

Strategies to optimize medication use in the physician group practice: The role of the clinical pharmacist

Emily Beth Devine, Susan Hoang, Albert W. Fisk,
Jennifer L. Wilson-Norton, Nathan M. Lawless, and Clifton Louie

Abstract

Objectives: To (1) describe the role of clinical pharmacists in providing population-based pharmaceutical care as employees of a physician group practice, (2) describe the strategies used by pharmacists to optimize medication use, (3) quantify improvements in care, and (4) illustrate the calculations used to quantify cost savings.

Setting: Community-based, multispecialty, physician group practice located in the north Puget Sound area between 2003 and 2007.

Practice description: Using four cornerstones (evidence-based medicine, therapeutic interchange, academic detailing, and a local pharmacy and therapeutics committee), the pharmacists provided population-based pharmaceutical care, leading generic switches, target drug programs, and prescription to over-the-counter medication switches. They also led disease management programs, managed drug recalls, implemented electronic health records, negotiated budgets with health plans, and led patient assistance programs and prior authorization programs to improve patient satisfaction.

Practice innovation: Implementing these strategies from the vantage point of a physician group presents a seldom-realized employment opportunity for pharmacists.

Main outcome measures: The impact of these strategies is measured by process, use, and clinical outcomes metrics. These, in turn, are linked to incentive payments in the pay-for-performance environment or to a lowered per member, per month cost in the capitated environment.

Results: In 2006–2007, 71% of our hypertensive patients received generic agents compared with a network average for receiving generic agents of 43%, while the proportion of patients with controlled blood pressure increased from 45% to 60%. We saved \$450,000 in inpatient costs for deep venous thrombosis.

Conclusion: Clinical pharmacists employed in a physician group practice can optimize medication use, improve care, and reduce costs.

Keywords: Pharmacists, physicians, strategic planning, medication use, quality of care, cost containment.

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Emily Beth Devine, PharmD, MBA, PhD, BCPS, FASHP, is Research Associate Professor, Pharmaceutical Outcomes Research and Policy Program, University of Washington, Seattle. **Susan Hoang, PharmD, BCPS,** was Pharmacy Practice Resident, University of Washington Medical Center, Seattle, at the time this study was conducted; she is currently Director, Level I Pathways, US Oncology, Houston, TX. **Albert W. Fisk, MD, MMM,** is Medical Director; **Jennifer Wilson-Norton, BPharm, MBA,** is Director of Pharmacy; and **Nathan Lawless, BPharm,** is Clinical Pharmacist, Everett Clinic, Everett, WA. **Clifton Louie, BPharm, DPA,** is Associate Dean, School of Pharmacy, University of California, San Francisco.

Correspondence: Emily Beth Devine, PharmD, MBA, PhD, BCPS, FASHP, Research Associate Professor, Pharmaceutical Outcomes Research and Policy Program, University of Washington, Box 357630, Seattle, WA 98195-7630. Fax: 206-543-3835. E-mail: bdevine@u.washington.edu

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Pharmaceuticals currently account for 10% of health care expenditures in the United States.¹ Employing a clinical pharmacist within a physician group practice is an underused strategy that has the potential to improve quality and contain pharmaceutical costs. Seasoned pharmacists possess the clinical and business skills to work within physician groups to provide population-based pharmaceutical care, including analyzing patient mix characteristics and drug use patterns (and implementing strategies intended to optimize prescribing patterns), improving quality, and slowing the rising cost of pharmaceuticals.

Objectives

In this report, we describe the role of two clinical pharmacists employed in a multispecialty physician group practice. We describe several strategies used by the pharmacists in the group's employ—strategies that optimize medication use, improve quality, and enhance patient satisfaction while slowing the rise in expenditures on pharmaceuticals. We provide examples of outcomes and detail the calculations used to quantify the savings. We link the savings to incentives provided in either

the pay-for-performance (P4P) or risk-sharing, capitated-payment environments. We close by listing several keys to program success. Our goal is to equip pharmacists with the information needed to describe and justify these roles to administrators, with the goal of enabling new opportunities for employment.

Impact of pharmaceuticals on the U.S. marketplace

Health spending in the United States has risen dramatically in the previous 25 years and now accounts for 16% of the gross domestic product.¹ This rise in spending has been coupled with rapid changes in the health care system occurring during this same time frame. The introduction of diagnosis-related groups in 1983 launched a paradigm shift from a cost-reimbursement to a prospective, capitated-payment system² and ushered in the resulting managed care era of the late 1990s and early 2000s. The term "managed care" represents two major types of health plans: health maintenance organizations (HMOs) and preferred provider organizations (PPOs). Both require a network of patients, providers, and health plans.³ The defining features of HMOs are that providers assume total responsibility and at least partial risk for the care of enrolled patients, as well as agree to accept a per capita (capitated-payment) form of reimbursement, commonly calculated using a metric of dollars reimbursed per member per month (\$MPMP).⁴ In contrast, the PPO is a discounted fee-for-service arrangement and allows enrolled patients to select from a wider, yet still limited, choice of providers.³ HMOs played the primary role in slowing the rise in costs in the late 1990s, but pushback has recently caused PPOs to predominate.^{5,6} However, in 2007, 21% of covered workers were still enrolled in HMOs, which remain less expensive.⁷ Under the PPO structure, P4P initiatives⁸ have gained popularity as a way to increase efficiency and provide incentives to providers to improve the quality of care. Still, room for much-needed improvement exists, as a landmark study published in 2003 revealed that patients receive only 55% of recommended care for chronic disease states.⁹ Clearly, improving health care quality while controlling costs remains at the forefront of the U.S. health care system.

While expenditures on hospital care and physician services account for the largest share of health care spending, prescription drug expenditures make up 10%.¹ Of the increase in prescription spending between 1994 and 2006, 42% resulted from an increase in the number of prescriptions dispensed per person, from 7.9 to 12.4; a trend toward the use of newer, more expensive drugs (34%); and manufacturer price inflation (25%).¹⁰ The pharmaceutical industry spends heavily on direct-to-consumer advertising, physician marketing, and sampling.¹⁰ Equally disturbing is that studies have estimated that annual health care expenditures on drug-related problems among ambulatory Americans was estimated to be \$177.4 billion in 2000.¹¹

In coming years, drug costs are forecast to increase between 12% and 14% in the clinic setting.¹² Several potential blockbuster drugs are expected to come to market, specifically specialty drugs used to treat cancer, rheumatoid arthritis, and

At a Glance

Synopsis: Pharmacists employed at a community-based, multispecialty, physician group practice optimize medication use, improve quality, enhance patient satisfaction, and slow the increase in drug costs, according to this description of emerging opportunities for pharmacist careers. In this setting, pharmacists' interventions included generic switches, target drug programs, and prescription to over-the-counter medication switches. They also spearheaded disease management programs, managed drug recalls, implemented electronic health records, negotiated budgets with health plans, and led patient assistance programs and prior authorization programs to improve patient satisfaction. In 2006–2007, 71% of the practice's hypertensive patients received generic agents compared with a network average of 43% and the proportion of patients with controlled blood pressure increased from 45% to 60%. A total of \$450,000 in inpatient costs were saved for deep veins thrombosis.

Analysis: *Operational support, access to sufficient data to measure program success, and sufficient technological infrastructure to communicate with providers are the three major factors needed to ensure the success of pharmacist-managed strategies. The highest levels of physician leadership must support these initiatives to ensure success. Access to timely and accurate pharmacy claims data at the physician level is necessary to monitor ongoing prescribing patterns for program success. Implementing electronic health records will facilitate efficient communication of pharmacist-led strategies and tracking of their success.*

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