of every five U.S. adults will use prescription medicines, over-the-counter drugs, or dietary supplements, and nearly one-third of adults will take five or more different medications.

Reasons for this increase come from a mix of factors: new prescribing guidelines that emphasize combination therapy, a host of new therapeutic drug advances, increased incidence and diagnosis of chronic disease, and pharmaceutical company advertising (both direct-to-consumer and to providers). And as Americans age, their prescription drug use tends to increase. Those over age 65 purchase more than 70 percent of prescription drugs, and four out of five older adults take at least one prescription daily. Prescription drug use is expected to advance even more rapidly as the first Baby Boomers enter retirement years.

In this environment, the potential for DTM to positively impact patient safety and health care outcomes cannot be overemphasized—whether DTM is delivered by pharmacy benefit management organizations, health plans, or care management companies. Although it is still a relatively new discipline, DTM has already earned the respect of employer purchasers of commercial health care management services. Studies continue to demonstrate that drug therapy is often the best way to manage chronic conditions and avert expensive hospitalizations. The opportunities to improve patient care through the combination of pharmacy data and clinical management abound in number and significance.

**URAC’s DTM Accreditation Program**

As URAC was crafting standards for Pharmacy Benefit Management in 2006 and 2007, DTM standards were initially included as part of that accreditation program. But as URAC progressed through the standards development and Beta testing process, DTM emerged as a distinct service or group of services that demanded its own accreditation program.

“We always envisioned that we would have DTM quality standards but we believed that DTM would start as one module within the PBM program,” said Alan P. Spielman, URAC’s president and CEO. “Setting DTM apart as an accreditation program of its own...
provides an opportunity for a range of health care management companies beyond health plans and pharmacy benefit management organizations to seek accreditation.”

Broadening the reach of DTM acknowledges the integral role DTM plays in care management.

“The reach of URAC’s DTM accreditation extends to case management, disease management, pharmacy and other organizations that are interested in exploring more sophisticated ways to manage medication and incorporate DTM into their care management programs,” Spielman said.

The genesis of Disease Management

“Disease management has its origins in DTM,” said Tracey Moorhead, president and CEO of the DMAA: The Care Continuum Alliance. “It goes back to the early 1980s when pharmaceutical manufacturers began to look at developing programs to increase adherence to prescribed medication protocols to help individuals manage chronic conditions. The field has evolved significantly to include additional services to

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URAC’s DTM Accreditation standards address a broad range of functions within an organization:

- The organization promotes appropriate therapeutic outcomes for targeted consumers and reduces incidents of adverse events. Organizations should have procedures in place for population-based programs that identify patients with particular disease states who would benefit from DTM, and then recruit those patients with an opportunity to participate in a DTM program with an eye towards patient safety and appropriate drug use.

- The program promotes coordination of care. URAC standards address qualifications of those coordinating care, accessibility of services for the patient, and other aspects of care coordination.

- Qualifications of staff that perform all DTM functions are appropriate for the services they perform, and clinical oversight is provided.

- The program uses evidence-based medicine for clinically appropriate, safe and cost-effective DTM. Program processes are regularly reviewed and updated by the organization’s Pharmacy and Therapeutics committee or other clinical oversight body. Decisions should be made based upon effectiveness and cost.

- The program promotes communication about the use of medication for patients. The organization should ensure that the consumer has information about drug cost and effectiveness—whether it’s a choice between a generic or name-brand version of a drug, or in the context of a multi-level formulary. Communication may be in multiple formats (web, print, or face-to-face consultation with a pharmacist) and easily understandable.

- DTM accreditation requires a process for DTM outcomes measurement and quality improvement, including structured quality improvement projects. Reporting of outcomes does not have to be to any particular organization—it may be to an internal quality committee.

- The DTM program affords participating consumer rights, shared decision-making and education. It is patient-centered, making sure the patient is informed of any available decision-making tools, education materials, or telephonic support.
beneficiaries that complement DTM, but certainly DTM remains a crucial component of disease management or population health improvement.”

Moorhead relates a case example of DTM at work within disease management practice: in conversation with a beneficiary, a disease management expert realized the patient had been prescribed the same blood thinner by two different physicians, and was as a result taking two doses of a very potent drug. The patient was experiencing severe side effects, including dizziness. Recognizing this as a potentially unsafe and crucial drug-to-drug interaction, the disease management expert called both physicians and told them the double prescribing had inadvertently occurred, then worked with them to remedy the situation.

“If the disease management program had not been monitoring the situation, the patient could have suffered a life-threatening condition,” Moorhead said. “This is the type of DTM that disease management companies are using today. Whether they get the drug information from claims data, pharmacy benefits management data or from the patient themselves, disease management companies frequently integrate DTM into their programs, to the great benefit of patient safety and better outcomes.”

**Defining effective DTM programs**

Today, DTM works to optimize therapeutic outcomes for targeted consumers as a result of appropriate drug therapy. According to a 2006 consensus document published by the Academy of Managed Care Pharmacy, DTM programs require several steps to occur in order to be effective:

- The right medication must be prescribed at the correct dose and for the proper duration.
- The medication must be accessible to the patient. The patient must get the prescription filled and must be adherent to the therapy.
- Patients must be monitored to ensure that best outcomes are achieved, that the objectives of therapy are being met and that adverse events are minimized.
- Patients and caregivers must be properly educated and counseled and their medication therapy properly managed.

URAC’s DTM Accreditation standards expand upon these principles with standards promoting core organizational excellence and a clear focus on patient safety, outcomes measurement and quality improvement. Three key principles ring clear throughout the standards:

- The program must strive for appropriate therapeutic outcomes for targeted consumers through improved medication use;
- It should reduce the incidence of adverse events; and
- It should be developed with oversight of the P & T Committee or equivalent clinical oversight body.

“The key is to make sure the right population is getting the right drugs and the right dose at the right time,” Spielman said. “It’s not just that they get the prescription filled, but that they understand and adhere to their drug regimen.” Because DTM is still evolving, it is also important that standards provide a blueprint for organizations to follow while they continue to innovate.

“URAC’s PBM and DTM accreditations establish a framework for buyers and consumers so they know what to expect from a quality provider of those services,” Spielman said. “Because URAC regularly updates its accreditation standards based on industry-wide best practices, accreditation is a means to continuously challenge the industry to improve and raise the bar for quality.”

**Promoting guidelines to the industry—raising the bar on quality**

Moorhead noted that URAC’s standards provide valuable guidelines without being overly prescriptive.

“Standards need to ensure flexibility because this is a field that changes more rapidly than others as new therapies come on line and are approved,” she said. “The URAC standards recognize that practical applications and best practices in the field are going to filter up from those who are delivering the services to those who set standards.”

For purchasers, URAC’s DTM accreditation sets an organization apart...
from the pack, ensuring buyers they have met high quality standards.

“URAC accreditation is an important tool for purchasers to identify those programs which have voluntarily submitted to accreditation,” Moorhead said.

Patient safety integral focus of DTM

As beneficial as medications can be, their misuse, underuse and overuse pose serious potential hazards. According to a March 2005 Harris poll, one in three adults who take prescription drugs on a regular basis have frequent problems adhering to their treatment regimens. While two-thirds of those polls said they simply forgot to take their prescriptions, others failed to do so because of concerns about the drugs themselves, such as effectiveness or side effects, or because they could not afford the cost of sticking to the drug regimen. Adverse drug errors, or ADEs, are a significant concern in health care management today.

In 1996 the Institute of Medicine put the human and economic costs of medical errors in the spotlight through its groundbreaking report, “Crossing the Quality Chasm.” Ensuing reports have continued to pound a drumbeat for systemic changes to improve how health care is delivered, reshaping the industry’s definition of quality patient care along the way. In 2006 IOM released “Preventing Medical Errors,” another addition to the Quality Chasm series, highlighting the “unacceptable costs of medication errors”. One study estimated 380,000 preventable ADEs in hospitals each year, another estimated 450,000, and the committee believes that both are likely to be underestimates. The numbers are equally disturbing in other settings. One study calculates, for example, that 800,000 preventable ADEs occur each year in long-term care facilities. Another finds that among outpatient Medicare patients there occur 530,000 preventable ADEs each year. And the evidence suggests that both of these numbers are likely to be underestimates as well. Furthermore, none of these studies includes errors of omission—failures to prescribe medication in cases where it should be. Taking all of these numbers into account, the committee concludes that there are at least 1.5 million preventable ADEs that occur in the United States each year.

“URAC recognized the need for leadership to emphasize patient safety as a serious aim in health care management,” Spielman said. “We focused on consumer safety initiatives through our revised Core Standards, released in January, 2006.

The same Core Standards are a part of the new Drug Therapy Management Accreditation.” Among the standards is a requirement for accredited organizations to maintain at least two Quality Improvement Projects (QIPs). At least one of the QIPs is required to focus on consumers; the other QIP must focus on error reduction and/or consumer safety.

“URAC accreditation is an important tool for purchasers to identify those programs which have voluntarily submitted to accreditation.”

—TRACEY MOORHEAD, PRESIDENT AND CEO, DMAA: THE CARE CONTINUUM ALLIANCE
“The URAC standards are important as they provide guidelines for identifying important issues in patient safety, such as drug-to-drug interactions, gaps in care and medication adherence concerns,” Moorhead said. “Overuse, underuse and misuse are three of the most important patient safety issues identified by the Institute of Medicine and early disease management programs. To have patient safety concerns codified in accreditation standards is important for the industry.”

For more information about URAC’s PBM and DTM Accreditation programs go to www.pbm.urac.org.

Alan P. Spielman is URAC’s President and CEO, and has more than three decades of leadership experience in health care, business management and strategy in both the private and public sectors. Since assuming leadership of URAC in 2005, Spielman has overseen URAC’s achievement of deemed status for Medicare Advantage programs, the development of the first-ever Pharmacy Benefits and Drug Therapy Management accreditation programs, and creation of URAC’s Best Practices in Consumer Protection and Empowerment Awards Program.

Spielman came to URAC from Covington & Burling, a global law firm specializing in regulatory matters, where he was a senior advisor for health care reimbursement policy. Prior to that, he was with Medco Health Solutions, Inc., a major pharmacy benefits management company, as vice president and general manager for federal programs. Spielman also held a variety of senior executive positions at the Blue Cross Blue Shield Association, including leadership of the Federal Employee Program. Spielman has testified frequently before congressional and state legislative committees on health care issues. He is also author of several articles on health care marketing and care management.

Spielman began his career in government with the Health Care Financing Administration (now the Centers for Medicare and Medicaid Services, or CMS) and the Congressional Research Service. He holds an MBA degree in health care marketing/management from Loyola College and a Bachelor of Arts degree from the Johns Hopkins University, where he also continued graduate study in health economics. Beyond his master’s degree, he has attained the Managed Care Professional designation.
Tracey Moorhead is president and chief executive officer of DMAA: The Care Continuum Alliance. DMAA convenes all stakeholders providing services along the care continuum toward the goal of population health improvement. These care continuum services include strategies such as health and wellness promotion, disease management and care coordination. Based in Washington, DC, DMAA represents more than 200 corporate and individual members in promoting the role of population health improvement to raise the quality of care, improve health outcomes and reduce preventable health care costs for people with chronic conditions and those at risk for developing chronic conditions.

Moorhead is recognized as a leading health care advocate with considerable experience in public policy and coalition management. She effectively directs policy formulation and strategic advocacy efforts, as well as represents the disease management community before the media, allied organizations and constituents, and all levels of government.

Moorhead previously served as executive director of the Alliance to Improve Medicare (AIM), a bipartisan coalition advocating comprehensive Medicare improvements. In that role, she coordinated and moderated educational and policy briefings for congressional staff; directed AIM’s policy research, development and communications efforts; and developed grassroots programs in conjunction with AIM member organizations.

Moorhead also served as vice president, government relations for the Healthcare Leadership Council (HLC). In this role, she coordinated a nationwide, multi-million dollar grassroots outreach campaign to senior citizens and partner organizations to increase awareness and participation in new Medicare benefits.

Footnotes

2 Report Brief, Preventing Medication Errors. Institute of Medicine, July 2006.
7 Report Brief, Preventing Medication Errors. Institute of Medicine, July 2006.