Managed Care Pharmacists: Leading the Way for a New Millennium

As the new millennium approaches, the opportunities for managed care pharmacists look more promising than ever. Opportunity was a central theme that emerged during AMCP's Ninth Annual Meeting, *Winning Strategies for Chronic Care*, held May 8–10 in New Orleans. This article recaps the perspectives of two managed care executive recruiters and two health plan medical directors on where managed care pharmacy is heading.

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What kinds of skills and expertise will managed care pharmacists need to succeed in the future? What role will PBMs serve in the coming years? Two managed care executive recruiters, Robert Clarke of Furst Group and Gregg Fell of MRI Sales Consultants, shared their perspectives on these and other topics during a managed care pharmacy Primer Session entitled, "Changing Roles for Pharmacists in Managed Care," held on May 8. The session also highlighted the results of a new, unpublished survey of managed care pharmacists.

MANAGED CARE PHARMACISTS: MORE SKILLS, MORE CLOUT

Managed care pharmacists are gaining clout within the organizations they work for and are paying close attention

to what skills they'll need in order to succeed in the future. Those were among the key findings of a recent survey of more than 200 managed care pharmacists conducted by Furst Group Management Partners Inc., a managed care executive search firm based in Rockford, Illinois.

The survey, completed this spring, found that a vast majority of managed care pharmacists (93%) believe they would need more education to succeed in the future, regardless of the pharmacy practice setting they plan to work in, said Robert Clarke, principal of the Furst Group/MPI. Ironically, the same survey found that pharmacists with advanced degrees now earn an average of only about \$7,000 to \$8,000 more annually than colleagues with undergraduate degrees only. "I think that is going to change very rapidly," Clarke said. "The industry is changing and the demand for experience and higher education is increasing dramatically."

Managed care pharmacists increasingly are moving up the ranks within their organizations, Clarke said. Among survey respondents, the five most frequent job titles were: director of pharmacy, regional pharmacy director, pharmacy manager, vice president of pharmacy, and director of pharmaceutical division. The survey also found that these individuals were reporting to top brass within their organizations, such as medical directors, vice presidents, CEOs, senior vice presidents, and vice presidents of clinical pharmacy. According to Clarke, "The important thing here is that [managed care pharmacists] are reporting very high up in the organization, and I don't think you would have found that three to five years ago."

Managed care pharmacists also recognize that more demands will be placed on them in the future as employer purchasers, consumers, advocacy groups, and others hold managed care organizations more accountable for the quality of care they provide. More than 61% of respondents said they believe individual pharmacists, not just

pharmacies, will need to be credentialed. Forces driving this trend include the influence of the HMO accrediting body, the National Committee for Quality Assurance (NCQA); the emerging concept of pharmaceutical care, which diminishes the importance of drug dispensing while emphasizing the pharmacist's role in care management; and the need for pharmacists to stand on a more equal footing with physicians as members of the health care team.

Managed care pharmacists "have an opportunity in the next half dozen years to play a very dramatic role in

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the way health care is delivered in this country," Clarke said. Consider the area of chronic disease management as an example. Studies have found that 50% of patients with chronic illnesses don't follow their prescribed drug regimens, resulting in an annual cost of more than \$100 billion in additional health care bills and lost productivity. "Think of the impact you can have on that number."

PBMs—A CHANGING BREED

Results of the survey also suggest that the role of PBMs over the next few years could change substantially. According to Clarke, roughly 32% of respon-

dents said they plan to eventually bring in-house services now being performed by a PBM, compared with only 11% who said they plan to outsource their pharmacy component to a PBM.

The trend toward bringing pharmacy services in-house makes sense, given the number of managed care organizations that have grown in size due to mergers and acquisitions, Clarke said. The larger the health plan, the more cost-effective it is to offer PBM services, disease management, and other in-house products. Bringing PBM services in-house also allows health plans to keep a finger on the pulse of what's going on, making it possible to quickly respond to emerging changes in the market. Bringing PBM services in-house also gives plans direct ownership of important pharmacy data. This is critical for proper formulary management, conducting outcomes studies, and promoting patient wellness and satisfaction.

PBMs will continue to play a significant role in the future, but they will be different than they are today, moving more into other areas such as data analysis and medical informatics, Clarke predicted.

MANAGED CARE PHARMACY: AN INDUSTRY STILL EVOLVING

One only needs to look at the evolution of the HMO industry to get a glimpse of where managed care pharmacy is heading, said Gregg Fell, president of MRI Sales Consultants, a managed care executive search firm based in Baton Rouge, Louisiana.

During the early development of HMOs, there was much reluctance on the part of physicians, consumers, purchasers, and others to accept managed care, Fell noted. But once the idea caught on, rapid growth in membership, revenue dollars, and the number of new players quickly followed.

Fell believes managed care pharmacy has been on an almost identical path, and now is undergoing the second phase of its evolution—one marked by

mergers, consolidations, and takeovers, along with a trend toward centralizing power and decision making within individual organizations. The industry also is witnessing the rapid introduction of new pharmacy benefit management products into the market. HMOs and PBMs are no longer limited to just offering mail-order services, formularies, and generic substitution programs. They now offer innovative products and services, including disease management programs, outcomes measurement, and call centers, where patients can phone in and receive a prescription via a pharmacist or nurse, or receive information concerning drug interactions. Some PBMs are even offering consulting services to HMO clients on what steps they can take to pass NCQA accreditation surveys, according to Fell.

REGIONAL DECISION MAKING, DATA SYSTEMS KEY TO FUTURE

Fell predicts that within the next five years, the trend will shift toward more local and regional decision making within managed care pharmacy. Companies "are realizing that it is very difficult to effectively manage health care in a global sense," Fell said.

The use of information systems also will continue to grow; companies already are "investing millions of dollars in new information management systems and database technologies. Data systems need to be more flexible than ever and able to change quickly," Fell added. The trend toward integrating medical and pharmacy data also will continue.

Managed care pharmacy is growing at an even faster rate than managed care as a whole. This is because many HMO professionals have migrated into the managed care pharmacy industry, bringing with them successful ideas and business strategies, and leaving behind those ideas and strategies that failed to work previously in the managed care setting, Fell believes.

Pharmacy managers must assume more of a leadership role to make truly

positive changes that lead to improved quality of care and lower costs within the health system. "The demands of the pharmacy manager today are greater than ever before," Fell emphasized. Purchasers and consumers of managed care services want better and more sophisticated information, including specific information on prescription drug use and costs. Meanwhile, health plan physicians, customer service representatives, sales and marketing people, financial analysts, and senior managers increasingly are consulting with pharmacy managers for their input on issues ranging from pharmacy benefit design

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to negotiating pharmacy and drug manufacturer contracts to formulary management and development.

Pharmacists who can effectively merge their clinical expertise with the right business skills are poised for success as managed care continues to evolve, Fell believes. Pharmacists also need good computer and communication skills to meet the emerging demands of the market.

MEDICAL DIRECTOR PERSPECTIVES: CLINICAL TEAM APPROACHES TO CHRONIC CARE

Pharmacists are no longer simply dispensers of medication. More and

more, pharmacists, especially those in managed care settings, are working closely with physicians to improve the quality and cost-effectiveness of patient care. During a concurrent session on May 9, Bruce Nash, M.D., of Community Health Plan, Latham, New York, and Sam Ho, M.D., of PacificCare, Cypress, California, talked about specific ways pharmacists can lend their clinical expertise to create a positive impact on their organizations and their patients.

For generations, pharmacists have for the most part played a highly subservient role to physicians, even in situations where the pharmacist knows what's best for the patient. But that's starting to change.

"This is your opportunity to seize the moment," Dr. Nash told his audience of managed care pharmacists. "Don't wait for someone on the medical side to ask you to do it," Nash advised. "Be proactive."

Pharmacists, especially those in the managed care environment, serve as important resources for physicians and managed care administrators, Nash said. Pharmacists need to step forward with specific clinical issues that arise as well as ideas for improving care that they may have been reluctant to bring up in the past. "I guarantee you, if it's not appreciated today, it will be appreciated tomorrow," he said.

Pharmaceutical profiling offers many opportunities for pharmacists to make positive contributions. Nash said "There's an enormous amount [of information] pharmacists have about each dispensing physician they work with and, right now, we can say that knowledge has not been captured to a significant extent." This includes not only information garnered through sophisticated computer systems, but "informal" knowledge the pharmacist has about the various prescribing habits of individual physicians.

One example includes recurrent prescription errors by an individual physician. "I dare say that a lot of you know which doctors [in your plan] are making a lot of prescription errors, and

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I would dare say, no one is reporting them." Even the best doctors will sometimes make errors, Nash observed. But pharmacists need to notify medical directors of situations when an individual doctor shows consistent problems, such as making several prescription errors in a month. He offered other examples of where pharmacists need to intervene in the care process:

▲ A patient comes in for a refill on an antibiotic. Records show the patient has been on the drug for more than four weeks, but is not feeling better.

▲ A pharmacist discovers that a patient is not complying with her medication regimen.

▲ A patient is confused about the right dosage because he is on a single drug that was prescribed and subsequently refilled in different dosage forms. Coumadin, for example, may have been prescribed for the same patient in doses of 1, 2, 5, and 10 milligrams. The patient says he has been combining tablets of different strengths to get the right dose, but the pharmacist discovers that the patient has been associating the wrong color tablet with the wrong dose, and therefore has not been taking the correct dose.

▲ A patient comes in for a refill for a cholesterol-lowering drug. The pharmacist asks her when she last saw her doctor for her cholesterol problem, but she cannot recall.

Nash recalled a personal experience where a pharmacist alerted him to a problem with adverse drug reactions. The patient was a 55-year-old male who smoked, was under stress, suffered from respiratory and gastrointestinal problems, and was on three medications—Theodur, Zantac, and Propulsid. The pharmacist pointed out to Nash that Theodur, a muscle relaxant, can cause

gastrointestinal reflux by lowering esophageal sphincter pressure. He suggested switching the patient to a beta-agonist inhaler for his respiratory ailment. Since the switch, the patient no longer suffers from stomach problems, and so is no longer taking the H2 antagonists. "I think there are a lot of patients out there who are subject to the side effects of their own medications, and physicians really aren't aware of some of the more subtle effects of those interactions."

"We need a mechanism to tell the physicians," when such situations arise, Nash said. "As we redesign systems of care, we have to come up with better ways of [doing this], and the dispensing pharmacists are right down there on the front line and able to help us," he said. "I think pharmacists can lead the way in trying to establish some guidelines, or at least work with the clinicians to establish guidelines, for effective intervention and treatment in some of these potential problem areas."

Many other opportunities await pharmacists as more specialty clinics develop to manage patients with specific medical problems that are effectively treated by medication, including anticoagulation, cholesterol, diabetes, asthma, and hypertension clinics. "I have no question that the care can be provided in an equal, if not better manner, in a well-designed system run by pharmacists," Nash said. "That's probably the future, and you need to be prepared."

MEDICAL GROUPS: NEW OPPORTUNITIES FOR MANAGED CARE PHARMACISTS

Managed care pharmacists have new opportunities to work directly for large medical groups that are focused on improving patient outcomes and lowering medical costs, says Dr. Sam Ho of PacifiCare.

In California, where many large medical groups have successfully adopted managed care techniques, some

physician groups are employing clinical pharmacists on staff to institute therapeutic interchange programs on-site, Ho told attendees. Other emerging opportunities for managed care pharmacists include working at specialty clinics and instituting H. Pylori programs to successfully identify and treat patients with gastrointestinal problems on H2 antagonists who should be monitored and treated with the appropriate antibiotics when needed, he said.

At PacifiCare, which serves more than 1.5 million patients primarily through IPA/Network Model, a medical group, managed care pharmacists are highly integrated within the system, along with physicians, nurses, medical directors, data analysts, and wellness and health improvement practitioners, Ho said. Many serve on Pharmacy and Therapeutics Committees at the medical group level, he said. "The challenge for clinical pharmacy is to begin to do population-based measurements, integrate total health care costs and outcomes data with pharmacy data, and of course, overcome physician prejudices and biases."

Pharmacists provide academic detailing at the physician level, and often work with the local medical directors to educate and persuade doctors to prescribe more cost-effective therapies. Pharmacists also perform drug utilization review, develop physician prescribing report cards, develop prescribing guidelines and clinical pathways, and help physicians understand patients' pharmacy benefits, Ho said.

Pharmacists were instrumental in a program instituted at two PacifiCare medical groups to increase the use of OTC medications for certain patients on antihistamines and NSAIDs, while decreasing prescription drug usage. Other successful programs included getting physicians, with patient consent, to switch to less expensive brands of ACE inhibitors and H2 antagonists. ■