

Meeting Payer Needs for Pharmacist-Provided Services: The Time Is Now!

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Executive Summary: A Call to Action!

Background

Pharmacies in American communities play a major role in patients' lives and in the healthcare system. According to the 2007 edition of *The Chain Pharmacy Industry Profile* by the National Association of Chain Drug Stores (NACDS) Foundation, there is a pharmacy, on average, within 2.36 miles of any resident in the United States. Pharmacists are exceptionally accessible and convenient healthcare providers. In 2006, the pharmacy industry dispensed over 3.4 billion prescriptions in the United States; of these prescriptions, 72 percent (2.4 billion) were dispensed by the 39,000 chain pharmacies across the country. However, pharmacists not only provide patients with medications, but also offer counseling to patients regarding drug interactions and managing medication therapy.

Research indicates that pharmacists are widely considered one of the most trusted healthcare professionals in the nation. Integrity ratings revealed that pharmacists are the second most highly regarded healthcare professionals at 73 percent.

By helping patients take their medications properly, pharmacists help to prevent more serious health problems, the kind that inflict steep human and financial costs for patients, their loved ones, and the entire healthcare system. A report released in August 2007 by the National Council on Patient Information and Education said, "In the United States and around the world, there is compelling evidence that patients are not taking their medicines as prescribed, resulting in significant consequences. Lack of medication adherence is *America's other drug problem* and leads to unnecessary disease progression, disease complications, reduced functional abilities, a lower quality of life, and even death." The report cited economic analysis that concluded, "poor medication adherence has been estimated to cost approximately \$177 billion annually in total direct and indirect health care costs."

Pharmacists help to prevent more serious health problems, the kind that inflict steep human and financial costs.

It is interesting that the impact of chronic health problems on our nation has given rise to a new concept, "presenteeism." This reflects growing awareness that the costs of "absenteeism" from work due to illness are only the tip of the iceberg. Reduced performance by those present, but suffering from untreated illness, also takes a toll.

In October 2007, the Milken Institute released a report that indicated the seven most common chronic diseases in the nation put a \$1.3 trillion annual drag on the economy. The report estimated the drag could reach nearly \$6 trillion by the middle of the century. The appropriate use of medication, with other preventive measures, can help battle chronic diseases. The Asheville Project, an initial year-long experiment in the North Carolina city from 1997 to 1998 that is being replicated nationwide, is showing that pharmacist-provided care produces successful outcomes in diabetes patients.

Intuitively, and according to demonstrated examples, it makes sense that the healthcare system needs to leverage the value of community pharmacy for the benefit of healthcare quality, affordability, and access. Moving from intuition to reality, of course, requires alignment of anticipated results, financial models, interest among healthcare industry stakeholders, and more. This report is a step toward that vision.

Purpose

The Comstock Consulting Group (CCG) has been working with the NACDS Pharmacy Industry Council's Value of Pharmacy Committee on a collaborative project to help the industry better understand how to transition to a broader role in the healthcare delivery system. The ultimate goal is to develop pharmacist-delivered services that are recognized and valued by payers, patients, and providers as augmenting the overall quality of patient care.

Methods

Telephone interviews were held with public and private payers and strategic healthcare stakeholders. In addition, payers and healthcare partners participated in three live stakeholder roundtables.

This Executive Summary briefly previews the final report, which will provide recommendations gathered from these stakeholders with regard to the opportunities and challenges for the community pharmacy industry to become a recognized provider of value-added healthcare services.

Opportunities

This research confirmed that numerous opportunities are available, and it demonstrated that community pharmacy is poised to play an even more integral role in the healthcare system as stakeholders search for more efficient and cost-effective models of healthcare delivery.

Convenience and a positive image, combined with technological capabilities and unique professional expertise that could significantly improve the patient care experience, give the community pharmacy industry a solid advantage. Collaboration with other healthcare providers, such as physicians and other prescribers, will be key.

Community pharmacy is poised to play an even more integral role as stakeholders search for more efficient and cost-effective models.

The opportunities identified in this project share a common theme: prevention and management of chronic disease. This overarching goal is the greatest opportunity in light of the following facts:

- The population is rapidly aging (over 80 million people >65 by 2030);
- The prevalence of lifestyle-related chronic disease is increasing; and

- The increasing number, availability, and cost of medications place a premium on pharmacists' core competency in pharmacotherapy as a way to manage overall health system costs.

Payers—health plans, employers, and government—are exacting change in the healthcare delivery system by demanding increased transparency, greater accountability, better value, and less waste, which lead to a more sophisticated healthcare consumer. As payers squeeze excess cost out of the healthcare system, the future environment will increasingly demand an upfront demonstration of value for payment.

Challenges

The consensus is that the time is now for community pharmacy to take a proactive role in defining its vision, shaping its models and roles, and taking the necessary risk to change.

- The industry needs to specifically define the community pharmacy vision for the future and the role of the pharmacist in it.
- It will not be easy to change in paradigm from product provider to service provider.
- There is risk for early adopters.

The Charge

There is a 2- to 3-year window to determine who will seize the new opportunities. Business as usual will result neither in recognition and acceptance of new roles, nor in new payment streams for community pharmacy.

Keys to success include a significant investment of time, money, and other resources. Also critical is a willingness to think creatively and to work collectively with community pharmacy stakeholders to take risk.

We have confirmed that payers are willing to pay for services, if shown relevant data that support the investment (positive return on investment). Some are even enthusiastic about partnering with pharmacy to lower total healthcare costs and improve patient outcomes. However, this project convinced us that two critical steps are necessary for community pharmacy to definitively demonstrate value, ensure financial support from payers, and achieve long-term success of a service-based model:

Stakeholders recognize the big gap in care relating to medication use; pharmacists, uniformly recognized as the drug experts, could fill it.

- Develop strategic alliances and partnerships, especially with physicians. Physicians and other stakeholders recognize the big gap in care relating to

medication use, and pharmacists, uniformly recognized as *the* drug experts, could fill it.

- Innovate and highlight ways in which the pharmacy experience is changing, with a greater emphasis on health broadly, and not only on dispensing prescription drugs, although this is an important aspect of health. Consumers will respond to a “changed face.”

Next Steps

The success of the industry in seizing the numerous opportunities available will hinge on the degree of innovation and entrepreneurial spirit in each company and subsector, a willingness to take risk, and a specific point of accountability in each organization for managing this critical transition.

During the transition to a greater role for community pharmacy, the industry would benefit from continued focused efforts by NACDS and the NACDS Foundation in the following areas: research, conducting outreach to member companies desiring to participate in the process, constructing new pathways for provider and payer alliances, tracking and reporting on progress, and sharing key learnings. Incentives must be aligned, not only among payers, physicians, pharmacists, and patients, but also within the industry—between the business operations and the professional pharmacists who reach patients every day.

On the road to success as service providers, the industry must take the key step of changing the consumer experience by

- Embracing the vision for a broader role in healthcare delivery;
- Creating the necessary alliances;
- Defining and developing the necessary demonstrations; and
- Collecting and presenting results to payers.

These are necessary steps to fulfill the promise for the community pharmacy industry as a healthcare service provider, for the ultimate benefit of patients and the entire health care system.

II. Project Description

The National Association of Chain Drug Stores, Inc. (NACDS) retained us, the Comstock Consulting Group, to work with its Pharmacy Industry Council Value of Pharmacy Committee (the Committee) on a project aimed at convincing healthcare payers that pharmacists are a valued community health resource that can and should be utilized in patient medical management programs.

Our goal was to solicit direct input from a broad range of payers, as well as potential partners for retail pharmacy, in order to understand current perceptions and attitudes. This project parallels and augments the broader industry initiative, Project Destiny, which will “develop a sound strategic business and financial plan that will establish community pharmacy’s future role in the delivery of health care.”

It is the first time that the industry has directly sought out the views of healthcare payers and identified their needs in order to develop a roadmap for community pharmacy to follow in its transition to a broader role in the healthcare system.

Working with the Committee, we developed interview instruments and a list of potential interviewees from different stakeholder groups: payers (public and private), employer–purchasers, providers, and consumers. These interviews provided 360-degree insight into perceptions of community pharmacy and its role.

In all, 48 separate 45- to 60-minute interviews were conducted with individuals representing payer organizations (public sector, health plans, employers, employer coalitions, third-party administrators, brokers, and benefit consultants) and other stakeholder groups viewed as potential partners and allies (professional associations; physicians; allied health professionals, such as nurses; case managers; pharmaceutical manufacturers; academia; and consumer advocacy groups).

To gain further insight and test possible concepts, we hosted three 4-hour roundtable discussions in April 2007. In one session, participants primarily represented private sector payers (e.g., insurers, managed care organizations, employers, employer coalitions). In another focus group, participants were mostly from public sector payers (e.g., Medicare, Medicaid, Federal Employees Health Benefits Plan, state health benefit plans, Veterans Administration). The third roundtable was attended by representatives of other key stakeholders, who represent potential partners moving forward. In all cases, we sought to have the consumer voice represented.

On the basis of the output of these leadership roundtable discussions, follow-up calls were held with a number of the interviewees to gather more detailed information on opportunities identified.

Finally, a roundtable discussion was held with 15 members of the Value of Pharmacy Committee, including both NACDS members and associate members, to elicit their views on the project and the current status of the industry, and to solicit their opinions

regarding the most significant challenges that will need to be overcome to change the current business model to one with more of a service focus (see chapter IV).

This report describes what was learned during the 5 months of the project and articulates the steps community pharmacy needs to take to demonstrate and ultimately get paid for their capabilities. It describes the necessity of changing the image of the industry with consumers and of creating alliances and demonstrating value to other healthcare providers, particularly physicians, as a necessary prerequisite to “making the case” with payers for reimbursement for pharmacist services.

Hopefully, it will provide a viable approach to position community pharmacy as a valuable provider of healthcare services in the eyes of the necessary constituencies: physicians, patients, and payers.

III. Current Trends

America's healthcare system is in the midst of enormous change. Cost pressures are forcing the reexamination of what care people pay for, who they pay to perform the services they need, and how they pay for that care.

All healthcare sectors are redefining how they add value in a marketplace that is dramatically changing. New financing mechanisms, new healthcare delivery models, and new technologies are emerging in an environment that is demanding greater transparency, better healthcare information, and improved measurement of outcomes to determine payment. These changes are largely driven by an aging population, the exploding epidemic of chronic disease, global health threats, and runaway healthcare costs.

All healthcare sectors are redefining how they add value in a marketplace that is dramatically changing.

Demographics

Coupled with the evolving roles of all healthcare stakeholder groups is the overarching context of demographics. The reality is that our aging society, with its prevalence of chronic disease, will become increasingly dependent on a wide array of powerful medications to maintain function and vitality.

In 2006, prescription drug sales totaled \$249.8 billion. Because of new drug development and increasing drug usage, the percentage of the healthcare dollar spent on prescription drugs will continue to escalate.

Advances in pharmaceuticals, genomics, and proteomics predicted for the coming decades make it impossible to deny the growing strategic importance of drugs in the practitioner's armamentarium. Nor is it possible to deny the growing need, from an economic and quality-of-care perspective, to actively manage medication therapy. These facts alone create a very strong argument for the skills of well-trained pharmacists. As a corollary, with more pharmacotherapy comes more risk of adverse drug interactions, leading to greater cost. The Institute of Medicine has suggested that this risk to patient safety represents a new disease.

Changes in Financing

Relatively recent changes in public benefit programs, such as Medicare Part D, and in private benefit programs, such as the move to consumer-directed health care, have created new business opportunities for pharmacists.

Employers, the main purchasers of health care in the commercial market, are redefining their traditional role as health insurance benefit managers and financiers. They, along with health insurers, are successfully pushing consumer empowerment tools that will result in a dramatic change in expectations and behaviors, as consumers increasingly determine how their healthcare dollars are spent.

The government, which provides a significant portion of all healthcare dollars through public programs, is looking for new payment schemes, and in the process redefining long-established reimbursement methodologies and relative marketplace positioning.

These new and emerging resource management strategies, which place a premium on outcomes, require a reorientation of the roles of providers in an effort to optimize health at the lowest possible price point.

New Delivery Models

There is widespread interest today in the creation of efficient, cost-effective, high-quality alternative models of healthcare delivery. Creating such models requires a reevaluation of the application of skills across all healthcare professionals, targeted to optimize underutilized services.

The locus of care is changing. There is growing support for community-based, patient- and family-centric care, with a focus on collaborative, integrated, team-based approaches to healthcare improvement. The new model emphasizes wellness and a continuum of case management support across sites of care throughout the life span. Such a model provides a significant opportunity for pharmacists to exploit their role as physician extenders.

The impact of technology—automation, robotics, tele-health, and information technology—will largely redefine how healthcare providers deliver, manage, and monitor care. In recent years, the necessity of a robust information technology infrastructure in promoting the necessary delivery improvements has been recognized, and some progress has been made toward its development. Because of its leadership in this area, the retail pharmacy industry is well positioned to be a key player in facilitating further advancements.

The Profession of Pharmacy

Pharmacists are still among the most trusted healthcare professionals. On the professional side of pharmacy, progress continues to be made through education; the threshold for the adoption of change is thus much lower than on the business side. Pharmacists today are recognized by all healthcare stakeholder groups as *the* drug experts, aware of costs, insurance coverage issues, and drug interactions. And this expertise is readily available because they are the healthcare professionals most accessible to the public. Unfortunately, pharmacists have long been viewed as the “invisible ingredient” in health care. Much to the detriment of the profession, this perception remains prevalent.

Pharmacists are still among the most trusted healthcare professionals.

Conclusion

On the basis of our research with industry experts, many chain pharmacies saw the writing on the wall a number of years ago. Even though the threat was imminent, profit margins were still adequate, and overall the industry preferred to hang onto average wholesale price and a product model rather than create viable service models.

Recent health trends and health system changes have given community pharmacy an advantage. The internal industry environment and the broader external healthcare landscape have changed significantly in just 7 years.

In addition, it appears that the industry has more allies. Government has opened the door to payment for pharmacist services with medication therapy management (MTM), and the Veterans' Administration health system has shown the importance of pharmacists in team-based models of care. The Pharmaceutical Research and Manufacturers of America (PhRMA), which is facing significant industry challenges, is very eager to partner with community pharmacy, especially on adherence programs. Large private payers have expressed a willingness to engage with community pharmacy in pilot projects. Employers, disappointed with the results of traditional disease management programs, are looking for new approaches to manage cost and increase employee productivity.

Today, many retail pharmacies are reassessing the risk of and the need for making difficult changes to be a competitive healthcare service provider. Opportunities have been enhanced for community pharmacy to leverage its unique professional competencies and to take advantage of its commercial assets to become a pivotal player in healthcare delivery. Emerging scientific advances increasingly will require someone to be both patient and payer advocate at a time of increased awareness of resource constraints. The pharmacist is well positioned to play this role.

IV. The Industry's View of Itself

On May 31, 2007, a roundtable for the Value of Pharmacy Committee was held. The purpose was to gather information in a group setting on the industry's perception about its own strengths and weaknesses and thoughts about moving forward, as well as to share findings of the project with the Committee. The meeting was attended by both NACDS chain members and associate members representing pharmaceutical manufacturers and other suppliers.

Each participant was initially asked to respond to the question, "What do you see as the two top challenges for this project?" Responses addressed both external and internal challenges.

The Committee sees the overarching external challenge as differentiating the skills of pharmacists from those of other healthcare providers, such that payers are convinced that these services add value to patient care and should be reimbursed. Perceptions need to be changed across the entire spectrum of payers—from health plans to employers to patients. A key point is that changing the patient/consumer experience, and thus their expectations and value perception, will be critical to creating acceptance and demand.

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Internal challenges identified ranged from creating buy-in, from both senior operations management and the pharmacists themselves, to defining and operationalizing scalable business models with a viable transition plan. Receptivity to driving the new model will depend on how the pharmacy function contributes to sustained profitability of the entity.

The Committee recognizes that gaining agreement among the different subsectors of the industry on strategies and tactics needed to create a tipping point with regard to perceptions and expectations will not happen quickly and will not be easy to achieve.

Internal Assessment

The Committee then discussed a number of questions that were derived from comments or observations made in either the focus groups or the telephone interviews. These questions will force an internal assessment that is critical to leveraging the industry's strengths and overcoming barriers so that it can take advantage of current and future opportunities.

What is the vision of community/retail pharmacy? Is there agreement across sectors?

The group agreed that pharmacists, as professionals, do have a vision—to do the best for each patient. Pharmacists see themselves as responsible for ensuring positive

outcomes from drug therapy, which represents a shift from a focus on the right medication to a focus on health outcomes from therapy.

However, they concluded that there is no agreement on a vision for community pharmacy as a business, either within the industry or within individual corporations. Instead, there are varying visions, depending on the company and its makeup, size, percentage of revenue made up by pharmacy, and so on.

It may not be necessary or attainable for the various subsectors to have the same business vision. Rather, the goal may be to deliver recognized professional pharmacy services in a retail environment, leveraging the convenience and accessibility that is a major competitive advantage. In some cases pharmacy will remain a “convenience” to leverage sales in core products. In other instances it is, and will remain, a strategic business.

It was agreed that an industry vision is only part of the story. Equally important to success will be the ability to specifically define what payers need and how those needs are determined, and then to develop strategies to meet those needs.

What are our core competencies?

The Committee opined that the unique competencies of pharmacists that should be leveraged in making the case for payment for services relate primarily to technical knowledge and expertise, as well as communication and counseling skills. Pharmacists are widely recognized as the “drug experts” and are effective patient advocates, providing advice and guidance on health-related issues.

Committee members, as well as many project participants, pointed out that education has been out ahead of the business of community pharmacy for a long time. Thus new graduates are ready, willing, and able to function in new roles, *if* the business context is supportive.

On the business side, convenience, accessibility, and technological capabilities are also seen as competitive advantages.

What do we see as the most important opportunities?

The Committee identified opportunities in three broad areas: prevention/wellness, acute interventions, and chronic care management. For each, potential strategic partners, both locally and nationally, were identified. For example, in addition to insurers, managed care organizations, and employers, physician groups, public health, disease groups, benefit consultants, and AARP were cited.

The committee feels that it is wise to go for quick wins first, by getting into a service that is currently being reimbursed (e.g., immunizations, MTM) with a goal of breaking even. They recognize that payers will require a demonstrated return on investment (ROI) for any services, through decreasing total dollars spent on health care and improved patient outcomes.

Who is responsible for making the transition work?

The group discussed the salient questions: Who should lead the charge? Who is ready to move? Within each company significant investment in preparing for the paradigm shift will be needed. It was concluded that all industry sectors should invest to scale. The big chains must be actively engaged. A team, not one individual, will make it happen within each company.

What information will be needed to get buy-in to move forward?

To help sell this need for transition internally, the group discussed the creation of a “kit” showing long-term ROI and expected outcomes, and describing what is operating in the external environment that is supportive. It was suggested that the kit could then be used to make the case with payers. But for the industry to have credibility with payers, it should look at successful programs, identify the operational implementation models, and apply them internally in member companies. The results could then become the documentation that payers need.

How do we overcome competitive issues to become collaborative where appropriate?

Information about best practices that are replicable and scalable could be shared if conceptual, while avoiding operational issues that competitors are unable to reveal. For example, what is the local environment like? Where is the alignment and why? What services are being provided that are well received? What incentives are being provided? Is there a pattern?

Barriers

The Committee also identified the following as barriers to a smooth transition to a service-oriented business:

- Revenue is critical and upfront costs are an issue.
- Pharmacists need to be freed up from certain routine tasks if they are to deliver services, but regulations impede efficient use of resources.
- Administration drives production over communication with patients.
- Some pharmacists are reluctant to change. For many, attitude is influenced by what the work environment supports.
- Consistent protocols for services across a network are lacking.
- Services cannot be implemented all at once across a large system, but as services with demonstrable payer benefit are defined, they will be expected across the entire network.

One other significant concern was expressed by both the committee and project interviewees. Current marketing strategies adopted by some large chains clearly emphasize the accessibility, knowledge base, and customer focus of community pharmacists. While broadly disseminating this message is a necessary prerequisite to changing public perceptions, such efforts can backfire if the entity is not fully prepared to provide that experience to consumers who seek it. Our interviews suggest that

pharmacists proactively providing counseling services is a very uncommon consumer experience today.

V. Stakeholder Perspectives

Overview

Our work revealed several perceptions that represent common threads among stakeholders. Similarly, all participants seemed to agree on certain facts that impact community pharmacy's ability to develop successful strategies.

The following question was posed, in one way or another, by virtually all stakeholders: "Has the community pharmacy industry decided that it is committed to moving from a commodity/product-based retail industry to a healthcare service provider?" Today, no clear answer is coming from the industry. Thus, it is not surprising that others are unsure of the industry's long-term intent. There is general skepticism about the retail pharmacy industry's readiness, willingness, and ability to make the tough changes necessary. Varying agendas among the subtypes of retail pharmacies are seen as a serious challenge to success.

Participants were in agreement that numerous current and future opportunities are open to community pharmacy, but noted that if the industry does not move quickly, the window may close, as others will assume those roles. At the present time, many stakeholders expressed the opinion that retail pharmacy is not uniformly taking advantage of service opportunities that are already being paid for in the public and private marketplace. Some managed care representatives stated that they were unable to get retail pharmacies to actively support medication therapy management (MTM).

There was broad agreement that public and private payers will continue to ratchet down costs. There will not be any "new" dollars. Therefore, strategies should not focus exclusively on short-term financing; rather, the industry needs to take a longer view focused on demonstration of value through measurably improved health. Many stakeholders highly recommended that the industry consider its value proposition from the perspective of consumers, who increasingly are becoming more involved in their health and health care, as both payers and decision-makers.

There was little argument about the ability of well-trained pharmacists to provide value-added medication management services, but there was a uniform concern about adequate manpower to perform these services. As a result, it is recommended that the industry carefully assess work flow and design, as well as specific task assignment, and consider lobbying for appropriate regulatory changes to permit more efficient use of resources.

Perhaps one of the most worrisome observations to come out of this project relates to participants' personal experience. No one was able to point to an instance in which he or she (or, with rare exception, a family member) had received robust, face-to-face counseling services, such as those proposed to be provided by community pharmacists and reimbursed by payers. Many participants were aware that pharmacists are required

to offer counseling, but many times consumers sign away those rights, without realizing they are doing so.

The Traditional Payers

The consensus of the dozens of payers who participated in this project is that they will pay for those things that they see value in—services that demonstrate return on investment (ROI) with measurable results.

Across the spectrum, payer perception of the added value that retail pharmacy can bring to the healthcare system is directly linked to a demonstration of cost savings and improved health outcomes. Health plans, employers, and benefit consultants all agreed that “retail pharmacists will have to prove they can provide a valuable service at the lowest cost, while also lowering the ‘spend’ on drugs.”

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All payers, public and private, are looking for a decrease in spending, or at least slowing in growth, while getting more value, that is, more return in health. The payer is not wedded to a specific source of the solution. Pharmacists, physicians, nurses, or others can be involved. Payers simply want to arrest spending growth and stay competitive with a healthy workforce. To this end, some employers have expressed a willingness to make modest investments in programs and services that intuitively will improve their employees’ health and productivity, and possibly save money in the long run. However, overall, these employers are in the minority.

Some employers are unaware of what a pharmacist can do. However, payers who are more knowledgeable are supportive of, and enthusiastic about, the potential value of community pharmacy, as long as services are integrated into existing employer benefit designs and priced competitively. Many believe that the value of pharmacy has been demonstrated for some services in some settings, but not adequately in the retail setting. Many large payers are at the “show me” stage. Though they believe that MTM for specific populations will demonstrate a measurable impact from the pharmacist intervention, versus the more common process of simple network outreach, they want proof. One national payer pointed out that the company has reimbursed for cognitive services for years, and has experienced the value that comes from physicians successfully partnering with pharmacists on care delivery.

This relative payer apathy regarding the specific purveyor of value-adding, cost-reducing service means that the retail/community pharmacy sector must carefully define its new role and distinguish its unique competencies that translate into superior value. Though the simplistic message is clear—reduce cost and prove it—the real goal for sustainability of the business model has to be value, which includes the critical dimension of quality, as measured by patient outcomes.

Pharmacists need to demonstrate to patients and their providers that their services add value in order to get payers to reimburse for them. Participants urged the industry to initially work on business models that focus on marketplace collaboration and do not require going to payers. One astute observation was that “pharmacists need to start by demonstrating their value to *other* health care professionals.” Several payers opined that “Retail pharmacy is well positioned to compete . . . but should integrate and partner [with other healthcare providers and stakeholders], not compete head on.”

Physicians As Partners

Therefore, a critical enabler for the industry to successfully transition is the provider community, first and foremost physicians. This emphasis on creating value for physicians and their patients is a critical step on the road to reimbursement for pharmacy services. Partnering with primary and specialty physicians to create better delivery models that demonstrate cost savings and improved quality is a key to success. Payers pointed out that without clear and definitive alignment with physicians, it will be difficult, if not impossible, for community pharmacy to demonstrate value in terms of better patient outcomes.

Physicians and payers alike observed that “retail pharmacists need to work hard to integrate with other providers in the chain of care, which will put them closer to the patient.” This integration will require proactive outreach to establish relationships with physicians that rarely exist today. From the physicians’ perspective, coordinating with pharmacists and taking advantage of their skills and accessibility has the potential to lighten the workload, especially for primary care physicians, as well as to improve patient care. Community pharmacists need to convince physicians that they can make their lives easier and help them achieve the outcomes they desire for their patients.

As the percentage of graduating physicians going into primary care falls, practicing primary care physicians’ numbers continue to shrink. These physicians are also working longer hours for less remuneration. This shortage, as well as a desire of all health professionals to be challenged, enhances the likelihood of increasing physician support.

One physician participant observed, “Physicians working in integrated health systems or hospitals view pharmacists as part of the care team, with the same commitment to patient care. They do not, in general, view retail pharmacists as having the same vested interest in their patients.” Overcoming this perception and creating common incentives for physicians and pharmacists is a logical and necessary prerequisite to value demonstration. This integration of interests can create a domino effect by increasing the ability of physicians to care for patients and increasing patient satisfaction. Clearly there is an advantage to both the patient and the payer if pharmacists help patients optimize their pharmacy benefit coverage, understand their medications, eliminate potential drug interactions, and promote adherence.

Every model CCG identified that is designed to expand the role of the pharmacist involves three core components: coordination, communication, and metrics. As one executive put it:

The key to this is aligning relationships to monitor and manage the dispensing of drugs as a person's condition evolves over time and across care settings . . . all information in one place . . . connected with pharmacy and principal care physician. . . . Make sure the right drugs are taken at the right time, under the right condition. Set up triggers for intervention. Then streamline communication with the principal care physician, the patient, and the family caregiver.

In summary, CCG believes the message coming from project participants is clear. Long-term success will require that community pharmacy build the necessary alliances with physicians and other providers, at both the national and the local level, to demonstrate what community pharmacy has to offer. If the goal is creation of viable business models designed to position retail pharmacy as a medical service provider, the importance of recognizing this intermediate step cannot be overemphasized.

The Consumer As Payer

Both health plan and employer participants recommended that, in addition to focusing on traditional payers, community pharmacy take advantage of the healthcare consumerism movement and market directly to consumer-patients. Over time, consumers are paying more of the cost of their health care, including pharmaceuticals. This will undoubtedly lead to a change in behavior, but it will be a challenge to get consumer-patients to consistently act differently—to be less passive and more proactive with their health.

Today, consumers are confused over who is who and who does what when they enter the community pharmacy. The industry has to change the public's baseline expectation and experience. It is worth the effort to step back and reevaluate the opportunities the industry has to capitalize on the consumer as a payer—and what it will take to be successful.

The public currently has a baseline experience that is understandably characterized by a retail mindset when they enter the community pharmacy. It will take a significantly altered environment to change that view. There is a fundamental disconnect between the image of a store where someone can buy soft drinks, cookies, candy, and cigarettes and that of a physician's office. So if the goal is to get the consumer-patient to think of the pharmacy as a healthcare setting, the environment has to be compatible with a health message.

Most consumers do not think about a relationship with a pharmacist and do not generally see pharmacists as adjuncts to their primary care physician. Yet, if the pharmacist's professional image can be reframed as a trusted advisor to the patient, there is every reason to believe that it will be possible to build a personal relationship

between the patient and the pharmacist, and simultaneously employ the patient as a bridge to strengthen the relationship between the physician and the community pharmacist. There is no doubt that the best business plan for pharmacy services will fail without good communication among pharmacists, physicians, and patients.

Community pharmacy can also take advantage of its real estate in marketing to consumers. One participant observed, “The best ‘bang for the buck’ for the consumer is not the same as for third-party payers. Consumers focus on time and location, as well as affordability.” When compared with other providers, pharmacists have the huge advantage of location and can leverage their real estate. Consumers go to the pharmacy approximately 10 times as often as they go to the physician’s office, and it appears they choose a pharmacy primarily based on convenience. They tend to assume a certain standard of quality and service related to the product, and nothing more.

Thus, direct-pay consumer customers will not materialize without an investment of resources. Our experts pointed out that “Consumers are clueless about what pharmacists can do, beyond ‘lick and stick.’ They are unlikely to seek out pharmacists and want to engage them [pay them or support payment] unless skills and services are very well marketed.” It will be incumbent on the retail pharmacy industry to recast its image with the public. The following comments from participants make this point: “Image follows performance!” “Consumers will respond to a ‘changed face.” “Brand the pharmacy around health, not drugs.”

In essence, changing the consumer experience, and thus the consumer’s expectations and value perception, will be critical to creating acceptance and demand.

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VI. Targets, Partners, and Models

Our work on this project has convinced us that community pharmacy can enlist allies from among *all* key stakeholder groups, if and when it articulates a value proposition that is aligned with the potential target or partner's interests. In this section, we provide specific examples of entities that CCG believes would respond positively to overtures from community pharmacy. The comments regarding specific organizations are based on information that was provided as part of this project. More general recommendations regarding stakeholder group engagement are based on our experience.

Health Plans

Health plans were very clear that reimbursing for pharmacist-provided services will require community pharmacy to be able to demonstrate that those services result in a degree of compliance that would not otherwise occur. They are looking for demonstration of cost-benefit and better patient outcomes.

To evaluate economic results, one must be able to look longitudinally at *all* costs—both direct and indirect—and measure the *total* cost of care over time. Unfortunately, in many health plans, costs are in “silos,” making it hard, but not impossible, to collect the necessary data.

Pharmacy must differentiate its services from similar services provided by others. Pharmacy benefit managers and health plans are all doing more direct outreach to members. For a percentage of members, face-to-face counseling may be preferable to mail reminders or telephone counseling. Pharmacists need to show they are the most cost-effective means of providing face-to-face counseling services.

Several plans pointed out that getting payers to reimburse will be a long-term proposition. The industry needs to make pharmacist-provided services an integral part of its business and get out of the mindset of initially going to payers. Chains must take risk initially. Payers recommended that retail pharmacy chains build internal demonstration projects by mobilizing their companies and large customers and piloting pharmacist-provided services.

WellPoint

WellPoint is the nation's largest health insurer. Despite the caveats noted above, executives affirmed that they “want to make it work with the [pharmacy] network.” WellPoint has reimbursed for cognitive services for years. Its network physicians successfully partner with pharmacists on care delivery.

However, WellPoint noted that not all retail pharmacies are taking full advantage of current opportunities with medication therapy management (MTM) and immunizations. When WellPoint rolls out its programs, retail pharmacists are infrequent participants. They believe it is due partly to lack of pharmacist time, and partly to lack of incentives, as the dollars for the program flow to the business operation, not to the pharmacist.

From a health system perspective, WellPoint thinks a change is needed in economic incentives for providers and patients; siloing the pharmacy is not the answer. Plans, along with employers, are key to making it work and eliminating the siloing that occurs today. WellPoint pays the total healthcare cost for its members, so siloing makes no sense.

CIGNA

CIGNA has created a Gaps in Care Program in which pharmacists play a central role in identifying and resolving errors, gaps, and omissions in care. CIGNA is still in the design phase of the program and is currently focused on communications with physicians. The next step will be improved communication with patients. However, this insurer is actively looking for ways to also improve communication with pharmacists, though most conversations to date have been limited to chain headquarters.

CIGNA believes there is a need to segment members by risk, and is using such segmentation for specialty pharmacy members. The effort relies on telephone communication by RNs and LPNs with specialty pharmacy members.

The company is currently using its own pharmacists to do Medicare Part D MTM counseling, and has had good success. However, executives agree that some members would do even better with face-to-face counseling.

Presbyterian Health Plan

Presbyterian is a large integrated delivery system in Albuquerque, New Mexico, with 500 employed physicians. The system is ranked in the top 10 in the country. It contracts with nearly all the remaining 2,000 doctors in the state.

They have a robust pay-for-performance initiative, and all strategies are tied to it. Aligned incentives among physicians, pharmacists, and other providers are critical, as are effective partnerships.

Presbyterian's pharm clinicians (licensed as midlevel practitioners who can prescribe under protocol) have been providing MTM to high-risk seniors since 1993. These individuals, in addition to PharmD training, have completed clinical assessment courses, have more than 300 hours of direct patient care, and are sponsored by physicians. The pharm clinicians see patients on a schedule and have access to the same medical records and infrastructure that the physicians do. Physicians have aligned incentives and are required to support the MTM programs.

They have also begun contracting with pharm clinicians in the community with their own office practices. These services are billed through the medical, not pharmacy, benefit.

Presbyterian's leaders are very supportive of involving retail pharmacies. They believe that pharmacists are underutilized in the retail setting and that their service needs to be aligned with physicians.

As part of the Quality Improvement Program, they will begin contracting with retail pharmacies to provide another layer to their MTM program. This service will be available to non-Medicare patients with chronic disease, such as diabetes, or polynarcotic use. Pharm clinicians can refer patients to the retail pharmacy for more frequent monitoring and adherence management, and the retail pharmacist can refer patients needing more intensive evaluation/counseling to the pharm clinician or the physician, both of whom have access to more clinical and lab data.

Retail clinics can also be reimbursed for immunizations, smoking cessation counseling, and, if the pharmacist is a certified educator in a disease state, case management/education.

Presbyterian is currently in the process of developing a plan to build the network. All community pharmacists will be eligible to participate, provided that they meet the requirements, which include data capture and outcomes tracking.

Special Needs Plans

(Also see more detailed description in chapter VII.)

This rapidly growing group of plans, which serve the highest cost, frail Medicare population, represents a specific, high-impact target for community pharmacy. With these patients, short-term interventions can have long-term impact and generate a quick ROI for the payer, who is at full risk for all costs associated with care.

The institutional special needs plan category of patients, both those in the community and those in nursing homes, would have the quickest and highest payoff from direct pharmacist involvement. Another excellent opportunity could be seized with patients in assisted living facilities, which has a different structure than do nursing homes.

A lot of small plans are just getting started and have not yet defined a service model. These plans should be a primary target for community pharmacy.

Medical directors of these plans have identified five measures that they believe would most advance care for these patients. Four can be impacted by better drug management: rehospitalization for ambulatory care sensitive chronic conditions; emergency room visits; adverse drug events, in relation to transitions; and nursing home admissions.

The Academy of Managed Care Pharmacy

The Academy of Managed Care Pharmacy (AMCP) specifically wants to reach out to retail pharmacy. In the past there has been some animosity between them, but MTM provides opportunities for collaboration. Managed care needs to work through retail channels to reach patients, but AMCP members have found it difficult to get community pharmacy to step up. Another problem is that most people are in plans in which the risk is siloed, unlike in Medicare Advantage where it is shared across providers.

Employers/Employer Coalitions

How does a community pharmacist collaborate with national entities? Or, is it more appropriate that the local pharmacist collaborate with local providers, employers, and so forth? Economically, how does a national entity collaborate with myriad local pharmacists and negotiate local contracts, without dictating terms? Sometimes, national players have a take-it-or-leave-it attitude. Community pharmacy clearly needs more localized options to test the waters with new services, while collecting the necessary data to demonstrate their value.

Though they are still the minority overall, employers who have been actively involved in shaping innovative benefit designs and strategies such as value-based purchasing are becoming more aggressive in their pursuit of that value and more demanding of health plans.

According to a recent report by Hewitt Associates, more employers are enhancing health benefits by offering tools, wellness programs, quality information, and pay-for-performance programs. Nearly two thirds of the relatively large employers surveyed plan to take more aggressive, multiyear approaches to improve healthcare options offered to workers. This goes against the thinking of many in the benefits industry who predicted that employers would limit their focus to cost shifting. A majority of employers provide disease management or wellness programs.

Most participants agreed that employers should be a primary target for messaging about the value of community pharmacy. Drugs are 20% to 25% of a big spend for employers. More employers are looking at alternatives to optimize the value they get for this spend, but they are not convinced they have the right information to make good decisions.

Employers may have more incentive to get involved with community pharmacy than do health plans, which experience more turnover. This is especially true of government employers, whose workers tend to stay for life. For this reason one knowledgeable individual suggested looking at trying to engage municipalities or their employee labor unions (e.g., AFSCME), as there is more incentive for these employers to focus on services and strategies that may not pay off for a while.

The Asheville Project brought accountability to managing disease and aligned the interests of pharmacists, physicians, and patients. It also measured the total cost of care over time, which is critical to evaluation. Unfortunately, in many health plans, costs are siloed, making it difficult to collect the necessary data. As a result, employers may initially have to rely on measures of patient satisfaction, which are reported to be generally positive.

Some employers, though certainly not all, will support these programs on the hypothesis that they decrease hospitalizations and lost work time. They look at the evidence that

exists and do the right thing. If people need more care, it is encouraged. The role of employers in educating their employees makes a big difference.

The following critical success factors have been identified for Asheville-like programs:

- Critical mass. These projects present a chicken-and-egg problem. A business case needs to be made for both the employer and the pharmacists, who need to invest time to get the required training.
- Purchasers that will make an initial investment on faith that it will pay off later
- Ultimately, demonstrable outcomes, such as total claims for those enrolled versus those not enrolled

However, Asheville has its skeptics who point to attrition rates, even with incentives. They also point out that the specific drivers of success have not been isolated. Even advocates question its scalability. Patients clearly need reinforcement at every turn, employee groups need to be segmented for attention, and the model needs to be refined.

Nonetheless, interest in these employer initiatives to improve employee health is growing. For example, more than 40 employers are participating in the current Diabetes Ten City Challenge.

Coalitions are in a good position to impact their employer–members' thinking. Recognizing this fact, in early May the National Business Coalition on Health (NBCH) announced a partnership with the American Pharmacists Association (APhA) Foundation to implement the APhA Foundation's HealthMapRx Program, a pharmacist-coordinated patient self-management program modeled on the Asheville initiative. Utilizing the purchasing power and community leadership of its more than 70 employer-based member coalitions, NBCH will work to help members' employees better manage chronic health conditions.

Educating employers and speaking their language is uncharted territory for community pharmacy. But it is well worth the effort for the industry to learn to put what it has to offer in terms employers understand.

Case Managers

Case managers already have many of the relationships that pharmacists need. They may choose to compete; however, our work on this project and others strongly suggests they are champions of collaborative practice and are actively pursuing partnerships with a wide range of healthcare providers to help improve patient care.

The Case Management Society of America is the project director and sanofi-aventis is the sponsor for the new National Transitions of Care Coalition (NTOCC), formed in October 2006 to address the gaps that occur when patients leave one care setting and move to another. These transitions include patients moving from primary care to specialty physicians; from the emergency room to the intensive care unit or surgery; or

from hospital to home, skilled nursing facilities, or assisted living. The NTOCC will work to ensure appropriate synchronization of services, enhance medication adherence, improve patient self-management, and address complex issues such as health literacy, patient safety, and nonadherence.

Three workgroups have been formed:

Education and Awareness. This group will work to address awareness and general knowledge about the problems associated with transitions of care and provide the necessary information to various stakeholders: patients, caregivers, healthcare professionals, and government officials.

Tools and Resources. This group will identify practical tools and resources that can be used by healthcare professionals, caregivers, and patients to improve communication in a consistent manner between care settings and reduce risk associated with care transitions.

Policy Advocacy. This group will assess ways to improve care through enhanced communication tools and collaborative partnership. It will also evaluate the possibility of enhanced reimbursement for transitional care support and technical medical information shared between care settings.

Participation of community pharmacy in this effort is important as there is a large role for retail pharmacists to play related to transitions of care.

Physicians/Physician Associations

Throughout this report, we emphasize the importance of aligning relationships with physicians, as those are the persons the patient wants in charge of his or her care.

The goal should be to create alliances with physicians, by positioning the pharmacist as a clinical risk manager for patient outcomes. The pharmacist needs to be seen as an integral component of the continuum of patient care with the physician, the payer (health plan/employer), and the patient, in order to achieve optimal health outcomes for the patient.

It is perhaps advantageous in establishing relationships with physician organizations for pharmacists to seek collaborative practice authority, almost always under protocol, unlike some professionals who desire to practice independently. However, physicians and community pharmacists need common incentives, such as exist in hospital and integrated practice settings, where the relationships and mutual respect are well-established. E-prescribing will help accomplish the necessary alignment.

On the national level, through its trade associations, community pharmacy should reach out to primary care physician associations such as the **American Academy of Family Physicians** and the **American College of Physicians**. There may be ways to capitalize on the impending shortage of primary care physicians.

To facilitate involvement in disease management, pharmacy should consider aligning with specialty societies representing physicians who care for patients with targeted chronic diseases, such as the **Society of Endocrine Medicine** if the interest is in diabetes, or the **American College of Cardiology** if the interest is congestive heart failure. Another target might be the **American Board of Quality Assurance and Utilization Review Physicians** which represents physicians who are involved in the newly created NTOCC (see “Case Managers” section above).

These contacts in professional associations could augment relationships developed with primary care and multispecialty physician groups locally. Physician leaders in both small and large multispecialty group practices are very supportive of more structured relationships with pharmacists in their communities, with the caveat that good communication among physicians, pharmacists, and patients needs to be ensured.

As an example, **Lahey Clinic**, a large multispecialty practice outside Boston, now has clinical pharmacists in its internal medicine practice. However, the chief operating officer pointed out that Lahey can't hire enough pharmacists, so he would be very supportive of partnerships with pharmacists in community retail stores.

He suggested that pharmacies work to connect with clinics and physician practices through an electronic consult sheet. He envisions a front-end clinical function enabled by a pharmacotherapy prescription from the physician whereby a PharmD would carefully review medications against lab values and send comments back to the physician electronically. He believes this would be very helpful to physicians and it would definitely improve continuity of care.

He also sees great potential for retail pharmacies to provide services on the back end, focused on counseling, education, and medication adherence. These services may not need to be provided by a PharmD. In fact, retired nurses or other health professionals with excellent counseling and education skills and cultural competency may be more cost-effective.

Whereas at Lahey and similar clinics, good information is readily available about the cost of different drug brands, many practitioners do not have access to such information. Thus, here too pharmacists could be helpful.

Finally, it should be pointed out that a number of participants expressed a lack of optimism about the value of the pharmacy link with retail clinics, as some believe that physicians do not have faith in that model, and physicians are key to pharmacy's success.

Safety Net Providers (e.g., Community Health Centers, Safety Net Hospitals)

In 2001, the Health Resources and Services Administration (HRSA) established Alternative Methods Demonstration Projects (AMDPs), which allowed covered entities that applied and were approved by HRSA to pursue alternatives to contracting with a

single pharmacy, as required by previous regulations. The alternative models include the use of multiple contract pharmacy service sites; utilization of a contract pharmacy to supplement in-house pharmacy services; and development of a network of 340B covered entities. The intent was to allow community health centers and other 340B safety-net providers to develop new ways to improve access to 340B prescription drugs for their patients.

In January 2007, HRSA proposed new guidelines that would allow covered entities to utilize multiple contract pharmacy service sites that are not approved AMDPs. Participants familiar with HRSA and safety net providers pointed out that this creates a significant new opportunity for community pharmacy with the 14,000 safety net entities, plus all of their satellites.

Consumers

Throughout this report, we have also stressed the importance of “the public” as both an ally and a paying customer. We have stressed the need for pharmacy to create an environment in which the patient’s expectations are to ask questions and interact with the pharmacist. Thus, the strategy should include changing consumer–patients’ perceptions by changing their pharmacy experience and getting them to demand services.

The consumer is the ideal champion for change, as in other industries, and can be community pharmacy’s best advocate. Unfortunately, consumers today are largely unaware of what pharmacists can do, beyond “lick and stick.” They are unlikely to seek out pharmacists and want to engage them (either pay or support payment for them) unless skills and services are very well marketed. Good marketers in other industries are able to convince people they need things they didn’t know they needed. It is critical that the image of community pharmacy be drastically altered, if the public is to be actively engaged in supporting a new role for community pharmacy.

Consumer–patients increasingly want autonomy, convenience, and control. As they assume more responsibility for healthcare decisions and the cost of those decisions, they will demand transparency, convenience, and value.

A recent Harris Interactive poll was commissioned by management consultant Booz Allen to examine how the transition to a more retail market in health care is impacting consumer decision-making and behavior. The study found that as healthcare consumers take on greater cost responsibility, they are more likely to shop for healthcare services and to expect competition among providers and suppliers. But they still lack the information they need to make informed choices in critical areas. In many cases, consumers want their physicians to provide needed information on cost and quality. However, physicians are often unwilling or unable to assume that role. Patients need to be responsible for their care, because clinicians alone can’t do it. Supports for consumers need to be in place, and the pharmacist is a natural provider of that support.

Although today only a minority of consumers appear to be active in managing their healthcare costs, the gap between emerging patient needs and what providers are supplying has opened up opportunities for new, trusted sources of healthcare information, and perhaps services. The survey confirmed that for information about prescription drugs, consumers trust pharmacists most—even more than their physicians.

Consumers in plans with health savings options also appear more willing to spend now to avoid potential health problems later. In the survey, over 40% of consumers with health savings accounts or health reimbursement accounts said they would pay an additional \$500 and 18% would pay up to \$2,500 to avoid possible future health issues.

Even if pharmacist skills and services are well-marketed, some consumers will not appreciate the value of engaging with pharmacists, partly because the retail setting is less conducive to trust than is a clinical one. However, if pharmacists align with the patient's physician, who recommends pharmacotherapy service and explains its value, these individuals will be much more likely to be willing, even enthusiastic about pharmacist counseling.

These two findings—the innate sense of trust consumers already have in pharmacists as medications experts, and the willingness of some to pay for services likely to prevent future health concerns—reinforce the notion that the consumer as payer is a viable target.

Perhaps more important, results of this project have reinforced the importance of the consumer experience and perception in influencing the views of payers and providers and their receptivity to new pharmacist roles. Building a coalition with the patient at the center is definitely a winning strategy.

Quality Improvement Organizations

The state Quality Improvement Organizations (QIOs) represent another viable potential partner for community pharmacy at the local/regional level, as they need a lot of help in meeting their charge from the Centers for Medicare & Medicaid Services. As part of this project, CCG interviewed leaders in the New Mexico and the Rhode Island QIOs.

The **New Mexico Prescription Improvement Coalition** (the QIO that includes the state pharmacy association, state government, American Association of Colleges of Pharmacy, and managed care) has been working on setting state standards for what a provider should be evaluating, especially for diabetes. The big focus is on encouraging and accelerating e-prescribing and on MTM. They are working with pharmacists around the state who will be doing face-to-face MTM.

Since Medicare Part D, 17 new plans are operating in the state, but all have different criteria for MTM. The Coalition is looking at doing a pilot and is recommending face-to-face counseling. It is building a payer-based consortium and hoping to change the

insurance code. Major plans are financially supporting e-prescribing. They are not as far along with MTM.

Quality Partners of Rhode Island is doing a pilot with Blue Cross Blue Shield Rhode Island in which the patient gets the first dose of medication in the doctor's office, with a push on generics. Although pharmacists miss the first-fill charge, they generally like the program, according to an executive at Quality Partners.

Rhode Island also has a transition-of-care form that follows the patient. It is owned and managed by the primary care physician. Currently, the utilization is reported to be fair. Some concerns about accuracy are being examined. Part of the problem is a lack of standards: For example, how specifically is a pressure sore measured? Although this form is not currently electronic, it is a good precursor for an electronic medical record.

The state is actively working on e-prescribing. Four percent of scripts are sent electronically, which is second highest in the nation. Though it can take a lot of cost out of the system and significantly improve safety, the state recognizes that e-prescribing is not nirvana.

The **Care Transitions Program** at the University of Colorado Health Sciences Center focuses on a coach model to help support patients and families in managing care transitions. Most of the coaches are nurses or social workers who teach self-care and how to ask questions. By using a medication reconciliation tool, they find many discrepancies.

The director believes that pharmacists could play an important role in the program, and he does work with some chain pharmacists who do brown-bag sessions with patients. They are doing training with a number of QIOs (e.g., New York and California). This may represent an opportunity for chain pharmacies to work with the program and the coaches, through the QIOs.

VII. Opportunities

The underlying theme stressed throughout this project was the need for the healthcare system to place much more emphasis on the prevention and management of chronic disease. This observation was quickly followed by the acknowledgment that under the current healthcare delivery and financing system, pharmacists are a seriously underutilized asset.

Though participants varied somewhat in their estimation of the breadth of services they felt pharmacists were competent to deliver, they offered nearly uniform advice to focus first on the core competencies associated with their recognized position as medication experts and *get pharmacotherapy right!* By combining clinical and cost-effectiveness in medication advice and counseling and promoting adherence to medication, pharmacists can best use their skills to improve healthcare delivery. Pharmacists are also recognized as effective patient advocates, providing advice and guidance on numerous health-related issues.

In describing the opportunities, we recognize that given different current business models and competitive positions, various services will not have equal appeal or even applicability to all subsectors of the retail pharmacy industry. Different services will need to be developed to fit into the business models of the industry subsectors and different tactics will be needed to market them.

All segments cannot be mobilized in the same way. Each subsector has some competitive advantages that might be used to capture market share for some strategies/services. For example,

- Large chains have the ability to leverage purchasing power to lower the cost of product and have the capital to invest in further automation to enhance efficiency of distribution.
- Grocery chains have the ability to leverage synergies with food products.
- Mass retailers may highlight pharmacy as just one element of a broader healthcare strategy.
- Small and regional chains have more capability to develop and quickly and uniformly implement a service offering throughout a smaller system.

Not all pharmacies are taking maximum advantage of currently reimbursed services, such as Centers for Medicare & Medicaid Services (CMS)-supported immunizations and medication therapy management (MTM) programs. It appears that, regardless of the business setting, an incremental strategy and definitive “just do it” approach is most likely to be successful in reaching the tipping point. However, pharmacies must be sure they are prepared to deliver a service before promoting it.

Medication Consultation Services

Medicare Part D provides an opportunity to leverage the role of the pharmacist to be a pivotal player in healthcare delivery. It created significant impetus for pharmacist-provided medication services with its MTM requirement, but this is only part of the story. (See appendix D for a discussion of the requirements and current status of MTM programs.)

The definition of MTM can be expanded to include services associated with the obtaining of an acute prescription, which pharmacists have been providing for decades without payment. It may also encompass nontraditional kinds of specialized pharmacy services, which might be defined by a retailer. And it provides a possible opening to partner with other providers to help with chronic care management. As a first step, it would behoove the industry to come to agreement on common definitions of all the elements of medication consultative services.

Chronic Pharmacotherapy

Start narrowly, such as with patients with multiple chronic diseases and multiple medications, to facilitate the ability to measure results. MTM services for high-risk, complex patients have a high likelihood of saving money for payers and improving quality of care for patients. This group has the highest risk of adverse drug events and a quick return on investment (ROI) to the payer is likely.

To optimize resource utilization and promote cost-effectiveness, some have suggested that the initial comprehensive medication review be conducted by a pharmacist, but some follow-up coaching/counseling to support adherence should be delivered, either face-to-face or by telephone, based on need, by a health educator or nurse, under the supervision of the pharmacist.

Acute Pharmacotherapy

It will be a challenge to persuade payers of the value of pharmacist interventions with acute scripts, as payment has been hidden in the dispensing fee. These conversations between pharmacist and patient at the time the patient picks up the acute script are of value because they frequently pinpoint the driving issues around medication compliance. It is worth the effort to try to make the case for the pharmacist's ability to address this significant safety gap, which has been widened by faster introduction of drugs, acquisition of drugs from outside the United States, and low-priced generic programs that have increased pharmacy shopping. It is recommended that pharmacists be much more proactive with these services and not leave it up to the patient to initiate the conversation.

Specialized Pharmacy Services

The term *specialty pharmacy* does not have to imply a focus on rare, high-cost conditions. One suggestion is to consider a program in which the pharmacist places a call to a patient a day or two after the new script is picked up to see if the patient has any questions.

Care Transitions/Medication Reconciliation

A well-recognized cost, quality, and safety problem cited by project participants relates to the gaps in care that occur when patients leave one care setting and move to another, such as from hospitals to nursing homes to home care. Care is rushed and responsibility is fragmented with little communication across care settings or multiple providers. This is especially problematic for frail, elderly patients who have complex medical needs. No one is tracking what meds patients are on when they enter the hospital, what they are on when they come out, and what they are keeping in their medicine cabinet at home. Integration of care with regard to medication is desperately needed across all sites of care. The issue can be addressed only by breaking down silos and barriers between different healthcare settings and working collaboratively for the good of the patient. Pharmacists are in a good position to help caregivers of frail, elderly patients to better coordinate and manage medication needs.

Pharmacists are in a good position to help caregivers of frail, elderly patients to better coordinate and manage medication needs.

Physicians in general think a lot of the problems with medical management are related to care transitions. Safe and effective transitions have been identified as a priority by the medical directors of the Special Needs Plans Alliance (see further discussion of SNPs later in this chapter). What is needed to better manage transitions is a point of coordination, and nobody has stepped up to the plate yet to assume this role, creating a significant opportunity for community pharmacists.

The value of a pharmacist helping to coordinate transitions between sites of care was demonstrated in a recently published study (Schnipper et al. 2006) that showed a drop in errors from 11% to 1%. Though several professional pharmacist associations are involved in the recently created National Transitions of Care Coalition, community pharmacy needs to demonstrate its interest as well.

Disease/Chronic Care Management

About 133 million people, or 45% of the population, live with at least one chronic condition. That number is expected to reach 171 million by 2030. Almost half of those with a chronic illness have more than one.

We believe that community pharmacy should note several key points about involvement in disease management/care coordination:

- Physicians *must* be looped in to these efforts or they will fail.
- Results to date are clear: The best models have *not* been defined.
- The need for more personal contact and the advantage of face-to-face interaction is a natural opportunity for community pharmacy.
- The industry should work proactively to develop relationships with plans and vendors who are developing new models.

The MacColl Institute for Healthcare Innovation developed the Chronic Care Model, which identifies the essential elements of a healthcare system that promotes high-quality disease care. The model has been implemented, tested, and refined. Among its tenets, it emphasizes a team-based approach to care, case management, information sharing, self-management support, and utilization of community partnerships. All of these elements can be enhanced by including community pharmacists.

Retail pharmacy is well-positioned to compete with pharmacy benefit managers (PBMs) and disease management (DM) programs, but should integrate and partner, not compete head on. DM and MTM can be complementary. PBMs, health plans, and integrated systems are increasingly doing more of the same outreach, so there is a need to partner and make the case for the unique advantage of face-to-face counseling with some subsets of patients.

In fact, results of traditional DM programs are not impressive. To be effective, coordination is needed at every contact. No one is helping patients understand and comply with medication and self-care regimens, though private markets would pay for this. The vendors of DM programs would benefit from building relationships in the retail space where interventions, at least with some patients, can be much more effective.

Community pharmacy should go to employers and employer coalitions and offer a more integrated DM program, one in which biometrics are obtained (unlike traditional telephone programs) and effective communication channels are established among pharmacists, physicians, patients, and caregivers. The hallmark of pharmacists working with physicians is an augmentation to DM. As one employer representative put it, "Step up and say, 'I *can* do what all the others haven't done.' Advertise that people can *talk* with a pharmacist, face to face."

Community pharmacy should go to employers and employer coalitions and offer a more integrated DM program.

Status of Disease Management

Without question, HMOs and employers are buying disease management, as evidenced by the growth in spending on these programs: in 1997, \$78 million; in 2000, \$1.2 billion; and by 2008, an estimated \$1.8 billion will be spent on various types of disease and case management services. The public sector, particularly CMS, is also investing heavily in programs aimed at improving care for patients with chronic illness.

Despite the apparent enthusiasm, there is little evidence that, as currently practiced, DM is worth the investment. A review of 44 studies published in 2005 (Goetzel et al. 2005) that looked at the financial ROI for programs addressing asthma, congestive heart failure (CHF), diabetes, depression, and multiple illnesses found positive results only for CHF and multiple conditions. Other results were mixed or interventions cost more than they returned.

The authors of this review noted several limitations. First, direct comparison among studies is difficult, as DM is defined and practiced in different ways. A few studies included face-to-face interventions; more included employee mail, Internet, and telephone delivery of information to targeted patients. Second, the interventions in some cases were offered as self-management tools directly to patients, whereas others focused on physicians by providing them with reminders and prompts to deliver evidence-based medicine. Third, the studies varied greatly in terms of design, duration, cost, comprehensiveness, and intensity.

Chronic Care Improvement Under MMA

Currently, at least three efforts sponsored by CMS are under way:

- The Medicare Coordinated Care Demonstration Project was established in 2002 with 15 sites. It targets beneficiaries in traditional fee-for-service (FFS) Medicare, Part B with congestive heart failure, diabetes mellitus, chronic obstructive pulmonary disease, or other diseases specified by the Secretary of Health and Human Services.
- The Medicare Health Support Program, also aimed at beneficiaries under FFS, addresses fragmentation of care. Begun in 2005, it will run for 3 years. There are 8 different models in different areas.
- Medicare Advantage organizations were required as of January 2006 to implement a chronic care improvement (CCI) program and report on ongoing activity in advance of CMS audits, using a specific template.

CCI organizations are required to guide the participant in managing his or her health, including all comorbidities, relevant healthcare services, and pharmaceutical needs. Pharmacists are neither designated nor excluded. However, MMA requires MTM to be coordinated with CCI programs, creating an opportunity for pharmacy involvement.

Though it is too early for results from the Medicare Health Support Program or the one aimed at Medicare Advantage organizations, the first report to Congress on the Medicare Coordinated Care Demonstration was recently provided by Mathematica Policy Research and is available on its website at www.mathematica-mpr.com/publications/pdfs/mccdfirsttwoyrs.pdf. A stated program goal was the active sustained involvement of treating physicians, a historical deficit of DM programs.

The Medicare Coordinated Care Demonstrations varied by financial risk, number of enrollees, target population, voluntary (opt-in) versus population (opt-out) enrollment, use of information technology, fees, and Rx coverage. However, interventions were similar.

The study found no effects on adherence or self-care. Only 3 of the 20 programs reduced hospitalizations or gross costs. There were no effects on mortality and only scattered modest effects on quality indicators. Yet, patients love the programs.

The report concluded that DM does not work better mainly because changing patient and provider behavior is hard. The programs were limited in their use of behavior

change models, and there was no incentive for physicians to communicate. The usual care providers were minimally engaged, despite active involvement being a stated goal of the CCI demos.

What worked best? It is difficult to say. What was more apparent was what was *not* sufficient. There was no advantage in greater size, more expense, sophisticated information technology, or greater disease severity. A single disease focus wasn't better and more personal contacts weren't sufficient. Improvements in quality of care didn't guarantee better patient outcomes in the short run.

Mathematica concluded that disease management/care coordination isn't a panacea. There is no single necessary or best approach and it is not necessary to target only the highest risk patients. It did note that experienced nurses and more in-person contacts resulted in better outcomes.

With the assumption that CMS does not wish to declare disease management/care coordination failures and abandon the demos, it was suggested that the next steps include testing the replicability of the few successful programs identified. First, more detailed information needs to be collected on the nature and continuity of nurse-patient interactions and the evidence basis for assessments and care planning. Then specific and structured interventions need to be defined.

Special Needs Plans

As part of the Medicare Modernization Act of 2003, CMS demos that had focused on very high risk, frail beneficiaries being cared for by full-risk special needs plans (SNPs) were allowed to move into the mainstream.

There is no mandated model. The goal is innovation in chronic care, with benefits tailored to the needs of the target population. These plans offer a platform for Medicare/Medicaid integration, provide the opportunity for fast entry in a growth market, and allow for risk-adjusted financing.

There are three types of SNPs, each of which specialize in the care of a high-risk population:

- Institutional plans, which cover institutionalized patients or those in the community with similar needs/conditions. Evercare (owned by UnitedHealthcare) runs most of them. The business model is that of a nurse practitioner working in a defined community or nursing home to improve drug utilization and patient outcomes.
- Chronic care SNPs, which are mostly run by DM companies. Beneficiaries are individuals with chronic disease approved by CMS on a case-by-case basis. The interaction and effort is slightly more intensive than it is with standard disease management, but it is still largely a nurse-managed telephone service.

- Dual-eligible SNPs, most of which were former Medicaid plans that moved to Medicare with the drug benefit migration. Here, most of the innovation is with small local plans, especially in Minnesota, Wisconsin, and Massachusetts, rather than with the big player, WellCare.

In 2004, only 11 SNPs were approved. In 2005, there were 136 plans; in 2006, 276 plans. In 2007, 476 SNPs are serving over 1 million beneficiaries, including 40 national demonstrations that are transitioning to SNP status. The original SNP legislation was limited to a 3-year period. However, there is current lobbying for a 3-year extension.

Though the SNPs are at risk for all Medicare costs for the population, one principal driver is frailty, and to be successful, the plans *must* be able to manage this.

The National Health Policy Group facilitated the creation of a SNP Alliance, the purpose of which is to ensure the long-term business viability of the SNPs. Participation is by invitation only. The SNP Alliance is looking at several key issues:

- **Payment.** At full implementation, risk adjustment on the highest cost group still underpays by 15% to 20%. The insurance structure simply does not work for these patients.
- **Quality measurement.** HEDIS measures focus on acute illness and don't deal adequately with the complexity of chronic illness. The medical directors of the SNPs have identified 10 quality domains, among which are continuity; safe, effective transitions; polypharmacy; comorbidities; and end-of-life care. Preliminary process and structure measures have been established and, to be a part of the Alliance, plans must be working on implementing these measures.
- **Transitions.** Safe and effective care transitions are a key priority, as the gaps in care represent a major source of poor quality and unnecessary costs. The physicians see a lot of the problems with medical management as being related to care transitions.

Our expert believes that the institutional SNP category of patients, both those in the community and those in nursing homes, would have the quickest and highest payoff from direct pharmacist involvement. One especially good SNP in this group is Commonwealth Care Alliance in Boston, which serves primarily frail elders and adults with disabilities. These patients benefit greatly from connections with people and resources in their neighborhoods.

Another excellent opportunity could be seized with patients in assisted living facilities, which has a different structure than do nursing homes. These residents increasingly qualify for nursing homes and thus would be eligible for SNP coverage. Some SNPs are defining their service area as a network of assisted living facilities in a specific geographic area.

Many small plans are just getting started and have not yet defined a service model. These plans should be a primary target for community pharmacy. Sometimes the SNP begins by looking at what is currently being done and what it is costing, with the intent of modifying the model as it develops. However, if the SNP is overwhelmed by enrollees, it never goes back to take the time to reengineer the process to come up with a better approach.

The best leverage with the Alliance is with the quality angle. The Alliance plan medical directors have identified five measures that need to be addressed to advance care for these patients:

- Rehospitalization for ambulatory care sensitive chronic conditions;
- Emergency room visits;
- Adverse drug events, in relation to transitions;
- Nursing home admissions; and
- Patient satisfaction.

As four of these can be impacted by better drug management, anyone who can decrease adverse drug events and improve adherence should be welcome at the table. For better management of transitions a point of coordination is needed, and nobody has yet stepped up to assume this role. Could this be a significant opening and opportunity for community pharmacists?

Prevention, Wellness, and Health Promotion

The industry should take advantage of the consumerism movement and directly target the general public, patients, and families as new payers. Over time, consumers are paying more of the cost of their health care, including pharmaceuticals. Consumers can also be a bridge to help build relationships between physicians and pharmacists. The goal is to package and sell value-added services to consumer–patients that meet public expectations and demands. The best bang for the buck for the consumer is often not the same as for third-party payers. Consumers focus on time and location, as well as affordability.

The industry should take advantage of the consumerism movement and directly target the general public, patients, and families as new payers.

Here are some suggested services that could be marketed directly to the public or perhaps advertised through employers:

- **Health benefit counseling.** Help patients optimize coverage benefits and find the most cost-effective medical regimen by using information to compare the relative cost of similar brands; move to over-the-counter remedies; and so forth.
- **Family consultation service.** For a monthly fee, offer families with complex problems someone to call anytime to get good independent advice, comparable to the coaching role some physicians are considering.

- **Screening services.** Collaborate with retail clinics to offer health assessments and screening (blood pressure, cholesterol, blood sugar), providing ease and convenience.
- **Health education programs.** On site, in the workplace, in the community. Consider smoking cessation programs, weight management classes, and education on how to interact with physicians and pharmacists over medications.
- **Immunizations.** Easy to do, currently reimbursed, well received, quick, no real need for privacy.
- **Ancillary information services.** Become a conduit of information on community health resources.

VIII. What Needs to Happen?

In this section, we have set out recommended steps for retail pharmacy as a unified industry, as well as suggestions for actions more suited to individual companies. This compilation of ideas either is derived directly from what we heard from project participants, or represents our assessment of actionable strategies and tactics to move the industry along the road toward a service-based model.

Global Industry Strategies and Tactics

Focus on the common mission to demonstrate the industry's value.

Strategic Partnerships

- Create alliances with physicians nationally through professional associations, such as the American College of Physicians, and specialty societies, such as the Society of Endocrine Medicine and the American College of Cardiology.
- Create alliances with other provider groups, such as the Case Management Society of America and the American Nurses Association.
- Create alliances with disease advocacy groups, such as the American Diabetes Association and American Heart Association.
- Create alliances with consumer groups, such as AARP.
- Create alliances with employer and insurer trade and professional associations, such as the National Business Group on Health, BlueCross BlueShield Association, and America's Health Insurance Plans, at the national level.
- Create an ongoing dialogue with specific payers (health plans, pharmacy benefit managers, employers, employer coalitions, third-party administrators, brokers, benefit consultants):
 - ✓ Invite participants in this project to commit to be part of a transitional advisory group.
 - ✓ Meet with them in a listening session focused specifically on payers' needs that might be addressed by the industry.
 - ✓ Identify specific deliverables to be incorporated in business plan development.
 - ✓ Ask them if they will make an investment in pilot projects.
 - ✓ Plan for regular communication—face-to-face and by telephone.

Marketing/Image

Some companies have already rolled out new marketing strategies promoting the accessibility and expertise of their pharmacists. However, in light of the centrality of the public image of retail pharmacy overall to success, collaboration among industry competitors on a national campaign makes good sense. A 2020 vision for community pharmacy could be a start. Then, commit to the direction and the investment!

Other action steps that could be undertaken uniformly or by individual companies:

- Image follows performance! Consumers will respond to a “changed face.” Consider these quick wins to transform the consumer experience:
 - ✓ Gain agreement that during October (American Pharmacists Month) every script will be handed to the patient by a pharmacist.
 - ✓ Gain agreement on a list of a dozen “problem” medications that must always be handed to the patient by a pharmacist.
 - ✓ Provide a card with each prescription filled that lists all the unique services provided as a part of that process.
 - ✓ Provide a card with 10 factoids to increase consumer health awareness.
 - ✓ Provide a coupon for a free medication consult.

- Brand the pharmacy around health, not drugs. ***Brand the pharmacy around health, not drugs.*** Connect to more health-related items, depending on subsector, such as directing customers to healthy food (grocery) or adding durable medical equipment (chain).

- Gain agreement on a few simple steps to execute consistently that would change the consumer experience, such as posing a standard question with every pharmaceutical purchase, “Do you have any questions about your medication or your health that our pharmacist could answer?”

- Launch an “I love my pharmacist” toll-free number to capture positive consumer experiences that can be used to promote the new image.

- Develop a robust earned media campaign designed to stimulate public and policymaker awareness of the emerging role of the pharmacist.

- Create a “Smart Pharmacy” logo, to be displayed in pharmacies that achieve certification (the meaning of which is to be determined) in certain core services.

- Define each employee’s role within the pharmacy and make it very transparent to the customer.

- Use a sign-in process for counseling to present an image of a healthcare facility rather than a retail environment.

- Make nonbusiness contributions to the community, such as providing scholarships and mentorships, funding pilots, and performing demos.

- Provide one-stop shopping for information on community resources/services.

- Look for ways to integrate retail pharmacy with community resources not traditionally seen as healthcare-related.

- Develop a program that can be presented at employer conferences, such as one on trends in controlling pharmaceutical benefit costs or solutions from effective use of pharmacists.

Industry Transition

The following activities/action steps should be undertaken by the retail industry to facilitate broad-based movement toward a service model. Where it seems logical that a particular step precede another, it is clearly delineated. However, a number of these activities can occur simultaneously.

- **Define core values and a vision** that aligns the business incentives with those of the front-line pharmacist to make this transition.
- **Define services.** Standardize protocols for medication therapy management (MTM) services. Then communicate the standards to payers so they know what they are buying.
- **Define roles.** Make them transparent to the customer. Look at dentistry, where there is a clear and consistent service model and clear role definitions for different professionals. Consider standardized uniforms that distinguish each professional.
- **Identify and document success.** Develop an ongoing process to review and collect data on MTM under Medicare Part D, in Medicaid, and in private systems. Track experience and cost savings documented in other settings where pharmacists have more clinical roles. Look for evidence of replicability and publicize findings.
- **Design a robust longitudinal study.** To date, there have been few objective, robust studies to demonstrate the value of pharmacist services.
- **Show the industry is “walking the walk.”** If the industry believes what it is promoting, companies should pay for these services in benefit designs *and* promote them to employees; in other words, pilot pharmaceutical care services internally to build demonstration projects.
- **Explore the concept of the midlevel “pharmacy educator.”** There is broad agreement that some counseling services could be performed at lower cost by someone with less technical knowledge than a PharmD but with excellent communication skills. Identify potential barriers (e.g., regulatory). Perform cost-benefit analysis of resulting operational efficiencies.
- **Identify and develop legislative, regulatory, and administrative law strategies** at the state and federal levels that will bring the issue into the forefront and enable change.

- **Develop a toolkit** to “sell” internally: Show long-term return on investment; expected outcomes; and what is operating in the external environment that is supportive.

Action Steps for Individual Companies

Focus on segmentation of goals and delineation of services based on chosen business model.

Though detailed recommendations for business and practice models for individual companies or industry subsectors are beyond the scope of this project, certain steps are generally applicable to any company that chooses to make a strategic investment in pharmacy services:

- Commit to taking the risk and making the investment.
- Survey your customers. Find out what people want but are not getting to clarify how to add value. Drill down past the top cut on satisfaction.
- Clearly define the services to be offered.
- Go for quick wins first, by getting into a service that is currently being reimbursed, such as immunizations or MTM, with a goal of breaking even.
- Ensure that customers know who the “person in the white coat” really is.
- Assess the workforce to optimize manpower. MTM will require the pharmacist to move some time from dispensing to consulting. Evaluate your current staffing levels and determine if pharmacist dispensing can be made more efficient through increased use of technicians, insurance clerks, automated dispensing systems, and central fill.
- Assess the local environment. Who is doing something currently that might be built upon? Where are the high-impact opportunities and relevant partners? Proactively work to build the necessary relationships.
- Reach out to local physician groups and show them how pharmacy services can make their life easier and improve patient outcomes.
- Tie the business model to existing programs such as disease management to appeal to employers.
- Form alliances with healthcare-coverage-related service providers (e.g., brokers, consultants, third-party administrators, insurers) to build a sufficient customer base to make the service model financially viable.

- Develop collaborative projects/pilots at the local level to grow the databank on value demonstration. Create internal teams with clinical and operations representatives to execute the pilot.
- Create an image of health in the stores with a medically oriented environment. Have professional staff in the aisles to provide information to customers.
- Look for ways to leverage information technology. Set up automatic mail or e-mail reminders for services that consumers want and physicians won't object to pharmacies providing.
- Create mini personal health records with pharmacy data and labs.
- Look for ways to leverage the strengths of the retail and mail-order environments.
- Develop and market the service plan.
- Consider whether the pharmacy is currently giving away something that others might pay for.

In conclusion, research we conducted as part of this project shows that various stakeholders recognize that community pharmacists can enhance patient care and outcomes and decrease healthcare costs. Payers are willing to compensate pharmacist-provided services if community pharmacy can document and demonstrate their value. On the road to success as service providers, the industry must take the key step of changing the consumer experience by embracing the vision for a broader role in healthcare delivery, creating the necessary alliances, defining and developing the necessary demonstrations, and collecting and presenting results to payers.

Only then can the promise for the community pharmacy industry as a healthcare service provider be fulfilled.

Appendix A: Interview Questions

A. Current Role

1. (a) What do you see as the role of community pharmacists today?
(b) What do they do?
(c) How well do they do it?
2. Have you had any personal experiences you'd like to share?
3. What do you believe is the perception of your organization (sector) overall toward the role of community pharmacy?

B. Future Role

1. What is the optimum role for community pharmacy?
2. Do you think there is a role for community pharmacy to play in improving quality of patient care? In reducing costs? In improving access?
3. What types of services could/should pharmacists provide that they are not?
4. Do you think there is a role for community pharmacy to play in improving quality of patient care? In reducing costs? In improving access?
5. What types of services could/should pharmacists provide that they are not?
6. What would enable the uptake of such services?
7. What impedes acceptance?
8. Who would be supportive and why?
9. Who would be opposed and why? Do you see ways community pharmacists might help to achieve more focus on prevention? Competition and unique advantages?

C. Business Model

Currently the business model for community pharmacy is based on compensating pharmacists for filling prescriptions.

1. In your opinion, does this model promote or impede quality, cost-effective care?
2. What thoughts do you have about how to make a transition to payment for medication management services?

D. Employers/Payers

1. Does your benefit design encourage mail ordering of drugs?
2. Are there any incentives for medication adherence? If so, how is it measured?

3. What would have to happen for you to see enough value to pay pharmacists for cognitive services?
4. Do you currently have any such programs?

E. Consumers

1. In addition to filling your prescriptions, what services does your pharmacist provide to you? Which of these services are of greatest value?
2. What services would be most helpful for your pharmacist to provide that he or she may not provide today?
3. Does your health plan pay for additional pharmacy services?
4. If it does not, are there additional services you would like your pharmacist to provide that you would be willing to pay for?
5. How can community pharmacy improve the quality of patient care?

F. Summary

What is the biggest single change that community pharmacy could make that could bridge the gap from where you perceive it is today to your ideal view of where it could be in the future?

Appendix B: Telephone Interviews

Note: The names of interviewees have been removed in the interest of confidentiality, although organizations are identified. In addition, there has been minor editing of the interview transcript.

Payers (Health Plans)

CIGNA

XX is in charge of clinical pharmacy programs and the Gaps in Care Program. He feels pharmacy plays a central role in identifying and resolving errors, gaps, and omissions in care. He wants to find ways to improve communication with pharmacists. CIGNA is still in the design phase of the program and is currently focused on communications with physicians, after which it will move on to communication with patients, so pharmacists are down the road. Most conversations with pharmacies to date have been limited to chain headquarters.

He stresses the need to segment members by risk. CIGNA is currently using such segmentation for specialty pharmacy members. The effort relies on telephone communication by RNs and LPNs with specialty pharmacy members.

Cigna is currently using its own pharmacists to do Medicare Part D medication therapy management (MTM) counseling, and has had good success. However, he feels some members would do even better with face-to-face counseling.

We discussed the importance of identifying specific barriers to compliance/adherence and tailoring interventions to address those barriers. XX suggests we need “shareware” surveys to assess barriers; then competition can focus on the best method of addressing those barriers and link to solutions.

Anthem/WellPoint

There have been few conversations recently about this topic, either at WellPoint or with the Federal Employees Health Benefits Plan. WellPoint is focusing on price negotiation as it puts together its pharmacy network. The main areas of negotiation relate to rebates and discount off average wholesale price. There is also a focus on cost-share models in benefit design to encourage use of generics.

There is some increased interest of late on patient safety initiatives, as well as on strategies to match members with the right economic product. For example, if two or three brands could treat a particular condition equally well, has the physician taken price and convenience into account in prescribing?

What would induce payers to reimburse for MTM and other such services? XX points out that payers hear a lot about cost/benefit trade-offs, but the data are usually “soft and mushy.” He believes that community pharmacists will need to show payers that their

counseling will create a level of compliance that would not occur otherwise. He feels there should ideally be demonstration of cost-benefit and better patient outcomes.

Pricing models have focused on capturing a percentage of the “save.” If a patient is taking meds regularly and this keeps him or her out of the emergency room or even doctor’s office, then the provider of the adherence service charges 25% of the save. But estimating cost savings in a cost environment that is growing is problematic. It is also challenging to estimate the value of something that doesn’t happen.

Whether one looks at pharmacy benefit managers or health plans, or integrated systems like WellPoint, there is evidence of more direct outreach to members. XX acknowledges that face-to-face may have an advantage over mail reminders or telephone counseling for a percentage of members. But the real question is, Are pharmacists the most cost-effective means of providing face-to-face counseling services? Probably not; however, their expertise is needed for the initial clinical consult.

XX thinks we’ve come full circle with the threat to MDs from Minute Clinics and the like.

Also, we really should think of the value proposition from the patient’s perspective. This is a great issue to work in the current consumer-driven healthcare environment. What if the insurer is not involved? Would a patient in a plan with a substantial deductible pay a set fee per month to work with a pharmacist to help manage his or her multiple meds and chronic diseases?

Maybe the concept should be to package and retail value-added services, not pills, to consumer–patients.

Deseret Mutual Benefit Administrators

“I would be happy to visit with you. I have long thought that there is significant opportunity to expand the role of pharmacists as healthcare professionals.”

XX is most interested in “disruptive technologies” in health care, which he points out are very controversial. He will be meeting with Clayton Christensen at Harvard Business School along with others interested in finding ways to apply concepts of disruptive technologies to health care.

Years ago when he was in public health he approached the Utah Medical Society with the notion that there were cheaper and more efficient ways to provide simple straightforward health service than by using MDs. Of course, as he points out, physicians always talk about the problem with continuity of care and cite “risks” if nonphysicians make medical decisions.

He feels concepts like Minute Clinics can fill a much-needed space in health care, especially for indigent or uninsured patients.

He gives the example of treatment for a sore throat to argue that a pharmacist, working with a lab, could provide more efficient, more cost-effective, and perhaps even better care, given pharmacists' greater general knowledge of what is going on in the Rx world.

The shortage of primary care MDs, as well as a desire of all health professionals to be challenged, may mean that any resistance from physicians will lessen over time.

He thinks the ideal would be some type of structure that links physicians and pharmacists with a lab, and believes this would result in significant improvement in quality of care and probably patient satisfaction.

We also talked about the trend for some specialists (e.g., oncologists, immunologists) to administer very high cost pharmaceuticals and biologicals in their office in order to have another source of income (frequently the doctor marks the drug up three to four times his or her cost). Many plans are moving to specialty pharmacies to address this problem. Pharmacists in these settings have a very clinical role, interfacing between patients and physicians.

From a personal perspective, XX sees retail pharmacists doing what their employer, the chains, and so on pay them to do—put pills in bottles, get scripts out the door. He says his wife has experienced interactions during which she had the desire to sit down and learn more about the drugs the physician was dispensing to her or her kids, and the pharmacist seemed eager to do so. But time, lack of proper facilities and the fact that the employer does not compensate the pharmacist for counseling precluded meaningful interaction.

Kaiser

XX thinks Kaiser in California may be more impressive than it is in Colorado. Characteristics include collegiality, evidence-based practice, and partnerships between pharmacist and physician, enabled by technology.

The major barrier in general is resentment on the part of physicians if anyone comes between them and their patients.

Experience from Congressional Budget Office days: During early 1990s reform efforts and as part of Medicare legislation, XX talked about reimbursing pharmacists for these types of services. The reaction was general skepticism: Pharmacists want to inject a “new transaction” into health care and get paid for it. How do we verify what was done? How do we determine how much advice is needed? What about quality control? Is the manpower there to do this?

Kaiser and Mayo feel that an academic background is needed; in other words, what is needed are relatively recent grads who are clinically current enough, not older pharmacists whose training is not current and who would need significant updating.

Look for low-hanging fruit. Get patients who don't need it off their polypharmacy. But under the current reimbursement mechanism pharmacists don't have any incentive to limit drugs—just the opposite! Adherence is definitely low-hanging fruit.

We need to explicitly define what services we are talking about.

Currently all Centers for Medicare & Medicaid Services energy is focused on *not* reimbursing new services; rather, they farm out decisions to the private sector.

Scott & White Health Plans

Scott & White (S&W) has a chain of nine pharmacies in central Texas and has a pharmacy benefit manager. A new pharmacy is currently being built with two counseling rooms for chronically ill patients. As a vertically integrated organization, S&W can do things others would find difficult.

XX believes that pharmacists are quite clinical and function “below pay grade” in retail environments. In light of the shortage, pharmacists are hard to retain in an “Rx mill.” In the S&W environment, they have the opportunity to use their clinical skills.

S&W has a pharmacy residency in conjunction with the University of Texas. New grads are eager to do clinical work. S&W employs such new grads, as well as more seasoned pharmacists, many of whom have been with the system a long time.

Medication therapy management was introduced for Part D. Also, a pharmacist connected to the internal medicine practice sees diabetic patients in the pharmacy who participate in a program in which they are counseled monthly. As an incentive, the copay for some of their meds is waived. The primary reason a patient may decline is logistical—the burden of having to travel up to an hour to be seen every month.

Patients who have participated in the program were found to have an average 0.6% decline in Hgb A1c after 6 months, as well as improved compliance with meds and self-care.

When the program started the physicians were skeptical of its success as many of these patients had multiple problems, including obesity. But the physicians didn't have the time (or perhaps the skills) to counsel effectively. Now most are very enthusiastic.

S&W also calls new plan members to discuss ways to optimize their benefit and to decrease their costs. At the same time, preventive guidelines are also looked at and reminders given to those due for a screening.

Traditional disease management does not work very well, because to be effective coordination is needed at every contact. S&W is working to integrate community resources, such as Meals-on-Wheels, that see patients where they live. That environment has a tremendous impact on an individual's health and frequently providers

are not aware of circumstances or conditions that may have a negative impact on health. "We need to break the problem into small pieces."

He views the trend of nurse practitioners and physician assistants running clinics in a retail setting as parallel to the newer roles for pharmacists.

Lots of opportunities are coming down the pike, if pharmacy can take advantage of them. In the old days people got a different level of service from their community pharmacist, and we may be seeing a movement back to the future.

Wells Fargo Insurance Services of Virginia, Inc.

XX feels people need to have skin in the game for the market to work. He and his partner are in self-funded plan administration. His clients are autonomous, so they can decide to do something and see the return. He is knowledgeable about Asheville because a large client there introduced him to the project.

The head of the Virginia Pharmacy Association was helpful in getting him an audience with pharmacists, some of whom might not otherwise have been interested in the opportunity to work with his company.

He has several other small clients that are implementing similar strategies, mostly around diabetes. Many have blue-collar workers. One client has retirees. Many of the workforces are aging.

Nurse practitioner on-site models are popular, and they can include a pharmacist role. Raw data show major improvement in the number of employees taking medications and in performing testing. Both employer and employees are pleased. People see value in employers offering this benefit.

Pharmacists are paid for their time. He says he is fine doing this, as otherwise he would pay the nurse practitioner. The number of visits averages about four per year but the plan is tailored to need.

He thinks unions are a good entry point to talk about pharmacist models.

He mentions a National Public Radio program out of Chapel Hill called People's Pharmacy.

American Healthcare is a company outside Sacramento that he works with. American Healthcare started out working with independent physician practices who were taking on full risk, helping them to manage drug costs. Many preferred lists were based on manufacturers' drug lists.

Mail order inhibits monitoring. We need to mix medical and pharmacy data and look at costs across silos. Carriers today are merging data. Money needs to be spent on chronically ill patients to save money.

He is trying to get employers to realize that just looking for discounts does not necessarily result in cost savings.

He started trying to build data-mining capability in 2002. Now he is trying to beef up his company's third-party administrators' capability. He would like to be able to better track data and find people not meeting quality criteria, but doing so is expensive. His company might try to get an intern from Virginia Commonwealth University, or apply for a grant.

Presbyterian Health Plan

Presbyterian is a large integrated delivery system in Albuquerque, New Mexico, with 500 employed physicians. It is ranked among the top 10 integrated delivery systems in the country. It contracts with nearly all the remaining 2,000 physicians in the state.

It has a robust pay-for-performance initiative, and all strategies are tied to it. It paid out \$14 million in a very small state. He feels aligned incentives among physicians, pharmacists, and other providers are critical, as are effective partnerships.

Presby has been providing medication therapy management (MTM) to high-risk seniors (5+ meds, 2 or more of the top 5 comorbid conditions, >\$3,000/yr on meds) since about 1993. Prior to Part D, Medicare Advantage had no funding for a pharmacy benefit. The service has been provided by pharm clinicians employed by the system who are licensed in New Mexico as midlevel practitioners who can prescribe under protocol. These individuals, in addition to PharmD training, have completed clinical assessment courses, have more than 300 hours of direct patient care, and are sponsored by physicians. (He thinks either South Carolina or North Carolina also licenses this professional and this year three or four other state legislatures were looking at the issue.) The pharm clinicians see patients on a schedule and have access to the same medical records and infrastructure that the physicians do. Physicians have aligned incentives and are required to support the MTM programs. They will also be required to use e-prescribing when instituted.

Now they have also begun contracting with pharm clinicians in the community for their own office practices, not in retail settings. These services are billed through the medical, rather than pharmacy, benefit.

He is familiar with Asheville and supports the involvement of retail pharmacies. He wrote an expansion of the program into this year's Quality Improvement Program, whereby retail pharmacies will provide another layer to Presby's MTM program. This service will be available to non-Medicare patients with chronic disease, such as diabetes, or polynarcotic use. The intent is that pharm clinicians can refer patients for more frequent monitoring and adherence management to the retail pharmacy, and the retail pharmacist can refer patients needing more intensive evaluation/counseling to the pharm clinician or physician, both of whom have access to more clinical and lab data.

Retail clinics can also be reimbursed for immunizations, smoking cessation counseling, and, if the pharmacist is a certified educator in a disease state, case management/education.

Presby is currently in the process of developing the plan to build the network. XX is working with four pharm clinicians, who have provided these services for 15 years, to design the programs and build the network. Presby may initially assign patients to a community pharmacy. All community pharmacists will be eligible to participate under contract amendments, providing that they meet Presby's requirements, including data capture and outcomes tracking. Presby does not want to reimburse for scattershot services with no measurement. It would like to have some of the contracts in place by the end of the year.

XX feels that pharmacists are underutilized in the retail setting, but their services need to be aligned with those of physicians. He is not very optimistic about the value of the link with retail clinics, as he believes that physicians do not have faith in that model, and physicians are key to success. Common incentives are needed for physicians and pharmacists. Though MDs in integrated systems and hospitals view pharmacists as part of the care team, with the same commitment to patient care, they do not, in general, view retail pharmacists as having the same vested interest in their patients. E-prescribing will help accomplish the necessary apparent alignment.

XX does not think Presby's program (large system with a lot of clout in a small state) is reproducible across the country. He thinks a lot of creativity and lots of models will be needed.

He has written a chapter on managed care pharmacy that will appear in Aspen Publishers' managed care books and in the textbook used on this topic at pharmacy schools. He is presenting this weekend at the New Mexico Pharmaceutical Association meeting and will announce the expansion of Presby's MTM program to the retail community.

USAA

USAA, a mutual (private) insurance company owned by its members, truly believes in investing in employees, and in answering the question, "What do we have to do to take care of this population?" The company has around 21,000 active employees and dependents: 62% are female, the average age is 38, and the average length of service is 5 years. USAA has a very rich benefit plan, including retiree health benefits.

XX thinks more employers would recognize the value of investing in employees if they treated employees as fixed, not variable, assets.

USAA employees appreciate the supportive culture and their appreciation is reflected in their attitudes at work. The company received the *Business Week* customer service award this year. The USAA Take Care of Your Health Program won the Koop Award in 2006.

The company's general pharmacy strategy includes an open formulary with incentives for generics and use of mail order (it is moving to a single copay for 3 months of meds). It views filling scripts as strictly a commodity business and wants to dispense at the lowest possible cost.

A parallel strategy involves the use of an onsite pharmacist, with a separate counseling room, at the San Antonio headquarters (12,000 employees), with plans for part-time pharmacists at Phoenix (3,000 employees) and Tampa (2,000 employees). Humana, the third-party administrator for the self-insured plan, staffs the pharmacy.

USAA has a sophisticated data warehouse that has shown that 2.5% of the population is responsible for 40% of claims, much of the excess being attributable to excess drugs. Their voluntary Individual Health Management Program targets the top 40% of the population in healthcare expenses by offering telephone counseling by advanced practice nurses, supported by a PharmD. The participants are solicited by invitation from Humana. He notes that as soon as people go through their stop loss, consumption skyrockets.

XX does not feel optimistic that we can get to where we need to be in prevention and population health with the current system.

He does not feel that health plans provide good service to employers, most of whom do not have robust data warehouses. Healthcare cost drivers are too complicated for most employers to understand, and they should be able to expect a high level of customized service from health plans, with targeted programs to help control costs. USAA lets Humana do what it can, then provides programs itself to fill the gaps.

Mayo

Mayo Clinic Health Solutions is a for-profit subsidiary of the parent Mayo organization. This group provides health and support services to payers.

As we explored the idea of pharmacists serving as consultants, several issues were identified:

- Students who graduated after 1997 are better trained to consult with patients on drug therapy than are doctors. However, most pharmacists 2 to 3 years out of school never use this knowledge.
- Lack of compensation for consultations creates a barrier. The state of Minnesota launched an effort in April 2006 through Medicaid that pays for medication therapy management. It is very successful but metrics are immature at this point. The state has mandated the publication of these efforts.
- They recognize that integrated medical systems like Mayo can readily deploy the skills of pharmacists in a variety of ways, but that replication outside a closed system is challenging.
- They also pointed out the imperative that pharmacists must be trained to do MTM for it to be successful.

- Another model in which pharmacists' consulting skills are deployed is in Mayo's 13-story residential high-rise. Here retired Mayo employees receive routine counseling within the building.

A tool is available that can help sort patients who would benefit from MTM. CommunitycareRx has developed a product sold to third-party payers that flags for the pharmacist those patients who will likely benefit from drug therapy.

Community First Health Plans

Counseling is the "oath" of the pharmacy profession. However, the retail model does not accommodate it. XX recognizes that Part D Medicare is paying for medication therapy management counseling, but she is very concerned about billing practices. She recognizes that the dispensing fee in part covers counseling.

But what constitutes counseling? How do you prove value? She feels pharmacists need to start by demonstrating their value to other healthcare professionals. When pharmacists are in a clinical setting, they have the opportunity to demonstrate their skills when making rounds with their counterparts as a team of caregivers.

With regard to convenient care services like Minute Clinics, XX points out that pharmacists are well trained and of a higher level than nurses and are ready to take on this role.

The current information technology system in pharmacies has flagging capability but a move to a medical management system would flag better.

Providence Health Plans

XX is a veteran PharmD, formerly having worked for Kaiser. She observes that the greatest barrier for advancing the role of community pharmacists and receiving reimbursement from payers is lack of a partnership with physicians. The industry needs to demonstrate its value to sell its services.

She thinks the business of pharmacy is also a barrier to successful transition. Pharmacy has become a commodity versus a service-of-care provision. "When you go to a grocery store, you are thinking about groceries, not pharmacy services." There is not enough financial remuneration at this time to support additional services.

Another barrier is lack of access to medical records. Electronic medical record and pharmacy systems are not integrated, especially in retail and community pharmacy.

She observes that there is a need for drug cost transparency.

She believes the best and first opportunity to see transitional change in pharmacy is in long-term care.

As a plan operator, she says, “I will pay more to pharmacists willing to work with me to meet my needs.”

Academy of Managed Care Pharmacy

XX sees “unbridled opportunity” with medication therapy management (MTM) enhanced by Part D. MTM could foster productive relationships between managed care organizations (MCOs) and retail pharmacies and offset the “unholy alliance” necessitated by the need for contracting but fraught with antagonism. Retail realizes it needs to have a relationship with the MCOs to serve a large segment of the population. To date, the emphasis has been on bottom-line interests, that is, negotiations focused on discounts on the average wholesale price, with associated ratcheting down that creates animosity. But MTM is changing the dynamics. Both parties need to step back to appreciate that there is a different dimension to the contractual relationship, one that focuses on better care and health outcomes for the patient. The independents seem to be in the lead in recognizing that MCOs may be interested in better care.

But it is a hard sell. “If I am going to invest as a business, I need to believe that it will have a cost offset, a payoff.”

She is very cynical about benefit consultants, and points out that a more coordinated approach to benefit design is needed. A recent study looked at the relative cost of the pharmacy benefit in two large plans, comparing mail order versus retail. Retail actually had a cost advantage for the plan sponsor (employer) but mail order had an advantage for the member, because of the benefit design.

She agrees that for counseling a PharmD is not needed; instead, someone with less technical knowledge but excellent communication skills would do a better job at a lower cost.

XX is concerned for the profession, if pharmacists do not step up and take advantage of the opportunities. Her members cannot get retail pharmacists, or their employers, to actively support MTM.

Recently pharmacists have been edged out, after many years, as the most trusted health professional by nurses. And nurses will offer significant competition to pharmacists, if they don’t “get their act together.”

The older, classic pharmacy window is the archetype of retail pharmacy. There is little direct contact with the pharmacist behind the bulletproof glass. The industry must change this image.

Payers (Employers)

Emerson Electric

Emerson has 135,000 employees, of which 60,000 to 70,000 are in North America. It also has self-funded plans for salaried employees in Mexico, but little involvement in Europe.

XX perceives pharmacists as being highly paid, well-educated professionals who should not be used to count pills. He believes they could be much better utilized, and points out he is personally unclear when he goes into a pharmacy who the people in the white coats are.

He is strongly supportive of the nurse practitioner convenience clinic set-up, and thinks many people would love to go into a popular chain pharmacy for minor health problems and would pay directly. He is not concerned at all about clinics overstepping appropriate bounds, as their lawyers will make sure that doesn't happen. He thinks that physicians are too busy and "important" to be bothered for minor problems and doesn't think they are very concerned about them anyway. Furthermore, people can't get in for 3 days.

He is not concerned that some say the pharmacist's desire to get more involved in health care is underscored by the desire to make more money, as clearly all businesses and professionals have a similar desire.

If we truly cared about high-quality, high-value care, then plans and primary care physicians should have been managing specialists and hospitals—but that is not what happened.

His operation is not centralized; rather, it is strung out. A large concentration of plan beneficiaries numbers only about 500. The company looks to the health plan for recommendations on disease management, but the plan is not doing a lot. He does not personally feel expert in the disease management arena at all, and has never heard of the Asheville model.

However, he thinks it makes logical sense that pharmacists could help patients with a specific disease, such as diabetes, to better manage their health. He feels that if a pharmacy chain came to him with a proposal with a modest cost attached, he would seriously consider the program as the right thing to do. He would not demand that a definitive return on investment be demonstrated, as he is cynical about attempts to measure cost avoidance.

As in any transaction, it is important to know who the seller works for. The pharmacy benefit managers became part of the fabric of the benefit chain, but they may not have incentives that are aligned with the employer or the employee.

He points out that somebody needs to create a differentiated, value-added service model worth paying for. He thinks in most cases it makes more sense for pharmacies to

go to the plans, not employers, to sell these services. Some health plans might “get it” themselves, especially if they have enlightened employer customers. (However, we can’t forget that 85% of employers just want to buy the insurance and forget it.) On the other hand, few plans sell on the point that a service is the right thing to do. They do not realize that many employers really want their employees to like them and feel good about what they offer.

The pharmacy might go directly to a forward-thinking company that purchases more on intuition than data to make its case. A simple, straightforward proposal is best.

He likes the idea of offering a medication review for patients, as he does not think this is done by physicians, and physicians don’t seem concerned. This review should also help the patient get the most from benefit dollars by recommending less expensive meds that work as well. He questions whether this might fly in the face of incentives in a product-oriented model in which the pharmacist makes more on more expensive product. He is intrigued by the notion of the pharmacy not owning the drug. He points out that when Emerson switched PBMs, he started seeing incentives for higher priced drugs.

He notes that the perception that all pharmacists and front-line staff are not equally well trained in customer service is exacerbated by the confusion and antagonism surrounding numerous complex benefit plans that the pharmacist and patient together must negotiate. He suggests the staff could benefit from customer service training.

Dow Chemical

Dow is not doing a lot related to plan design. Rather, it follows the general recommendations of its plan administrator. The company’s greatest concerns are quality of care and patient safety issues overall. It is concerned about employees properly using medications to achieve benefits and minimizing adverse events and issues related to medications. To this end a number of efforts are under way. More than a year ago, Dow started promoting a new commercially available tool called RxWise and also negotiated a discount for the tool. It is a flash-drive or web-based tool that enables the user to assess any medication or combination of medications including prescription drugs, over-the-counter medications, botanical remedies, herbal remedies, and even food for potential consequences or interactions. It is a kind of drug use review effort put into the hands of the consumer. The tool is updated regularly from the provider so it does not become outdated as new meds or findings appear. Before releasing this tool to employees the corporate medical director met with physicians in Dow’s major communities to make sure they understood the tool and the company’s programs. It is hoped that in the future the tool will be more sophisticated and will actually add pharmacogenomic intelligence so it can be more personalized.

Dow is also providing employee education on wise use of medication as part of a series of modules called “Positive Action.” The modules are available as notebooks or online for employees and families.

Delphi (GM spinoff)

Delphi is the largest supplier of auto parts for the industry. XX says this issue in a nutshell boils down to cost. What value do pharmacists contribute in the near term, that is, next quarter? He points out that industry measures quarter to quarter, and benefit managers are looking to hold down healthcare costs only in the aggregate. That is how they are rewarded/bonused, not for better employee health. Their view of pharmacy is also tainted by their overall negative perception of pharma.

Asheville was effective, but why? Because of free meds? Because of the pharmacists? Because of other things provided? And they had to pay people!

Payers are trying to eliminate steps, not add them. They must demonstrate definitive return on investment, or this approach adds complexity and cost.

In the retail setting, costs are frequently higher than in mail order; this won't fly. The focus is on the product and its cost. Service may be of interest to some (perhaps unions, but they did not complain about the move to mail order).

He asks, To what degree do the retail pharmacies want to get involved in health care? Maybe better put, What is the vision for the future? Consider the Minute Clinics concept and ask, Who is competing with whom for what?

How do you create easy (seamless) access to pharmacists at no additional cost? He is not sure it can be done.

Primary care docs might consider adding a midlevel pharma educator to the office in order to compete for the additional reimbursement that will become available when medication therapy management (MTM) is mandated under Medicare Part D beginning with pilots in 2008.

He points out that public payers may be more willing to go this route, as their administrative costs of 6% to 7% are much lower than in the private sector.

The industry should be willing to invest in pilots to prove the value. Schools of pharmacy should be interested in doing this, though what is learned in the academic setting may not easily lend itself to replication.

The industry could try to make MTM a mandated provision of universal coverage, such as in Massachusetts.

He suggests we talk with banks who are trying to add value to their health savings accounts, such as Fifth Third, LaSalle, PNC, and Wachovia.

Benefits Consulting Attorney

The attorney provided the following written answers to the questions:

A. Current Role

1. (a) The role of community pharmacists today is to fill a niche as the big pharmacy-related groups go from huge to enormous.
(b) What they do is fill prescriptions on a more personalized basis with more individual service.
(c) They meet needs of people who want personal attention, who want pharmacists to know them and something about their prescription history.
2. I had a prescription for toothpaste filled at one of the huge pharmacy-related stores. When I went back for a refill, they had trouble finding any record; when they finally found it they had inaccurate information on the amount of prescription and whether I could renew once without obtaining another dentist prescription. After I switched to a local pharmacist, they maintained a record, were up-to-date on my renewals, and when they could not immediately fill the toothpaste prescription, arranged to mail it to me at no additional cost to me. I have never encountered service even approaching that at any of the biggies.

B. Future Role

1. The question is too vague in this context. I will take a stab at it with a limited understanding of what you are driving at. There likely is no role for community pharmacy as we know it today, or at best a limited niche role for the reasons discussed in the previous section, that is, to provide personalized service.
- 2-7. The answers are too interrelated to address in the format above. I will approach it a different way. Defining any future role of community pharmacy might be approached by looking at the future of health care. As health care goes, so goes pharmacy. Then, what are the gaps to be filled?

Big companies are merging or being acquired and becoming enormous companies. In the process they become less flexible, less maneuverable, and less willing to do custom work. That leaves a gap—or niche.

Health care generally is moving in the direction of alliances that naturally fit, such as imaging groups and neurosurgeons; hospitals and their own pharmacies; chain food stores and their own pharmacies along with home healthcare products; and primary care teams made up of physicians, nurses, physician assistants, psychologists, maybe dentists, and—maybe—pharmacists.

Drug purchasers such as self-funded group health plans are teaming with pharmacy benefit managers (PBMs) to obtain drug discounts. Smaller and insured group health plans operate almost exclusively through insurers who have alliances with PBMs. There is little opportunity for community pharmacists in the current, traditional role in this environment.

Concurrent is development of consumer-directed health care with more individual responsibility and introduction of disease and case management and other forms of

healthcare coaching to help individuals with prescription drug issues. While there is a role for pharmacists here, they will compete with the care and case managers and others who already have alliances and already are in place, that is, established—or at least way ahead of the game as far as pharmacists go.

What is the potential role, then, for community pharmacists? Put another way, where are the gaps in the prescription drug milieu that might be filled by pharmacists?

Consider what appears to be the environment. Individuals needing prescription drugs want

- Effective drugs;
- Safe drugs;
- Immediate access to and availability of drugs;
- Cheap or at least less expensive drugs;
- Someone else to pay for the drugs; and
- Someone to sue if things go wrong.

The list goes on, but this helps create a picture of the environment.

Politicians, particularly governors and mayors, are looking for political points and calling for or authorizing importation of prescription drugs. The market is calling for faster introduction of drugs. At the same time, the market wants safer drugs and faster and more effective drug testing. And, they want the drugs at less cost.

At the same time, the breadth of healthcare personnel who can prescribe drugs (a matter of state law) has broadened. It includes nurses in all states. Alternative medicine practitioners may be able to prescribe in some states. U.S. citizens now may travel to some other countries to obtain certain prescription drugs legal in those countries but not legal in the United States. And, those prescriptions may legally be reimbursed tax-free under the U.S. tax code. There is economic incentive to purchase and consume prescription drugs from outside the United States.

In this environment, the safety gap might be filled by community pharmacists. Post-Food and Drug Administration safety concerns and drug importation safety concerns create this gap.

Though nurses and alternative medicine practitioners, and likely many physicians, may know that a certain prescription is appropriate for a certain condition, can any of them assure the content of the prescription? More simply, do they know and, if so, understand and take the time to explain all the potentially realistic side effects? From experience, I know they do not. Though my experience is only anecdotal, I think it would be relatively safe to make some generalizations as to the scope of lack of knowledge or communication of side effects.

Thus, a consequence of these efforts to move/introduce drugs faster, through more conduits, and increasingly from outside sources is that safety looms as a major gap.

In addition to these forces creating the safety gap are the more normal ones already common, such as overprescribing, lack of coordination of prescribing, and lack of knowledge of medical history of the patient.

Can community pharmacists fill the gap in prescription safety?

If they can, other issues have to be addressed as indicated from the questions listed in this section:

- B6. What would enable uptake of such services might include awareness, recognition, and communication of the safety gap; maturation and spread of concepts underlying consumer-driven health care (CDHC); and appropriate alliances.
- B7. What would impede acceptance would include obfuscation, minimizing, or complete masking of the safety gap; cost; and lack of a bridge or relationship between the safety pharmacist and the prescription plan buyer (e.g., employer, insurer, PBM).
- B8. Healthcare payers—particularly both self-funded and insured employers, consumers, healthcare professionals, and policymakers—would be supportive. The payers, consumers, and healthcare professionals would be supportive for improved health outcomes, cost savings, and reduced medical errors and liability. Policymakers would be supportive for those reasons to the extent they could take credit.
- B9. Those opposed would be anyone generally who sees the cost of safety pharmacists as just another cost without substantiation of hard cost savings. Others whose prescription drug-related businesses would be harmed would be opposed.
- C1. By controlling substances you promote quality and cost-effective care. The real question is whether it is the most effective and efficient way, either under current circumstances or as they will be. The fact that community pharmacists as a group are shrinking suggests the model no longer is effective.
- C2. The services need to be expanded, and alliances need to be formed to build sufficient customer base to work financially. Because individuals want others to pay for all aspects of their health care, they expect their employer or other insurer to pay for such services. Consumers are not likely to pay for it except under the parameters of CDHC.

This leaves developing alliances with healthcare coverage-related service providers, such as brokers, consultants, third-party administrators, and insurers to include medication management service programs in the broad spectrum of healthcare-related services. Even then, these medication managers may need to form associations or partnerships among themselves to have bargaining clout with the payers.

AON

XX does a lot of work with employers and the value of pharmacist services is *not* on their radar screen. The entire concept of clinics or counseling is relatively new.

To make the pharmacist proposition appealing, the industry needs to tie the business model to existing health plan or employer programs. Also, to sell the idea it will be very important for the industry to be able to strongly make its case with measurable results. He recognizes the health improvement metric can be soft.

If a chain pharmacy goes to an employer and says it has a great program that tracks employees and provides counseling, the employer is going to route that chain pharmacy to the disease management firm to try to meld the efforts.

He suggests chains should consider the value in breaking even on the counseling proposition to season it with payers and demonstrate its utility/value. For payers to see value, it must be quantifiable.

On the direct-to-consumer idea, he envisions a baseline set of tests that could be offered, providing ease and convenience for the customer without the hassle frequently associated with going to the doctor's office.

He expresses concern that currently pharmacists do not have time for such activities.

Payers (Government)

Centers for Medicare & Medicaid Services

Healthcare spending will grow from \$2.1 trillion in 2006 to \$4.1 trillion in 2016 (from 16% of gross domestic product to 19.6%). The tsunami of 77 million baby boomers begins hitting 65 in 2011. Healthcare spending in this country is not sustainable.

In 2006, government spent 40% of the dollars spent in the United States on prescription drugs. Currently, the Centers for Medicare & Medicaid Services (CMS) spends more than \$1.6 billion per day, 365 days per year. Spending on Medicare alone will double to \$862.7 billion and will account for 20.9% of total healthcare spending in 2016. Overall message: Government health spending at its current pace is not sustainable.

Rx spending will average 8.6% growth over the next several years. Spending on brands will contribute to more of this percentage toward the end of the decade as fewer generics enter the market and higher spending continues on drugs targeting therapeutic categories (e.g., spending on diabetes products grew 15.5% in 2006). As overall spending on brand-name drugs and biologics increases, we can expect the scrutiny on this spending to increase as well. The current negotiations debate in Congress will not end this year. This is also fuel for the biologic similarity pathway debate.

For these reasons, CMS is trying to refocus all healthcare spending to be consumer-driven, value- and performance-based, evidence-based product preferences. The future

environment will demand a demonstration of value for payment. The days of paying set fees for more services will evaporate. Physicians and other institutional providers are seeing the beginning of the new environment. The more unnecessary spending we can eliminate, the more dollars will be available for cost-effective, high-value/high-yield treatments (i.e., prescription drugs).

Consumers will have to have more of a role in health care, but this transition will not be easy. Just 10% of overall healthcare spending goes to drugs, but payments for prescription drugs represented 20.4% or the largest share of out-of-pocket spending of all health services, and a recent PricewaterhouseCoopers survey found that two thirds of consumers estimate that between 40% and 79% of U.S. healthcare costs are attributable to prescription drugs.

Pharmacy must become a symbol of value, rather than a center of cost. Value won't be compensated on a per-unit basis; more than that must be coming from the pharmacy. We need to shift to a system that compensates the pharmacy for value delivered rather than the number of pills dispensed. We also need to realign the incentives in health care, especially in drug delivery.

Part D provides an opportunity to leverage the role of the pharmacist to be a pivotal player in healthcare delivery. Everyone thought pharmacy benefit managers would step up, but pharmacists played more of a role in assisting beneficiaries than anyone else did. He sees the success of Member Health and the merger of CVS and Caremark as portents of things to come.

The Pharmacy Quality Alliance is a great start in the effort to measure value, which must happen before it can be compensated.

Pharmacists clearly can play a greater role in prevention. Twenty-three percent of Medicare beneficiaries have five or more chronic conditions that account for 68 percent of Medicare spending. They see an average of 13 physicians. They get 50 prescriptions filled annually.

The December 2006 tax code changes made pharmacy, not physicians, the primary provider of vaccines under Part D. If a patient gets a vaccine at a physician's office, he or she has to submit a paper claim for reimbursement. But if the vaccination is done through a pharmacy, submission is electronic. Therefore, vaccine administration is a big opportunity but the chains may not see it. In 2008 Part D will pay for vaccine and administration. So pharmacy could be administration in and out of network. A call letter clarifying these details will be issued by CMS soon.

Pharmacists have also played a role in disaster planning and should recognize this role as an opportunity.

The business model for pharmacy is changing. Customer pressures will continue to drive change. New services will necessitate change. The key to success will be offering

a lower premium and higher value. Over the next few years Part D data will prove the value of pharmacy. There is a 2- to 3-year window to define who will seize the following new opportunities:

- Medication therapy management;
- Vaccines and administration fees; and
- Pilots and demonstrations.

The need for lower cost services will drive business to either a nurse or a pharmacist, whoever can best seize the opportunity.

The big question is, Can/will pharmacies support their pharmacists in a new way of delivering health care that is not product centered but rather patient centered?

Health and Human Services

XX asks, What is clinically and economically viable? Is it possible for pharmacists to offer a premier service to customers? He sees a possible parallel to Home Depot for those who do not want or need hand-holding but want a convenient source. Note: Home Depot drove the midlevel stores out of business.

What is it that people want but are not getting? The answer to this question will define how you add value. For example, when a customer comes into the pharmacy, the technology system could flag a particular health condition for the pharmacist. The pharmacist could then insert a flyer that offers the customer an opportunity to come in on Tuesday night for counseling or a seminar on lowering cholesterol, weight loss, diabetes, or smoking cessation. People may be more attracted to these services in a pharmacy setting than in a hospital.

Pharmacists have the asset of being in a better position to see people more often than the doctor does. How does the industry ride its advantages?

TRICARE

XX has a unique view of the proposition we posed about the role of pharmacist. He describes the environment, saying in the 19th century health care was home based. Relationships between physicians and pharmacists were fuzzier.

In the 20th century, the scientific tsunami hit, and it became intervention-based (not always of value) and about bricks and mortar. In the 21st century he sees consumers demanding convenience. In some ways he sees us going back to the future, enabled by technology that will permit cost-effective focus on population health. Health as it exists in the community (schools, workplaces) takes on a greater importance, as do lifestyle and prevention strategies. In this model a pharmacist can become more important.

Consumers don't see the world as being divided into professional silos. As people make more decisions about how to take care of themselves and choose to self-refer, they won't necessarily show up in the doctor's office. They may choose to download information and go to the pharmacist for assistance.

We may be able to sell an expanded role for pharmacists, but then different healthcare professionals in their silos will fight over a smaller total, creating a lose–lose situation. Pharmacists need to partner with others (especially physicians!) rather than try to compete.

The counseling function will be impeded by a lack of privacy. Some counseling may occur over the phone or via Internet. That way the patient picks the time and is ensured privacy.

In the Department of Defense and TRICARE he witnessed an important, strong role of a pharmacist in a team-focused model. He feels the value of pharmacists has been demonstrated there.

He observes that there are certain absolutes in the current environment. For example, government programs will continue to ratchet down costs. And private payers will do likewise.

He cautions against strategies that focus on short-term financing. He suggests a longer view focused on health. He believes there is a real bang in models that focus on health over dollars. But third-party payers are looking to transfer more and more costs. What does a consumer do without a third-party payer? The best bang for the buck for the consumer is not the same as for third-party payers. Consumers focus on time and location, as well as affordability. He says that compared with other providers, pharmacists are well positioned for consumers in the new models of healthcare delivery.

HRSA

XX points out that for the Health Resources and Services Administration (HRSA), the payer, when it comes to drugs at least, is the Centers for Medicare & Medicaid Services.

XX recommends we look at the Bureau of Primary Health Care's 340 B Program and familiarize ourselves with its provisions. Many centers use the program to provide drugs to patients. It is very cost-effective.

Each clinic decides for itself how to use pharmacists. For best practices, check with the National Association of Community Health Centers.

From personal experience, he sees pharmacists generating income for employers only by putting pills in bottles. They don't have time for anything else.

Payers (Consumers)

National Consumers League

The first concern raised is the need to have separate space for counseling in order to protect consumer's privacy. In XX's neighborhood near Dupont Circle, the traditional local pharmacies do not have such space. However, she points out that some chains

have developed a space in some locations. She says her husband, who is on many meds, sees a CVS pharmacist for counseling at a CVS center just down from the traditional CVS on 17th & P St. He says he values the face-to-face service.

On the other hand, XX gets her meds online because it is more convenient. She would need to perceive some definite value-added to take the time to go in and would not want to pay a premium.

Convenience is an important issue for consumers. She cites an independent community pharmacy with a little pharmacy located in the lobby of a big medical building at 2141 K St. as a real convenience, which is an advantage. She notes that retail pharmacy must create a new pharmacy experience to sell.

Though there are some numbers on cost reductions and quality improvements from preventing drug–drug interactions, she thinks the data will need to be much more robust for it to be appealing to employers like those of the National Business Group on Health.

She sees medication therapy management as very positive. Although she thinks that some people with good incomes might pay out of pocket for such services, she does not think lower income folks would consider it.

Providers

American College of Physicians

The American College of Physicians (ACP) supports pharmacist counseling, but has taken no position regarding payment for such services. ACP is also very supportive of electronic medical records and e-prescribing as a way to improve communication and patient safety.

ACP does have concerns about retail health clinics. It released a set of principles in January 2007:

- Retail health clinics should have a well-defined and limited scope of clinical services given the limited clinical services that can be provided in such settings. These services should also be consistent with state scope-of-practice laws.
- Retail health clinics should establish arrangements by which their healthcare practitioners have direct access to and supervision by physicians.
- Retail health clinics should use standardized medical protocols based on evidence-based practice guidelines.
- Retail health clinics should have a system in place so that information about the care provided is communicated to the patient's primary care physician and/or "medical home."
- Retail health clinics should have a referral system that sends a patient to physician practices or other entities appropriate to the patient's symptoms when they are beyond the clinic's scope of practice and/or to establish continuity of care where appropriate.

- Retail health clinics should provide for continuous coverage of patients during off hours, either directly or through arrangements with other practices in those cases in which such follow-up cannot be arranged with a personal physician with whom the patient already has an ongoing medical care relationship.

AMA/North Mississippi Medical Center

Twelve years ago XX worked with the University of Mississippi to build a model program with clinical pharmacists 24/7. A PharmD, whose salary he pays, works full-time in the clinic, assisted by two students. The PharmD does drug profiles—some Medicare patients are on 12 drugs—and makes rounds. There are group visits for diabetes and congestive heart failure patients. Clinical improvements have been measured. XX can't afford to do this in his private office, but would like to.

He has trained nurse practitioners and nurse midwives. He believes there is a need for all providers to be sensitive to convenience and affordability.

XX also provided the following written answers to the questions:

A. Current Role

1. (a) Filling scripts is the priority for most pharmacy businesses today. Community pharmacists spend the majority of their time dispensing and working with insurance companies to get approvals to fill prescriptions. Pharmacists are the healthcare professionals most accessible to patients for providing drug-related information, but have little time to perform these functions. Their role should be counseling, answering questions that will enhance adherence, and alleviating concerns about side effects to ensure that patients take their medications. If a health issue is identified, pharmacists should reconcile it with primary care physicians. They should also be the source of cost-effective recommendations to the physicians, as pharmacists are the drug experts, aware of costs, insurance coverage issues, drug interactions, allergies, and so on.
 (b) Medication therapy mediation: information and knowledge to the patient with dispensed product. Consultants between insurance companies and the physician. Dispensing and phone calls take up most of their time. Rx volume is emphasized more than is service.
 (c) Some provide medication therapy management (MTM) better than others do. Unfortunately, the pharmacy turns into a business instead of a service. Insurance issues and business decisions often prevent the pharmacist from providing the counseling patients deserve. Measurable value is the adherence to maintenance medications, little or no readmissions to hospitals, and cost efficiency for the patient.

B. Future Role

1. Combining clinical and cost-effectiveness in medication advice and counseling. Ensuring adherence to medication and resolving adherence issues related to cost, insurance coverage, complexity of medication regimen, and so on.

3. Skill (blood pressure monitoring, glucometer teaching, asthma counseling). More disease state management, adherence monitoring and counseling, drug therapy evaluation, and recommending changes to physicians that will be more cost-effective. Medication reconciliation is important when patients have changes in therapies.
6. Reimbursement for cognitive services (Medicare will recognize first- then third-party payers). Fewer dispensing disputes, which would free up time for these services. This would require state law and regulatory changes.
7. Recognition/incentives from third parties and pharmacist motivation to lobby for this recognition. State laws and regulations that focus on the dispensing function rather than cognitive skills. Businesses that focus on volume, not service.
8. Many physicians would be supportive because the healthcare continuum for their patients would be completed. Primary care physicians do an excellent job with diagnosis, but patients will have questions later. Pharmacists would have more time to teach about the meds and medication devices, goals of therapy, and importance of adherence. Patients will be supportive because of the potential to be better educated on their health and experience a higher quality of life. Some patients would welcome this more than others. It could be a choice that the patient could buy into. Cost-effective recommendations would be supported by the patient, insurance carrier, and the government. Businesses if it generates revenue and volume.
9. Other ancillary services (dietitians, therapists, nurse practitioners) may feel that they deserve reimbursement for services before the pharmacist. The federal government will have to realign budget priorities if it is to recognize and pay pharmacists for extra time spent with patients. Some physicians may still consider the pharmacists' role as dispensing only. Some patients would not want to pay extra for these services. If there is no reimbursement for cognitive services, businesses will not offer these services.

Do you see ways community pharmacists might help to achieve more focus on prevention? Disease state management, participating in case management, clinic atmosphere to really get to know patients' medical histories. Administering immunizations, smoking cessation programs, blood pressure/cholesterol screenings, and subsequent referral to physicians if appropriate.

Competition and unique advantages? Pharmacists are the drug experts. They are the most trusted professional. Not taking advantage of both of these aspects is a tragedy. Competitors would be the Internet, which provides easy access to drug information, cost, and so on.

C. Business Model

1. The business model is usually unacceptable, even for dispensing the meds. Dispensing fees are very low and barely allow for pharmacists to keep their doors open. Establishing rapport with MDs is hard enough, but if the time to make this

investment is not available, the pharmacist's future is dim. The low-priced generic programs have increased pharmacy shopping, which increases the likelihood of dangerous drug interactions, duplications, and so on. Quality of care is improved if patients understand and adhere to therapy. A pharmacist is in a unique position to address both quality of care and adherence. Coordination of care is paramount, and all involved parties should have immediate access to changes in medical conditions and medication regimens to prevent adverse consequences and higher costs.

2. Collect data. Submit data to the Centers for Medicare & Medicaid Services (CMS). Have the American Medical Association and CMS support this reimbursement. Show proof that without pharmacist teaching and participation with patients, healthcare funding is chasing its own tail. The initial spending would decrease future spending.

San Ysidro Health Center

Supply is not keeping up with demand, especially in rural areas. The clinic had trouble recruiting, especially because it needs bilingual pharmacists. It has to pay around \$100,000 in the San Diego area (around \$50/hr.). XX does not think Medicare Part D, which will pay \$15/patient, will compensate for the time trade-off for counseling one patient versus getting a certain number of scripts out, even if just 5 minutes is spent per patient.

State Boards of Pharmacy require that patients be given the opportunity to ask questions and require that the counseling be provided by a licensed pharmacist, not a pharm tech or some type of midlevel. But he says you run up against the quality silos—or at least that is given as the rationale for not permitting others to perform these tasks.

In the retail setting 30% to 40% of patients pass on the opportunity for counseling because they are in a hurry or because of language or literacy barriers. There also is little time as pharmacists are pushed to get scripts out. He acknowledges that his clinic doesn't do all they could, as they too have to get out 500 to 600 scripts a day with about 2.5 pharmacists.

He points to the problem of burnout in chains and thinks even in places like Kaiser where they have much better integration of care, pharmacists still have to juggle dispensing and counseling services.

Retail pharmacy's business model is totally volume and profit (margin) driven. If retail pharmacy were really community-focused it would be concerned about other issues, such as manpower, service, diversity, and collaboration. That would help it change its image with the public. XX feels there was no collaborative effort with community pharmacy when it came to implementing Medicare Part D.

The public never hears about retail pharmacy outside of a business context. Pharmacies are not seen making nonbusiness contributions to the community. Retail pharmacy could provide scholarships, mentorships, and so on, if it cared about its

community and manpower shortages. It should fund pilots and demos and step up to the “community plate.” It can help health centers and create scholarships to encourage bright students to go into pharmacy.

San Diego recently built both a pharmacy and a business school. Local business got behind the business schools to make sure they attracted bright young minorities from the community. No one came to the aid of the pharmacy school to help it recruit.

Pharmacies also could be supporting changes in licensing and scope of practice to allow creation of a midlevel position within the industry that would help alleviate some of these problems and make it more feasible to provide more services. In California this is just what dentistry has done. An “extended dental functionary” is an assistant to the dentist, not a dental hygienist. There are specific training and state certification requirements.

XX thinks the traditional dispensing model is not the way to go. The squeeze on reimbursement from payers (plans, employers, pharmacy benefit managers) will only continue to get worse. The industry should get on the population health bandwagon, focusing on disease management and chronic care. He points out that the Institute for the Future in San Francisco has talked about a community-based expanded model of care, in which the physician works with a team of professionals and community resources to manage the health of the population.

XX thinks folks like Kaiser have “the biggest dog in the hunt.” It, as a payer for the group’s health, will benefit.

Tutwiler Clinic, Mississippi

In the clinic, a nurse goes through the patient’s meds with the patient. XX feels an LPN with good communication skills could educate patients, but the state requires a PharmD, which is not very cost-effective.

To provide for her indigent patients, XX accesses all the free drug programs run by the pharma companies. Sometimes she buys the drugs herself and gives them to the patients.

In the hospital a retired pharmacist is paid to go through charts to make sure patients’ lab values are compatible with the dosage of meds prescribed.

Many patients see many physicians and frequently the doctors don’t know everything prescribed. Medicaid provided a Palm with every patient’s information, including all the physicians the patient has seen, the meds prescribed, where the patient got them, and how many pills were prescribed. She discovered that in order to get three filling fees, some pharmacists provided only a 30-day supply when the patient was eligible for 90 days. On the other hand, she points out some pharmacists have been willing to open in the middle of the night to fill a script.

XX does not think pharmacists should look to education as a way to make money in their stores. She also thinks the notion of a midlevel practitioner (pharm educator) has great merit. She also points out that pharmacists need to let the physician know if a patient is not filling scripts.

XX believes the notion of eyes and ears in the community can be helpful in ensuring better care, but there are challenges. Suspicion, language, and cultural barriers all have to be overcome. Who can best do this?

Lahey Clinic

Lahey now has clinical pharmacists in the internal medicine practice. They carefully review meds against lab values. Lahey can't hire enough, so would be very supportive of partnerships with pharmacists in retail stores in the community.

XX suggests that pharmacies could hook up with clinics/practices like Lahey and create an electronic consult sheet. This front-end function would need the competencies of a PharmD, but would be very helpful to physicians. Pharmacists could send comments back to the physician electronically. There is no competition here and it would definitely improve continuity of care. However, he does not believe that retail pharmacies will be able to hook up with these multispecialty practices without it costing them.

Retail pharmacies could start small with a subset of patients with a particular disease or those on multiple meds.

He thinks this approach might help the retail pharmacies to recruit (and perhaps pay less) because many pharmacists don't want to work in "Rx mills" and would enjoy this clinical component.

XX also sees great potential for retail pharmacies to provide services on the back end, focused on counseling, education, and medication adherence. Electronic connectivity through a simple software package to link communications—patient, pharmacist, physician—would be very useful.

He thinks this person does not need to be a PharmD; in fact, it may be better to have someone who can relate to specific patient groups and has excellent counseling and education skills. It would be less expensive to use retired nurses or other health professionals. They could work part-time, sometimes from the pharmacy, sometimes via telephone or the Internet. There would need to be a conscious focus on privacy issues and cultural competency.

Though at Lahey and similar clinics, good information about the cost of different drug brands is readily available, many practitioners do not have access to such information.

XX points out that with the commoditization of health care and better information, people will just want the lowest price and will be able to bid for it.

Changes in health care and access to new information is creating more competitors. For example, Lahey wants access to all the prescriptions that a patient is on, as well as over-the-counter and herbal remedies. It has an agreement with two health plans to get this information. But some entities, such as Per-Se, owned by McKesson, want to charge a set fee per patient to provide this info.

The retail pharmacies will have to prove that they can provide a valuable service at the lowest cost. How important is branding/customer loyalty to them? He believes that if a physician were to tell his or her patient to go into a local chain pharmacy to get counseling, the patient would do so. The pharmacy should include consultation plus coordination of meds. XX thinks some patients would pay a fee for this for themselves or perhaps for an elderly parent.

Strauss Surgical Group

XX is a big advocate of team-based models of care and recognizes the underutilization of pharmacists. He points out the importance of proper training for counseling/drug therapy.

He also stresses the value of piloting and demonstrating the added value of the pharmacist. He believes the pharmacist needs to show the payer and others how it looks in practice.

He has offered to pilot a counseling program in the hospital he is building in Chicago.

He will forward a recent position paper developed by the medical society. He also flags the importance of couching the idea as being nonthreatening to doctors. It is not about scope of practice.

Case Management Society of America

The Case Management Society of America (CMSA) has grown significantly in recent years and now has more than 10,000 members. Of these, 87% are in nursing; the next highest percentage is social workers. With the growing interest in collaborative practice models, some pharmacists and physicians have joined.

Recently, the organization has developed linkages with the National Association of Social Workers as well as the American Board of Quality Assurance and Utilization Review Physicians.

CMSA is also the project director for the new National Transitions of Care Coalition (www.ntocc.org). This coalition has several pharmacist organizations represented, including ASHP, AMCP, and ASCP, in addition to NQF, URAC, NBCH, AGS, and United Healthcare. CMSA intends in the future to add AARP, diversity groups, and others.

CMSA has been able to get the attention of some employers because of a belief that nonadherence issues (in either employees or family members) can impact productivity

and lost work time. There is a perception that some employers are much more aggressively pushing plans to ensure the employer is getting the results it expects in terms of better health.

Many consumer coalitions are also more actively trying to educate consumers about how to take better care of themselves, including how to interact with pharmacists regarding medications.

A lot is going on with pharmacy and case management currently. CMSA is training case managers and pharmacists on the use of adherence guidelines developed by CMSA. The guidelines are being used in collaborative practice models in hospitals, managed care, and employer settings. The programs are offered at no charge around the country, depending on funding support. CMSA will list on its website the plans offered as they become available for individuals to sign up. They are also offered at the annual conference and CMSA trainers can provide company training when requested. The courses can be taken online, though nonmembers pay a subscriber fee for the 24/7 e-library.

CMSA has also worked with Auburn University School of Pharmacy to create a collaborative training course on motivational interviewing for pharmacists and case managers. The first group trained included faculty from pharmacy schools, so that the skills could be taught to PharmD students. There are a number of pilots, mostly in hospital settings.

The next 2-day session is July 27–29. There are usually around 30 participants in each class. Some pharmacists are using the guidelines at the pharmacy window to promote improved patient adherence. At the CMSA Collaborative Practice Summit in October 2007 there will be a panel presentation by pharmacists and case managers who have these programs in place, focusing on the clinical and financial outcomes they are seeing.

CMSA is also actively working with the Society of Hospital Medicine on issues related to discharge planning.

Public Policy

National Health Policy Group (National Chronic Care Consortium)

The National Health Policy Group provided the following written answers to the questions:

Focus on high-risk group—fastest growing, highest cost, most vulnerable healthcare group. It's where most adverse drug events occur. Not that other issues or population segments are unimportant. It is just that this is where you can get some immediate payoff . . . greatest good for the effort.

Establish closely aligned relationships with the principal care physician, the one who is, or should be, primarily responsible for the ongoing management of care. This person does not always have to be the internal medicine or family practice physician, depending on the problem. The physician is the person that the patient sees as making the key health and treatment decisions—the person supplying the prescription.

Establish integrated pharmaceutical care methods. The National Chronic Care Consortium developed an integrated pharmaceutical care method and toolbox in collaboration with the National Pharmaceutical Council. Principles still apply.

The key to this is aligning relationships to monitor and manage the dispensing of drugs as a person's condition evolves over time and across care settings. All information should be in one place, connected with pharmacy and principal care physician. Focus on transitions between care settings, new prescriptions, change in level of care, and so on. That's where lots of unnecessary problems arise. Then streamline communication with the principal care physician, patient, and family caregiver. Set up triggers for intervention. Make sure the right drugs are taken at the right time, under the right condition. The pharmacist has a major role to play in the process.

With reference to how pharmacists might think about payment, given changing structures, pharmacists might consider identifying what they can do to control adverse drug events and share in the risk/rewards of capitation. Rather than make money on volume, they can make money on improving outcomes. They also might consider setting up family consultation service for a monthly fee. Families with complex problems would value having someone to call anytime to get good independent advice, comparable to the coaching role some physicians are looking at.

Pharmacists might also look at establishing a trigger for receiving a complexity-adjusted payment from Medicare for fee-for-service payment. When a person is prescribed a certain drug or a certain volume of drugs, it would trigger the need for a special pharmacy management approach and trigger a supplemental payment to a pharmacist with special expertise who would activate and manage the complex pharmacy intervention.

A complexity adjuster might be applied to a physician's overall payment when the physician provides evidence that a high percentage (to be defined) of his or her patients are high-risk Medicare and/or Medicaid beneficiaries, with *high risk* defined as people with late-stage chronic conditions, people with comorbid chronic illnesses, frail elders, adults or children with disabilities, or people using a certain type of drug or a certain number of drugs. They would also need to provide evidence that they are doing something important with the payment, like pharmacy oversight. The physician or clinic could then get a risk-adjusted payment (per member per month payment) for use in paying a pharmacist with a certain skill set to monitor medication, provide consultation, and so on.

Something like this might also be attached to a pharmacy benefit manager or a Medicare Advantage (MA) plan. Another way would be for Medicare to pay for pharmacist oversight under certain conditions as part of a care management benefit, linking it to a bill now running through Congress sponsored by the American Geriatric Society. It might also be done as a separate authorized benefit under fee-for-service, like what is being pursued for care management costs by the American Geriatrics Society. The first way is best, from a patient care perspective.

XX's group had demonstrated that the Centers for Medicare & Medicaid Services (CMS) were paying way too much for the lowest risk quartile and about 2.5 times too little for the highest risk quartile under MA. CMS demos focused on the high-risk frail population being cared for by special needs plans (SNPs), which accepted risk for all Medicare costs for the population. As part of the Medicare Modernization Act of 2003, these demos were allowed to move into the mainstream. Dual eligibles (which cost as much as all the rest of the Medicare population combined in total federal and state dollars) can participate.

In 2004, there were only 11 SNPs; in 2005, 136; and in 2006, 276; today, 476 are serving 1 million beneficiaries. A sunset provision for the SNPs was included in the legislation, in order to allow them to fly under the radar screen, as otherwise the projected cost would be enormous. However, they are lobbying for a 3-year extension.

A SNP Alliance was created. Participation is by invitation only, unlike an association that must allow anyone to join. The Alliance is looking at several key issues:

- At full implementation, risk adjustment on the highest cost group still underpays by 15% to 20%. The insurance structure just doesn't work for these patients.
- HEDIS measures really focus on acute illness and don't deal adequately with the complexity of chronic illness. The medical directors of the SNPs have identified 10 quality domains, among which are continuity; safe, effective transitions; polypharmacy; comorbidities; and end-of-life care. Preliminary process and structure measures have been established, and to be a part of the Alliance, plans must be working on implementing them.

- The number one priority is transitions. Eric Coleman at the University of Colorado has done work on identifying practical best practices that can be implemented even in the absence of a robust information infrastructure.

He believes other countries have as much difficulty managing the cost of care for these patients as we do. The issues are the same. Where you attack them may be different. Other countries have financing silos too and, in some cases, even more bureaucracy.

There are three types of SNPs:

- **Institutional plans.** Cover institutionalized patients or those in the community with similar needs/conditions. Evercare (owned by United Healthcare) runs most of them. The business model is that of a nurse practitioner working in a defined community or nursing home to improve drug utilization and patient outcomes.
- **Chronic care SNPs.** Mostly run by disease management (DM) companies. There is a slightly more intensive interaction/effort than in standard DM, but it is still largely a nurse-managed telephone service.
- **Dual-eligible SNPs.** Most were former Medicaid plans that migrated to Medicare with the drug benefit migration. Here, most of the innovation is with small local plans, especially in Minnesota, Wisconsin, and Massachusetts, rather than with the big player, WellCare.

Though the SNPs are at risk for all costs, one principal driver is frailty, and to be successful, the plans must be able to manage this.

XX thinks the institutional SNP category of patients, both those in the community and those in nursing homes, would have the quickest and highest payoff from direct pharmacist involvement. One especially good SNP in this group is Commonwealth Care Alliance in Boston, which serves primarily frail elders and adults with disabilities. These patients benefit greatly from connections with people and resources in their neighborhoods.

Another excellent opportunity could be seized with patients in assisted living facilities, which have a different structure than do nursing homes. These residents increasingly qualify for nursing homes and thus would be eligible for SNP coverage. An SNP might define its service as all assisted living facilities in a specific geographic area.

A lot of little guys are just getting started and have not yet defined a service model. These plans should be a primary target for community pharmacy. Sometimes a SNP gets started by just looking at what is currently being done and what it is costing, then gets overwhelmed by enrollees and never goes back to take time to reengineer the process to come up with a better approach.

Currently, legislation does not require reporting, though XX thinks CMS should do so. In Alliance meetings he asked the plan's medical directors to come up with no more than five measures that would most advance care. They named

- Rehospitalization for ambulatory care sensitive chronic conditions;
- Emergency room visits;
- Adverse drug events, in relation to transitions;
- Nursing home admissions; and
- Patient satisfaction.

Four of these measures can be impacted by better drug management. Anyone who can decrease adverse drug events and improve adherence should be welcome at the table.

We should look for business opportunities that provide the opportunity for short-term interventions that have long-term impact. Ensure integrated pharmaceutical management and align relationships, especially with the physician, because that is the person the patient wants in charge of his or her care.

Safe and effective care transitions are the number one priority for his Medical Group (not for the Alliance as a whole), which is working within a list of 10 quality domains for serving high-risk beneficiaries approved by the Medical Leadership Group, with support for implementing these domains as a condition of membership in the Alliance. Medication management is also one of the domains, but the doctors see a lot of the problems with medical management as being related to care transitions. XX thinks the best leverage for this project with the Alliance is with the quality angle. What is needed to better manage transitions is a point of coordination, and nobody yet has "the lock" on this. As the purpose of the Alliance is to ensure the long-term business viability of the SNPs, there is a significant opening and opportunity for community pharmacists in vying for this role.

The pharmacist is also an important player on the care team creating personal health records (PHRs), but is not the launch point. The launch point needs to be at the intersection of the patient/physician relationship. However, he is not convinced that a PHR owned by the patient would work all that well with a high-risk population, where most of the problems of mismanagement are.

In Medicare, the pharmacy benefit manager will have reason to manage the PHR but you still need to hook the physician in. It's also important to keep in mind that patients will want a right to get their drugs from multiple pharmacies. We've got to find a way to build off a medical record coming out of the principal care physician's office where most of the care is provided. That record can be linked to multiple pharmacies, with a pharmacist providing oversight and consultation, but the ongoing ownership is kept rooted in the patient/physician relationship.

Academia

College of Pharmacy, University of Minnesota

XX observes that pharmacists are not understood. He believes that the profession has brought its problems on itself. Neither the public nor payers know what a pharmacist is capable of. He sees a major challenge in changing that dynamic. He believes that the profession has to convince others that it adds value and define what that value is.

Whereas he recognizes that public surveys indicate pharmacists are some of the most trusted health professionals, he does not think that trust has been earned. He is convinced the perception exists because the pharmacist gives patients what they want: a reliable product, in a convenient setting, at little or no cost, without asking a lot of questions.

His work (focus groups) suggests that patients do not necessarily want pharmacists to come down from the riser to talk with them. They want to know they are up there focused on ensuring they get the right drug in the right dose.

He believes that the pharmacist needs to build relationships. In the current environment the customer is loyal to the drug store, not the pharmacist. Building relationships is a key to the future. He believes that the patient can be the bridge to build relationships between providers (doctors) and the pharmacist.

He sees a distinction for the pharmacist between providing basic education versus medication therapy management.

He is also convinced that pharmacists are overpriced in the marketplace.

XX does not think the industry has made the case for its value, nor has it adequately adopted technology.

An observation: "Too often professionals position themselves at what we are good at versus what society wants."

An observation: The chains are big and have a cookiecutter approach, when it would be more advantageous to tailor their services to the specific community.

He sees a parallel between the evolution of chiropractic and that of pharmacy.

Care Transitions Program

University of Colorado Health Sciences Center

XX has been working for more than a decade on quality and safety. His program tries to make practitioners more skilled at handoffs and supports patients and families in managing care transitions. Pharmacists can be the first line of defense. Through a coach model, the program teaches self-care and how to ask questions. Most coaches are nurses or social workers who focus on medication reconciliation. Many

discrepancies are found by using a medication reconciliation tool. Some chain pharmacists will do brownbag sessions with patients; however, they may not want to advertise this service as they would be quickly overwhelmed.

XX mentions some studies published on pharmacist-led interventions in Australia. He emphasizes that the counseling needs to be both “practical and pragmatic.” Sometimes a pharmacist’s extensive drug knowledge can be a barrier to recommending an easy approach, and even complex patients need their regimens to be as simple as possible. The regimen must fit the person’s lifestyle. It is hard for a pharmacist to extol the virtues of getting all meds from one place as it looks self-serving, yet this makes tracking much easier.

He works with and advises family caregiver advocacy groups: Suzanne Mintz (National Family Caregivers Association), Carol Levine (United Hospital Fund), and Gail Hunt (National Alliance for Caregivers). He helps them think about next steps in advocacy.

He recommends that pharmacists explore the possibility of new relationships, such as by partnering with quality improvement organizations (QIOs), as the QIOs can’t meet the Centers for Medicare & Medicaid Services charge alone. He is doing training in New York and California. Maybe chains might want to work with coaches.

Indiana has a “docs for docs” initiative. In that state a practitioner can pull up meds, labs, X-rays, and everything about treatment from anywhere. The state has a rich history of electronic records and e-prescribing, which created the capacity. Four hospitals recognized the value and put up funds. People have said you could pay for these systems just by eliminating one unnecessary lab test per patient. The regional health information organizations (RHIOs) are not necessarily enablers of these systems. For example, he points out that his state of Colorado has a RHIO, yet it isn’t where Indiana is.

He believes that chain pharmacies could come forward as leaders.

Auburn University

The “mentality of relative morality” is a serious problem in the industry. That is, it is okay if everyone is doing it! XX is concerned that well-intended students’ enthusiasm is squashed 2 to 3 years out of school in the retail environment.

He states that a lot of the chains have not been fond of him ever since the 20/20 exposé. He reports that he has gotten hate mail and that a pharmacy trade publication called him a traitor. He states that he did not know they were going to do an exposé on a large pharmacy chain’s lawsuits. In fact, he has had a good working relationship with the pharmacy chain. His focus was on the study Auburn did that showed 7 of 25 patients on Coumadin[®] were not warned of possible interactions with aspirin.

He thinks the chains take a very short-sighted view—they look at ways to “add more dimples to a golf ball, rather than think about a round ball.”

He developed a course in motivational counseling for nurses, pharmacists, case managers, and other health professionals. It has been very well received by case managers and he is running institutes with the Case Management Society of America to train the trainer on motivational counseling. Very few pharmacists have been participating. In the July institute, the five participants were all from Auburn and the dean was paying their way. He also points out that at his own institution the nursing school has never asked him to teach the course to students.

Many chains have call centers that could use the skills of motivational interviewing. He worked with a large pharmacy chain, but it did not want a holistic approach; it wanted screening questions only. However, he points out that you can't impact patient ambivalence with a 30-second interaction.

One Blue Cross Blue Shield organization hired pharmacists to work with the case managers because the nurses do not have the clinical skills and competency that the pharmacists do.

He has given a lecture called "Pharmacy, Whose Profession is It?" in which he discussed his concerns about relative morality. He asks, "What level of risk is it okay to expose the public to because you don't have time to counsel?" He is very concerned that the chains continue to violate the Omnibus Budget Reconciliation Act of 1990 by getting patients to sign away their right to counseling because they do not have the time.

He thinks that if all the major chains could afford to put in drive-through windows, they could ensure their pharmacists have the time to counsel patients properly and protect the public the way the industry is supposed to.

UIC College of Pharmacy

XX was the principal investigator on a recent study on first-year results of medication therapy management (MTM) programs under Medicare Part D. He feels many plans entered cautiously and provided minimal MTM benefits because of the way the funding was provided. MTM is part of administrative overhead, not a service fee. Each plan contracts separately and can negotiate a fee, purportedly to allow the marketplace to take over and different types of programs to be offered. Plans have been doing little because they can see what they spend but not really what they get. Most programs are cookiecutter, not customized. Only 4 of the 21 programs examined contracted with pharmacies at the time of the study, but he thinks this number has doubled and is rising, as insurers move away from doing the MTM in-house.

Of the three primary components—education, adherence, and medication review—most focus only on education, through mailings, as it is very inexpensive. It is also minimally effective with most patients. He is doing a systematic review of the literature to look for evidence of the value of interventions such as mailed educational materials. He is 75% complete and has found little evidence of value.

Adherence programs comprise numerous components: pill boxes, reminder systems, tailored/simplified/more convenient drug regimens. They are much more effective generally but more hands-on, thus time-consuming.

He makes an important point about adherence being a double-edged sword if the overall drug regimen is not reviewed. As an example, a patient who has been less than compliant with his diuretic for high blood pressure goes to see his physician who notes he is not well controlled, and decides to add a second drug, at the same time reinforcing the need for him to take all his meds. The patient may now have an adverse reaction such as hypotension.

XX references a recent article on adherence that he will send. He points out that most studies on adherence are of very poor quality. There is no control for crossover bias. The better studies suggest that complex interventions are effective but time-consuming. Not surprisingly, the amount of time spent was directly correlated with positive results, that is, improved adherence.

The value of multiple interventions makes sense, as the reason for lack of adherence varies greatly from patient to patient. Much of the lack of adherence is either belief (patient doesn't think illness will hurt him or her, for example) or behavior oriented (sometimes this is related to the complexity of the regimen). If it were possible to sort out for a given patient the reason for failure to comply, efforts could be more targeted and less costly.

To this end, along with colleagues (including psychologists) from the Health Research Policy Institute at the University of Illinois at Chicago (UIC), he is looking for grant money to pursue research. The project, using patient questionnaires, will attempt to discern the barriers to compliance for individual patients and look at potential interventions.

These types of questionnaires have been used with HIV/AIDS patients and those with depression. He wants to adapt the approach to adherence in geriatric patients.

He will also provide a paper on the value of a pharmacist helping to coordinate transitions between sites of care. The study showed a drop in errors from 11% to 1%.

XX is working on an Agency for Healthcare Research and Quality contract for a prospective intervention study. The protocol is complete and they will begin enrolling patients in August. Six hundred patients will be enrolled at one of three institutions: UIC, Duke, or Baylor.

They have defined as a high-risk population patients 65+, with 3+ conditions, on 8+ meds, with 3+ providers, who have regular physician visits. He notes the statistic that in general, there is a 10% increase in drug-related problems for each additional med, and at about 10, the increase is even greater. Intervention points (triggers) include an

emergency room visit in the past 30 days, a new drug, a new physician, a hospitalization, or an invasive procedure requiring consent.

There will be three groups: a control group, a basic MTM group (will get med reconciliation with pill bottles, etc.), and a more intensive MTM group that will receive a drug-related problem assessment, streamlined therapy, and so on. Changes will be phoned in to physicians. Tools will be provided.

The study is intended to emulate what is likely going on in the marketplace.

He is also looking at how plans are identifying those patients who will be eligible for MTM services, as they may not be targeting the population who can benefit the most.

XX feels that because of the importance of interests, setting, and linkages, clinic pharmacists are better suited to provide MTM services than are retail/community pharmacists.

American Association of Colleges of Pharmacy

[Note: The interview below was conducted prior to this project in conjunction with our 21st Century Models of Care initiative.]

The American Association of Colleges of Pharmacy (AACP) president is at the University of Minnesota. Pharmacy is ahead in interprofessional/interdisciplinary education. In response to the Institute of Medicine (IOM) Bridge to Quality report, they embedded all the core competencies in their accreditation process, which will be fully rolled out in July 2007.

XX will be heading up meetings of the AACP Professional Affairs Committee, which is looking at ways to take a leadership role in this area.

Pharmacists, unlike psychologists, have not sought independence. They seek collaborative practice authority, almost always under protocol.

The newest IOM report, Preventing Medication Errors, points out that the health system lacks a clear leader in improving medication use. Physicians own a big piece but their practice model does not allow them to have the oversight that a community-based set of eyes could provide. Payment strategies also don't match the need for the coordination of medication use management.

We are at the tipping point in recognizing that the practice model needs to change. When you've lost your last cash-paying customer through Medicare Part D and chain pharmacies are pricing generics at low, flat fees, making a living through drug distribution and margins isn't going to work.

There are two powerful examples of innovation in design and management of pharmacy practice:

- VA pharmacy operations, where much drug distribution has been automated and pharmacists have been redeployed into patient care and monitoring of complex patients
- Kaiser in Colorado, which has a 12- to 14-year history of developing the most elegant and effective best-practice system for design and management of pharmacy practice. The system is population directed and patient focused. It is evaluated using clinical and financial metrics as well as clinician and patient satisfaction scores. When incentives are lined up, pharmacy management can make a huge difference, and this is beginning to be realized. This Kaiser system has the top marks in the country for five of the National Committee for Quality Assurance measures, three of which are pharmacy related.

With regard to Asheville, there is a question with regard to replicability and sustainability. It is hard to let go of the current reimbursement model when it is not clear if there is enough business for the new medication therapy management model to make it viable. It is sort of left-brain versus right-brain work. And, unfortunately, all the productivity measures today focus on the number of Rxs. You measure what you value and value what you measure. Can we change it?

Clinical pharmacy was actually invented in the 1970s at the University of California, San Francisco. It is definitely easiest to replicate the role in an institutional setting. The chains have been experimenting for many years, looking at the work and the practice setting. Independents are a bit more self-motivated.

The Pharmacy Quality Alliance is looking at metrics for the Centers for Medicare & Medicaid Services.

Pharmacy-Related

American Pharmacists Association (APhA)

Sees pharmacists, in general, are interested in assuming new roles, and at some level able to do so (with perhaps some additional training). As with most things, pharmacists' readiness to change seems to follow a bell-shaped curve. Bridging today's business model with this new one is the real challenge. As there is not currently enough work to do (or demand for it) in the new service model, pharmacists are trying to straddle the two worlds—and can't. The volume of scripts weighs them down and holds back change. It is a chicken-and-egg argument.

The question is, Is the whole movement doomed to failure? What has to happen to enable change?

XX's view is that the industry has to agree on a basic set of services that can be uniformly instituted and that are associated with the general obtaining of an Rx. The public currently has a baseline pharmacy experience that is steeped in a product model. The industry has to change the public's baseline expectation and experience. Some in

the industry seem to think that some magical process will tip the scale—that somehow they ought to wait for a “home run.” But incremental change is more realistic. Some chains seem to think, “If we can’t do it all, we can’t do anything.” And it simply may not be possible to simultaneously have a service across 5,000 chain stores. They want to focus only on “what is the return on investment of the new business model.” But business won’t suddenly appear. The question is, How do we go from zero to 60 mph?

He thinks more of the chains have some elements of service, but most has been driven by formulary switches.

Payment is only part of the problem. The industry/profession is struggling to define what service “it” is. The purchaser wants to know what he or she is buying and expects some consistency.

XX thinks that getting the industry parts together on this will be a real challenge. One company may not want to do one thing because it has a pharmacy benefit manager and it doesn’t want to interfere with that function and its revenue. The company may get concerned that if the service is too clinical it won’t be doable in all stores. The industry spent a great deal of time and energy just achieving consensus on what medication therapy management is.

He points to dentistry as a model we should look at. There is a clear and consistent service model and clear role definitions for different professionals in that healthcare sector.

Currently, the service of medication counseling is a joke: “just sign on the line that you have no questions.”

He also thinks the current public relations campaign to get people to talk to their pharmacist may backfire, if people try to do this and have a bad experience.

People pay attention to what they are measured on, and in retail pharmacy it is the number of scripts out the door. There is great potential for a service model but a lot of barriers, both internal and external, and the industry had better get on with addressing those internal things it can control.

What could give the industry the necessary shot in the arm? He points to the recent flat-fee prescription move as something of a wake-up call, but points out that it is more the competitive shock than the strategy; in fact, the \$4 generic is further commoditizing the profession.

But the profession has allowed itself to become commoditized, at least in the retail space. Yet groceries are commodities and still grocers can put some customer-attracting bells and whistles out there (e.g., the Trader Joe’s shopping experience).

Offering of immunizations worked well, for those who took advantage of it. The service was well received and easy to implement. Privacy is not really needed.

XX wonders why pharmacies are bringing nurses in to provide minor clinical services that a pharmacist could provide, if indeed they want to change the perception and the role of the pharmacist.

Minute Clinics provide a great opportunity for collaboration on patient issues. How should the real estate of community pharmacy best be used? “You need to decide what business you are in, to answer that question.”

The good news is there is an unmet need, and it is possible to appeal to employers who want healthier employees. They want to get value for the drugs they are covering and are not sure how to best get that value.

Next steps: The industry needs a starting point. One thought is to get the industry to generally agree on a couple of simple steps and execute them well to change the patient experience.

***HRSA Pharmacy Services Support Center
American Pharmacists Association***

XX has worked with community pharmacy for years to roll out service models.

Health Resources and Services Administration (HRSA) clinics have a productivity quotient. Clinic doctors spend an inordinate amount of time figuring out how to do pharmacotherapy with very complicated patients. The consult model helps, though you have to figure out where the funds come from.

He believes that today retail pharmacy is doing a good job of fulfillment—you can’t argue with this successful distribution mechanism. And payers enjoy continuing to whittle away at the remaining very small margins.

He states that good data show that involvement of pharmacists decreases cost and improves patient outcomes, from projects like Asheville, Project Impact, and Florida Medicaid (preliminary data). A meta-analysis done many years ago suggested that for every \$1 investment, there is \$8 in benefit.

Florida ran into problems because the required reengineering interrupted the distribution process, in which billions have been invested. This is a problem because that is where the money is made.

Although use of techs has improved (states have different ratios permitted), it needs to be looked at more closely. Also, the use of technology could be improved.

There is a need to change the internal incentives (bonus structures should be used) and raise the volume. Currently not enough patients are enrolled in Part D to make it worthwhile for most pharmacies to change operations.

The link with clinics is all about increasing traffic into the store.

Having pharmacists involved in immunizations improves the immunization rate in the community.

Providing education in diabetes self-management results in better health in a relatively short time frame.

One important gap in care comes with refills. Pharmacists can assess whether a patient is responding to meds, and perhaps even ferret out some of the reasons for nonresponse, such as lack of adherence.

He feels that the results of telephone medication therapy management may be acceptable in most cases, if there is an initial face-to-face meeting/assessment.

He believes that pharmacotherapy has to be part of the medical benefit, and suggests addressing the pharmacotherapy visit as a specialist consult and seeking reimbursement as such. He feels that patients are more likely to recognize value if pharmacotherapy is part of the medical benefit.

Physician practices that are at risk for total healthcare costs should be especially receptive to the involvement of pharmacists. Physicians can identify those patients who have been given the right treatment yet aren't getting better.

In most states there are collaborative practice agreements whereby PharmDs can change Rxs.

The Omnibus Budget Reconciliation Act of 1990 supported prospective drug utilization, so it does not create a change in scope of practice.

There is an advantage to both patient and payer if the pharmacist helps patients optimize coverage benefits—"connecting the dots." Present it to physicians as a service that will help them achieve the outcomes that were intended when the Rx was written.

XX points out that there is a big opportunity with the safety net (14,000 entities plus all satellites). Currently, each can contract with one community pharmacy to provide services. At least one chain pharmacy has built a whole information technology system to deal with this. They can tap into community health center data to confirm eligibility.

A publicly traded chain has shareholders. There is a need to educate these shareholders who are also healthcare consumers.

The business model from the perspective of distribution is okay. XX is not certain the data support the fact that big chains can't sustain a product orientation. If they can improve their purchasing power and invest heavily in automation, perhaps they can sustain it indefinitely. Some big chains are lobbying states to allow them to level the workload across the country by scanning an Rx into the system in one state and finding out where there is excess product. Through automation, one pharmacist can oversee operations in another part of the state.

Small and medium-size chains don't have the volume or economies of scale to do some of this. The industry knows the margin of the pharmacy versus front end of the store for different subsectors. Where is the profit? How has it changed?

Pharmacy Society of Wisconsin

The Pharmacy Society of Wisconsin has been working for more than a year as a collaborative group with nine payers and a diverse group of pharmacists, some of whom work with payers, in the design of a pharmacist medication therapy management (MTM) program.

Ten years ago the Society was involved in creating an intervention-based program in Medicaid (BadgerCare) whereby certain services were provided in the course of dispensing. Professional pharmacy codes are used in the adjudication system. This, for some, presents barriers, as the codes are cumbersome and somewhat hard to use. Therefore, some pharmacists refuse to be in the program. The system is based on a reason–action–results paradigm and reimbursement is based on an enhanced dispensing fee.

In addition to the state Medicaid program, five other plans in the state that currently reimburse for some pharmacist services (glucometer and inhaler instruction; therapeutic interchange; medication review, etc.) are involved. Each covers different services, so it is confusing, and it will become more so as new services pop up for MTM billing. Her group came together to address these frustrations and try to identify best practices.

In November 2005 the Society put together a task force of members, including independents, health system pharmacists, and pharmacists in payer organizations. The goal was to bring pharmacists and payers together on the same side of the table. This became the Wisconsin Pharmacy Quality Alliance. Those involved include middle management pharmacy directors at payer organizations; three small HMOs; a small pharmacy benefit manager; the state; and two indemnity insurers, one covering teachers, the other state employees. Both of these insurers use Medco and Caremark.

The first meeting was held in July 2006. All participants were very excited about creating a win–win for both pharmacists and payers. To be in the network, a pharmacy has to meet 13 best practices. But if it does so, it knows it will be paid well enough to change its business model.

The task force is talking to Walgreens, which has a lot of stores in Wisconsin. They also have two small chains—Aurora Pharmacies and ShopKo. It is easier for independents to change their business models, but there still needs to be enough volume for pharmacists to get involved.

The task force plans to approach payers first, over the summer. A software program is being developed for the project.

Level 1 services are those already being paid for by some entities, but these services need to be standardized. Wisconsin law requires pharmacists to counsel on new Rx's and on refills. Most of these services require the prescriber to be contacted. They are easy to bill as the system is web-based.

Level 2 services are disease-management-like, condition-specific modules. If a patient falls into a high-risk category, he or she can have a level 2 review. Modules all have algorithms. The use of disease management terminology proved problematic with payers.

XX also described a huge public health initiative on immunizations, but the payers shot down pharmacist involvement because of perceived complexity of the reimbursement being in the medical benefit. "Too many cooks in the soup!" The issue is always where payment comes from. The medical and drug benefits are siloed.

The group decided not to start with Part D plans because of a lack of incentive for them to embrace the pharmacist role. The plan is to develop interface with hospital discharge planners to address gaps in care. The group also wants to approach providers.

Virginia Pharmacists Association

XX says there are some good partnerships between small or regional plans and state pharmacy members. She talks about challenges inside the industry. She and her members focus more on the professional role of pharmacists than on the chains' business models.

The industry needs to define core values and a vision. The subsegments of the industry do have differing agendas. She feels that the retail industry must align the business incentives with those of the front-line pharmacist to make this transition. Pharmacists have been removed from the marketplace.

The profession of pharmacy went through a visioning session several years ago with an eye toward 2010. In essence, pharmacists see themselves as responsible for ensuring positive outcomes from drug therapy. This is a shift from a focus on the right medication to a focus on health outcomes from therapy.

XX feels there is even greater opportunity than the NACDS project focus. We should look at the value proposition for optimizing therapy of people on polypharmacy.

She draws a parallel with chiropractic services 20+ years ago. If someone was in pain and wanted to be treated by a chiropractor, he or she paid out of pocket, because it was of value to him or her. Over time, patients and chiropractors lobbied plans and employers to cover the benefit. The difference is that people aren't in pain from not having meds managed.

Salaries on the retail space are so high they outprice care models, and pharmacists are paid about \$75/hr to spend time stocking shelves, answering phones, and filling out paperwork—things that should be done by a much lower cost resource. As a result, stores are not getting full value for the dollar. An NACDS study of how pharmacists spend their time found 30% of it was spent filling out forms and doing benefit adjudication. XX finds the dynamics in the retail market baffling—they don't make sense.

She suggests looking at municipalities as employers to try to engage them; government employees tend to stay for life, so there is more incentive for these employers to focus on services/strategies that may not pay off for a while. She has also had conversations with unions recommending they negotiate for services that can lead to better health. She will provide contacts for these two groups.

When discussing Asheville and the fact that people were given incentives to participate, she opines that incentives may need to be a part of any pharmacy service strategy, such as waiving a copay for certain meds if the patient will sit down with the pharmacist once a month. After all, people aren't used to this and won't readily see how it benefits them. The only problem is, once an incentive is provided, it would be very hard to take it away.

Healthy behaviors and pharmacy services are like anything else—to sell something, it needs to be creatively marketed.

Pharmacists need to partner with their employers (chain, mass, supermarket) to create new service models. Unfortunately, new grads, who are best trained to do this, get frustrated because they have little understanding of the retail business. Schools of pharmacy generally have only electives in business and these courses are generally pursued only by those planning to open an independent operation.

At least one chain pharmacy has invested in coordinated health centers and the like. It is focused on emerging marketplaces to attract the best and brightest new grads. However, she is not sure if this is an emerging business model or a short-term strategy to offer free service.

Ahold-Giant

XX thinks the drug-store chains will move ahead first, as pharmacy is their prime business. The industry is enjoying an uptick from Medicare Part D but he is not convinced that all segments are jumping on the bandwagon to take advantage of it.

He thinks “we need a general [industry] vision, then we will ‘Stop & Shop-ize’ it.”

His focus is on figuring out how to optimize connection to other lines of business in the grocery market. As an example, one retail outlet has a scannable savings card. The retailer worked with a local hospital and a group of overweight patients on a pilot program. The patients had specially marked cards that tracked what foods they purchased.

Specialty pharmacy does not have to be disease focused. It might involve a program geared toward patients who are on a new drug who get a call from the pharmacist a day or two after picking up a new script to see if they have any questions.

His company is opening a central fill mail-order operation. Why not also establish a phone bank to utilize the rich repository of his company’s data?

In Maryland, CareFirst Blue is telling pharmacies about new clinical opportunities, but not all are taking advantage of them. As a result, Ahold-Giant, which has responded promptly, is doing most of the services, even if not providing the drugs. And it is the service that will ultimately distinguish the winners, as pills are a commodity.

He is not sure what the future of retail clinics will be.

His view is that the biggest challenge facing the NACDS Pharmacy Industry Council is that not enough retailers are actively involved. Mostly the associate members are involved, and they are not the ones who will make this transition work.

Kerr Drug

There are many ongoing efforts to explore the future of pharmacy. XX sees our effort and the others as very important. The day has come and there is an urgent need to change. When he graduated in 1967, the dean told the graduates to be prepared for major changes in the next decade. Now it is 4 decades later!

Project Destiny: Much broader project (NACDS with the National Community Pharmacists Association and APhA) to define the business and professional models, focus on interoperability, and develop a communications plan.

XX believes that his peers understand the need to adapt, but there is a difference of opinion as to the urgency, based on different business models. But of 25 members of the board of directors of NACDS, only 1 or 2 are not fully “there.” The big guys may be less stressed. One large-chain CEO questioned the goals of Project Destiny. A one-store independent is in great need of a new model.

With a different reimbursement model, all will benefit. He has a strong belief that if pharmacists have the opportunity to do more than counting and pouring, the time freed up will help relieve the workforce shortage. Then assets can be redeployed. Economically, it will provide huge savings to the industry. Regulations vary but generally require a pharmacist to be doing more than may be necessary.

Kerr has 26 clinical pharmacists who meet with patients, but they still need PharmDs providing the fulfillment function under current regulations.

Next steps: Project Destiny is aggregating project findings to come up with metrics to account for the value of pharmacy.

Internal barrier: Major investment in capital and in people. The top of the food chain has less urgency because it is less strained.

Eight to ten years ago the industry looked at giving up average wholesale price (AWP). He felt then that the industry should be proactive, but it wasn't. AWP is now under siege.

He notes the external barriers: regulations, state boards, policy, and current reimbursement models.

Pharmacy benefit managers (PBMs) make money on rebates. Will they be against the new models? PBMs will still be needed for fulfillment—formulary development; aggregating clients.

The healthcare model has been siloed. So much of the professional contribution has been stripped out and marginalized.

Caremark

“As a preface to our discussion I've attached the Asheville Project study, which I'm sure you've seen. . . . While these projects achieved good outcomes, replicating them and the process used to achieve them on a large scale—community by community—will be challenging given the current retail pharmacist business paradigm, skills, and training. I think we'll find many pharmacists who just want to dispense pills and others who may want to play a more engaged role with the patient.”

Caremark has a network of 60,000 retail pharmacies and 17,000 independents. They cover about 100 million lives. They provide disease management, through a call center with 1,500 nurses, to about 115,000 members, a small number, relatively speaking.

The general perception is that the role of pharmacists is “commoditized” in retail. There are not enough (or enough well-trained) pharmacists to carry out counseling and medication therapy management (MTM) roles. Time is an issue in the retail setting.

Conversations between pharmacy benefit managers (PBMs) and larger chains are limited to interactions around contracted prices for product and margin. PBMs don't think chains see value in providing additional services when they are paid for product. XX does not see this changing! Customers are still just asking for costs around drugs to be lowered.

He sees the potential Caremark–CVS merger as providing significant opportunity to help CVS understand what needs to happen to move away from commoditization. The opportunity relates to leveraging the strengths of the retail and mail-order environments.

He notes that the cultures of the two companies are quite similar. This may mean CVS has a chance to be first out of the gate with workable, profitable new services.

Caremark has seven mail-order facilities. They attract a different type of pharmacist, they have no problem recruiting, and turnover is low. Their pharmacists are very happy with their work because they get to utilize their clinical skills, working with patients and with physicians.

Medicare Part D incentives will provide impetus for these programs. Beginning with pilots in 2008, counseling will be required in pharmacies and additional MTM services will be compensated. This should be a clear stimulus for action now.

Programs in which private health plans reimburse for these services are limited. In the Diabetes Project, employers paid for services outside the plan.

The Minute Clinic connection can be leveraged to create synergies, or become competitive.

Benefit consulting firms play a significant role in what Caremark chooses to do, as they have a major influence on the choices of their employer–clients. They make money by reducing the overall benefit cost, of which drugs represent a relatively small percentage, so they tend to take a simple view—get a decrease in drug price. We need to get the practice leaders to the table and make it their idea. They will then convince the payers.

When we do not or cannot focus on the total end-to-end health spend on a patient, it is a challenge to get payment for prevention and adherence. Though at least one large corporate employer has taken away the barriers to getting chronic meds for its employees, there was not a sudden rush among employers to follow suit, because it was done on faith that it made a difference.

Reactions from other sectors:

- The medical community might be threatened.
- The PBM sector overall is likely to be supportive, given the potential synergistic opportunities.

- Health plans will support with reimbursement only if the case can be made. If one of the big guns jumps on board, others will follow. One major insurer just instituted reimbursement for e-mail—others will follow.
- PhRMA will be an ally on the issue of adherence.

The problem is more likely to be the chains' need to compete among themselves and the independents having their own agenda. The individual companies won't get together easily. However, the product (MTM, etc.) will stimulate competition.

There are likely to be different products to meet the different business models of the subsectors. As large chains are already partnering with clinics and have the resources to invest, product development and move to market is likely to be quicker.

The good news is, from the payer-participant perspective, there can be value added—if they get it right! The payer will be able to distribute the lowest cost drug, and the participant can choose how he or she will obtain it—through either mail order or face-to-face at a community pharmacy, where he or she can get information regarding the cost of purchasing a 30- versus 90-day supply, learn about generic equivalents, and be counseled on adherence, drug interactions, and so on. He or she won't need to worry about paying more in a retail environment.

They need to build relationships in the retail space, where disease management is much more effective. The results from Asheville, versus those produced by the leading disease management vendor, speak to the importance of face-to-face, high-touch services.

Pharmaceutical Research and Manufacturers Association (PhRMA)

XX sees the little guy really feeling the pinch, whereas the big store is not as dependent on the pharmacy as a key profit center.

Does not think the business model for chains is conducive for face-to-face because physical accessibility is a barrier.

Health plans see value in the services but some believe they can deliver them cheaper. They may not appreciate the distinguishing feature of pharmacists, in terms of training, which directly relates to quality and better outcomes.

The direct-to-consumer approach needs to be compatible with public expectations. XX does not believe the customer expects counseling so the industry may need to package the counseling to meet public expectations. It is important to become more visible.

The industry needs to translate the current models to consumer models. Recognize that the integrated health plan model works well. What can we learn from it?

There is alignment between manufacturer and pharmacist—one has direct contact with consumers and the other is trained directly on manufacturer’s product. But neither can prescribe.

Legislators see the pharmacist as strictly focused on reimbursement (i.e., as self-interested).

Other

Quality Partners of Rhode Island

The Regenstrief Institute had one of the first databases that connected data from employers, physicians, plans, and pharmacy so as to assess outcomes.

XX was involved in a series of focus groups and videos that demonstrated how much some patients value the personal touch of a face-to-face or even telephone encounter. He feels they learned a great deal from these focus groups about what patients want.

XX points out that “pharmacists are expensive.” Some counseling and care management is really cookbook and doesn’t necessarily need their expertise.

He believes the industry needs to “look outside the bubble” of its current activity.

He thinks the large chains should have a chief medical officer who helps them look across the continuum of longitudinal care—from hospitals to nursing homes to home care—and identify the gaps that occur especially during transitions. Someone should be carefully tracking what meds patients are on when they enter the hospital, what they are on when they come out, and what they are keeping in their medicine cabinet at home. Integration of care with regard to medication is desperately needed across all sites of care. Lack of integration is a serious cost and quality problem.

He notes that doctors feel they are behind the times. They need to develop more patient-focused practices. Community health centers picked up on the concept of open access (no need for appointment) early on and patients love it.

What steps does the industry need to take to change the business model?

- Restructure the delivery process and utilization of staff. He points out that having nationally certified technicians with career ladders led to a dramatic drop in turnover. However, the model is still being tweaked.
- Pharmacy is very excited about e-prescribing and it can take a lot of cost out of the system and significantly improve safety; however, it is not nirvana. In Rhode Island, 4% of scripts are sent electronically, which is second in the nation. Integrate technology into filling to save more time through use of robotics.

- Better utilization of all skills, staff, and credentials. Thinks the industry has made changes but that it is only about 20% of the way there. Regulatory and safety concerns will have to be addressed.
- Strongly recommends that retail pharmacists work hard to integrate conversations with other providers in the chain of care, which will put them closer to the patient. People walk into their pharmacies at least 10 times as often as they walk into the doctor's office.
- Somehow there needs to be an automatic signal that something has changed, such as an emergency room visit, a new med, a visit to the doctor, or hospitalization.

Blue Cross Blue Shield Rhode Island is doing a pilot whereby the patient gets the first dose of medication (pushing generics) in the doctor's office. Pharmacists miss the first fill charge, but generally like it.

Rhode Island also has a transition-of-care form that follows the patient. It is owned/managed by the primary care physician. The utilization is fair; its accuracy is being examined. Part of the problem is a lack of standards, such as how specifically a pressure sore is measured. Although this form is not currently electronic, it is a good precursor for electronic medical records or, better, possibly a personal health record.

Though pharmacy has been advanced in technology and real-time info, he thinks it is missing an opportunity here. Pharmacy needs to leap out of its own space and broaden its influence with other industries and individuals in the patient care chain. It is said it had been proven that every dollar spent on pharmacotherapy results in more dollars saved on total health care. "Pain is the motivator."

Challenge: Defining model and roles. Can you integrate the new approach into the current business model? The issue really is "follow the money." Where do the dollars flow?

He cautions we should not confuse what people can do with what the environment forces them to do.

His quality improvement organization is working on a new reimbursement model for primary care.

He thinks the physician focus on the "medical home" is something of a smokescreen. Physicians have not listened to consumers who want and need more access than doctors who want to go home at 5 p.m. are giving them. Clinics are taking off because people demand ease of access.

Rhode Island, which is heavily Italian, has had an influx of Hispanic and Portuguese, many of whom work in healthcare settings, such as nursing homes. The inability of patients and care providers to communicate can create frustration and anger.

***Prescription Improvement Coalition
New Mexico Medical Review Association***

XX is the former state Health and Human Services Director and advisor to Governor Richardson. Prior to that, she worked in the Clinton administration, focusing on health and health care.

She does not believe consumers will pay for pharmacy services out of pocket because they are accustomed to these services being covered.

XX suggests we look at large plans' practices in working with private firms to contract out case management type services for chronic disease. She notes that vulnerable segments of the population will value high-touch services.

She is a big advocate of medication therapy management (MTM) and suggests looking at what the New Mexico Prescription Improvement Coalition (the quality improvement organization that includes the state pharmacy association, state government, American Association of Colleges of Pharmacy, and managed care) has accomplished in setting state standards/clinical guidelines for what a provider should be evaluating, especially for diabetes. See www.nmmra.org. The big focus is on encouraging and accelerating e-prescribing and on MTM. They are working with pharmacists around the state who will be doing face-to-face MTM.

Now with Medicare Part D, 17 new plans are operating in the state. But plans all have different criteria for MTM and there needs to be an agreed-upon definition. They are looking at doing a pilot and recommending face-to-face counseling. She is building a payer-based coalition and is hoping to get a change in the insurance code. Major plans are putting money on the table for e-prescribing, working with 148 physicians. They are not as far along with MTM. They are trying to deal with problems from practice, not policy. They did not want MTM in statute, but rather as a recommendation in the regulations.

ACP Foundation

The Foundation's primary focus for 4 years has been health literacy. It started in 2004 with a conference with the Institute of Medicine (IOM) and a mix of national, regional, and local organizations, from academic medical centers to a community intervention in Iowa. They looked at doctor-patient communication specifically around pill bottle labels (directions and warnings). These labels are regulated not by the Food and Drug Administration but rather by state pharmacy boards.

An IOM report in Aug-Sept 2006 and a December article in *Annals* highlighted the evidence that patients do not understand labels. The ACP Foundation is now putting together a technical advisory board on labeling. XX suggests getting feedback on the idea of a dosing matrix. What is the clinical difference between "take one pill 3X/day"

and “take one pill q8h”? She points out that some experts feel there may be only a dozen or so drugs for which a precise dosing schedule is needed.

The Foundation is also creating tools to help physicians educate patients in self-management. It spent 18 months developing a tool for diabetes.

Thompson Healthcare

Information technology infrastructure and interconnectivity is 15 years behind. Not much is happening with decision support at the point of care. It could be done but no one will put money on the table.

Thompson is working with the Medical Society of New Jersey on an “EMR lite” project. A web-based tool takes information from practice management databases and, using existing data, provides benchmarks and risk-adjusted comparisons, adds lab data, and creates disease registries for common illnesses to help with patient management.

However, he feels a better approach is to create web-based personal health records (PHRs), owned by the patient. The records can be populated in an ongoing way with claims data, demographics, diagnoses, Rx info, lab data, all provider encounters, and any information the patient wishes to add (e.g., over-the-counter meds) or allows any provider to add, coupled with educational information on relevant diseases.

The PHR is much easier, though payment and privacy are still issues. While the claims data can automatically populate the PHR, it has to be organized first. Buyers are plans and self-insured employers, as they have the data. When patients change plans, the data must go with them. Medicare has some demos. Integrated delivery systems are also in a good position to do this.

Thompson just received a huge contract from the Centers for Medicare & Medicaid Services (CMS) to build an analytic ready decision-support database to help CMS measure cost and quality and be a more prudent purchaser. It will include data from plans, providers, and pharmacy. It is very much like what Thompson has done for private payers like General Electric.

Thompson has also recently rolled out a consumer decision-support tool for private payers—plans and self-insured employers. It offers a web-based PHR, prepopulated with claims data. It is owned by the patient, tells the patient about gaps in care, and can be populated with other information as the patient chooses. Other optional components include health plan, physician, and hospital selectors; a treatment cost calculator; and other consumer decision support. It needs to be coupled with some personal-touch services, especially for complex patients, such as those services focused on medication therapy management and adherence. Pharmacists can provide information for the record, or can use the PHR when they counsel patients.

Appendix C: Stakeholder Roundtable Proceedings

Stakeholder Roundtable: April 4, 2007

Note: This is a distillation of the meeting discussion without any interpretation, analysis, or prioritization.

Participating Organizations

American College of Clinical Pharmacy
American College of Physicians
American Nurses Association
Caremark
Case Management Society of America
Fayetteville Medical Associates
Finch University
Hudson Health Plan
National Association of Chain Drug Stores
National Business Coalition on Health
National Consumers League
Scott & White Health Plan
Strauss Surgical Associates
TH Benefit Compliance
WellPoint, Inc.

General Points

- The industry of retail pharmacy needs to define specifically the business it wants to be in—retail sale of drugs, or the healthcare industry, focused on optimizing pharmacotherapy. What is the retail vision for the future and what is the role of the pharmacist in it?
- Pharmacy should not think it can be “all things to all people.” Stick with core competencies, rather than tackle scope-of-practice issues. There is a huge opportunity in just redesigning/reengineering pharmacotherapy to get it right.
- It is important to first think “What is the right thing to do, as professionals?” Then try to pull in reimbursement. Start with the desired outcome. But measurement will require sophisticated methods and tools.
- Create the partnerships and alliances that will be necessary for the industry to be able to transform itself. Employers and the workplace provide important opportunities to reach patients with prevention strategies. The National Business Coalition on Health will be a distribution channel for the Asheville model. WellPoint, as a very large payer, is committed to positive working relationships with the pharmacy network.

- There is potential for other noneconomic collaborative projects. What can we do about the estimate that 30% of the population will be diabetic in XX years?
- We must address the fact that delivery fragmentation keeps the “wars” going, not just in this arena, but across all areas of clinical practice. Politically, we need to do something, as these wars waste energy that could be much better spent!
- Can we create a way for the “cottage industries” to function like virtual integrated delivery systems? Is it scalable? The ability to align financial incentive is key.

Opportunities

Clinical

- Health disparities represent a real opportunity and can be a business hook.
- There is a strong economic model for adherence, and integrating adherence strategies into pharmacoeconomic models creates a win–win situation.
- Polypharmacy must be tackled.
- Medication reconciliation is critical, as there are more disconnects (e.g., hospitalists caring for inpatients who are then transferred back to their primary care physicians).
- Get back to basics on retrospective DUR.
- Medication therapy management (MTM) currently may not be the right model; the clinic model may be more robust.
- Consider opportunities with populations other than Medicare.
- Vaccines given in a local pharmacy can save home healthcare dollars.
- Over-the-counter meds and herbals contribute to many adverse drug interactions. Can/should the pharmacist review and provide advice on these products?
- Consider creating an alliance with local employers through brokers or other third-party administrators to offer education/training programs to employees on how to interact with physicians and pharmacists regarding medications. This type of education/training is a first step in helping to create partnerships between the pharmacist and individual employees. The consultative role begins after the relationship building has taken hold.

Business

- Real estate is a key opportunity.
- Brand the pharmacy around health, not drugs.
- Pharmacies could be the place where consumers hook into electronic medical records (when they exist).
- Why are we repackaging at the retail level, rather than using blister packs?
- What could the industry/profession do with the capital currently tied up in inventory if it did not own the product?
- Free up time by ensuring access to a search engine available to pharmacists, physicians, and plans with all necessary information on formularies, costs, and so on.

One Possible Model

- The physician addresses the cultural desire of patients to leave the office with a prescription by providing one for pharmacotherapy, general or relative to a specific disease state.
- Create a front-end process of clinical consultation, through simple electronic connectivity between physician and pharmacist. The consultation consists of a review of drug regimen for interactions, dosage against lab values, and so on.
- Ensure information travels with the patient, as well as between doctor and pharmacist.
- Create a back-end process of patient education/counseling. This activity may not need the clinical acumen of a PharmD; rather, the provider needs excellent counseling skills and cultural competency.

Challenges/Barriers

Clinical

- Culture—individual, professional, and organizational culture—as well as the system is a barrier.
- It will be a challenge to get consumer/patients to act differently. But it can be done with the right message. It is how you market the idea. We need to change the mindset around the role of drugs. American culture tends to support the quick, easy fix—“just give me a pill to take and everything will be all right.”

Providers need to be comfortable saying “No.” It will take creative economic incentives for all parties to ensure more appropriate medication use. Consumers should also be rewarded if they help achieve a positive outcome.

- Some of the lack of compliance/adherence relates to a lack of understanding or personal beliefs about the value of drugs and their impact on health. The ACP Foundation estimates that 90 million Americans do not understand their medications or how to take them. Better tools are needed for physicians, but physicians also need to partner with pharmacists.
- Consumers are also confused over who is who and who does what when they enter any part of the healthcare system, including community pharmacy (pharmacist vs. tech). There are also trust issues, especially in some cultures.
- Pharmacists need to get involved in what is going on in the rest of health care. Network pharmacists are not on board the population health bandwagon and could provide value and gain significant advantage.

Business

- The pressure to change is mounting, as income from the current model declines. Yet, the industry is undercapitalized to reengineer the model of practice.
- Currently there are CPT codes for the pharmacist to provide some of these services, but the practical and economic models are not supportive.
- The industry has a marketing challenge. However, image follows performance, and consumers will respond to a “changed face.”
- Community pharmacy could link into community networks, such as peer-to-peer support, but doesn’t.
- Workspace design must ensure privacy.
- Need to demonstrate value.
- Getting payers to reimburse will be a long-term proposition. The industry needs to make cognitive services an integral part of the business, and get out of the mindset of initially going to payers. Start narrowly, such as with patients with multiple chronic diseases and multiple meds, to facilitate the ability to measure results.
- Some point out that going to insurers may be difficult for community pharmacists in that insurers tend to work with bigger players. But employers and community pharmacists are already more closely aligned by geography and culture, making the employer a good starting point.

- Can we create an economic model that shows what the overall cost of an individual's care would be if he or she did not get a drug? It is very difficult to measure and put a value on something that doesn't happen, but there are some studies on this.
- Although we can make an empirical argument for the value of these services, that will not be enough. Look at the literature to see if anything of use has been researched and proven. Look at the interests of those you ultimately want to pay for the services, and create a model proactively that ultimately will make the case.
- "If we build it, they will come." This is especially true of the most needy individuals—minorities and those with chronic conditions as they are not getting what they need from the current healthcare system.
- In government-sponsored programs, to bring value, pharmacy vendors have to be able to offset the price of drugs, because the education and counseling is tied into the price of the drug.
- We need to focus on the long term and look at total healthcare spending. We need to cite good studies that demonstrate the impact of drugs, properly taken, on total healthcare costs.
- Effectively case-managing patients requires that the right dialogue take place among physicians, nurses, and pharmacists and the patient.
- Pharmacotherapy is not about unit cost. It is about getting the right drug to the right patient at the right time at the best price—then ensuring adherence.
- WellPoint (an example of a large payer) is at the "show me" stage. Though WellPoint believes that MTM for specific populations will demonstrate a measurable impact from the pharmacist intervention versus the more common process of simple network outreach, it wants proof.
- There are no standards for MTM programs. Each plan can set its own criteria for inclusion and its own level of service for different categories of patients.
- We need to change the economic incentives for providers and patients, not just silo the pharmacy. Plans, along with employers, are key to eliminating the siloing that occurs today. Large plans pay the total cost so siloing makes no sense. And neither plans nor employers want to keep costs down at the expense of patient outcomes. Employers are partly to blame because they evaluate pharmacy benefit managers on getting the drug spend down.
- The primary medical home model of ACP has a new reimbursement model for primary care that focuses on episodes of care.

What Are The Most Important Next Steps?

- Conversations with people outside the industry are a good start.
- Clarify the business, and stick with core competencies (e.g., pharmacotherapy).
- Start with a business model (models) that does not require going to payers. Focus on marketplace collaboration, with a goal of virtual integration.
- Do something quickly! Develop pilots with both commercial and Medicaid payers.
- The “big guys” who can afford it will need to underwrite large Asheville-like pilots that align economic incentives and demonstrate value. This will drive the rest of the industry.
- Free up time so pharmacists can be accessible and consumers don't wait in line for their Rx, much less counseling.
- Create time and incentives for pharmacist to participate in health plan programs. Dollars need to flow to the pharmacist, not just accrue to the business operations.
- Once a thorough clinical consult (the quality control) has determined that the treatment is right, automate everything!
- Pharmacists need to talk to patients! Patients respond to different incentives.
- Transform the consumer experience by defining each employee's role within the pharmacy and making it very transparent to the customer (as it is in dentistry).
- Pharmacists should highlight their key position to enhance patient safety (e.g., imported drugs, drug–drug interactions). Misuse of Rx drugs causes more hospitalizations than does illegal drugs or alcohol! This is a safety issue.
- Bring in minority representatives (from both a political and constituent perspective).
- Create a pharmacy home for those using mail order.

Stakeholder Roundtable: April 17, 2007
Focus on Public Payers

Note: This is a distillation of the meeting discussion without any interpretation, analysis, or prioritization.

Participating Organizations

Agency for Healthcare Research & Quality
American Pharmacists Association
Centers for Medicare & Medicaid Services
Consumer Health Education Council
Healthcare Visions, Inc.
HPN WorldWide
HRSA Office of Pharmacy Affairs
HSA Consulting Services
Intrepid Healthcare Group
Meals-on-Wheels, Greater San Diego, Inc.
National Association of Chain Drug Stores
New Mexico Medical Review Association
PricewaterhouseCoopers
Sanofi-aventis
TRICARE
University of Illinois at Chicago, College of Pharmacy

CMS Perspective

Healthcare spending will grow from \$2.1 trillion in 2006 to \$4.1 trillion in 2016 (16% of gross domestic product to 19.6%).

The tsunami of 77 million baby boomers begins hitting 65 in 2011. Healthcare spending in this country is not sustainable.

In 2005, government financed more than 40% of all health services. In 2006 40% of the total dollars spent by the government in the United States was spent on prescription drugs. Currently, the Centers for Medicare & Medicaid Services (CMS) spends more than \$1.6 billion per day, 365 days per year. Spending in Medicare alone will double to \$862.7 billion and will account for 20.9% of total healthcare spending in 2016.

Government health spending at its current pace is not sustainable. Payers such as CMS are looking for a decrease in spending (or at least a slowing in growth) and more value (getting more return in health). The debate is about brand-name drugs. We do have low-cost generics.

Rx spending will average 8.6% growth over the next several years. Spending on brands will contribute to more of this percentage toward the end of the decade as fewer generics enter into the market and higher spending continues on drugs targeting therapeutic categories (e.g., spending on diabetes products grew 15.5% in 2006).

Of Medicare beneficiaries, 23% have five or more chronic conditions that account for 68% of Medicare spending. They see an average of 13 physicians. They fill 50 prescriptions annually.

As overall spending on brand-name drugs and biologics increases, we can expect the scrutiny on this spending to increase as well.

For these reasons, CMS is trying to refocus all healthcare spending to be consumer-driven and value-, performance-, and evidence-based. The future environment will demand a demonstration of value for payment. The days of paying set fees for more services will evaporate. Physicians and other institutional providers are seeing the beginning of the new environment. The more unnecessary spending we can eliminate, the more dollars will be available for cost-effective, high-value/high-yield treatments (i.e., prescription drugs).

Pharmacy must become a symbol of value, rather than a center of cost. Value won't be compensated on a per-unit basis; more than that must be coming from the pharmacy. We need to shift to a system that compensates the pharmacy for value delivered rather than the number of pills dispensed. You need to be able to measure value before it can be compensated. The Pharmacy Quality Alliance (PQA) is putting together quality and value metrics to support the role of pharmacists as pivotal players in health care.

We must think of costs longitudinally and realign delivery incentives. Long-term-care pharmacy has major misalignment of incentives. Squeezing the balloon in one place has no overall impact. Once incentives are aligned, community pharmacy is the only resource well-positioned to deliver low-premium, high-value services.

Consumers will have to have more of a role in health care, but this transition will not be easy. Just 10% of overall healthcare spending goes to drugs. However, payments for prescription drugs represent 20.4%—the largest share of out-of-pocket spending—of all health services. As a result, consumers think that drugs represent way more than they do as a percentage of spending. A recent PricewaterhouseCoopers survey found that two thirds of consumers estimate that between 40% and 79% of U.S. healthcare costs are attributable to prescription drugs.

Looking to become a provider under Part B of Medicare is not a good strategy, because CMS is not going to keep increasing payment.

Pharmacists played a leading role in getting the Part D benefit off the ground. It represents a new role for pharmacy benefit managers (PBMs), which have taken a backseat and let the plans take the risk.

Important Trends

- Member Health, a small PBM that put its emphasis on helping consumers choose the right plan under Medicare Part D, is now one of the top PBMs for the

benefit. The company went out of its way to approach the federally qualified health centers. It is safety net friendly, with a positive attitude and good coordination, according to the Health Resources and Services Administration (HRSA).

- The CVS–Caremark merger is also pivotal, as it represents a change from a B to B business to a B to C business.
- Mail order is not seeing a great uptick. Consumers want face-to-face interaction.
- Pharmacists have been given the opportunity to capitalize on vaccine administration.
- Pharmacists played major roles in recent disasters: 9/11; Katrina
- The industry cannot rely on the CMS pilots. It must make its own investments (the dollars are not there to sustain the current model), but results of some public models with outcome measurements may be leveraged.

Parallels to Look at/Learn From

Look at the evolution of chiropractic services. Patients who were in pain paid out of pocket for these services. Over time, patients successfully lobbied for inclusion of chiropractic services in many benefit plans.

There is a parallel in poorly aligned incentives for physicians; for example, they get paid more for procedures than for cognitive/counseling-type services. Physicians initially resisted the idea of a bonus payment for quality reporting, but now they are jumping on board.

“Back to the future”: We are increasingly looking at a 19th-century approach to care, enabled by 21st-century technology and information transfer.

Where has value been demonstrated? Look at pockets of success to see what can be replicated in communities. For example, in addition to integrated delivery systems, which have major advantages that cannot be replicated outside of them, HRSA clinics have shown that inclusion of pharmacists in direct delivery of care is cost-effective—a win–win–win for patients, clinics, and the government. But when they have tried to expand and pull in community pharmacy, they have not had much luck!

Much change is driven by government. The Omnibus Budget Reconciliation Act of 1990 identified and supported a new role for pharmacists. We can learn important lessons from the CMS chronic care models. Although not specifically focused on medication therapy management (MTM), they should help illuminate better ways of caring for these patients, and from this we can extrapolate the pharmacist’s role.

Payer Views/Issues

Pharmacy needs to become less a symbol of cost and more a symbol of value. The definition of value is important. But it differs from group to group and person to person. Look at the work of PQA and the Agency for Healthcare Research and Quality (AHRQ) to see what metrics are of value from different perspectives.

Who is interested? Some say plans are more interested in e-prescribing than in MTM, and more willing to pay for it. Some form of rebate or concessions to plans is needed to incent behavior change. Some say employers don't really pay attention because the information presented is too complicated. [Note: In the roundtable with private payers quite a different view was presented.]

Transitions in care are a disaster and represent a significant opportunity. The Joint Commission on Accreditation of Healthcare Organizations points out that the number one cause of errors relates to hand-offs.

Pharmacy should think, "Would the consumer buy it? What is of value from the consumer perspective?" Pharma has been looking at the notion of value from the payer perspective. It is tough to ask for reimbursement for something you should already be doing! And if you have been doing it for free for 25 years, how do you get someone to pay? You can't win the value battle if focused only on pharmacy.

We are moving away from third-party reimbursement, so don't look there. There may not be two audiences (i.e., payers and consumers). As costs shift to consumers, insurers will do what consumers demand.

AHRQ can be helpful in supporting pilots, information technology data mining, and outcomes assessment. Most DeCiDe (Deliberative Citizen's Debates) Projects are quite short-term. One prospective study is focused on transitions in care in the outpatient setting.

Private markets would pay for compliance.

Why is the current business model attached to sundry ops? We need to understand this to extrapolate what might work moving forward.

Innovation and better care are not necessarily lower cost. But cost savings may accrue on productivity, not in healthcare dollars per se. We need to be able to look longitudinally at all costs—direct and indirect.

Manufacturers will participate more, but they will feel increasing pressure to decrease cost and increase value. Pharma has to move from seller to buyer (with consumers), or accept a regulated market. It must respond to the pressure of buyers or the pressure of government.

Given the increasing dominance of pharmacotherapy, in the future will people ever need to have surgery?

Opportunities

- “Retail pharmacy is sitting on the mother lode!”
- Leverage the advantage of your real estate! Pharmacists are in the right place at the right time.
- Define services (like MTM), communicate them, and do not let the plans do it.
- Connect to more health-related items. Use info to help consumer find most cost-effective med regimen (relative cost of similar brands; move to over-the-counter, etc.).
- Identify what payers versus employers versus consumers want (or will want) and fill the need.
- Look at lessons from the CMS chronic care models.
- Optimize use of information technology; institute some form of automatic reminders. Pharmacies are doing online adjudication now, but consumers don’t know this.
- Open dialogue with electronic medical record companies.
- There is a big opportunity with the safety net. One chain is looking at taking advantage of it.
- To get physicians involved, show how it makes their life easier and improves outcomes, as this aligns common interests. Look for ways to capitalize on the impending shortage of primary care physicians.
- Who needs retail pharmacy’s geographic distribution system and who might pay to piggyback on it?
- Could a group of employers, partnering with retail pharmacy, get special prices on drugs?
- Is there a difference between acute care and chronic care scripts?
- Diversification: immunizations, durable medical equipment, etc.
- Become the link to other community resources.
- What works and why? Pull together information on best practices.

- Pharmacy should engage in research on evidence-based practices through strategic partnerships.

Consumer Opportunities/Issues

The consumer is the ideal champion for change, as in other industries. The consumer wants autonomy, convenience, control. Build a coalition with patients at the center!

Consumers are clueless about what pharmacists can do, beyond “lick and stick.” They are unlikely to seek out pharmacists and want to engage them (pay them or support payment) unless skills/services are very well marketed. Good marketers in other industries convince people they need things they didn’t know they needed!

We are a very autocratic society. We don’t trust others. Value is created through pull on consumers. The consumer is a part of quality and affordability and has a role in value creation. Patients need to be responsible for their care, because clinicians alone can’t do it. Supports for consumers need to be in place, and the pharmacist is a natural.

Some do not see the value of engaging with pharmacists. The retail model is not conducive to trust! But if their physician suggests it and explains why, they will be more likely to do it. (NACDS was engaged in a compliance/persistence project but could not get the consumers engaged because the project did not close the loop with providers.)

Federal regulations prohibit pharmacists from recommending a care plan, but there are ways to help patients find the medication regimen that is best for them.

Retail pharmacy is well-positioned to compete with PBMs and disease management programs, but should integrate and partner, not compete head-on. These programs, as currently designed, are not really effective. No one is helping patients understand and comply, though private markets would pay for this.

Although decreased hospital length of stay was driven by payers, minimally invasive surgery was driven by consumers. A J.D. Power survey found that of components that drove satisfaction, convenience was number one. Take advantage of location!

A recent pharmacy survey found customers’ interaction with pharmacists was way down, below interaction with pharm techs. Seventy-two percent of purchases are made at specialty stores, not at department stores—consumers also want customization. Can we capitalize on this mindset? On this survey, Medicine Shoppe came out best, and it is more specialist oriented. There will not be one good solution. Can consumers be mobilized to demand these services, as they did with regard to coverage for chiropractic services?

An inner-city clinic found patients chose only 20% on cost; convenience and access were more important. Sixty-eight percent would have gone to primary care physicians, but could not get in. If primary care physicians can’t handle the volume, they may send patients to a clinic or pharmacy for services.

In surveying consumers, we should drill down past the top cut on satisfaction.

All the successful big projects (e.g., Asheville) have had incentives for consumers. In some, employers make cash payments to participants!

Consumers should be able to compare all drug prices. *www.flrx.com* does this.

Business Issues

Define urgency in industry terms, but, more important, identify the consumer's urgency.

Ensure the evolution is synergistic with what is going on in the rest of health care.

Where are the incentives? Where is the industry support? Payment for services is not enough! The right training, time, space, and cultural competency are needed. Different players might emerge if the incentives and support are there. The current big players did not exist until incentives drove a product model.

We need to define models that are sustainable, replicable, and scalable.

Workforce/Training Issues

The average age of independent pharmacists is 57.

Some pharmacists are reluctant to take on a broader role; the industry may need to stratify the workforce. The dispensing function will remain for those who do not want to change.

The ratio of pharmacists to techs varies by state. The industry is looking for ways to move pharmacists into more of a consulting role and have techs fill scripts (or automate).

Education is outpacing the market. New graduates are ready, but the opportunity isn't there.

Ultimately, it is about the profession of pharmacy. But will retail let pharmacists change?

Research

Well-designed research studies eventually prove things, but pharmacy journals are filled with useless information on pilots or programs/services provided that are not well-defined so results are not believable. We need well-designed clinical trials that look at processes. A single study won't answer all the questions. There is a lot of interference in Part D and it has been implemented very differently, so it may not be possible to really evaluate pharmacy services.

Stakeholder Roundtable: April 18, 2007
Focus on Private Payers

Note: This is a distillation of the meeting discussion without any interpretation, analysis, or prioritization.

Participating Organizations

AARP
Academy of Managed Care Pharmacy
Aon Consulting
Healthcare Visions, Inc.
Meals-on-Wheels, Greater San Diego, Inc.
MidAtlantic Business Group on Health
Motorola
National Association of Chain Drug Stores
Pittsburgh Business Group on Health
PricewaterhouseCoopers
Sanofi-aventis
TRICARE

“A payer is anyone who pulls out a buck!” The key to success is to “Put patients at the center.”

Employers

Most participants agreed that employers should be the primary target for messaging about the value of community pharmacy. Drugs are 20% to 25% of a big spend for employers. More are looking at alternatives to optimize the value they get for this spend, but they are not convinced they have the right information to make good decisions.

Employers have more incentive to get involved with community pharmacy than with health plans, which experience more turnover. Also, there is little brand loyalty to plans or pharmacy benefit managers, and a lot of competition among them.

Asheville-like projects present a chicken-and-egg problem. A business case needs to be made for both the employer and the pharmacists, who need to invest time to get the required training.

The Pittsburgh Business Group on Health has a mix of eight employers involved, from high tech to old steel. In the area, 80 pharmacists are certified. Employers are paying on a per-visit basis. Some pharmacists are working hard to make it convenient for employee/patients, by meeting over coffee or going to their homes. Though initial visits are usually 60 minutes, some patients are so complex it takes 3 hours. One chain has a subset of pharmacists who rotate through stores. One employer has a 75% participation rate, but the employer is small. One has 17% of employees taking meds for diabetes. Medication copays differ from employer to employer. When the copays were raised, employees started enrolling in the program, as out-of-pocket costs are a big driver.

In these models, comorbidities are identified. There are some minimum requirements for participation, such as seeing the physician quarterly. The projects try to get patients to comanage conditions. Reportedly, patients really buy in and talk about how their quality of life has improved. In fact, every measure has been positive.

Some employers support these programs on the hypothesis that they decrease hospitalizations and lost work time. They look at the evidence that exists and do the “right thing.” If people need more care, it is encouraged. The role of employers in educating their employees makes a big difference.

Asheville not only brought accountability to managing disease and aligned the interests of pharmacists, physicians, and patients, but also measured the total cost of care over time, which is critical to evaluation. Unfortunately, in many health plans, costs are siloed. It is hard to collect the necessary data. However, you can measure patient satisfaction.

Critical success factors for these programs:

- Critical mass (chicken-and-egg); need to ramp up customers and pharmacists
- Purchasers that will make investment on faith that it will pay off later
- Demonstrable outcomes (e.g., total claims for those enrolled vs. not enrolled)

Skeptics point to attrition rates, even with incentives. Patients clearly need reinforcement at every turn. How can the model be refined? The population should be segmented for attention; for example, what ought to be provided to those who are healthy to keep them that way? How do you reach those in need who may be mail-order customers?

Human resources benefit folks are increasingly stretched and do not spend much time on pharmacy benefits, according to a benefit consultant. Most do not understand value-based purchasing. Although senior management at leading companies buys in to the concept, time and resources to implement value-based purchasing are lacking.

Coalitions are in a good position to impact their employer–members’ thinking. Perhaps pharmacists (working through the American Public Health Association and NACDS) could develop toolkits to help employers initiate something like an Asheville model.

Should we try to develop a roadmap request for proposals for employers regarding what they should be looking for in pharmacy/pharmaceutical care benefits (including medication therapy management [MTM])? Educating employers and speaking their language is uncharted territory for community pharmacy, but it must put what it has to offer in terms payers understand. Find a way to show a “profit margin” through savings.

It may be important to segment under-40 and over-40 populations, as cost drivers are quite different.

Consider if there is a difference between old unionized “legacy” companies and newer companies (e.g., tech companies), in terms of their interest in these programs/services.

The CEO of Virginia Mason in Seattle is working with employers and Aetna to improve value. He told employers that they were getting what they paid for and if they wanted something else they needed to pay differently.

Consumers

Over time, consumers are paying more of the cost of their health care, including pharmaceuticals.

Consumers choose a pharmacy based on convenience. They don’t think about a relationship with a pharmacist and do not see them as adjuncts to their primary care physician. They tend to assume a certain standard of quality and service related to the product.

Consumers need “surround sound.” You can’t predict when people are ready to hear, and people take in information in different ways. They need to be equipped to have meaningful conversations with physicians and pharmacists. They need to feel they have a role in their health. Pharmacy is already well positioned to make consumers feel important to their own health.

Physicians

Services can create a positive domino effect by increasing the ability of physicians to care for patients and increasing patient satisfaction. Yet, some do not think their physicians would be supportive of these services. These efforts will stumble at best, if there is not good communication among pharmacists, physicians, and patients.

Medication Therapy Management

The Centers for Medicare & Medicaid Services gave pharmacist “counseling” an official name. This was the first time pharmacists were recognized and paid for providing the service.

The Academy of Managed Care Pharmacy (AMCP) specifically wants to reach out to retail. In the past there has been some animosity between them, but MTM provides opportunities for collaboration. Managed care needs to work through retail channels to reach patients, but AMCP members have found it difficult to get community pharmacy to step up. Another problem is that most people are in plans where the risk is siloed, unlike in Medicare Advantage where it is shared across providers.

Disease management and MTM can be complementary. In fact, results of traditional disease management programs are not impressive. Most programs do not get biometrics, so results can’t be effectively measured. Community pharmacy should go to employer coalitions and offer a more integrated program, one in which biometrics are obtained and effective communication channels established among pharmacists, physicians, patients, and caregivers. The hallmark of pharmacists working with

physicians is an augmentation to disease management. “Step up and say, ‘I can do what all the others haven’t done.’” Advertise that people can talk with a pharmacist.

Internal Issues

The large chains have the financial resources, but regional chains generally take more risk and experiment with innovative services. All segments cannot be mobilized in the same way.

Metrics

Three new efforts are under way to develop metrics for ambulatory pharmacy by the end of this year. In conjunction with National Quality Forum (inpatient) and HEDIS (outpatient) measures, PQA will be able to identify those playing a valuable role. Employers will gravitate to those who can show better results. To get these results, pharmacy and pharmacists will have to look differently at what they do.

Workforce

Is there the workforce to support this new service model? Pharmacists have had the education for years, but have not been able to use it. The past business model doesn’t work any longer. Schools of pharmacy are changing the curriculum. Maybe some people who do not want to invest 5 to 6 years could be fast-tracked to take on some counseling functions. What is the future of the specialty? How do you identify pharmacists who want to work with people?

Summary of Ideas

- Make pharmacies centers of excellence.
- Use roving pharmacists.
- Utilize pharmacist time more efficiently: Employ insurance clerks to interface with plans; greater use of central fill.
- Implement more robust e-prescribing (patients do not understand this and should).
- Collaborate with Minute Clinics, etc. (some employers are reimbursing).
- Determine what can be done and by whom under scope-of-practice acts and then figure out how to build on it.
- Counsel on over-the-counter (OTC) drugs/herbals (many OTC drugs today are powerful!).
- Pharmacy Quality Alliance: Use metrics for pharmacist services.
- Provide immunizations.

- Provide screening services (most employers do not have the resources to do health fairs).
- Set standards for data collection (e.g., biometrics).
- Employ greater use of computer systems; for example, set up reminders for services that consumers want and docs won't object to.
- Create "mini" medical records with pharmacy data and labs.
- Integrate with electronic health records.
- Integrate with mail-order programs.
- Advertise directly to consumers.
- Offer health promotion, such as smoking cessation or weight management counseling. Consider support groups.
- Decouple linkage between waiving the right to counseling and acknowledgment of HIPAA rights. Currently it is deceptive.
- Identify "what's in it for me" for each stakeholder (patient, plan, employer, physician) and develop a tool that adds value.
- Target the population to be offered MTM services (define eligibility to make the greatest impact).
- Create an image of health in the stores with a medically oriented environment. Have professional staff in the aisles to provide information to customers.
- Survey and listen to the public.
- Consider staff training in customer service.
- Look at where healthcare delivery is likely to be in 3 to 5 years, given the current focus on measurement, transparency, disclosure, pay for performance, and information technology. Then look for ways to fill gaps in care.
- It could be difficult to sell services that tie a patient to one pharmacy. How important is brand loyalty?
- If the firewall between clinic and pharmacy were removed, pharmacy could then look at linking with labs, providers, and plans.

Appendix D: Current Status of MTM Programs

Because Medication Therapy Management (MTM) represents such a key opportunity for the profession of pharmacy, we have included several sections on the current status of these programs.

MTM was first recognized in law with the passing of the Medicare Modernization Act in 2003. Each Medicare Advantage plan and prescription drug plan (PDP) must include MTM programs for its enrollees. Under the Medicare program, targeted MTM beneficiaries must have multiple chronic conditions, be taking multiple medications, and be likely to incur high drug costs (>\$4,000 in 2006). This is the criteria for MTM under Medicare Part D as defined by the law. For Medicare programs, Centers for Medicare & Medicaid Services (CMS) regulations further state that MTM programs may include elements that promote

- Enhanced enrollee understanding (via education, counseling, and other means) that promotes the appropriate use of medications and reduces the risk of potentially adverse events;
- Increased enrollee adherence to prescription medication regimens, such as refill reminders, special packaging, and other compliance programs; and
- Detection of adverse events and patterns of overuse and underuse of prescription drugs.

However, it is important to note that MTM programs are not limited to Medicare Part D plans. In addition, it is important to note that MTM services could potentially be provided by other healthcare professionals, so plans that include pharmacists as part of their MTM program should be recognized.

Examples of MTM Companies

Below are brief descriptions (adapted from their websites) of three leading companies providing MTM services. They offer community pharmacists an opportunity to be part of their growing networks.

Mirixa

Mirixa Corporation (formerly Community MTM Services, Inc.; www.mirixa.com) is a leading developer of innovative clinical solutions that facilitate pharmacist-based patient care services and is a leader in MTM technology solutions.

Mirixa's CEO Don Hackett said,

There is much to be gained from inventing and deploying technology solutions that integrate pharmacists into the continuum of care delivery. A "triangle of trust" exists among patient, physician, and pharmacists and there is a lot we can do to enhance that triangle and leverage it to improve patient care. In the next year, the industry is going to experience a dramatic shift as a result of innovative

technology solutions that further strengthen the patient–physician–pharmacist relationship, lower costs, and improve the quality of health care delivered.

Pharmacists, in addition to their important dispensing role, are also clinical service providers, risk managers, and financial advisors to the patients they loyally serve. Pharmacists will soon serve as the local distribution point for digital identities that enable personal health records to reach their full potential.

MirixaPro is a secure web-based technology that streamlines the delivery of highly targeted patient education and intervention programs. Patients are delivered care that is optimized with regard to their medical needs, insurance coverage, and personal treatment plan requirements.

Mirixa technologies are in use today by thousands of pharmacies, speeding the flow of critical information among pharmacists, patients, and physicians. Mirixa has assembled the largest pharmacy services network of its kind with over 40,000 contracted community pharmacies, including both independents and chains. Through its Internet-based clinical technology and national network of pharmacies, Mirixa enables its health plan, employer, and pharmaceutical clients to expand the reach and breadth of their direct-to-patient services.

Outcomes Pharmaceutical Health Care

Outcomes (www.getoutcomes.com) is a privately held limited liability company formed in January 1999 to become a leader in the emerging market for medication therapy management services (MTMS). It started with a model for the delivery of pharmaceutical care in the group healthcare market, self-insured and underwritten employers, insurance brokers, a major health insurance company, and a utilization review company.

Highly significant in the company's development to date has been the creation of an Internet-based claims processing system, so providers may access the system via the Internet and submit their MTMS claims.

Now Outcomes offers Medicare PDPs and Medicare Advantage plans; a turnkey MTMS system, inclusive of provider training; electronic claims platform; covered services menu; fee schedule; quality assurance; network management; and provider report cards, as well as data management and reporting.

Outcomes' service line also benefits employer groups, health plans, pharmacy benefit managers, disease management firms, and case management companies by delivering a cost-effective approach to advancing healthcare quality and controlling utilization through the provision of patient-friendly personal pharmacist services, delivered at the local level.

Effective January 1, 2007, the base Medication Check-Up™ payment for most Outcomes plans increased. Claims data was reviewed going back to 2003 and it

was found that an estimated \$600 was saved in avoidable prescription drug, medical, and hospital costs for each covered patient who received the Medication Check-Up service.

First Health Select

First Health Select's (FHS; www.firsthealthpartd.com) Rx Checkup is a cognitive service provided by registered pharmacists to FHS Medicare Part D members.

FHS recognizes the important role that pharmacists can play in patient care. In view of the extensive medication knowledge possessed by this profession and the fact that its members most likely come in contact with their pharmacist more often than with any other healthcare professional, FHS believes pharmacy is an underutilized resource to improve patient outcomes.

Here is how the FHS Rx Checkup works:

- The FHS member contacts the pharmacy to schedule an Rx Checkup.
- The pharmacist sets aside an adequate amount of time to review the patient's medication history as well as interview the patient regarding medical conditions and over-the-counter medications.
- The pharmacist documents this encounter on the FHS Rx Checkup Progress Note Form. Recommendations for changes in therapy are included on this form and faxed back to FHS as well as the patient's primary care physician.

This counseling session allows pharmacists to take a break from the dispensing role and use their expertise to improve patient outcomes.

First Health Select pays a fixed rate per Rx Checkup, once per member per calendar year.

Medicaid MTM Programs

Mississippi Medicaid

In 1998, Mississippi was the first state to receive federal approval to reimburse pharmacists for MTM encounters. It is authorized to bill up to 12 visits per year, per patient with asthma, diabetes, or hyperlipidemia or on anticoagulation therapy.

Iowa Pharmaceutical Case Management Program

The Iowa Pharmacy Association worked with the Iowa Medicaid program in 2000 to implement the pharmaceutical case management program. Services are provided by pharmacist–physician collaborative teams. If patients take 4 or more medications, 12 disease states are covered. Patients can be contacted and urged to participate. The first year, 31% of eligible patients were seen. They had a 12.5% improvement in the Medication Appropriateness Index.

Missouri Medicaid Pharmacy-Assisted Collaborative Disease Management Program

This physician–pharmacist collaborative model, providing face-to-face meetings with one or both providers, was established in June 2003 for high-risk beneficiaries with asthma, depression, diabetes, or a history of congestive heart failure (CHF). After the first year treating 1,203 high-risk patients, Medicaid officials estimated that per capita annual expenditures had been reduced by \$6,804 and they projected annualized savings of \$2.4 million.

Virginia Healthy Returns

This pharmacy-assisted disease management program using pharmacists and nurse consultants for coronary artery disease (CAD) and CHF was begun in June 2004. A 10-month review reported improved results in 9 of 12 clinical outcomes. Self-care practices had improved. Overall expenses per beneficiary dropped by \$23, which led to a 2 percent gross savings for the program. The savings was derived primarily from a decline in pharmacy expenses.

Minnesota Medicaid MTM Program

Minnesota began its program in April 2006, modeling it on that of Iowa. It utilizes the core elements of an MTM service developed by APhA and NACDS. Participants are taking 4 or more drugs for two or more chronic conditions, or have drug therapy issues likely to result in significant nondrug Medicaid costs.

North Carolina Lock-In Program

For beneficiaries taking more than 11 meds per month, this program, begun in June 2006, reimburses pharmacies that voluntarily agree to provide MTM services to beneficiaries designated for lock-in. Beneficiaries must receive medications and services from their usual pharmacy. The program reimburses on a per-patient monthly basis.

Wisconsin Pharmacy Quality Collaborative MTMS Program May 2007

Background

The Wisconsin Pharmacy Quality Collaborative (WPQC) is a group consisting of both pharmacists and health plan/purchaser representatives dedicated to creating a quality pay-for-performance demonstration project that will align incentives for both pharmacists and payers. The group was established July 17, 2006. The tentative goal for the start of the demonstration project is fourth quarter 2007.

Objective

To establish a uniform set of pharmacist-provided MTM services and a quality credentialing process in Wisconsin through a collaborative venture between third-party payers (health plans, employers, and government agencies) and pharmacy providers in the state. The expected results of this healthcare quality initiative include

- Improved medication use among enrolled patients as evidenced by attaining specific patient care outcomes;
- Improved patient safety (decreased numbers of medication errors and adverse drug events);
- Reduced healthcare costs for participating payers; and
- Professional recognition and compensation based on the development and implementation of pharmacy practice services that improve the use and safety of medications.

Quality-Based Requirements

Pharmacies must provide the following services or meet the following characteristics in order to be included in the pilot network for this project. Pharmacies will have policies and procedures in place ensuring the provision of these services. WPQC endorses these requirements as best practices that maximize patient safety in the medication use process. These requirements will be augmented as the program expands in order to continually increase the quality of pharmacy services provided. Specific educational tools and training programs will be provided to participating pharmacies to facilitate the consistent implementation of these best practices.

Medication Therapy Management Services: A Critical Review **(Final Report; May 17, 2005)**

The Lewin Group was charged with developing a methodology for evaluating payments that could provide a sound economic basis for the continued development of MTMS.

Interview findings and a literature review suggest that cost reduction and improved health outcomes can occur when MTMS are provided, especially to elderly patients. A recent review of the Cochrane Database found that pharmacist interventions can change patient behavior and adherence to medication regimens.

Adjustments in provider incentives need to be made. Fully capitated plans (e.g., Medicare Advantage–Prescription Drug [MA-PD] plans) could be the natural beneficiary of MTMS, if these services reduce overall per member, per month (PMPM) healthcare expenditures. Because PDPs are not at risk for overall health costs, they find MTMS less financially rewarding, as they sometimes drive up drug costs. Any savings on PMPM total healthcare costs are external to PDPs under Part D. The fact that MTMS must be paid out of administrative costs could work against this positive incentive, even for MA-PD plans, if adequate funds are unavailable.

In a final rule, CMS stated that insufficient standards and performance measures for MTMS exist at this time to support further government specification concerning MTMS and service-level requirements.

Other conclusions from this report include the following:

- The Medicare Modernization Act is too limited in its definition of the population required to receive the service.
- Patients are highly supportive of MTMS; some are self-pay.
- The acceptance of physicians' use of "incident to" payment structures in some states is evidence that physicians are willing to view the pharmacist as a partner in patient care.
- Payers have a considerable body of evidence from which to draw. Most payment systems today are variants of fee for service. Medicare MTM implementation can provide lessons from which other payers can draw in developing a service package and business model.
- Pharmacists specifically dedicated to and compensated for providing direct patient care must be available.
- The most prevalent MTM-related activities can be grouped into
 - MTM/polypharmacy;
 - Disease management;
 - Lab testing/screening; and
 - Wellness programs/immunizations.
- MTMS can be delivered at multiple levels of complexity, with licensed pharmacists delivering first-line medication management and more highly trained

or credentialed pharmacists delivering more complex services such as disease management.

- A pharmacy payment system must provide unit payments adequate to cover at least pharmacist labor costs. The pricing system must also provide adequate aggregate payments to sustain and provide for growth in number of providers.
- MTMS concepts have been developed in public programs, where the fee schedules are too low.

The Medicare Prescription Drug Benefit: Monitoring Early Experience
Testimony of the American Pharmacists Association, Submitted to the Senate
Committee on Finance
May 2, 2007

Most plans have fallen short of the mark. The cost of a plan's MTM program is part of the Part D plan's administrative overhead. As there is no separate payment, there is little incentive for a stand-alone PDP to provide a robust MTM program. The MA-PD programs have a greater incentive because they will capture savings in their medical benefit from healthier patients. More needs to be done to align incentives.

Barriers to robust MTM include the following:

- Lack of service standardization;
- Variability in how patients are targeted;
- Lack of standardized documentation and billing requirements;
- Inconsistent contracting processes;
- Disruption in continuity;
- Inadequate promotion of MTM benefits to patients;
- Lack of access to important healthcare information;
- Deficiencies in required robust outcomes measures (PQA working on it);
- Inappropriate incentives, such as requiring that MTM be covered by administration fees; and
- Absence of links between Part D and Parts A and B data, which hampers the ability to evaluate overall impact.

“Survey of Medication Therapy Management Programs Under Medicare Part D”
(J Am Pharm Assn Nov-Dec 2006)

Interviews or surveys were conducted with 21 programs representing 70 health insurance plans covering 12.1 million Medicare enrollees: 90.5% restricted enrollment based on number of diseases, with a median of 3 (range 2–5) diseases required, and 95.2% had requirements for the number of medications (median 6; range 2–24).

The most frequently provided MTM services were patient education (75%), patient adherence (70%), and medication review (60%). MTM program services included mailed interventions (76.1%) and in-house call centers (90.4%). Though only 4 of the 21 MTM programs contracted with pharmacists to provide some or all of their MTM services, these plans covered a large number of beneficiaries (7.5 million lives). The conclusion was that the programs were highly variable and definitive evidence supporting the effectiveness of many of the most common interventions was lacking.

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Marcia L. Comstock, MD MPH, President of Comstock Consulting Group, LLC was a co-incorporator of Wye River Group on Healthcare, Inc., and served as its chief operating officer and a member of the board of directors from its formal inception in June 2001 until September 2006. She is also co-founder of the Foundation for American Health Care Leadership.

Dr. Comstock is an experienced consultant on national healthcare policy and the evolving roles of healthcare stakeholders. She has worked at the national, state, and local level with public and private sector entities and trade and professional associations, applying strategic intelligence, third-party advocacy, and consensus-building techniques to identify and advance elements of a common public policy agenda.

A Certified Physician Executive and Fellow of the American College of Occupational and Environmental Medicine, Dr. Comstock also has extensive experience directing programs in corporate health and productivity enhancement.

From 1998 to 2001, in addition to healthcare consulting, Dr. Comstock served as Fellow, Health Care Policy & Workplace Issues for the National Chamber Foundation, U.S. Chamber of Commerce. She advised the Chamber president and its members on the impact of proposed health-related legislation and assisted the Chamber in advocating for healthcare, safety, and other regulatory issues of importance to American business. She planned, promoted, and implemented national and regional forums to discuss and debate issues related to access, affordability, and quality, and to propose solutions to health system deficiencies.

Dr. Comstock's consulting experience spans a cross section of healthcare stakeholders, including employers, business associations, healthcare providers and associations, and pharmaceutical manufacturers. She has consulted with business leaders on issues such as managed care, health risk management, and environmental health and safety. She has worked with a variety of organizations to evaluate the evolving role of different stakeholder groups in healthcare and with professional associations to support emerging roles for their members in the healthcare marketplace.

Dr. Comstock has 17 years of experience as a corporate medical director, first for AT&T Bell Laboratories from 1981 to 1992, then for Consolidated Rail Corporation from 1992 to 1998. Her responsibilities included development, implementation, and direction of employee-focused health services programs to enhance the health and productivity of the workforce and decrease health-related costs. She served as consultant to senior management on broad-based economic and humanistic health issues.

Dr. Comstock received her medical degree from Columbia University College of Physicians and Surgeons and a Master of Public Health from the Medical College of Wisconsin. She is board-certified in internal medicine, preventive medicine, and medical management.