Too Many Patients?

What expanded health insurance coverage may mean for community pharmacists

By Bill G. Felkey

LEFT: ANTHONY-MASTERSON & TOP: TRIANGLE IMAGES

The pharmacy profession has been very good to me throughout my career. I have been fortunate to be involved with every discipline and specialty of health care. Because information is a common denominator for all of health care, I am constantly attending and presenting at meetings and gaining a unique perspective on this topic in the United States.

Recently, I attended a high level discussion on how systems are preparing to cope with health care reform. The federal government is giving fair warning that the fee-for-service provision of medical care is being targeted for minimization and elimination where possible. How this will happen is by encouraging and fostering the accountable care organization (ACO). To understand how ACOs will operate, think of the HMO model, in which the health care provider is dominant. This is in contrast to a system where the insurance company gets the premium dollar and disperses it among providers.

The idea is to reimburse health care providers for treating a population of patients for a fixed cost. Many experts believe that health systems will be reimbursed at 100 percent of Medicare levels for all the patients for whom they provide care. Proactive health systems are already trying to realign their financial structure by reducing costs by 30 percent across the board to prepare for this changed environment. How are you planning for a changed health care system?

The Pharmacist Steps In

Primary care in the United States has, for several years, been experiencing one of its greatest shortages of physicians, primarily because not enough medical students select this option. Primary care, a broad-based

practice, tends to be reimbursed at a lower level than specialty care. Primary care physicians continue to be the gatekeepers to all other provider access, but this approach has created a serious manpower situation. Health care reform has just added tens of millions of patients who will need physician care. It is simply not physically possible for primary physicians to be the personal gatekeeper for millions of newly insured patients.

This is where pharmacists enter the scenario. A combination of "physician extenders,"—nurse practitioners, physician assistants, pharmacy-based retail clinics, and home health nurses, for starters—will find their skills in peak demand for these new patients. Even with the help of these professionals, additional solutions will be required: virtual visits, telemedicine, telepharmacy, home monitoring, and technology-assisted disease management. Patient engagement and connectivity will absolutely have to be used in both efficient and effective ways for the ACO to achieve sustainability and function within a strict funding environment.

Positioned to Provide Care

The evidence from the ground-breaking Asheville Project of the 1990s, all the way through to medication therapy management requirements, has positioned pharmacists to provide direct patient care, disease management, and medication distribution services. This includes the important medication therapy adherence services that ensure that medication—instead of more expensive inpatient admissions and emergency room visits—reduces the overall cost of care for ACO populations. The health system that will form the ACO also must create an integrated delivery network of providers who are either fully employed or working in a contractual relationship to care for the population of patients being managed by the ACO. One representative of a highly integrated network from Virginia says that pharmacists in the community were serving the needs of their ACO, but only by managing medication distribution services. The health system did not want to invest in building pharmacies that were wholly owned and managed by its organization if they could use the existing infrastructure already in place in their community.

A New Opportunity

I am proposing that we consider this huge influx of new patients in need of primary care a new opportunity for pharmacists at a grassroots level. Every health system that I work with is describing how multidisciplinary care teams will replace the current model of face-to-face patient visits with a primary care physician. The care team must be connected, and the growing electronic prescribing conduit will be an important component for the care team's communication to and from the pharmacy.

Provider and patient portals, personal health records, ambulatory medical records, and the new requirements with health care information technology—that meaningful use of technology can be demonstrated—provide tremendous opportunities for pharmacists. They can gain the additional information necessary to increase the role of primary care involvement within a given community. For health systems to receive federal stimulus dollars, a phase 1 requirement is being finalized by the federal government. By next year, health systems will have to prove that their use of electronic health records actually improves the quality, safety, efficiency, and care coordination of individual patients, along with addressing patient populations and public health needs in their communities. They will also need to demonstrate that they are engaging patients and their families in the health care process, and that they are adequately ensuring both the privacy and security of the personal health information that they house in their medical records.

Better Connected

If I look through the eyes of pharmacists at these specific requirements, they represent a substantial opportunity for a better connection to the critical health information necessary to increase care services to their patients. Health systems must use computerized prescriber order entry and e-prescribing in an increasing percentage of their orders. This, of course, will mean that pharmacists need to fully connect with these orders where appropriate, using their pharmacy management systems whenever they are directed externally to the health system and into the community.

Drug utilization rate checks for drug-drug, drug-allergy, formulary, and other items must be performed, and the responses to these alerts must be tracked and maintained. This means that prescriptions may arrive after some therapeutic issues have already been resolved for the patient, making it unnecessary for the pharmacy to

dispense the medications. An up-to-date problem list must be maintained at the 80 percent level for the patients being served. This problem list, which would use standardized terminology and diagnosis codes identifying all of the medical conditions currently active in a patient, could be made available by either the health system or the patient to the pharmacy. The problem list will be supplemented by recorded demographics and the tracking of vital signs in longitudinal records that can be electronically transmitted. Does your pharmacy management system have the capability to receive this data?

Specific records regarding issues such as smoking status for patients are required, and laboratory tests must be housed in a structured manner that could be exported (with permission of the patient) directly into a pharmacy management system. Consider how important it could become for MTM purposes to actually see the efficacy of prescribed regimens for your pharmacy's patients. These meaningful use requirements are also being directed to more fully engage patients in their own health status. For example, systems must be capable of sending reminders to patients relating to their behaviors for preventive or follow-up care, when that is a required responsibility of the patient.

We are seeing scenarios where, on request, it is required that patients be provided with an electronic copy of their health information, along with any discharge instructions and medications that are recommended for returning to their ambulatory care setting. This must occur within 96 hours of their discharge. To facilitate multidisciplinary care and medication reconciliation at these transitions, systems are required to produce a summary of the care provided in what is being labeled as a continuity of care document (CCD). Finally, systems must be able to produce electronic data in a structure that can be received by various public health registries such as the ones used for immunization to facilitate population analysis and trending.

Changing Environment

What I have described above has motivated health systems that are alert and proactive in this very changed environment to adopt new strategies and tactics. Community pharmacists reading this who would describe themselves as "serial entrepreneurs" will see the challenge to the status quo as an opportunity to be part of the solution.

You can complain about the level of reimbursement and the difficulty of documenting your care, but those are process problems that are not an issue if you keep your head down and focus on the potential of these opportunities in your community. Obviously, you don't have to travel far to talk to your own health system and bring to the table a group of community pharmacists who get this vision of a changed health care system. Don't you want to ensure that you are at the table when decisions are being made about how health care will be delivered in your own community?

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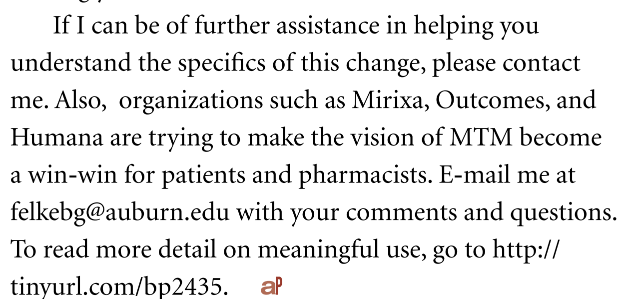
Even the pharmacist close to retirement has a role as a consultant or mentor; there is no excuse to not pay attention. Remember, those of you about to retire will be a patient in your community and therefore you have a stake in how you and your family are taken care of in coming years.



If I can be of further assistance in helping you understand the specifics of this change, please contact me. Also, organizations such as Mirixa, Outcomes, and Humana are trying to make the vision of MTM become a win-win for patients and pharmacists. E-mail me at felkebg@auburn.edu with your comments and questions. To read more detail on meaningful use, go to http://tinyurl.com/bp2435. aP

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