CONTINUING EDUCATION

The Evolution of Pharmaceutical Care into Managed Care Environments

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ABSTRACT: The objective of this month’s continuing education article is to describe the potential synergistic relationship between the practice of pharmaceutical care and managed care pharmacy, including exploring the barriers that must be overcome to achieve the full benefits of this relationship. The article suggests that the philosophy of pharmaceutical care practice can be facilitated within the context of managed care. The efforts to expand pharmacists’ scope of practice within the managed environment is a joint responsibility of the pharmacist and the managed care organization.

Literature references are included from International Pharmaceutical Abstracts and Medline.

KEY WORDS: Pharmaceutical care, Practice standards, Managed care, Documentation, Reward systems, Barriers

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In recent years, society’s demands to improve the quality and slow the rising costs in our health care system have intensified. Modern information systems technology and statistical software make it possible to define, measure, and compare patient outcomes among population groups with different characteristics or against a predefined standard. The technological tools have contributed significantly to the growth of managed care and outcomes management. It is important for health care professionals to understand, however, that outcomes management involves total patient care—not the care provided individually by various health care providers, but all aspects of patient care.

In order to make a substantive contribution to outcomes management, the pharmacy profession is beginning to embrace a new philosophy of practice. This practice philosophy is termed “pharmaceutical care.” Hepler and Strand’s definition of pharmaceutical care is:

“The responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient’s quality of life. The outcomes include: 1) cure of a disease; 2) elimination or reduction of a patient’s symptomatology; 3) arresting or slowing of a disease process; or 4) preventing a disease or symptomatology. Pharmaceutical care involves the process through which a pharmacist cooperates with a patient and other professionals in designing, implementing, and monitoring a therapeutic plan that will produce specific therapeutic outcomes for the patient. It involves three major functions that include: 1) identifying potential and actual drug-related problems, 2) resolving actual drug-related problems and 3) preventing potential drug-related problems. Pharmaceutical care is...provided for the direct benefit of the patient, and the pharmacist is responsible directly to the patient for the quality of care. The fundamental relationship in pharmaceutical care is a mutually beneficial exchange in which the patient grants authority to the provider and the provider gives competence and commitment (accepts responsibility) to the patient.”
Pharmaceutical care represents not only a change in what pharmacists do, but also an entirely different philosophy of practice. Its primary objective is to improve patient outcomes by shifting pharmacy services from a drug or product orientation to a patient orientation.

The concept of pharmaceutical care evolved to help maximize the contributions of pharmacists in reducing the costs of health care by decreasing the incidence of what has been termed “drug misadventuring.” Drug misadventuring includes, but is not limited to, overdose, subtherapeutic dosage, improper drug selection, drug interactions, adverse reactions, drug non-compliance, and untreated conditions. Studies have shown that as many as 27% of hospital admissions are attributable to drug-related problems.4

THE NEW “MANAGED” ENVIRONMENT

The proliferation of managed care organizations has resulted in numerous changes in the delivery of health care services. One of the more obvious effects of managed care is its influence on the participants in the sick-role process. During the 1970s and ‘80s the concept of physician-induced demand received much attention in the literature. The positive correlation between physician density and demand for services is well documented. Debate continues, however, about whether physicians may individually induce demand as a compensatory measure. Rice, in a “natural” experiment, demonstrated that physicians provided a higher quantity and intensity of services under reduced Medicare reimbursement. Hemenway and Fallon5 supported these findings when they showed that self-reported service intensity, operationally defined by answers to hypothetical clinical scenarios, varied among physicians who differed in their specialty and practice environments.

Managed care also increases competition in the health care marketplace. Employers and governments shop around for a managed care organization (MCO) that can provide efficient and economical care without sacrificing the quality of that care. Consequently, MCOs are joining Health Care Financing Administration (HCFA) and experimenting with methods of linking physician payment toward the achievement of certain clinical, economic, and humanistic outcomes.8.9

The infant stages of managed care saw incentives for physicians centered primarily around economic outcomes, i.e., cost savings. Physicians began trading service discounts for promises of volume. As the market strength of MCOs grew, physicians were asked to assume more risk. The use of capitated pay and shared-risk pools has become quite common. With advances in the use of claims data, greater availability and emphasis on outcomes research, and consumer demands for quality, physicians are now expected to achieve decreases in morbidity and increases in quality-of-life and patient satisfaction in order to be compensated.10.11

In summary, physicians who are salaried, capitated, or even those provided with bonuses from risk pools no longer have the incentive to induce demand. They now are getting paid to provide the most “bang for the buck.” The trend toward linking compensation to the achievement of outcomes should only increase in the years ahead. The responsibility of achieving quality patient outcomes should also be expected of pharmacists. After all, the very premise behind pharmaceutical care is the acceptance of responsibility by pharmacists. This can only be realized, however, if pharmacists can expand their roles on the health care team beyond being mere dispensers of drug products.

MANAGED CARE AND PHARMACEUTICAL CARE: A NATURAL MARRIAGE

Independently, pharmaceutical care and managed care have demonstrated impressive results in improving patient outcomes and reducing health care costs. The incorporation of pharmaceutical care practice into managed care systems is a natural one. Managed care organizations present pharmacists with unique opportunities to participate in formulary management, drug utilization review, and even as gatekeepers for primary care patients.12-15 With the implementation of pharmaceutical care, MCOs can benefit from the cost savings generated by the improvement of patient outcomes and the cost effectiveness of pharmacy services. Further, the improvement in patient outcomes may serve as a successful marketing tool for MCOs in competing for new groups of patients.

As MCOs coordinate patient care models that attempt to provide a continuum of care, it is fitting that the provision of pharmaceutical care by pharmacists be the expectation of benefits managers and physicians. Unlike other settings, involvement with managed care presents pharmacists with new opportunities to provide continuity of care and outpatient monitoring.16 This is due largely to the development of community-based information systems that can enhance the exchange of information between pharmacists and other members of the health care team.17 Current pharmaceutical care models suggest that pharmacists need to develop patient care plans, but developing these plans and providing effective drug treatment require a strong communication link between the physician and the pharmacist.1 This team relationship is possible in an MCO.

ADVANCING PHARMACEUTICAL CARE INTO MANAGED CARE ENVIRONMENTS

For pharmacists to take full advantage of the opportunities in the managed care environment, several barriers must be removed.

First, and foremost, pharmacy should adopt specific practice standards in implementing pharmaceutical care. Although pharmaceutical care has been formally defined, a specific model of practice in the community setting has not been described. Articles in the literature reveal that interpretation of pharmaceutical care functions by practitioners ranges from
more in-depth patient counseling to monitoring lab values. Furthermore, initial attempts to implement pharmaceutical care have been at large institutions where resources are more plentiful than at community pharmacies. Hutchinson and Schumock\textsuperscript{9} state that, "pharmaceutical care will fail if each pharmacy organization or individual pharmacists are allowed to define pharmaceutical care for their own agenda." There have been numerous calls for standards of pharmaceutical care practice in the literature. Standards of practice in the community setting have only recently been identified.\textsuperscript{20} Practice standards should be a clear, unambiguous set of performance expectations that are relevant toward improving patient outcomes, yet are feasible to implement and allow for flexibility depending upon the practice environment and patient case mix.

Once practice standards are adopted by the profession, physicians and benefactors managers should require that pharmacists adhere to them. Wolfgang and Rupp\textsuperscript{6} believe that in a managed care environment, the creation of qualitative conditions for participation in a pharmacy provider network is a concept that could find broad support. The condition that participation requires willingness and ability to provide pharmaceutical care could act as the catalyst for diffusion of a higher level of pharmaceutical care in the community setting.

A second barrier is the lack of documentation mechanisms for community pharmacists in the managed care environment. Documentation mechanisms are needed to provide evidence that a pharmacist is performing up to expectations and that patients are seeing a significant improvement in outcomes. If pharmacists can provide cost-effective services with a high level of quality, they need to be adequately compensated by MCOs. Currently, pharmacists are disappointed with their reimbursement rates from various MCOs. Strandberg et al.\textsuperscript{21} noted that many purchasers view pharmacy as a commodity to be bargained for, not as a service that can help manage health care costs. Other pharmacists are concerned about a bottom-line focus of managed care affecting profit margins.\textsuperscript{22} This is even more problematic when pharmacists’ services are viewed as “carve outs” and not a system component of overall health care delivery. Numerous studies have demonstrated the failure of MCOs to achieve overall cost savings when drug treatment is treated as a separate component to overall treatment.\textsuperscript{23} At the same time, others remain optimistic that proof of quality care and positive outcomes can actually improve reimbursement schedules, although contracts negotiated with MCOs thus far have been based strictly upon dispensary functions.\textsuperscript{24}

Mechanisms for reimbursement are in place and are gaining prominence, however, and pharmacists should communicate with MCOs about how to gain reimbursement for services. As has previously been done with physicians, MCOs should transcend the traditional monetary reward system of compensating pharmacists individually for prescription volume by including incentives for group performance. MCOs may consider pioneering efforts coordinated with pharmacists’ input to devise a systematic mechanism by which pharmacists can document the care they provide, that the care be linked to improvements in patient outcomes, and subsequently compensate pharmacists appropriately. Hence, the onus for proof of cost-effective service lies with pharmacists, but the responsibility to reward them lies with the managed care organization.

A third barrier is the interprofessional relationships between pharmacists and physicians. Despite physicians losing some of the autonomy they previously enjoyed before managed care, they may still serve as an impetus or an impediment to the acceptance of new services and technologies that affect health care costs and outcomes. Pharmacists have been cited as a potential barrier to the implementation of pharmaceutical care, since they may have traditionally viewed the responsibility for patient outcomes as primarily theirs.\textsuperscript{25} Louie and Robertson\textsuperscript{26} contend that many physicians do not accept a nondistributive, clinical role for pharmacists, and that physicians and other health professionals are often unaware that pharmaceutical care could meet a unique need to complement them, without duplicating or threatening their own roles.

How willing physicians are to accept a broader role for pharmacists is very important. To implement pharmaceutical care, pharmacists must depend on the patient’s diagnosis, results from laboratory tests, and specific recommendations by the physician. In order to gain physician acceptance for delivering pharmaceutical care, pharmacists must improve their communication skills with physicians, learn how to develop relationships with them, convince physicians to supply additional medical information along with the prescription, and market their services to physicians as being complementary, not competitive.\textsuperscript{27} Pharmacists may even attempt to obtain referrals for their services while educating physicians about the services that they provide in a nonthreatening manner.\textsuperscript{27}

One final barrier to the evolution of pharmaceutical care into managed care is worth mentioning. That barrier is pharmacists, themselves. Some practitioners display a propensity to resist change and cling to the traditional role of drug dispenser.\textsuperscript{28} Recent studies, however, have shown a trend to embrace change. In the development of an attitude scale toward health care reform, Desselle et al.\textsuperscript{29} reported that pharmacists desire a greater responsibility to promote healthy lifestyle choices and an expanded role in determining drug therapies. In a study to compare burnout between pharmacists practicing within an HMO and normative data for United States pharmacists, Gupchup et al.\textsuperscript{30} reported that HMO pharmacists rated personal accomplishment of their jobs significantly higher than the normative sample, which may be a function of pharmacists’ opportunity to participate in decision making. Further, studies have shown the ability of pharmacists to reduce mean prescription ingredient costs for an HMO,\textsuperscript{31} decrease the average cost of antihypertensive treatment in an HMO family clinic,\textsuperscript{32} and develop a drug use evaluation (DUE) program for hospital and outpatient facilities of an HMO.\textsuperscript{33}

If pharmacists, benefits managers, and physicians are able to remove the barriers to pervasive practice of pharmaceutical
care in the managed care environment, patients may look forward to a coordinated continuum of care that increases the likelihood of positive health outcomes. At the same time, managed care organizations can enjoy the resulting cost savings without a subsequent decrease in the quality of care provided.

CONCLUSION

Introspection into the profession of pharmacy and into the expectations of future services delivery by MCOs suggests a potentially synergistic relationship and the logical evolution of pharmaceutical care practice into managed care environments. Berger recently suggested that pharmacists be directed toward a change in attitude before they are expected to develop innovative practices and offer new services. Continuing education programs for pharmacists and faculty in colleges of pharmacy should stress the professional, legal, economic and moral benefit of pharmaceutical care. Professional pharmacy associations, state boards of pharmacy, and individual pharmacists should embrace a new set of standards for practice that transcend traditional dispensatory roles, encourage documentation of activities, and strengthen communication lines between pharmacists and prescribers as well as with benefits managers. Finally, MCOs can foster the development of cost-effective services by pharmacists by allowing them to participate in decision making, thus improving their job satisfaction, then rewarding them only when they have documented evidence of improving patient outcomes.

References

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After studying this article, the reader should be able to:

1. Identify the role of pharmaceutical care in outcomes management.
2. Discuss the impact of managed care on the provision and consumption of health services.
3. Identify opportunities and responsibilities of pharmacists and managed care organizations to optimize patient care through the use of pharmacy services.

SELF-ASSESSMENT QUESTIONS

1. Pharmaceutical care:
   a. is provided for the direct benefit of the patient's insurer.
   b. has three major functions including gathering, dispensing, and counseling.
   c. involves a mutually beneficial exchange between the pharmacist and the physician.
   d. is an entire practice philosophy oriented toward providing care to the patient.

2. Pharmaceutical care was conceptualized:
   a. as a response to demands by government that pharmacy relinquish its traditional roles.
   b. to optimize patient outcomes to drug therapy while reducing health care expenditures.
   c. as a means to reduce dispensing errors.
   d. to increase the workload for pharmacists.

3. Which of the following is true?
   a. The ability to link outcomes to practice is, in part, a function of advances in claims database management and outcomes research.
   b. Capitation is more prevalent when physicians have market strength over MCOs.
   c. Under managed care, physicians are better able to induce demand for health care services.
   d. Pharmacists should not bear the responsibility of optimizing patient outcomes.

4. Involvement with managed care can facilitate the provision of pharmaceutical care due to:
   a. the continuity of information available to pharmacists and other health care professionals.
   b. stronger communication links between the pharmacist and the physician.
   c. the opportunity for pharmacist participation in cognitive services, such as formulary management, drug utilization review, and gatekeeping.
   d. all of the above.

5. The barrier primarily responsible for impeding the expansion of pharmacists' scope of practice has been:
   a. the inability of pharmacists to provide cognitive services.
   b. the refusal by society to grant pharmacists this authority.
   c. the hesitancy by the profession in adopting new standards of pharmaceutical care practice.
   d. the desire of MCOs that pharmacists not do so.

6. One method for pharmacists to obtain reimbursement for the provision of cognitive services is to:
   a. seek monetary rewards linked to the performance of groups of pharmacists.
   b. demanding higher dispensing fees.
   c. disregard the need to document services provided.
   d. negotiate contracts laden with incentives for prescription volume.

7. Which of the following would NOT serve a pharmacist well in improving his/her relationship with a physician?
   a. Attempting to gain prescribing privileges.
   b. Marketing services complementary to physicians' practices.
   c. Enhancing his/her communication skills.
   d. Soliciting additional medical information about the patient from the physician.

8. Recent studies have shown that pharmacists:
   a. are unable to reduce drug costs in a managed environment.
   b. employed by an HMO rated their personal accomplishment lower than that of a normative sample.
   c. are less likely now to be involved in the development of DUE programs.
   d. desire greater responsibility to promote healthy lifestyle choices.

9. The potential relationship between pharmaceutical care practice and managed care can best be described as:
   a. antagonistic.
   b. additive.
   c. synergistic.
   d. inhibitory.

10. Pharmacists' job satisfaction is increased when they:
    a. assume less responsibility in rendering care for their patients.
    b. attend CE programs.
    c. dispense a greater number of prescriptions.
    d. participate in decision-making activities.
11. In what type of setting do you work (leave blank if none of the responses below applies)?
   a. HMO.
   b. PPO.
   c. Indemnity insurance.
   d. Pharmacy benefits management.

12. Did this program achieve its educational objective?
   a. Yes.
   b. No.

13. How many minutes did it take you to complete this program, including the quiz (fill in on answer sheet)?

14. Did this program provide insights relevant or practical for you or your work?
   a. Yes.
   b. No.

15. Please rate the quality of this CE article.
   a. Excellent.
   b. Good.
   c. Fair.
   d. Poor.

INSTRUCTIONS
    This quiz affords 1.0 hour (0.1 CEU) of continuing pharmaceutical education in all states that recognize the American Council on Pharmaceutical Education. To receive credit, you must score at least 70% of your quiz answers correctly. To record an answer, darken the appropriate block below. Mail your completed answer sheet to: Academy of Managed Care Pharmacy, 1650 King Street, Suite 402, Alexandria, VA 22314. Assuming a score of 70% or more, a certificate of achievement will be mailed to you within 30 days. If you fail to achieve 70% on your first try, you will be allowed only one retake. The ACPE Provider Number for this lesson is 233-000-98-002-H04. This offer of continuing education credits expires February 28, 1999.