Achieving the Vision of Pharmaceutical Care March 2005

A Vision of Medication Use on the “High Plateau”
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Crossing the Quality Chasm recommended ten new rules that should govern safer and more effective health care services. The following table describes one interpretations of how a redesigned medications use system for ambulatory care under these new rules for might compare to the existing medications use process (MUP) and its implicit “rules.” The new rules are supposed to be interrelated, so the discussion under each new rule often connects in some way to other rules. See also Donald Berwick’s simplified "user's manual" for Crossing the Quality Chasm.

1. Care is based on continuous healing relationships.
Old. Advice about medication use is usually offered only when a prescription is dispensed or refilled. Payments to the pharmacist are usually tied to a prescription transaction.

New. Physician pharmacist and nurse teams develop therapeutic relationships with patients. Progress of therapy is routinely monitored. Pharmacist or nurse cotherapist has responsibility to authorize refills, adjust doses and refer patients to prescriber. See Rules 6, 8 and 10). Visits with cotherapists for monitoring and advice are scheduled according to patient need independent of prescription refill cycle. (Prescriptions may be provided through a separate channel.)

2. Care is customized according to patients’ needs and values.
Old. Professional and business autonomy dictates care. “One size fits all.” Most payment plans use transaction-based direct prescribing controls, e.g., restrictive formularies, applied to every transaction with little regard to patient need. Exceptions to the norm, e.g., non-formulary drugs, cost prescriber extra time and inconvenience and may be expensive for the patient, regardless of patient circumstance. Drug utilization evaluation (DUE) is usually based on

New Patient needs drive care. Variation among patients is expected based on need, culture, psychology, etc. Most payment plans use indirect prescribing controls (education and cooperative practice) and evaluate prescribing based on efficient achievement of patient outcomes by a practice group over time, using outcome-linked process indicators. Pharmacists assist in adjusting and customizing regimens. Media and content of advice and information on medication use is
therapeutic agent only. It is used to enforce formulary choices and does not evaluate dose, duration or suitability to patient need. Pharmacist is used as unpaid agent to enforce uniformity within payment plan.

3. The patient is the source of control
Old. Payment system considers quality of life objectives as secondary to clinical objectives. The prescriber has sole responsibility for therapeutic decisions, including drug choice, despite strong influence by the insured's payment plan. Pharmacist has dis-incentive to discourage unnecessary drug use.

New. Quality of life is a primary objective of therapy. Patients are better informed and are given the opportunity to actively participate in decisions about their own care, including drug therapy and available alternatives. Prescriber or cotherapist takes time to educate patients about therapy to reduce demand for unnecessary and inappropriate prescriptions.

4. Shared knowledge and free flow of information
Old. Little sharing of information between physician, pharmacist and patient. Pharmacist and patient rarely have sufficient knowledge to intelligently coordinate or facilitate therapy. The desired standard for patient behavior is compliance or adherence. Patients rarely see their records. Some payment plans discourage or prohibit providers from discussing drugs or services that are not covered by the plan.

New. Information is shared frequently and automatically among physician, pharmacist and patient over secure electronic network. Patients normally have access to a copy of their records. Pharmacist and patient normally have sufficient knowledge to intelligently coordinate or facilitate therapy and are expected to do so, consistent with collaborative practice agreements and patient's abilities. The desired standard for patient behavior is concordance (essentially, active participation based on informed consent). Payment plans are open about coverage provisions and encourage providers to discuss drugs or services that are not covered by the plan. (See discussion of new rule 9.)

5. Decision making is based on evidence.
Old. Professionals justify variations in care (“practice pattern variation”) as a professional prerogative rather than a

New. Professional decisions, provider and payer practices are all subject to evidence and evaluation. Controls on medications use
necessity to meet individual patient need. Many managed care plans use their “business autonomy” to restrict prescribing without a clinical evidence base. Payment plans and provider organizations do not require evidence as a basis for their own business practices, e.g., restrictive formularies, prescription caps, exclusion from coverage. They exempt themselves from evaluation.

6. Safety is a system property

Old. Drug injuries are seen as being caused by “error.” Error is seen as personal failure, e.g. incompetence or carelessness. Litigation, personal blame, and secret settlements are used to resolve patient injury cases, even though they are ineffective for improving the system. Cooperation and delegation of authority to cotherapists is discouraged by payment policy and legal focus on individual provider. (See Rule 10)

New. Outcomes of drug therapy are monitored in an MMS. They are seen as being caused by system failure. Root cause analysis leads to improvement. Safety and effectiveness are seen as complementary and equal goals of quality improvement. Systems are understood to be essential for safe and effective medications use.

7. Transparency is necessary

Old. Patients are usually expected to follow directions rather than participate in their therapy, may not be well informed. Payment and managed care infrastructure is poorly regulated and subject to business rather than professional rules. Managed care/payment plan often unaccountable to patient or public under business laws and ERISA.

New. Patients (or caregivers) are normally fully informed of their needs and the choices available to them; potential risks and benefits of therapy; and what the patient should do (if able) to assist in his own therapy. Managed care is a partner in educating patients. Drug advice from pharmacist is active and suited to patient need. Pharmacists actively recommends their professional services and are visible performing cotherapist functions. Payment and managed care infrastructure is regulated, accountable under rules compatible with professional duties and ethics. Managed care/payment plan is not immune from any normal requirement for professional accountability.
8. **Needs are anticipated.**

*Old.* Medications use process (MUP) has little means to recognize and resolve most drug therapy problems before they become severe. MUP is informal and unorganized; has no means to identify recurring problems, i.e., system failures; therefore no means to correct them. Drug distribution is often “carved out” of health care and is most community pharmacists’ only source of payment for professional services.

*New.* Medication use process is planned and organized medications use system (MUS). MUS is built to recognize and resolve most drug therapy problems before they become severe, and to recognize recurrent failures. Drug distribution is integrated with the health care system, but is not the major focus of pharmacy practice. Pharmaceutical care is a required function and superior performers are systematically identified and rewarded.

9. **Continuous decrease in waste**

*Old.* The major (if not only) cost containment tool is component cost reduction. Drug costs are viewed in isolation from other costs. Restrictions, limitations, and denial of coverage are often the first and only method.

*New.* The major tool of cost containment is patient oriented outcome optimization. Instead of controlling separate budgets (“carve-outs”) providers assist in optimizing patient care. Mechanisms such as “provider accounts” and “member accounts” provide needed flexibility to meet specific patient needs.

10. **Cooperation among clinicians**

*Old.* Medical care is understood as “physician care.” Pharmacist care from community pharmacy is poorly coordinated with physician and hospital care. Managed care/payer framework does not encourage system, connection or cooperation of providers; discourages managed care leadership to systems, coordination of care across providers or sites of care.

*New.* Medical care and health care merge as a cooperative activity. Cooperation is encouraged as a priority, e.g., condition of preferred provider status. Every provider has a stake in patient outcome. Managed care system/payment plan provides incentives to pharmacists and physicians who enter into collaborative drug therapy management agreements, supported by drug therapy protocols. Seamless care across providers, sites and occasions of care. Managed care operates medication management systems with integrated pharmacy benefits into all aspects of care (carve-outs have been eliminated).

References
