



HCR checklist:

What you need to do NOW!

- ❑ **From last month:** The House of Representatives, in a rare Saturday session, passed health care reform (HCR) legislation and with it key medication therapy management (MTM) provisions. As the Thanksgiving break approached, the Senate began its first votes on the floor amid ominous talk of a scaled-down bill that could attract the 60 votes—and maybe a Republican or two—needed to avoid a filibuster.
- ❑ **Be ready on Twitter:** By the time the Hub reaches your mailbox, several scenarios could be happening. The legislation could have died in the Senate, a less ambitious HCR Lite bill could be in play, or the Senate could be debating a comprehensive version. HCR legislation could have been passed by the Senate, and a conference committee could be reconciling differences with the House version. Or Congress could be sending a final bill to President Obama for his consideration. In any situation, you need to stay in touch with APhA via Twitter for messages and requests to take action. Also keep an eye on pharmacist.com daily for updates, sign up on the website to be part of APhA's alert system, and follow APhA on Facebook. Most of all, stay in touch with your Senators and Representative, especially those with whom you have made prior personal contacts.
- ❑ **Join!** There's strength in numbers. If your membership in your national professional society is not current, go to pharmacist.com and join APhA today. Your professional future will be all the better for it.
- ❑ **Next month:** That's anyone's guess at this point. If a bill is enacted into law, the fun will be only starting, as the yet-to-be-defined details will be important to how pharmacists and their patients are affected. APhA is already laying the groundwork for the regulatory stage and its many uncertainties.

Tick tock, tick tock: Clock running out on Capitol Hill

Will we have health care reform (HCR) for the holidays? Or as in the tune "I'll Be Home for Christmas," will it be only in our dreams?

When this issue of the Hub went to print shortly before Thanksgiving, the final Senate bill had been released, and it included pharmacist-delivered medication therapy management (MTM) services and other important pharmacy-related language. The House bill, passed on November 7, contained many similar provisions. The Democratic majority appeared to be holding on long enough to get something on the President's desk if not by the holidays, then before the State of the Union address in late January.

The new Senate bill proposes a grants program to fund pharmacist-delivered MTM services. This is considered a very strong endorsement of the idea, focusing on how to incorporate the concept into patient care and not whether it should be included. Other pharmacy provisions of the bill would require the following:

- Pharmacists in certain medical homes
- Medication review and management in transitional care activities
- Testing of MTM services as a model of care by a proposed Center for Medicare and Medicaid Innovation

The Senate bill would also require greater transparency for pharmacy benefits managers, include pharmacy in health professional workforce strategies, provide a "fix" in the average manufacturers price (AMP) calculation, exempt pharmacies from certain durable medical equipment requirements, provide a "fix" for the gap in Medicare Part D coverage (the so-called "doughnut hole"), and address medication waste in long-term care facilities.

The House bill, H.R. 3962, passed as the midnight hour approached on November 7, required pharmacist-provided MTM services. "From the beginning of health care reform debate, APhA has focused on ensuring that Americans have access to pharmacists' services, in addition to

drug coverage," Thomas E. Menighan, APhA Executive Vice President and CEO, said in a news release. "H.R. 3962 recognizes that need. Regardless of how health care reform is financed or coverage is expanded, we must improve the quality of care and lower health care costs; pharmacist-provided clinical services can help to achieve these goals."

Making of a medical home: Pharmacists on the inside

If health care reform is enacted by Congress, the concept of the patient-centered medical home is likely to be at the heart of its futuristic vision. The idea is not a new one. Understanding the role pharmacists will play in such a system is likely to be a core part of the dialogue as policy makers seek ways that all providers can streamline, synchronize, and improve care.

Most pharmacists currently working in medical home settings focus primarily on collaborative drug therapy. They often work on staff and have earned their title as an integral part of the clinical team. A majority of states have enacted legislation since the 1990s allowing pharmacists to have a broader role in patient care, largely because of the success of these ventures. Here are the perspectives of several pharmacists who have worked in medical homes.

Responsibilities: As CEO of Medication Management in Greensboro, NC, Bryan Bray, PharmD, has worked with other clinical pharmacists to provide services for four large physicians' practices in the area for 11 years.

Bray said that clinical pharmacists are able to keep track of advancements in the field and are able to understand in detail the role medications play. The pharmacists see anywhere from 15 to 30 patients daily. They may provide drug therapy management, educate patients on self-management skills, and monitor medication regimens. "Right now physicians are seeing more patients and they have to see them quicker," he said. "Many are complex patients on multiple meds

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with multiple physicians.”

Chris Green, PharmD, with the Ohio State University College of Pharmacy's University Health Connection works on various patient issues, but one of his larger roles is researching answers to drug questions. Primary care physicians are overwhelmed with the large number of patients and the thousands of drugs available on the market, he said. “It's hard to have a breadth of knowledge of all of these medications,” he said. “I have been able to get medicine-related information more quickly and more accurately and provide good drug informational resources to patients and providers. It takes away the background research time that they don't have.”

Special patient populations: El Rio Community Health Center in Tucson—whose pharmacists were honored earlier this year with a Pinnacle Award from the APhA Foundation and one of whose pharmacists was profiled in the February 2009 issue of *Pharmacy Today*—provides services to 70,000 patients, predominately Latino and American Indian patients, at 16 sites.

Sandra Leal, PharmD, CDE, Director of Clinical Pharmacy, and her colleagues see primarily patients with diabetes who have special needs: those whose disease is difficult to manage or who are not attaining their glycemic goals. “She is able to truly provide patient education that is needed so the patient can understand what's going on and be more involved in self-management,” said Arthur Martinez, MD, MSHA, Chief Medical Officer at El Rio. “She is an integral part of our team because we know all of the benefits she provides for our patients.”

Challenges: Although many pharmacists' MTM practices are well established, the medical home model may bring some new challenges. According to Green, some practices experience turf issues between pharmacists and physicians who are new to a medical home. Bray explained that finding pharmacists in his region is a challenge, particularly ones who are clinically competent and have patient- and practice-management skills.

The majority of these issues are easily resolved, but one major challenge is still a struggle with most practices: money. “The biggest challenge is lack of a clear reimbursement schedule for pharmacists,” Bray said. “Reimbursement has never been separated from the drug product. This makes it difficult to gain adequate reimbursement to cover the pharmacist's salary under a traditional billing model.”

Although many of these groups have been able to fund programs, smaller practices can find it difficult to support an MTM pharmacist, according to C. Edwin Webb, PharmD, MPH, Associate Executive Director for the American College of Clinical Pharmacy. “Payment policy is one of the major stumbling blocks—politically and realistically,” he said. “It is hard to make a viable practice for services that don't generate revenue.”

Webb said that 80% of practices have four or fewer physicians, and these are the places where reinventing a fee structure will be a challenge. Even some of the larger medical homes are having difficulty meeting all of their patients' needs because of funding shortages. At El Rio, the three pharmacists on staff are paid mainly through grant money from the University of Arizona School of Pharmacy and a local Indian Tribe that recognized the benefits of the services pharmacists provide.

The El Rio pharmacists' time is taken up completely by serving their high-risk patients with diabetes. Martinez's goal for his program is eventually to fund enough pharmacists so that all patients with diabetes can receive MTM services.

Building a model: Although many organizations are making medical homes work with nontraditional funding (i.e., avoiding insurance companies), one group is trying to create a model that would bring insurance and MTM pharmacists into the mix and eventually work for all organizations. “We are seeing a lot of workarounds. What we want to do is get to the root of that and obviate the need for workarounds,” said Patricia Klatt, PharmD, BCPS, Clinical Pharmacist at the University of Pittsburgh School of Pharmacy.

Klatt is working in collaboration with the University of Pittsburgh Medical Center (UPMC) St. Margaret hospital and the UPMC Health Plan to create best practices for clinical pharmacists in a medical home setting, understand teaching opportunities, and, maybe most important, figure out how pharmacists should be paid.

The group has spent the past 2 years with four physicians' practices to understand how to integrate a pharmacist into a traditional practice to create a medical home. Stephanie Hackett, Project Coordinator and employee of UPMC Health Plan, said the insurer expects three potential payment scenarios to come from the research. By having a pharmacist take over care of high-risk patients, physicians will be able to see more patients and workflow will be improved. If the health plan sees money savings through measures such as increased usage of generic drugs or reducing unnecessary medications, it may allow pharmacists to bill for patient encounters. A combination of revenue sharing and patient billing will be used.

Making it work: Martinez and Leal work with the Health Resources and Services Administration on ways to replicate El Rio's practices for other organizations. Leal said that, although the model may not be widespread now, pharmacists can learn to create opportunities wherever they practice, from the Veterans Administration to universities sharing practitioners and community pharmacies hiring for patient care to telepharmacy work in rural or rugged areas. “There are a lot of models where there is great success even if they are not qualified for collaborative practice,” Leal said. “We truly believe that every site would benefit from having a clinical pharmacist.”

Editor's note: A longer version of this article is available in the Health Care Reform Hub section of pharmacist.com. A useful document, Integration of Pharmacists' Clinical Services in the Patient-Centered Primary Care Medical Home, is also available on the site. This article was written by Tammy Worth, a Kansas City-based health reporter.

HUB ON HEALTH CARE REFORM

provides readers with practical information on health care reform issues, what APhA is doing to keep pharmacists' important role front and center with decision makers, and simple ways for pharmacists to participate in the processes that will determine the structure, function, and processes of a reformed

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