Doctors and Pharmacists: Chemistry for Better Care

Doctors craftily are learning that the answer to balancing quality patient care with the health-care industry's push to see as many patients as possible can be as close as their friendly neighborhood pharmacist.

By Julie Sturgeon

Indiana University's med school failed to prepare Dr. Erin C. Snyder for the pickle she found herself in last year. The family practice physician in Fishers, Indiana, granted her nurse an emergency leave of absence but couldn't find a competent temporary replacement. Nor did the area's low unemployment rates help her hire additional needed staff. "I had people who wouldn't show up, nurses who refused to take patients to the rooms, receptionists who balked at answering phones," she says.

Her knight in shining armor during this practice nightmare turned out to be a local pharmacist. Thanks to a previous collaborative agreement arrangement, Snyder received important patient updates and messages through the pharmacist's follow-up calling service. "Reality is I don't want to see the patient for just a medication problem. I want them back if they have unaddressed medical problems or their yearlies," she says. "And with so many patients needing to be worked in a day, somebody who really needs me ends up waiting another 24 hours behind the guy whom a pharmacist could have helped."

Across the country, family physicians, internists and general practitioners lead the charge into a new practice protocol that some claim can even the scales in a stressed managed care world. Collaborative agreements — a treatment regimen the physician and pharmacist mutually agree on that permits pharmacists to shoulder patient education details and some intervention strategies — essentially give the druggist a new role for a new millennium: physician extender.

The American Academy of Family Physicians' 1998-1999 Reference Manual officially encourages such partnerships, as long as the physician retains the supervising driver's seat. "We may not cross paths, but the piece of paper we generate or call in for prescriptions means we already interact with pharmacists quite a bit every day," says Lanny Copeland, AAFP's

president and a practicing family physician in Albany, Georgia. Still, industry studies reveal that Americans spend $76 billion a year in the health care field due to prescription-related problems — that's a dollar's worth of problems for every dollar spent on medication. In fact, 10 percent of hospital admissions last decade were prescription related.

So the American Pharmaceutical Association Foundation opted for a more proactive approach: Project ImPACT. This two-year demonstration, initiated in 1996, selected 29 pharmacies — independent, clinics, chains, HMOs and even a grocery store chain — in 14 states to actively help hyperlidemia patients manage their diseases. Each of the 700 enrolled patients carries a doctor's certification for their participation, which involves a finger stick to determine lipid counts in the blood stream every month for the first three months, and quarterly thereafter. The pharmacist then sends progress reports to their physicians.

Compliance, APhA officials report, startled even them. Only 40 percent of the general public complies with its lipid-lowering medication. Project ImPACT's compliance figure more than doubles to 84 percent. "And we looked at whether the patient came in plus or minus five days for their refill — that's pretty tight," says William Ellis, APhA Foundation's executive director. He's also pleased with outcomes — using the National Cholesterol Education Program's goals as a benchmark, Project ImPACT patients tripled their colleagues' success. Forty-four percent of the partnership guinea pigs reached their desired cholesterol levels, while as few as 7 to 30 percent in the general population celebrate that milestone.

Yet despite such good news, association experiments don't hold the future, contends John Rovers, an associate professor of pharmacy practice at Drake University in Des Moines, Iowa. "Managed care is squeezing everybody fairly hard. And politically when some third-party starts interfering with us, we tend to circle the wagons and start the fire inside rather than outside," he explains. "Discussions at the national level are difficult to do and as a result we're seeing is that the greatest success when an individual pharmacist works out a deal with an individual physician in your town, rather than wait for the powers-that-be in Washington to sort it out."

Why Me?

In Rovers' observations, the typical patient knows to drill health-care providers about possible drug interactions and whether she can drink alcohol with the pills. There the sophistication stops. Yet patients still need knowledge on monitoring procedures, follow-up appointments, how to ensure the medication is doing its job, and who to turn to for specific problems. "At their core, people aren't sure who's responsible for what in the health-care system," he says. Collaborative agreements automatically tackle such great unknown territories.

In addition to documented compliance rates, doctors claim patients cradled in the arms of a physician/pharmacist partnership keep their scheduled follow-up office visits with better precision. "Not to mention the physician earns the same amount of money for that routine visit as he would if he saw these patients as emergency walk-ins screaming for help in the middle of the night," reminds James Bennett, co-owner of James Bennett Apothecary in Corinth, Mississippi, which offers several patient education programs to assist local physicians.

Time savings represent an obvious physician practice benefit — the average doctor can see three patients in the hour it takes Bennett to cover diabetes management basics with one in his store — but the pharmacist's feedback carries value, too. Snyder, for instance, prefers to read a professional's assessment on how a patient tolerated a drug two years ago, rather than require the ill person on the table to cough up specifics. "They generally don't even remember," she says. "And they have no clue we have 400 antihypertensives on the market, so telling me 'I didn't like that blood pressure pill' gets us nowhere."

Medical residents at the Glendale Adventist Family Practice Center in Glendale, California, often thank God they take pharmacist Tatyana Gurvich on their home visits. Gurvich offers a wealth of stories concerning near-misses and timely catches made possible by two professionals on the scene. The elderly woman who refused to show the team where she stored her medications particularly stands out in memory. Such behavior didn't strike the physician bent on his examine as odd, but Gurvich persisted. "In the end, she was sitting on a chest full of pills: thyroid medication this resident didn't prescribe, heart medications someone else had given to her," she recalls. The adverse interaction possibilities boggle the mind.

Snyder openly admits the pharmacist saves her skin, simply because patients usually remember medications to list between her office and his counter. "If something bad happens, professionally I can say, 'They didn't tell me that,'" she says. "But that doesn't help — the patient is still dead."

Pharmacists' individual rewards shine clear, too. Currently, prescriptions account for 75 percent of drug store receipts according to a survey by *Drug Topics* magazine. "In the past few years, the profit margin in filling prescriptions has gone to nothing. So if we don't use the knowledge base from our education more professionally, we'll be replaced by robots," Bennett says shaking his head. Not to mention many pharmacy grads fail to find job satisfaction in the lick, stick and pour routine after devoting six years of their lives becoming drug experts.

Finally, physician/pharmacist collaborations discover a stronger leg to stand on when confronting the pharmaceutical manufacturers' direct-to-consumer advertising push these days. Just as patients comply with directions when two people politely ride their hide, teamwork more readily convinces them the latest diet prescription isn't in the cards for their situation, either.

Role Models

According to university professors, collaborative agreements, in practice, fall into four popular trends across the country: on-staff pharmacists at medical practices, who are paid a salary by the doctors instead of a drugstore chain; independent pharmacists who team with area physicians but bill separately; independent pharmacists who bill the area physicians for their service; and pharmacists who consult on doctors' behalf but don't actually dispense medications.

1. On-Staff

Hospitalists like Jeanne M. Huddleston, the in-patient medical director of Mayo Clinic's Community Internal Medicine division in Rochester, Minnesota, represent the most evolutionary partnerships between physicians and pharmacists. But doctor groups who hire a pharmacist to join the staff enjoy the same relationship opportunities.

Parking a PharmD down the hall led to improved paperwork forms and care protocols for Huddleston's crew. Here, doctors merely fill in the dosage

amount on pre-printed prescription sheets and run through a series of prompts on typically hard-to-remember details, from how to avoid complications to nausea strategies. “The pharmacist assigned to a small cadre of doctors is very good at approaching those who wrote an order wrong or misunderstood how the medication should be ordered — we’re friends who bump into each other in the hall,” Huddleston, herself an internist, says.

In a practice setting, the pharmacist’s fee is part of the group’s salary structure, a set-up that shouldn’t attract the Stark Act’s radar gun, assures health-care attorney Stephen Bernstein, a partner with McDermott, Will & Emery in Boston. However, a physician group that teams with a pharmacist group to form a third joint venture could be suspect in his experience.

2. Separate Billing Practices

Project ImPACT’s emphasis on one physician independently offering a patient education program for specific diseases represents the most imitated model in the country today. James Bennett, on his own, designed just such a program with diabetes management in 1996. In the past three years, he has expanded to offer asthma, high cholesterol, high-blood pressure, women’s health conditions and anticoagulant self-management lessons from his entrepreneurial base. (The latter, a controversial direction, requires Bennett to occasionally adjust dosages.) In this archetype, the pharmacist picks up clients through any and all community doctors’ referrals, then boomerangs data he collects to those physicians.

Until recently, Bennett steered this program full steam ahead with no monetary compensation. Part of his non-payment status stemmed from a desire to prove his value to the physicians with no strings attached, but mainly it took this long to shake loose reimbursement checks from the insurance industry. Project ImPACT’s William Ellis reports his participants successfully won reimbursement from 41 regional insurance companies, “although if you went to the national insurers and asked if they pay pharmacists for educational services, they’d probably deny it,” he says. A few in the demonstration opted to bill the patients directly for the service.

3. Out of the Doctor’s Pocket

Industry experts in both disciplines also urge partners to consider establishing a per-patient fee the physician pays to the pharmacist, but this suggestion has crashed and burned in most real-life situations, Snyder says.

When she and her partner, David Blair, owner of Medical Compliance and Outcomes, speak around the country on collaborative agreement benefits, doctors claim they can't afford to pass out another slice of their pitifully thin co-pays now. Larger groups — such as Snyder's hospital employer — may discover different dynamics, however.

4. Consultant Only

Snyder was in her first year of practice as a full-time employee of Riverview Hospital when Blair approached her with his radical idea. His company would contact patients she specified to insure they were still taking the medication and suffered no side effects — and because he didn't dispense the drugs, neither party worried about sales improprieties. She jumped on the cutting-edge opportunity, and arranged for Riverview to pay the per-patient fee for the service. "Hospitals, insurance companies and big employers with health-care plans see the value in documentation that proves we're really taking care of the patient instead of running them through like cattle," she says.

Initially, Snyder knew such attention could help her adjust medications, but she overlooked the helpful fact that Blair understands over-the-counter complements, too. "Patients don't realize how many times a doctor is interrupted during the thought process. I appreciate a follow-up on things I meant to say but were long forgotten by the time the two stroke victims came in, followed by a guy with chest pains." Today, she also places some patients on additional six-week callbacks to check whether they scheduled specialist appointments, and reviews the pharmacist's feedback as a measuring stick for her own diagnostic skills. "Face it, patients don't pay for an office visit to tell you they're getting better," she explains.

In any form, AAFP's Dr. Copeland believes the collaborative concept promises still more in the future. "If we ever move toward capitated systems that concentrate on keeping patients healthy, partnerships may well work better than our current individual approach," he contends.

How to Ensure Better Partnerships

Because providers like Jeanne Huddleston and Catherine Cooke, a clinical pharmacist at the CareFirst Blue Cross independent practice association in Baltimore, work side by side with their collaborative partners, both stress that their more traditional counterparts need to work even harder

to institute upfront communication skills. “Nothing hurts more than turf battles over a patient,” Cooke says. “Close relationships equal consensus.”

Drake University’s Rovers labels such turf battles a fatal error, along with drifting into a situation where the pharmacist becomes an intermediary between the patient and you. “It can’t be a straight line situation; it has to be a triangle between the physician, pharmacist and patient. None of this running behind people’s backs to report stuff — pharmacists talk to patients and talk to physicians but not necessarily talk to physicians on patients’ behalves,” he warns.

So start with a page from Bennett’s book: Insist on meeting in person. He originally mailed letters to his doctor contacts and received zilch. Next, he scheduled a friendly breakfast meeting with five physician to present his orchestrated ideas face to face. One hour of everyone’s time parlayed into a stream of referrals that began the next day. However, the pharmacist still insists on meeting each new referring physician in person to boost confidence on both sides.

Before your first personal contact with the pharmacist — or if you prefer to seek a partner rather than wait for a pharmacist to approach you — call area pharmacy schools to solicit their insight and recommendations. Next, ask about the pharmacist’s residency specialty and determine if he has any niche training. And before you meet, prepare to discuss attitudes in these areas:

• *Which drugs you commonly prescribe and why.* You don’t need to agree on everything, but you do need common ground on the basics. “If the pharmacist believes a drug is no good while the doctor writes that drug on a daily basis, you’ve got a problem,” Bennett says. Include whether you prescribe placebos —pharmacists may differ on that philosophy.

• *The number of serious drug interactions the pharmacist has experienced.* Physicians commonly complain that pharmacists frighten their patients from useful medications by relaying drug interaction horror stories. Often, statistics bear out that the patient has a greater chance of running over a stray dog and then themselves being hit by a train two seconds after a lightning bolt fries the vehicle. “It’s a matter of experience,” Tatyana Gurvich assures. “A pharmacist whose been around long enough to see

many drug interactions *not* happen is more likely to stick to important, relevant information." It's a style issue worth exploring.

• *Future career goals.* Erin Snyder prefers to work with an independent pharmacist because this category is less likely to take a better salary package at another chain pharmacy in a year or so. Many patients change doctors each time their company enrolls in a new health-care plan; setting them up for the same merry-go-round at the drug store shreds the precious little loyalty you build these days. On that note, inquire into a chain pharmacy's employee turnover rate before making a final decision.

• *Criticism protocols*. Simply put, professionals work best when they respect boundaries. Decide how you like to be addressed when you've made a mistake. While you're on this fact-finding mission, object to one of the pharmacist's points to see how she handles opposition.

During the entire conversation, focus on whether the pharmacist does a competent job of explaining his program. Chances are he'll communicate that clearly — or poorly — with your patients. Be painstaking — after all, you're the buyer.

An overwhelming majority of collaborative agreement partners commit their partnership to writing, usually creating a separate statement for each disease approach. Many national associations and organizations publish patient care benchmarks, which make excellent protocol guidelines. But tighten each step, spelling out any and all actions you want the pharmacist to take, including over-the-counter recommendations, and in what order.

Detail payment structure as well as document the reasons you want to collaborate, but never go as far as stating baldly that you want to create more referrals or turn more patient opportunities. That widespread mistake lands you in the Stark Act's crosshairs, Stephen Bernstein advises. To be safe, ask a health-care attorney to review all final documents.

Finally, decide the best way to receive the pharmacist's feedback, whether as a chart notation, in a fax, by phone or e-mail. Cooke established a timeline for returning her information; during the first six months of her collaborative agreement, she tracked down the prescribing physician immediately whenever she needed to make a change recommendation. Don't

forget to hammer out whose office takes responsibility to phone the patient on a follow-up call, either.

Among the paperwork streaming your way, insist the pharmacist include still more: particularly documentation proving her service's worth. "Telling administration that 'I see patients and they get better,' doesn't cut it," Cooke admits. Request that the pharmacist provides hard evidence in the form of regular documentation on patient satisfaction, surrogate numbers, quality-of-life surveys. Lanny Copeland petitions his pharmacist partners to periodically fax price lists for common drugs, a customer service touch that helps him keep his patients' out-of-pocket expenses to a minimum.

"Doctors are a bit nervous about seeing their territory taken over by allied health people," Snyder says. "So I say start slow and decide for yourself how much business to give the pharmacist. As for me, if my hospital ever says we can't afford the collaborative service, I'll find other ways to cut the budget. The time savings alone allows me to actually go home to my family at night."

[sidebar A]

The Flip Side

Suspicions ar

agreements, and the reasons why you can dismiss these notions:

• **Pharmacists ultimately want to prescribe medications.**
The American Pharmaceutical Association official position shuns this direction. "In fact, the American Medical Association on a number of occasions has publicly stated it's in favor of teamwork and collaborative practice. It just wants to make sure the physician is captain of the ship and that's fine," says APhA's executive director, William Ellis, R.Ph.

Tatyana Gurvich's, a PharmD at the Glendale Adventist Family Practice Center, response rings blunter. "The most I ever do is recommend therapy. Heck, even when I write notes in charts, they must be very polite and

differential. So if someone says, 'You must do this and that, and I'll tell the patient,' he's just a bad pharmacist."

However, don't confuse prescribing powers with substitutions, a related situation that does raise family practice physician Lanny Copeland's hackles. "I have no problem with pharmacists deciding generic or brand name, but some advocate class substitution where they can move from one drug to a different drug in that class," he explains. "I'd love for them to talk to me about that but not arbitrarily proceed." Many partners spell out these conditions in detailed written protocols to cover misunderstandings.

• **Pharmacists are taking over patient education.**

Instead, think of it as pharmacists playing catcher to your pitcher, suggests Noel Wilkin, PhD., an assistant professor of pharmacy administration at the University of Mississippi. Doctors should continue to address medication concerns in their visits — then the pharmacist's reinforcement boosts patient compliance.

• **Pharmacists aim to expand their business at the sake of ours.**

Most collaborative agreements send the patient back to the doctor's office for check-ups or suspected problems. If you're lucky enough to enjoy a fee-for-service arrangement with that patient, it's money in your pocket. And, a majority of collaborative pharmacists today opt to bill insurance companies or patients, not their partners.

[sidebar B – protocol sample]

Diabetes Management

Clinical Pharmacy Services

Catherine E. Cooke, PharmD, BCPS

Scope of Practice for Clinical Pharmacists within the Diabetes Management Program

The clinical pharmacist, designated as Catherine E. Cooke, PharmD, BCPS, will provide the following services to patients who are seen at the Medical Center and who are enrolled in the diabetes management program.

1. Take medical histories (including medication histories). Included in this history will be questions about the occurrence of symptoms of hyperglycemia (polyphagia, polydispsia and polyuria) and hypoglycemia (warmth, nervousness, sweating, palpitations, headaches, confusion, blurred vision).

2. Measure pertinent vital signs (e.g. BP, HR, weight) and blood glucose (by fingerstick) and perform physical examinations of relevant organ systems for the purpose of monitoring the effectiveness and toxicity of drug therapy for patients with diabetes.

3. Order tests for the purpose of monitoring drug therapy for diabetes, e.g. HbA1c

4. Evaluate the patient's pharmacotherapeutic regimen to detect:

A. Drug-related problems (as defined by Hepler and Strand)

1. Untreated indication
2. Improper drug selection
3. Subtherapeutic dosage
4. Failure to receive drugs
5. Overdosage
6. Adverse drug reaction
7. Drug interactions
8. Drug use without indication

5. Design new pharmacotherapeutic regimens.

6. Write up SOAP-format notes that will be placed in the patient's permanent medical record.

7. Provide patient education regarding lifestyle management (in conjunction with the dietician) and drug therapy for diabetes.

8. Authorize adjustments in dosage as clinically indicated between physician visits.

9. Authorize refills in patients who are on chronic medications as clinically indicated between physician visits.

10. Authorize new antidiabetic medications (e.g. sulfonylureas, metformin, acarbose, insulin, troglitazone) as clinically indicated between physician visits.