Health Care Reform 2011: Opportunities for Pharmacists

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The health care reform initiatives of the last several years culminated in the passage of the Patient Protection and Affordable Care Act (HR 3590, Public Law 111-148) (ACA) and the Health Care and Education Reconciliation Act of 2010 (HR 4872, Public Law 111-152) in March of 2010. The impact of many provisions in these new laws, as well as the regulatory implementation of the Medicare Modernization Act of 2003, have provided new opportunities for pharmacists to expand their scope of practice.

So let’s delve back just a little bit in history because one of the most significant changes that came about in the health policy arena was the enactment of the Medicare Modernization Act of 2003, which was fully implemented in 2006. This law established the concept of MTM as a component of the provision of the drug benefit to high-risk Medicare recipients. The legislation did not designate pharmacists to be the only ones to provide MTM, but it did open widely the door to pharmacist provision of direct patient care. This was a key realization on the part of Congress that patients require a combination of information, education, and guidance, in addition to access to drug products, if optimal medication-related outcomes are going to be achieved. Some pharmacists have participated in this process, and most students now anticipate that providing MTM will be one of the core components of their practice. The establishment of partnerships between pharmacists, patients, caregivers, and other health care professionals will surely enhance the coordination of care that most Americans desire.

The enactment of the ACA and its companion law was the ultimate outcome of years of advocacy and legislative activity; over 10 different proposals were introduced in the 108th to 110th Congressional sessions. The need for health care reform has been recognized for well over 20 years, but the political climate was not right until the 2008 elections brought the Democrats control of the White House and a marked majority in both the House and Senate. There was not much disagreement as to the need for dramatic change in our health care system. The stumbling point to reform was the fact that many people had markedly different perspectives regarding what the solutions should be. The US health care system was foundationally based on free market principles and financially tied to the provision of fees for services rendered. Although some actively endorsed a single payer system, the compromise position in these two laws has ushered in an era of “coordinated” care that places responsibility for patient outcomes in the hands of patient-centered medical homes (PCMHs) and accountable care organizations (ACOs).

Many of the features of the ACA of 2010 have been enthusiastically endorsed by the public, including the prohibition of lifetime benefit limits and cancellation of coverage and the provision of coverage for nondependent children up to age 26. The mandate for all to have health insurance by 2014 has proved to be highly controversial. But if it stands up to the constitutional challenges, which
are legion, it will have a dramatic influence on every pharmacist and the profession as a whole. The results of the Commonwealth Fund survey of public views on the US health system from April 2011 indicates that 70% of the adults surveyed said our health care system needs to be fundamentally changed or completely rebuilt. Access, coordination of care, and efficiency of care remain critical issues. This should not be surprising since most of the provisions of the ACA remain to be implemented. That being said, what features did the public want to see in the health care system of the future? First, 93% believe it is very important for individuals to have one place or one physician responsible for their care and its coordination. Second, 96% think all of their physicians should have access to their medical records; therefore, despite some of the things we hear in the press about the privacy challenges of shared personal health information, the vast majority of Americans would rather have coordination of care. Third, 96% want information about the quality of care provided by different physicians, hospitals, and we could well add, pharmacists. Currently, most of us have more information about the electric razors and vacuum cleaners we purchase than about our health care providers. Finally, those surveyed expressed overwhelming support for physicians working in teams to improve patient care. Finally, throughout all regions of the country and all political affiliations, there was widespread support for the medical home concept in which one physician would be responsible for primary and coordinated care (Figure 1).

Although many elements in the health reform laws will ultimately impact the profession, a few key sections will have the most impact on our professional lives and those of our patients. These include health insurance reforms that expand coverage and thus will increase demand for medications. Pharmacy practice expansion—either in scope of practice or expectation from society—will be the outcome of several sections of the laws. Health professionals’ education and work force provisions will affect those of us who are involved in didactic and experiential education, while public health promotion and disease prevention, that is, wellness initiatives, are geared to increase immunization rates and encourage the provision of “individualized” wellness plans.

Since the PCMH is highly valued by citizens in all regions of the United States and among those of all political affiliations, pharmacists would be well served if they sought to be active members of PCMHs. The public also overwhelmingly supports physicians working in teams and with other health professionals to improve patient care. The message from the public is clear. As members of the health care professional community, we need to embrace this patient-centered movement and adopt a new practice philosophy through which pharmacists become active, contributing team players.

The consumer protections of the 2010 health insurance reforms are the ones that the public wholeheartedly endorses: new regulations on health insurance companies to protect patients, such as the ban on lifetime caps on coverage and cancellation of coverage, prohibition of exclusions from coverage because of preexisting conditions, no longer charging women higher premiums because of sex, and hospital transparency and accountability. The transparency and accountability issue may not get a lot of attention, but the point is that nonprofit hospitals have to make clear what their charity care policies are and make efforts to help patients with payment plans before sending them to collection agencies. Coverage and access expansions include being able to keep children on health insurance plans until they reach 26, new funding for community health centers to increase access and quality of care, free preventive and wellness care, and tax credits for small businesses offering health insurance to fewer than 25 full-time employees with average salaries less than $50,000 per year. Investments in training grants, scholarships, and loan-forgiveness programs to expand the health professional work force to increase quality and access to health care have received little attention but may be a major factor impacting student pharmacists and recent graduates. The mandate that all citizens must purchase health insurance is the major point of contention that may make everything in the laws inoperative. Currently, multiple lawsuits are challenging the constitutionality of the law, and they are largely based on the constitutionality of the individual mandate.

People, irrespective of what will happen in the court, are looking for change; they are looking for health professionals to step up and do more than they have done in the past. So what do we have are opportunities for expansion of the scope of pharmacy practice and enhancement of our contributions to direct patient care in all care environments. These new opportunities open the door for pharmacists to impact community-dwelling patients and those experiencing a transition between community and acute care, while others will facilitate pharmacist-patient interactions within
acute care settings. These provisions give us an opportunity to change the ambulatory care clinical practice model, and by ambulatory care I do not mean exclusively patients seen in traditional physician office practices or institutional ambulatory care clinics. Community-dwelling patients have been the focus of the majority of practicing pharmacists, and they now have avenues to participate in the emerging PCMH and ACO care delivery models. Several progressive pharmacy communities have broadened the scope of practice and implemented novel care programs well in advance of the enactment of the current health reform laws.

Since the early 1980s, many pharmacists from across the country have demonstrated the value of their progressive approaches. But these practice models have not been uniformly adopted, and innovative practices in the Commonwealth of Virginia, like many parts of the country, are inconsistently available. The Asheville Project, which was launched in 1996 and has reported longitudinal outcomes over many years, is an example of a highly cited innovative approach that rarely has been replicated. More pharmacists from across the country participated in the 10-city diabetes challenge project. Unfortunately, once the project was completed, the practice model did not become mainstream. It is time that these innovative patient care/pharmacist service models are available everywhere and become a core element of pharmacy practice.

The core elements of MTM services are standardized within the American Pharmacists Association/National Association of Chain Drug Stores Foundation framework. But have these guidelines been incorporated into state laws or practice acts? The answer is a resounding no. Thus, one of the benefits of the ACA is that the MTM language in section 3503 could serve as a model for legislative language and subsequent regulations at the state level. So what are the core MTM services and who should receive them? The core MTM services in the ACA law are highlighted in Table 1. The assessment of the health and functional status of each patient; formulation of the medication action plan; and the selection, initiation, and modification of a patient’s medication therapy are included in some but not all state collaborative drug therapy management regulations. The expectations of those who wrote and enacted the ACA legislation were that pharmacists can and should provide these services to a broader array of patients than was authorized in the Medicare Modernization Act of 2003 and revised in 2010. In fact, several legislators have recently proposed further expansions of the populations for whom MTM services should be available.

The PCMH concept was introduced over 40 years ago but has recently gained widespread support as evidenced by the hundreds of organizations and thought leaders who participate in the patient-centered primary care collaborative. PCMH care teams comprise many different health profession members, usually with a physician as the leader or captain. In order to be successful, PCMHs will need to be rewarded for making sure patients are getting appropriate counseling, are up to date with their preventive care, and are achieving their therapeutic goals. This is a prelude to what the Centers for Medicare and Medicaid Services (CMS) is going to expect from PCMHs and ACOs, and recent data from the CMS physician group practice demonstration project suggest that the quality of care can be enhanced and generate shared savings for the Medicare program and the practices. It remains to be seen how CMS is going to reward a practice for achieving these goals and how it is going to provide the public with data on how well individual PCMHs and ACOs are performing.

So, are pharmacists engaged in the PCMH arena? Yes, but we have not really had a broad impact. The published reports are sparse but indicate the success of these pioneers, particularly those in health maintenance organizations such as Kaiser Permanente and Group Health, who saw the value of this model and integrated innovative and progressive pharmacy services such as MTM into the core of their PCMH practices. Group Health of Washington

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<th>Table 1. Medication Therapy Management Components as Described in Section 3503 of the Affordable Care Act</th>
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<td>• Formulating a medication treatment plan according to therapeutic goals agreed upon by the prescriber and the patient or caregiver or authorized representative of the patient</td>
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<td>• Selecting, initiating, modifying, recommending changes to, or administering medication therapy</td>
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<td>• Monitoring, which may include access to, ordering, or performing laboratory assessments</td>
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<td>• Evaluating the response of the patient to therapy, including safety and effectiveness</td>
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<td>• Performing an initial comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events</td>
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<td>• Quarterly targeted medication reviews for ongoing monitoring, and additional follow-up interventions on a schedule developed collaboratively with the prescriber</td>
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<td>• Providing education and training designed to enhance the understanding and appropriate use of the medications by the patient, caregiver, and other authorized representative</td>
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<td>• Providing information, support services, and resources and strategies designed to enhance patient adherence with therapeutic regimens</td>
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<tr>
<td>• Coordinating and integrating medication therapy management services within the broader health care management services provided to the patient</td>
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put together a patient-centered model that includes pharmacists on each health team. Pharmacists perform high-risk complex medication management, medication education, and medication reconciliation. They are about three years into their implementation process. The results of the Connecticut Medicaid transformation project, which were recently published, clearly indicate that face-to-face pharmacist-delivered MTM yields cost-effective improvements in Medicaid patient outcomes. The investigators reported a 50% increase in the number of patients who achieved their therapeutic goals and an annual savings of $1123 per patient per year.

So, what does a PCMH model with a pharmacist look like? Although some place pharmacists at the center, it is not about us; it is about the patient. If we can keep our eyes on the patient instead of looking for what the benefit of inclusion is to each of us, then we will be on the right track and pharmacists may be viewed as essential members of the team.

The words of Frank Cerra, M.D., former senior vice president for health sciences and dean of the University of Minnesota Medical School, should give us all the stimulus to ACT NOW. He stated that “pharmacists...are not now in the game, they are not in the model that’s out there.” We’re to a degree an appendage to the model rather than a core element integral to the function and optimization of improvements in patient outcomes. His challenge to the audience in Minnesota was that “you need to take action now,” and “you need to engage in the discussion with those who are considering forming PCMHs and developing ACOs.” In fact, some pharmacists may need to take the lead in some of those discussions. We need to demonstrate value in every component of MTM and the other pharmaceutical care services that we provide. We need to show that the value of each service can be achieved in our local setting and demonstrate synergistic value when all of the relevant components and services are provided as part of comprehensive and integrated patient care.

With this team approach, one must have a common game plan and strategy that puts the patient front and center. Community and institutional pharmacists do not know what happened when the patients were acutely ill or independently living in the community, respectively. Patients want that to happen. So, if patients want that to happen and we want that to happen and we are able to have patients advocating for pharmacists having access to their electronic health records, then we can participate in the full scope of the patient care process, and everybody wins. A number of principles can serve as the foundation of pharmacist incorporation into the PCMH; chief among them is flexibility in PCMH design. Incorporation of pharmacists and their services either by their physical presence within the practice or through the design of effective “community linkages” should be considered to meet geographic and practice setting needs and variations. Although there is not necessarily one way to do this, to have “community” you have to be in contact with and interacting with other health care providers and patients.

Patients with acute care needs, as well as those in transitions of care, are most likely to be within the purview of care provided by an ACO. The regulations developed by Health and Human Services to implement the provisions in the ACA, which are designed to bridge transitions and encourage cost-effective coordinated care, were just recently released for public comment. Many controversial comments are coming forth now, and we will find out the degree of acceptance once final regulations are released, perhaps later this year. Some pharmaceutical care/MTM programs developed by integrated health care systems give us insight as to how pharmacists may be engaged with ACOs to enhance patient outcomes. Fairview Health System in Minnesota began providing MTM across the spectrum of its integrated health system of PCMHs, specialty clinics, acute care institutions, and community pharmacies in 1998. Services initially were provided to members of Fairview health care plan and those who were employees of Fairview Health System. So, Fairview didn’t wait until it had external payment for services. The system looked within its community of patients and could demonstrate value to the health system. The MTM model it developed was expanded to cover participants in the Minnesota Medicaid program when the state began to pay for MTM in 2005. Fairview Health System was able to do this in the free market, despite the fact that many tell us that no one is going to pay for MTM.

Hospitals have struggled with coordination of care historically since they represented only one or two parts within the circle of patient care (Figure 2). The enactment into law of section 3025 of the ACA, the hospital readmission reduction program, has raised the ante, and successful post-discharge transitional care coordination programs will need to be developed if hospitals do not want to experience the financial penalties for early readmissions. Data from some of the early initiatives, such as the one at the University of Michigan, are beginning to emerge. The initial Michigan project to enhance the delivery of care at the time of discharge, which involved pharmacist interaction prior to discharge, yielded minimal benefits. The second project built upon the first, and Michigan realized that the time of discharge was probably not the place it is going to work. So, now, the project is putting pharmacists in PCMHs, the receiving end, so that they can counsel patients who are returning from a hospitalization.

Michigan’s experience is not unique. Paul Bush, chief pharmacy officer at Duke Hospital, stated recently that “medical centers have not yet discovered how to perform well when patients enter the discharge phase of their hospital stay and transition to home.” So, if we look at this circle of care, it becomes obvious that the excellent and innova-
tive care that pharmacists provide in the emergency department and institutional setting may not translate to a reduction in inappropriate readmissions unless one changes the discharge process and the transition back to community (PCMH) care. ACOs, which are predominantly payment and delivery reform models designed to tie provider reimbursements to quality improvement and reductions in the total cost of care for an assigned population of patients, are thought by some to be the answer to this dilemma. In order for pharmacists to be integrally involved in ACOs, we are going to have to look at our value proposition, just as Dr. Cerra encouraged us to do as we approach PCMH practices.

Prevention and wellness is the last category that offers expanded opportunity. Section 4204 authorizes the development of demonstration programs to improve immunization coverage by awarding grants to states to improve the provision of recommended immunizations for children, adolescents, and adults through the use of evidence-based, population-based interventions for high-risk populations. Pharmacists have played a major role in flu immunization campaigns of the last few years and personally have administered millions of immunizations. This law expands funding, and the scope of immunizations that pharmacists are authorized to administer will likely need to be expanded so that we can participate in this effort to improve the wellness of our society. Section 4206 authorized the funding of pilot demonstration projects to test the impact of providing at-risk populations who utilize community health centers with an individualized wellness plan based on a comprehensive risk-factor assessment. These prevention and wellness initiatives cannot be achieved by conducting more community screenings. Instead, some health care professional—yes it could be a pharmacist—needs to work with individuals to develop individualized wellness plans and provide coaching and mentoring to help them achieve better health. Has this been happening? Yes, it has, to a degree—even in the private sector.

At the Mohawk Industries carpet factory in Dublin, GA, about 200 of the 750 employees signed up for an in-the-plant wellness program after the company described the benefits of lowering blood pressure and cholesterol and its commitment to help each person stay healthier. Alan Christianson, Mohawk’s benefits administrator, said that the company recognized that it could eventually face health costs so high that employees could not afford insurance. “We felt we had to do something about it,” he said. Now Charles Posey, an independent pharmacist who practices at the plant, monitors the workers’ blood pressure, provides low- to no-cost medications, and gives advice on obesity and other conditions. Pharmacists involved in other work site prevention programs include Antonio Tierno, who provides targeted education for diabetes, heart disease, asthma, and depression for Pitney Bowes in Connecticut. These corporate entities realize they have a vested interest in helping employees become healthier; they see and appreciate the value that pharmacists provide.

We are three years away from reaching the preferred future roles of pharmacists expressed by Joint Commission of Pharmacy Practitioners (JCPP) in 2005. Are we going to actualize our future? The ACA MTM language parallels the JCPP expectations that pharmacists should be able to select, initiate, monitor, modify, and be responsible for medication-related outcomes...that is just what the pharmacy community has been advocating. So we have some believers, the majority of those in the House and the Senate who voted in favor of the ACA legislation. Thus, we have reason for joy...we are making great progress...the opportunities lie ahead of us. What is it going to take? Who among you is willing to accept the challenge and opportunities?

We are going to have to develop business models that build upon cognitive and direct patient care services in addition to the provision of drug products. All pharmacists have to assertively utilize their knowledge and skill and accept responsibility for the medication-related outcomes of their patients. What does it take to optimize care? There is a theme here; it is more than the product. Pharmacy’s mantra for years has been to ensure that patients received the right amount of the right drug at the right time. But truly, the ultimate goal is for patients to consistently take their medications. Coaching, mentoring, and counseling are the types of support they need. So, the questions going forward are: Who should receive these MTM services, at what frequency, in what setting, using what model? Are all

Figure 2. The patient care cycle.
elements essential? How does one go about establishing the services? What do you need in the community, and what do we need in academic health centers? Finally, what do we need to provide our students so that they can practice at the top of their skill levels so that all patients receive the quality of care they deserve and, in many situations, expect from us?

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References