Designing a Framework for Pharmacy Practice: A Look at Consumer Reactions and Expectations

The Academy of Managed Care Pharmacy (AMCP) has had a task force at work since early 1999 to design "Pharmacy's Framework for Drug Therapy Management in the 21st Century." While there has been no shortage of studies and committees exploring the future of pharmacy, AMCP's endeavor has one important feature that sets it apart from previous efforts: It sought direct input from pharmacy's customers—specifically, academicians, drug manufacturers, employers, government officials, health plan administrators, patients, and physicians.

AMCP sees these individuals as key "consumers" in managed care pharmacy. And because AMCP values their health care decision making, the organization felt it was critical to include these groups' voices in creating a pharmacy framework that responds to their needs and expectations.

Toward this end, AMCP conducted a telephone survey of 20 individuals in September and October 2000. Some of the results were unexpected; others were compelling. In essence, it was felt that sharing

these insights could help stakeholders work together to design a more sensitized framework for pharmacy practice.

Respondents included two academicians, two representatives from drug manufacturers, four employers, two government representatives, five health plan administrators, two patient representatives, and three physicians. Each was asked about seven key customer expectations. Of these seven expectations, five prompted the most thought-provoking responses among the interviewees:

- Drug-related problems will be identified, resolved, and prevented.
- Care is coordinated.
- There is value in the care that patients receive and it is affordable.
- The system is accessible and is looking out for the patient's best interest.
- The system will provide adequate and appropriate information and education regarding appropriate drug use.

■ The Responses

This section includes responses to the areas addressed within these five expectations.

Asterisks (*) separate interviewees' responses. A diamond (◆) indicates that no differing or compelling statement was made.

Drug-Related Problems Will Be Identified, Resolved, and Prevented

Many of the respondents noted that while society generally expects that drug-related problems will be identified, resolved, and prevented, they say that: (1) such efforts are not being carried out; and (2) computer systems that link certain drug-therapy data between physicians' offices and pharmacies would help identify potential adverse drug events.

(1) Drug-related identification, resolution, and prevention efforts are not being carried out.

Academicians (one of two respondents agreed): "There are some good systems for monitoring and detecting drug-drug interactions using sophisticated software, but having the software and rating systems currently in place can never overcome a reimbursement system that works in the opposite direction."

Authors

LISA LOPEZ is president of Chaac Communications, a health care editorial consulting practice in Athens, OH. ALBERT WERTHEIMER, Ph.D., M.B.A., is a professor at Temple University School of Pharmacy, in Philadelphia, PA.

AUTHOR CORRESPONDENCE: Albert I. Wertheimer, Ph.D., M.B.A., Professor, School of Pharmacy, Temple University, 3307 N. Broad St., Philadelphia, PA 19140; Tel: 215-707-1291; Fax: 215-707-8188; E-mail: albertw@astro.temple.edu.

ACKNOWLEDGMENT: This article reports on a professionally conducted series of telephone interviews with pharmacy stakeholders and consumers regarding their expectations and reactions to the provision of drug therapy management services. Responses are categorized by participant affiliation, and some of the more insightful findings are presented here. This endeavor is a component of the Academy of Managed Care Pharmacy project to develop a Framework for the Provision of Drug Therapy Management Services in the 21st Century, slated for completion in late 2001.

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Drug manufacturers (two of two respondents agreed): Both respondents noted that there are opportunities to improve current efforts. "Managed care pharmacists are actually in a pretty good position to more closely mimic a hospital pharmacy than a retail pharmacy, with the added benefit that they can reach more people through sophisticated use of formularies and availability of drugs, and a sophisticated linkage with the medical partner of their managed care organization in which they view disease management as an objective. They may (target) diseases that cause multiple visits to specialists and hospitals or that require emergency room visits."

Employer purchasers (three of four respondents agreed): "I think the systems are in place—they are good and the health care offerings that the employers have do look closely at the drug component so that there's adequate access, it's affordable, and there's some level of cost-sharing. However, in many cases employers feel they are paying for a drug benefit and they're not sure what outcomes they're getting from it." *** "The largest insurer here has 75% of the marketplace and has a drug benefit program that employers buy as part of the benefit. Yet there's a feeling that employers have of, 'why am I spending all of this money on drugs when you haven't shown me anything?' Even in [the insurer's] disease-management program, drug is an afterthought with them. It's not an integrated approach. I haven't seen anything that shows an integrated model with good outcomes. [As an employee benefits consulting group], we've been able to show with some of the health conditions that by appropriate medical and drug treatments, you can increase employee performance. One example is Heinz. During certain times of the year they do a lot of wellness education on allergies and the use of sedating versus nonsedating because Heinz has bought into the model that says that nonsedating antihistamines will increase productivity and are a safety component. [The employer has] also pushed this back to the health plan and asked that

the nonsedating antihistamines be placed in an appropriate therapeutic class of being preferred because of the fact that they are a manufacturer."

Government representatives (two of two respondents agreed): "Part of what we're trying to do in this Congress is encourage research into what else can be done with regard to medical errors. This is research into how we perceive and address the problem, in other words, comparing our medical system to other systems, such as the airline industry, and how they handle problems. It includes conducting some of the research that has not been done on drug-drug interactions. We don't have hard research that we can tell doctors and pharmacists about certain things."

Health plan administrators (three of five respondents agreed): "There are no universally applied effective systems in place. HEDIS [the Health Plan Employer Data and Information Set] is not addressing the drug therapy process—and should." *** "I think the system is much more proactive and is working well. People are getting in the system earlier because they are more knowledgeable and more have health coverage than ever before."

Patients (two of two respondents agreed): "Consumers, even advocates, don't understand where health care decisions (much less process decisions) are being made. That process is closed and there's no way for consumers to really know what's going on. Nor do all consumers always have an adequate appeals process or independent review. They should have that as well. Certainly decisions (about what drugs to include in a health plan) should be made, but how we do that is more difficult."

Physicians (three of three respondents disagreed): "The current system is moderately effective at identifying and resolving drug errors and adverse events. I always found it kind of a joke that the FDA [Food and Drug Administration] sends out the forms doctors are supposed to fill out when they identify adverse drug reactions. Now I don't know any doctors that fill those out. They may see an adverse

reaction—the side effects of something—and unless the pharmacist finds out about it, which I think they're better at identifying and reporting, it's overall a moderate effort. Certainly the more major events are likely to be reported, where someone has been hospitalized."

(2) Linked computer systems would help better identify potential adverse drug events.

Academicians (two of two respondents agreed): "Pharmacy-based information systems are rarely used, and if used, there's no payor on the other end to recognize the value of those services. These type of programs are successful at reducing total [health care] costs, but they always increase drug therapy costs."

Drug manufacturers (two of two respondents agreed): "[This is also] a systems issue. There aren't systems in place to do things like provide outcomes data. If in fact we had a true physician/patient interaction system, something that captures electronically that interaction in the doctor's office and is put into a database, then you would have real-time studies. We miss the opportunity as soon as that patient sits down with the physician. The information, including the prescription, gets put on a piece of paper and gets filed away and is inaccessible to the rest of the health care scheme in most cases. That's why I think an electronic patient record form in U.S. health care would change the dynamics of health care delivery."

Employer purchasers (four of four respondents agreed): "PBMs [pharmacy benefit management companies] have done an excellent job with the messaging systems in place—we don't have that on the medical side. Pharmacy has been up to speed with technology, but it's a shame that we don't use it to get the pharmacist involved in it up front. Especially with all that point-of-care technology they talk about today. A physician could just do the diagnosing and this technology could help the doctor prescribe the right drug based on the plan's formulary and other conditions the patient has."

Government representatives (two of two respondents agreed): "As a health care system, we ought to move toward electronic prescribing and record keeping. But the question is, 'which sector absorbs the cost?' Electronic prescribing and record keeping lends itself to electronic patient compliance as well. There are some systems that monitor compliance through refills. Certainly the pharmacist can't be responsible for calling patients every four hours to make sure they're taking their medications. I hear about systems that are in place in pharmacies where they flag drug-drug interactions before they're filled, so either the pharmacists are escaping right past the flag or are turning the system off because it's a nuisance, and because they are thin on their margins."

Health plan administrators (five of five respondents agreed): Linked systems are good, but certain efforts, like routine and preventive care is "best carried out by non-MD types." *** "The only time we see any attempt at this [linking systems] is when we have money, but it usually falls by the wayside for other things. It happens every three to five years. So we don't get very far because it's just too complex to try to develop and link everything. Plus, with people moving in and out of plans, that makes it hard to do long-term studies. I think what will happen in the future is that a SmithKline or a Merck will open their own disease-centric sites, such as a diabetes center, and have people get a full array of services for their conditions."

Patients (two of two respondents agreed): "The resources that consumers are using to get information are the Internet; talking to doctors, pharmacists, friends, and relatives; and TV and radio."

Physicians (three of three respondents agreed): "Improved automation and the application of technology [are needed] where doctors don't have to think about their selection of drugs or scheduling of follow-up. Patients may change doctors and health plans, so a common database—a linking of databases by sharing of

data electronically—would be very helpful." *** "There are emerging more and more automated systems to try and catch potential drug-drug interactions, identify allergies, and these kinds of things before drugs are delivered. That will work best where the patient gets all their medications at one pharmacy or one pharmacy chain."

Care Is Coordinated

All respondents believed that coordination of drug therapy is particularly essential when care is provided by multiple health care professionals. They also said that communication among such providers is important. However, while many providers are competent, most respondents said that: (1) Few pharmacists are involved in collaborative, multidisciplinary care; and (2) the drug therapy process is still very much a paper-based, nonintegrated system that will require an investment in computer systems to coordinate and integrate medical and pharmacy information.

(1) Pharmacists are involved in multidisciplinary care.

Academicians (two of two respondents disagreed): "This is not often achieved. In some areas, such as diabetes and asthma, pharmacists are involved, but there are certain areas where they aren't and where compliance is very important, such as hypertension."

Drug manufacturers (two of two respondents disagreed): "So much of a pharmacist's job is regarded as physical dispensing; interpreting the prescription correctly, drawing it down from the inventory, counting out the requisite number of tablets, and then getting it to the patient, and increasingly, within the constraints of whatever health plan the patient is covered by. There is a whole other aspect of pharmacy, which is counseling and drug-utilization review, and even screening. In a hospital setting where you have a salaried pharmacist, they probably practice many of these broader disciplines."

Employer purchasers (four of four

respondents disagreed): "In California, big group practices have—from what I've heard—pharmacists on staff. I think that's ideal. Pharmacists should be working in the outpatient arena, not just the drug stores, but for groups of physicians they should be consultants providing their expertise. Perhaps they're reviewing a week's worth of cases that a doctor might see to see what drugs have been prescribed and what may or may not have been prescribed appropriately. If doctors don't have time to go back and check everything about a patient, to know that someone is monitoring them [is good]. Basically now there is no accountability. There might be in the hospital, but there isn't on the outpatient side."

Government representatives (two of two respondents disagreed): "Certainly the PBMs and managed care plans have been outspoken in demonstrating how they have the ability to operate effective disease-management programs. But the pharmacist has to be an integral part of that."

Health plan administrators (four of five respondents disagreed): "Pharmacists are often among the first to see things going wrong with patient compliance because patients come in for refills more frequently than they go for doctor visits—yet they are out of the loop with other providers," says one administrator. He continues, "There's an opportunity for quality control. They could reinforce preventive services—remind patients to get a mammogram or make sure the kids are immunized."

Patients (two of two respondents disagreed): "I don't know that people think of their pharmacists as a key player in the use of pharmaceuticals. When I ask pharmacists a question, I feel like I'm bothering them. In fact, when I go to pick up my prescription, I'm asked to sign a form, which automatically includes the sticker, 'I do not want consultation.' When you sign, it looks like you're signing for your drug. But there's an assumption that you do not want a consultation. It certainly doesn't suggest to someone that, 'Oh, I can talk to

my pharmacist about this."

Physicians (three of three respondents disagreed): "The pharmacist shouldn't just be the lackey of the physician—'do whatever I say.' A relationship between the physician and clinical pharmacist [should] set some guidelines or norms as far as that relationship and making decisions. Also, clinical pharmacy management programs should be monitoring and measuring their results and outcomes and have that be their 'truth in advertising.' It would let the referrers—the physicians—know what results you get."

There Is Value in the Care that Patients Receive, and It Is Affordable

All the respondents believe that drug therapy plays an important role in the quality of care patients receive. However, they vary in the degree to which they feel that: (1) the cost of drug therapy is an important consideration in the selection of drug-therapy options; (2) the value of drug therapy is demonstrated in improved health and higher employee productivity; and (3) the value of drug therapy is reflected through lower drug benefit costs.

(1) Drug cost should be considered in therapy selection.

Academicians (two of two respondents agreed): "Drug formularies can get at drug costs, but recommendations around use of certain drugs—evidence and supporting information—should be used."

Drug manufacturers: (two of two respondents agreed): "I do constantly remind people that price increases are a small portion of the total, and in fact, relative to what the newer products do versus the older products. We have to keep in mind is that we're talking about improved quality of life, the ability to keep people out of the hospital; then the answer is; there should be cost-benefit there. But it is a very difficult argument to get people to focus on."

Employer purchasers (four of four respondents agreed): "[The cost of drugs] is not painful for most consumers, but it is if you don't have coverage."

Government representatives (both respondents both agreed and disagreed): "In some cases cost is an important consideration. Nowadays with chronic illnesses, like Alzheimer's, the two drugs price-wise are the same. If you focus too much on cost savings, you don't get the full picture of appropriate use. Health care is not like a contract with the defense department where you're ordering parts."

Health plan administrators (five of five respondents agreed): "Health plans should be talking with the pharmacists and vice versa regarding what the health plan is doing regarding therapy decisions. On our part—and we should be doing this and we're not—health plans should be educating the pharmacists about what the P&T [pharmacy and therapeutics] committee is doing and involve them in our therapy decisions." *** "If you can determine that you have a drug that has the same effect as another drug and is half the cost of that other drug, it would be negligent to purchase one that costs twice as much."

Patients (two of two respondents agreed): "A lot of Medicare beneficiaries have joined HMOs, mostly because of the prescription drug coverage. But now that that's being decreased quite a bit and there are more expensive drugs, they have a lot of anxiety about how they're going to continue to pay for their drugs. There's also a concern [among consumers] about rising insurance costs, and formularies and their restrictions. They feel, and appropriately so, that these decisions are made by managed care companies with only the cost in mind, and that the physicians have been brought into the process of rationalizing the cost of drugs."

Physicians (three of three respondents agreed): "It would be inappropriate to not weigh in the cost. Cost to the individual member, but overall cost to the health plan, then the employer, and then the society—patients and doctors need to make that link more often. Even though the copayment may be only \$5, and it's one of the more expensive drugs, we ought to be looking at alternatives

because there are limited resources out there." *** "Yes, cost should be considered for multiple reasons: (1) many patients still pay out of pocket for drugs; (2) as a societal issue, the more expensive drugs are not always the better drugs (we could talk for hours about the pressures of direct-to-consumer advertising and the lack of balance of information about therapeutic options); and (3) most physicians don't know what the cost of drugs is. In our system, we frequently get little statements/reports from the pharmacy comparing the cost of different drugs and it's eye-opening. It makes me question whether the drug that costs 10 times more than the other drug is better."

(2) Drug therapy value reflects improved health and higher employee productivity.

Academicians (two of two respondents disagreed): There is significant lack of accountability in drug therapy, says one academician: For example, he says, "a health plan fragments the system when it turns the drug therapy benefit over to a company like PCS, who in turn can restrict the formulary and has carte blanche to do whatever they can to manage the budget. The fact that they're not managing hypertension patients with optimum drug therapy, for example, is irrelevant. They're reducing drug costs and that's what they're paid to do." *** "The flaw in the current system is that it's not in the managed care organization's benefit to do things that will prevent the disease in two to five years because the patient may not be covered by the plan for more than one year. So there's no incentive for the managed care organization to work with people on smoking cessation and weight control and exercise, because that's not going to save money now."

Drug manufacturers (two of two respondents agreed): "I think you have to look at the value of the pharmaceuticals, not the cost, and that we do that in everything we purchase. We trade off the cost of what we're going to pay versus the benefits that we'll receive."

Employer purchasers (four of four

respondents disagreed): "Disease management is a positive step in the right direction, but the danger is that the pharmaceutical industry has jumped on that bandwagon and gotten into that business and in a very subtle way is trying to promote the use of their drugs. They never name the drug specifically, but they see it as a marketing strategy. [As an employer], I would not use those programs because I see a conflict of interest. PBMs are suspect, too, because of their rebate incentives." *** "Unlike larger employers, small employers lack the sophistication about health care quality. It's perhaps the less-mature managed care markets where those employers lack that kind of sophistication to get past costs. You've got to get past that because if you can improve health outcomes, you will eventually improve costs. As an example, a lot of employers today won't cover Zenecal for obesity, and they don't understand the kind of morbidity associated with weight gain and [that] if you can reduce weight you can reduce cholesterol and diabetes-related incidents. I think we're at a point right now where we need to educate employers about total health outcomes."

Government representatives (two of two respondents disagreed): "The drug-utilization review system is how we identify prescribing patterns [for Medicaid] and it has been effective, but generally, systems aren't in place in our health care system to determine if patients are getting the appropriate therapy for their conditions."

Health plan administrators (five of five respondents disagreed): ♦

Patients (two of two respondents disagreed): "I don't know that people think of their pharmacist as a key player in the use of pharmaceuticals. I know when I ask pharmacists a question, I feel like I'm bothering them. In fact, when I go to pick up my prescription, I'm asked to sign a form, which automatically includes the sticker, 'I do not want consultation.' When you sign, it looks like you're signing for your drug. There's an assumption that you do not want a consultation. It certainly doesn't suggest to someone that, 'Oh, I can

talk to my pharmacist about this.'"*** "There's really a lack of good data analyzing the value of drug therapy right now. And what I mean by value is the most effective drug. They're not capturing that data—I'm not sure they're asking the right questions."

Physicians (three of three respondents disagreed): "Patients want to do the best they can, but they face a barrier in that if the cost is too high and even if that's what they know that's what they should take, they're not going to be able to [afford it]. A major barrier [to good outcomes/compliance] is dosing: patients with one- or two-times-a-day medications will have better compliance than those who have three- or four-times-a-day dosing requirements."

(3) Drug therapy value is reflected in lower drug benefit costs.

Academicians (two of two respondents disagreed): See #2.

Drug manufacturers (two of two agreed): "Employers have been asking health plans to carry [most of] the burden of the cost of drugs. The health plans are very mindful of it. Because they are measured on those budgets, they have more or less the ability to impact that depending on the amount of the control they have over being able to direct drug therapy to patients."

Employer purchasers (four of four respondents disagreed): It is possible for the value of the drug therapy to be reflected in the drug benefit, says one respondent. "The managed care and pharmaceutical industries think that employers have tons of resources that they can purchase these [disease-management programs] when in reality the HR [human resources] and benefits budgets are just squeezed like you wouldn't believe. Take health-risk assessments [HRAs]. If a company were doing annual HRAs that loaded into a database, I think you could really find a lot of potential, undiagnosed folks and recommend them to a primary care physician for screening or evaluation, but in reality, very few employers do health-risk assessments. It would be nice if some MCOs [managed care organizations] or PBMs could include that."

Government representatives (two of two respondents disagreed): ♦

Health plan administrators (four of five respondents disagreed): Drug therapy value would be best reflected if "doctors would diagnose the illness and the pharmacists would prescribe the medicine. I would like to see that happen because the pharmacist is more attuned to the medications than the doctors are."

Patients (two of two respondents disagreed): "There's concern [among consumers] about formularies and their restrictions. They feel, and appropriately so, that these decisions are made by managed care companies with only the cost in mind, and that the physicians have been brought into the process of rationalizing the cost of drugs."

Physicians (three of three respondents disagreed): "One of the concerns I have is that because of the payment systems and the at-risk systems and the preauthorization systems, it's often putting the pharmacist in the uncomfortable position of trying to broker what the health plan is demanding—'We won't pay for this drug'—and what the physician wants to prescribe. That's a very difficult and unreasonable position. It's less a discussion around appropriate therapy options than it is what will the health plan or insurance company pay for." *** "MCOs can and sometimes do change formularies frequently, which can change the patient's medication, so that's been at the MCO's request, not the physician's or the patient's request. Trying to coordinate the drug therapy of a patient who has different providers is difficult. Also, some patients don't understand why you need to treat hypertension for 5 to 10 years to get any benefit. They may think that 'If I'm not getting a benefit immediately, then I don't need to stay on the medication.' I think we as society look for an immediate fix, an immediate cure, and don't look for the long term."

The System Is Accessible and Is Looking Out for the Patient's Best Interest

In terms of this expectation, respondents believed that: (1) most pharmacists do not have access to clinical and patient data, but they disagree on whether they should; and (2) pharmacists must do a better job coordinating drug therapy concerns through coordination of care with other providers or through enhanced patient services.

(1) Give pharmacists access to patient data.

Academicians (two of two respondents agreed): "The dispenser has almost none of the clinical data to help assure appropriate drug therapy—it obviously would help. Currently [the exchange of such data] is at a pretty low level."

Drug manufacturers (two of two respondents agreed): "Managed care pharmacy isn't involved in the physical act of dispensing, therefore they can be involved in the act of thinking through how pharmacy care should be delivered. They have access to data on individual patients and all patients in the system. Access to those data, particularly if it's integrated with the medical diagnosis data—in other words, being able to cross-integrate the diagnosis, treatment, and the outcomes—is a huge potential advantage for managed care pharmacy."

Employer purchasers (four of four respondents agreed): "The model I've always tried to encourage people to think about is a system where the pharmacist is a primary care provider, where the pharmacist gets involved at the prescribing level with the physician at the drug-selection process. Our system today doesn't support that for a couple reasons: Physicians wouldn't allow that to happen because it would mean lost revenue for them, and pharmacists don't have the adequate training or resources to make that happen. Some chains are trying to improve that with counseling centers."

Government representatives (one of two respondents agreed): "There will always be a constant push and pull between the doctors, and I'm not sure I want to weigh in on that yet because I am a layperson when it comes to these areas. But I think

that that is one place where the more integrated systems of health care delivery have an advantage, and to the extent to which we are moving away from integrated systems is a disadvantage."

Health plan administrators (four of five respondents agreed): "Pharmacists should have access to such data. It's definitely important for them to understand what's being prescribed and are there any other contraindications out there. It is not their place to question what the therapy outlines are, but they should be able to have access to all pertinent data. This is a major quality part of the equation." *** "Our clinical information system is set up so that our physicians and pharmacists can see what drugs the patient is on. If either party has questions about the patient, they have the ability through this system to easily share information and concerns. We have taken further steps with additional programs to improve drug therapy outcomes. We have an anti-coagulation clinic that just focuses on patients who are on anti-coagulation drugs; the clinical pharmacists run that program with the physicians' input."

Patients (two of two agreed): While respondents agreed with this type of collaboration, they also felt that physicians should decide what type of drug patients get: "Ultimately patients should get the drug that their physician says they should get and it should be the physician who determines whether the drug is effective or not, and if it is determined to be effective, that the drug should be covered and covered at the copayment of the [health plan's] preferred drug. So, for instance, if the plan only covers a certain drug for a particular condition, but the physician feels another drug is more effective, the plan should [allow] the [patient to have the same] copayment for the physician-recommended drug as its preferred drug."

Physicians (two of three respondents agreed): "I think pharmacists should have a moderate amount of patient clinical data, definitely allergy, and certainly other medications. I'm not sure they need the full patient record from the doc-

tor visit, with the detail of medical history." *** "Many pharmacies have put in monitoring systems—do they have access to all patient data, clinical lab results? No. Nor do pharmacists have information about other drugs patients may be taking. I think good clinical pharmacists are looking out for the patients' best interest but are handicapped by the lack of patient information and lack of reimbursements for efforts to better monitor and manage patients."

*** "Physicians have been recoiling, particularly as their incomes have gone down and they're feeling hammered on by insurance companies and it makes them disgruntled and makes them say, 'I don't want my patient to be cared for by a pharmacist or by someone else; I don't want to share information.'"

(2) Pharmacists must improve drug therapy coordination with other providers.

Academicians (two of two respondents agreed): ♦

Drug manufacturers (two of two respondents agreed): "Pharmacists need to collaborate with other providers in the system. I think the Internet will assist in this collaboration. I see a great role for pharmacists in demand-management programs where they actually monitor and follow patients and proactively call them. I know that managed care companies are looking at the role of pharmacists doing this."

Employer purchasers (four of four respondents agreed): ♦

Government representatives (two of two respondents agreed): "Right now there's little teamwork going on in managed care—where, for example, a pharmacist has individuals referred to him. That's what managed care should be about—professionals working as a team. There needs to be a case manager or medical social worker to work with patients. We feel that pharmacists can work with these individuals more closely; there's a lot of potential for pharmacists to take on this role. I think other health professionals—nurses, dieticians, or exercise experts—could be a part of

this. The pharmacist is the best person to be there to counsel the patient for persons taking multiple drugs, especially people with chronic conditions."

Health plan administrators (five of five respondents agreed): "In our medical offices [group model HMO], we have clinical pharmacists as well as operation pharmacists in each of those medical offices. So the interaction between the nurse practitioner, the pharmacist, the physician, and the physician assistant occurs very easily as a result of the fact that they work for the same organization and have the same common goals."

Patients (two of two respondents agreed): "I think now there's a lot of turf battles. I think in a lot of other settings—hospitals and some managed care settings—that's starting to change, with pharmacists and physicians working together as teams with other providers, nurses, etc. It's been found that when doctors and pharmacists work together and communicate on a regular basis, that patient care is better, hospitalization goes down, and that there are fewer errors, especially medication errors."

Physicians (three of three respondents agreed): "In the present setting, I think pharmacists could provide checks and balances for doctors, watching for drug interactions, potential problems with allergies, giving a certain amount of added education for patients, perhaps advising other ancillary services or devices that may be useful to the condition/patient. I would like to see an expanded role for the pharmacist in assistance in drug selection." *** "As a society we're better at reporting on Firestone tires that need to be recalled than to identify patients who need to be on medications who aren't. One obstacle is the feeling that pharmacists, physicians, any provider that touches the patient needs to spend less time with that patient and see more patients in order to generate an income. In general, patients tend to move around a lot more to doctors and pharmacies and it's difficult to get the [providers] or their electronic systems to talk to each other."

The System Will Provide Adequate and

Appropriate Information and Education Regarding Appropriate Drug Use

The interviewees all agreed that informed patients are the key to improving compliance with drug-therapy regimens and to improving their health outcomes. The respondents differed somewhat, however, in their perceptions about whether patients receive and understand drug therapy education, including the purpose for drug intervention, and therapy options including lifestyle changes and self-care.

(1) Patients receive and understand their drug therapy.

Academicians (one of two respondents agreed): "Patients receive criminally negligent information about their drug therapy. They also do not understand how poorly their drug therapy is managed. Plus, their expectations are extremely low." *** "We've transitioned from a time where sick patients went to a doctor and took the prescription and treatment, to one where we're giving the patients information and choices about their treatment, and they're making decisions about the diagnosis. I think that's good; the baby boomers are approaching their senior years—throughout their lives they have demanded responsibility for their well-being and they'll continue to do that. But while individual physicians may allow that, the system overall is not set up to do that because the people who pay for the care may feel differently than the people who provide the care."

Drug manufacturers (both agreed and disagreed): "If you're a college-educated 45-year-old woman who insists on knowing what your options are—'What are the different diagnostic tests I can take,' 'What are the different results,' 'How do you interpret the results,' 'What's the variation of response typically with this test,' 'What are my treatment and prescription options?'—then you'll generally get a great deal more information [from the doctor] and good advice. Someone less willing to ask all those questions and who is perhaps less well-educated, and older, may not get the same sort of breadth of dis-

cussion." *** "AAFP [American Academy of Family Physicians] has encouraged pharmacists to be physician-extenders, which is a first step of what pharmacists can do. Maybe something that AMCP could do is look at how to bring these groups together to talk more about these collaborative things that need to be done."

Employer purchasers (four of four respondents disagreed): "There aren't a lot of opportunities for pharmacists to provide clinical intervention/counseling at the retail level because time is not on their side. Often they just want to give patients the prescription without having them wait too long. Plus, retail pharmacists are often understaffed. That's a challenge for any PBM or that any pharmacy system has on the retail side. Some PBMs are trying to find innovative solutions to try to include the retail pharmacists." *** "I still see very little patient education going on, over the counter and in terms of follow-up. From what I've seen not a whole lot has changed in maybe 20 years. The pharmacist is by and large busy filling prescriptions, taking care of paperwork, and following up on telephone calls."

Government representatives (two of two respondents disagreed): "We hear stories [from consumers] about counseling and compliance, that the counseling is not being done as it's intended to be done. For the large part, I think the busyness of the pharmacy is to blame, so the question is, 'How do we relieve the pressure on the pharmacist so the pharmacist can fill in the role that policy makers would want the pharmacist to do?' Policymakers are clearly aware that we are facing a pharmacist shortage. The question is, are there some things that can be done in a different way—pulling pills off shelves, counting pills, utilizing more automated and packaging systems—to make it easier for pharmacists to do their job?"

Health plan administrators (three of five respondents agreed): "Less than half the diabetics in the United States are under appropriate therapy. Even under well-run diabetes-management programs, there's probably 70% who are

properly managed. Patients still have little understanding of their disease. Less than a third of patients conclude their course of antibiotics appropriately—something as simple as that. We've still got a long way to go."

Patients (two of two respondents disagreed): While consumers often look to direct-to-consumer ads to get their information on drugs, "they feel those ads don't give them the full information about risks and side effects and safety issues. What they're doing is looking at the ads and pulling up more information

on the Internet."

Physicians (three of three respondents disagreed): "I think education of the patient often gets short shrift. Patients often don't get that unless they seek it themselves, ask questions or get it on the Internet. They've too long relied on doctors to spoon-feed them through the process."

■■ Conclusion

The AMCP Task Force is continuing its deliberations on these findings, and is expected to have a framework ready for comment in late 2001. In the meantime,

the project, funded by the Foundation for Managed Care Pharmacy (FMCP), is preparing a list of critical functions in drug-therapy management, along with an example of what a perfect score in that function might look like, and a self-assessment instrument for pharmacists to determine how well they are prepared to practice at the level of the Framework. The final product will be a generic document and practice-site blind, but will include specialty-specific assessments. ■