Building the bridge to partnership: Fostering the community and managed care pharmacy relationship

Cynthia Knapp Dlugosz

Ever since managed care first emerged on the health care scene, managed care organizations (MCOs) and community pharmacy have seemed to be on opposite sides of a fence.[1] As Shepherd[2] noted in 2007, the relationship between MCOs and community pharmacies has been marked by "a considerable amount of discontent and distrust." This difficult history may help to explain why few patient care–focused partnerships have evolved between MCOs and community pharmacies, despite the unprecedented opportunity for collaboration presented by the advent of medication therapy management (MTM).[2] It also may explain why many MCOs and community pharmacies often fail to recognize the considerable benefits the other party brings to the table.

If the promise of MTM is to be realized fully, MCOs and community pharmacists need to realign their goals and tap each others' strengths.[2,3] MCOs need to recognize community pharmacists as the "people on the ground"—health care professionals who have frequent contact with MCO members and are able to evaluate members' needs and understand their concerns.[2] Community pharmacists must recognize that they cannot provide MTM services in a vacuum; they can benefit considerably from the expertise, leverage, and technological and networking capabilities of MCOs.[2]

As Shepherd[2] observed, working together requires MCOs and community pharmacists to step forward, find common ground, and seek a new future. This article profiles several successful partnerships between MCOs and community pharmacists that are shaping that new future.

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Learning objectives

At the conclusion of this activity, the pharmacist will be able to:

- Explain why managed care emerged as a strategy for improving the cost effectiveness of health care, including prescription drug therapy.
- Discuss the evolution of medication therapy management in community pharmacy practice and managed care organizations.
- Describe successful medication therapy management partnerships between community pharmacists and managed care organizations.
- Describe the genesis of an elective managed care rotation in a community pharmacy residency program.
- Discuss how community pharmacists and managed care organizations can work together to improve adult immunization rates for influenza.

Managed care: Brief overview

Most people in the United States obtain group health insurance coverage through one of three entities[4,5]:

■ An employer (so-called private or commercial health insurance)

■ The federal Medicare program (all adults >65 years and younger adults with long-term disabilities)

■ A state Medicaid program (low-income adults and children)

The key stakeholders in the U.S. system are patients, payers (i.e., employers, federal and state governments), providers (e.g., health care professionals, hospitals, pharmacies), and health plans/insurance companies.[4,5]

Indemnity insurance was the predominant type of group health insurance in the United States until approximately the mid-1980s.[4] Under indemnity insurance, providers were paid on a fee-for-service basis—they charged a "usual and customary" amount for every service they performed.[5] Providers also were afforded considerable freedom in selecting treatments and deciding on a particular course of care.[5] Indemnity insurance therefore offered little incentive for providers to rein in their fees or perform fewer services.[4,5]

During the 1980s, payers began to embrace managed care as a more cost-effective alternative to indemnity insurance. Managed care is an integrated approach to the financing and delivery of health care services that seeks to put scarce resources to the best possible use in optimizing patient care.[4] One of the fundamental differences between managed care and indemnity insurance is the use of financial risk sharing to balance quality of care with cost efficiency; in the managed care approach, *all* stakeholders are required to accept and share financial risk for health care expenditures.[4,5] Managed care also held promise as a strategy for better coordinating the delivery of health care, regulating the use of health care resources, and implementing preventive care and disease management systems.[4] It rapidly became the predominant type of group health insurance.

Prescription drug coverage is an immensely popular health care benefit. Prescription drug benefits are a component of most private managed care plans.[4] The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (known as the Medicare Modernization Act) added outpatient prescription drug coverage for Medicare beneficiaries through the establishment of the Part D program.[6] Most state Medicaid programs have provided coverage for prescription drugs since their inception.[4] Consequently, the majority of Americans—approximately 85%—have access to comprehensive pharmacy benefits.[4] Use of prescription drugs is influenced by requiring a copayment or coinsurance amount; patients usually pay lower amounts for lower-cost medications or those with proven clinical benefits in chronic conditions.[4] Strategies for influencing the appropriateness of drug therapy include (but are not limited to) formularies, prior authorization, and drug use review.[7] The pharmacy benefit may be coordinated by an internal department within the MCO, a pharmacy benefits manager (PBM), or a combination of the two.[4]

Table 1. Examples of activities performed as part of MTM services[a]
Performing or obtaining necessary assessments of patients' health status
Formulating a medication treatment plan
Selecting, initiating, modifying, or administering medication therapy
Monitoring and evaluating patients' response to therapy, including safety and effectiveness
Performing a comprehensive medication review to identify, resolve, and prevent medication-related problems, including adverse drug events
Documenting the care delivered and communicating essential information to patients' other primary care providers
Providing verbal education and training designed to enhance patient understanding and appropriate use of medications
Providing information, support services, and resources designed to enhance patient adherence with therapeutic regimens
Coordinating and integrating MTM services within the broader health care management services being provided to patients

Abbreviation used: MTM, medication therapy management.
[a]According to individual patient needs.
Source: reference 20.

Evolution of MTM

In addition to establishing the Medicare Part D program, the Medicare Modernization Act introduced the term "medication therapy management." The act stipulates that Medicare Part D plan sponsors (i.e., companies that administer Medicare Part D benefits) must have an MTM program, which is defined as "a program of drug therapy management that may be furnished by a pharmacist and that is designed to assure, with respect to targeted beneficiaries ... that covered Part D drugs under the prescription drug plan are appropriately used to optimize therapeutic outcomes through improved medication use, and to reduce the risk of adverse events, including adverse drug interactions."[6] "Targeted beneficiaries" are Medicare Part D beneficiaries who have multiple chronic diseases, are taking multiple Part D–covered drugs, and are likely to incur annual medication costs that exceed a certain threshold set by the Secretary for Health and Human Services ($3,000 in 2010).[6]

As stated in the Medicare Modernization Act, MTM programs may include elements that foster[6]:

■ Enhanced enrollee understanding to promote the appropriate use of medications by enrollees and to reduce the risk of potential adverse events associated with medications through beneficiary education, counseling, and other appropriate means.

■ Increased enrollee adherence with prescription medication regimens through medication refill reminders, special packaging, and other adherence programs, as well as other appropriate means.
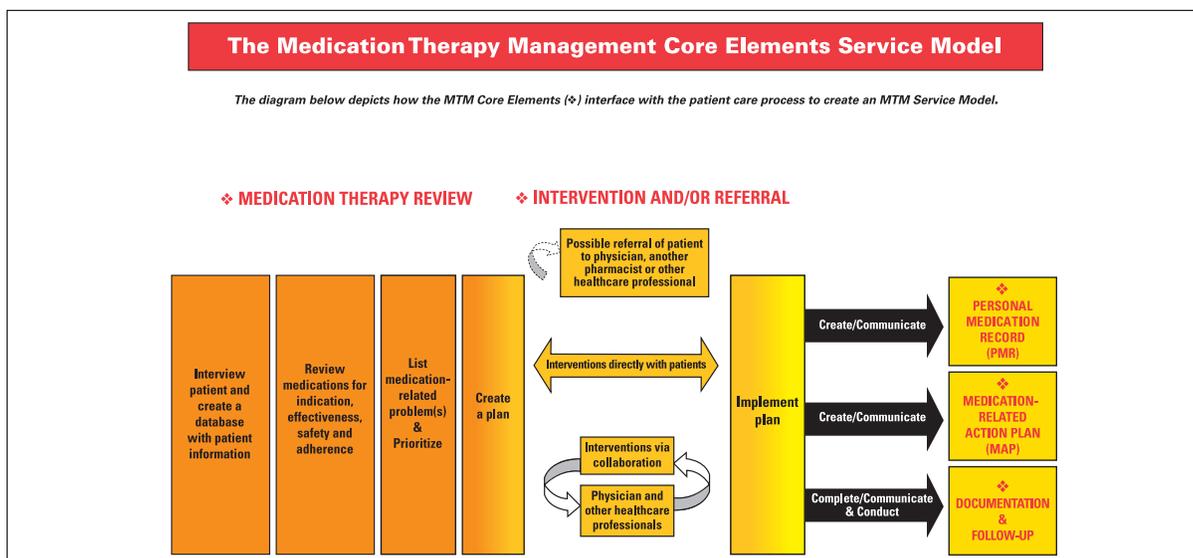
Figure 1. MTM core elements service model

Abbreviation used: MTM, medication therapy management.
Source: reference 21.

■ Detection of adverse drug events and patterns of overuse and underuse of prescription drugs.

Outside of these elements, individual Medicare Part D plan sponsors initially were given considerable discretion in deciding how and by what means MTM programs would be developed and delivered in their organizations to best meet the needs of their specific patient populations.[2,4,8–10] Partly to encourage innovation and competition, the Medicare Modernization Act provided no strict guidance regarding how MTM programs were to be designed, what services were to be provided, or how those services were to be delivered (e.g., in person, by telephone, as educational mailings).[11–13] Also, although the Medicare Modernization Act specifies that MTM services may be furnished by a pharmacist, it does not designate pharmacists as the sole providers; "other qualified providers" also may deliver MTM services.[6,8,12,14,15]

Because so much about MTM remained uncertain—and because the inclusion of MTM in the Medicare Modernization Act was widely viewed as a historic opportunity for pharmacists to develop, deliver, and be compensated for direct patient care services—a number of pharmacy organizations worked to create and advance their own visions of MTM for all patients, not just Medicare beneficiaries.[2,3,16–19] In July 2004, APhA, the Academy of Managed Care Pharmacy (AMCP), and nine other pharmacy organizations developed a consensus definition of MTM services intended to be applicable within diverse pharmacy practice segments and across broad populations of patients.[20] According to that definition, MTM is a distinct service or group of services that optimize therapeutic outcomes for individual patients; some examples are provided in Table 1. MTM services are independent of but can occur in conjunction with

the provision of a medication product. Programs that provide coverage for MTM services should include individualized services provided directly by a pharmacist to a patient, with face-to-face interaction as the preferred method of delivery.[20] It is recognized, however, that alternative methods of patient contact and interaction (e.g., telephonic) may be necessary for or desired by some patients or in some pharmacy practice settings.[21]

Building on the consensus definition, APhA and the National Association of Chain Drug Stores Foundation developed a model framework for implementing effective MTM services in pharmacy practice.[21] The service model, which was revised in 2008 and is supported by a number of pharmacy organizations, includes five core elements[21] (Figure 1):

1. Medication therapy review: a systematic process by which pharmacists collect patient-specific information, assess medication therapies to identify medication-related problems, develop a prioritized list of medication-related problems, and create a plan to resolve them.
2. Personal medication record (PMR): a comprehensive record of the patient's prescription and nonprescription medications, herbal remedies, and other dietary supplements.
3. Medication-related action plan (MAP): a document for patients to use in tracking progress for medication self-management.
4. Intervention and/or referral.
5. Documentation and follow-up.

In 2005, AMCP and the American Society of Health-System Pharmacists convened two executive sessions of various stakeholder groups for the purpose of sharing opinions on opportunities and issues related to the implementation of MTM.[14] AMCP subsequently assembled a work group of nine organizations to

Table 2. Important features and operational aspects of quality MTM programs

Important features of a quality MTM program
Patient-centered approach
Interdisciplinary, team-based approach
Communication
Population and individual patient perspective
Flexibility for broad application
Evidence-based medicine
Promotion of MTM services
Operational aspects of quality MTM programs
Patient identification and recruitment
Services to meet the needs of individual patients
Services tailored for setting, cultural differences
Coordination of care
Appropriate documentation and measurement
Quality assurance
Communications by the MTM program
Practitioners who can coordinate and provide MTM
Adoption of standardized documentation, billing, and payment systems

Abbreviation used: MTM, medication therapy management.
Source: reference 22.

Table 3. MTM Current Procedural Terminology billing codes

Permanent Code	Description
99605	MTM service(s) provided by pharmacists, individual, face-to-face with patients, with assessment and intervention if provided; initial 15 minutes, new patient
99606	Initial 15 minutes, established patient
99607	Each additional 15 minutes (list separately in addition to code for primary service)

Abbreviation used: MTM, medication therapy management.
Source: reference 28.

draft the consensus document *Sound Medication Therapy Management Programs*, which identifies seven important overall features and nine specific operational aspects of a quality MTM program (Table 2).[22] AMCP differentiates MTM programs and MTM services as follows[22]:

■ MTM *programs* are programs developed by health plans (e.g., MCOs) or other entities focused on optimizing patient therapeutic outcomes.

■ MTM *services* are components of MTM programs that are delivered by health care professionals.

The consensus document was validated after its release by the National Committee for Quality Assurance and revised in 2008.[22] It is intended to help designers of MTM programs "identify the critical elements that support an effective, sound MTM program and allow these programs to be constructive in encouraging positive patient outcomes."[22]

MTM in pharmacy practice

From the perspective of many pharmacists, MTM marked an *evolution* rather than a *revolution* in pharmacy services.[14] MTM was seen as a logical extension of the direct patient care services pharmacists have been providing at least since the 1990s, using the "pharmaceutical care" process.[8,17,19,23] These services have included[11]:

■ Disease state management.
■ Point-of-care testing and biometric screening.
■ Wellness programs.
■ Immunization services.

To pharmacists, MTM provides the means for completing the transformation of the profession from one focused on the drug product to one focused on the patient.[24]

A coalition of representatives from national pharmacy organizations—the Pharmacist Services Technical Advisory Coalition—worked with the American Medical Association to develop Current Procedural Terminology (CPT) codes for reimbursement of MTM services provided by a pharmacist in face-to-face encounters with patients.[8,11,17,25] These codes were first established in 2005 as Category III codes, which are temporary tracking codes intended to facilitate data collection on and assessment of new and emerging services and procedures.[17,26,27] They were elevated to Category I (permanent) status late in 2007, based largely on evidence of widespread use, including nearly 2.8 million face-to-face MTM encounters between 2004 and 2006.[16,25,27] The codes and descriptors are shown in Table 3.[28]

MTM in MCOs

Reflecting the lack of strict guidance in the Medicare Modernization Act regarding how MTM programs were to be designed, the initial programs developed by MCOs varied widely.[13,15,16,18,19,29] In general, Medicare Part D plan sponsors created MTM programs primarily using in-house pharmacists or other in-house providers, with services provided to eligible beneficiaries by telephone or through educational mailings.[4,16,18,25,29] A small number of plans contracted directly with community pharmacists or used MTM vendors to provide MTM services.[4,16,18,29]

APhA has conducted annual "environmental scans" of MTM providers and payers since 2007 to track progress and developments over time. In the most recent payer survey, 84% of the 69 respondents (largely MCOs and PBMs) reported providing MTM services as defined in the consensus definition.[30] Fewer than one-half of the payers (40%) reported using contracted pharmacists to provide services.[30]

MTM services today

Awareness is increasing among health care stakeholders that the benefits of MTM services transcend the Medicare Part D population.[14,22,31] Increasingly, MTM services are being made available to patients from many private and public sector payers, including state Medicaid programs, commercial health plans, and self-insured employers.[4,19,22,31] Some patients who recognize the value of MTM services but don't qualify under their health plans are electing to pay for the services out of pocket.[11]

The burgeoning popularity of MTM services raises the question of how MTM programs will identify enough qualified providers to care for all of these patients.[9] One answer is to increase the number of community pharmacists who are contracted to provide MTM services.

AMCP/APhA MTM Connections

AMCP/APhA MTM Connections was developed jointly by AMCP and APhA to advance the implementation and delivery of MTM and other clinical services by pharmacists and ultimately enhance patient care through improved medication use. It includes the MTM Locator and MTM Resource Library.

The MTM Locator is a self-reported and searchable directory of (1) MCOs with MTM programs and (2) pharmacists who provide MTM services. The directory is intended to help payers and providers find each other, according to characteristics selected in four categories.

The MTM Resource Library is an annotated and searchable bibliography of nearly 700 articles, white papers, reviews, monographs, and other resources on MTM and pharmacist-provided patient care services. Many of the articles are available as full-text PDF files.

AMCP/APhA MTM Connections can be accessed via the AMCP Web site (www.amcp.org; select "Professional Practice," then "MTM Resources online") or the APhA Web site (www.pharmacist.com; select the "MTM Central" tab).

MCOs and community pharmacists: Working together

A number of MCOs and community pharmacists have formed innovative partnerships focused on overcoming existing challenges and working together in pursuit of a mutual goal: improving the cost-effectiveness of medication therapy and helping patients obtain the best possible therapeutic outcomes. The profiles in the following section attempt to capture the range of those partnerships.

Wisconsin Pharmacy Quality Collaborative/ UnitedHealthcare

The inception of the Wisconsin Pharmacy Quality Collaborative (WPQC) can be traced to a 2005 Pharmacy Society of Wisconsin (PSW) leadership retreat and the realization by participants that "we have to stop talking to ourselves," recalled Chris Decker, PSW Executive Vice President and CEO. "For years, we had been discussing how we could advance pharmacy practice and help our members get paid for patient care services. But we rarely seemed to get beyond the discussion stage. When we did, the result was activities that were good but disparate."

A decision was made at that retreat to fund a senior staff position devoted to establishing a single, state-based pharmacy services program. The new PSW Director of Health Care Quality Initiatives worked with a task force representing community pharmacies, ambulatory care clinics, and MCOs to conceptualize a potential new MTM service model for Wisconsin.

With a draft document in hand, PSW met individually with nine payer/purchaser organizations that collectively insured more than one-half of Wisconsin citizens. The organizations were selected because PSW already had good working relationships with key personnel (e.g., CEO, medical director, pharmacy director). During those meetings, Decker said, "We asked each group the same question: are you satisfied with the medi-

cation use in your plan? We assumed the response would be no, and it was. They all told us they were paying too much for too little value. They were aware of widespread gaps in therapy, and they knew that nonadherence to medication therapy was pretty common."

PSW invited the payer/purchaser organizations to work with the association to brainstorm possible solutions to these problems. A group consisting of representatives from the payer/purchaser organizations, community pharmacists from the original task force, and pharmacists from other practice sites met for the first time in July 2006. As the group continued to meet every other month for the next 15 months, the details of the WPQC program took shape. (A comprehensive description of the WPQC was published in the September/October 2009 issue of the *Journal of the American Pharmacists Association*.[3]) "Everyone involved was kind of amazed that these natural competitors were working together," Decker observed. "Let's face it—there hasn't always been goodwill among these groups. The health plans competed with each other, and few pharmacists had good feelings toward any of the plans." Decker explained that one of the aims of the group process was to build understanding, trust, and confidence among the participants.

The group conceived a network of community chain, community independent, and health-system (i.e., clinic) pharmacies committed to improving medication use by patients enrolled in the participating health plans and reducing health care costs for payers and patients. The pharmacies would have to agree to implement certain quality-based, best-practice requirements as a condition of participation. Participating payers would compensate pharmacies for two levels of services:

- Level 1: drug product–focused interventions (e.g., discontinuation of duplicative therapy, dose adjustment based on renal function, addition of a medication based on clinical guidelines) that require prescriber approval
- Level 2: comprehensive medication review and assessment services (e.g., creating PMRs and MAPs for patients) provided face to face by pharmacists and usually conducted on an appointment basis

Network pharmacies also would have to use a Web-based MTM application—the McKesson RelayHealth MTM program—that was being designed specifically for the WPQC program for patient management, documentation of services, and billing.

Four of the payer/purchaser organizations involved in the initial WPQC discussions signed a letter of intent to participate in the pilot project. The WPQC program launched in March 2008 with two of those organizations: Unity Health Insurance, a regional MCO that insures approximately 42,000 people in Wisconsin, and Group Health Cooperative–South Central Wisconsin, a regional MCO that insures approximately 35,000 citizens.

Although UnitedHealthcare—a national health plan that insures approximately 600,000 people in Wisconsin—signed a letter of intent, the company did not join the program officially until April 2010. The delay did not reflect a lack of interest, as Terry Maves, UnitedHealthcare's pharmacy director for Wisconsin, was quick to point out. In fact, Maves was a participant in the initial program discussions, as both a representative of UnitedHealthcare and a member of the PSW board of direc-

tors. He recognized the promise of the WPQC program from the start. "The pharmacist services are designed to provide the best medication value to the patient," Maves noted. "They're not just about saving money."

The lag in UnitedHealthcare's participation had everything to do with the many layers of decision making and legal review required as the contract wended its way through the company. "It was one delay after another," said Maves. "Things you might not think of at first, such as issues related to patient privacy and HIPAA regulations."

The addition of UnitedHealthcare substantially increased the number of people eligible for WPQC services. With Wisconsin Medicaid close to coming on board, WPQC expects that more than 1.5 million people—close to one-third of Wisconsin's 5.5 million residents—will be eligible for the program by the end of 2010. Additional health plans may be added in future years.

Although data from the project are just beginning to be analyzed, preliminary results indicate that the savings to payers are well in excess of the payments to pharmacists. Unity Health Plan and Group Health Cooperative estimate that they saved more than $2.50 in drug costs for every $1 paid to pharmacists in 2009.

Partnership success factors. Decker and Maves agree that much of the program's success can be attributed to the collaborative approach to its development. "We had groups problem-solving together that didn't even talk 5 years ago," Decker marveled. "Everyone was focused on coming up with workable solutions to shared medication use problems. Providers and payers shared a common interest; we just need to confirm that commonality and ensure that the incentives were aligned to support collaboration."

Decker also believes that it was important to keep the program small initially, to reduce the risk to purchasers and bolster the chances for success. When the WPQC program launched, the network included 53 pharmacies and 121 pharmacists. Now, Decker said, the payers are asking to add more pharmacies to the network, to make it easier for more patients to take advantage of program services.

Unexpected challenges. Both Decker and Maves cited unanticipated delays as the biggest program challenges. In addition to the aforementioned legal holdups, the delays encompassed things like information technology system needs and prescription data retrieval considerations. "If I could share one piece of advice," Decker offered, "it would be expect the unexpected and plan for it. Almost everything takes longer than you think it will, or should." By planning for delays and continuing to devote needed resources to the development process, creating a program that decreases medication costs and provides the best value to the patient is possible. "After all," Maves concluded, "isn't that what we're all trying to do?"

Kroger Co./Anthem Blue Cross and Blue Shield/ City of Cincinnati

In some cases, one great idea begets another.

The Pharmacy Coaching Program for employees of the City of Cincinnati is a payer-driven, patient-centered partnership that was modeled after the highly successful Asheville Project. [32–35] In fact, a presentation by John Miall—former Director of Risk Management for the City of Asheville, NC, and one of the architects of the Asheville Project—provided the spark for the Ohio program.

Miall had been a featured speaker at a meeting of the Employer Health Care Alliance of Greater Cincinnati. The alliance membership includes employers (e.g., Kroger Co., GE Aviation, Procter & Gamble, Macy's, City of Cincinnati) that offer health benefits to a combined total of nearly 1 million employees and dependents. As a self-insured employer, the City of Cincinnati was intrigued by the potential for a pharmacy-based program similar to the Asheville Project to improve the health of city employees and reduce costs to the city health plan.

The Pharmacy Coaching Program provides incentives to city employees with diabetes, hypertension, or dyslipidemia to obtain pharmacist counseling for better self-management of their conditions. The city is waiving copays for diabetes, hypertension, and cholesterol medications for as long as employees remain in the program. Participants also receive $100 into their health reimbursement accounts as an extra incentive to participate in the program.

The program is a collaboration among the City of Cincinnati, Anthem Blue Cross and Blue Shield of Ohio, the Kroger Co., and Novartis Pharmaceuticals Corporation. As administrator of the City of Cincinnati health plan, Anthem identifies employees with the conditions of interest and processes program claims, including payments for pharmacist services. Specially trained Kroger pharmacists meet with eligible employees to design personalized treatment plans that include regular monthly or bimonthly follow-up visits. As part of this ongoing relationship, the pharmacists provide disease education, troubleshoot adherence problems, monitor treatment goals, examine patients' feet, and perform point-of-care testing. Novartis is funding a 2-year study of the program, analyzing both claims data and pharmacist-provided data to fully evaluate the effects of the program on participants' overall health. The study is being conducted by the health outcomes research organization HealthCore, which is a subsidiary of Anthem's parent company.

Barry Malinowski, medical director for Anthem, describes the Pharmacy Coaching Program as a "win–win–win–win" proposition for the groups involved. Malinowski estimates that approximately 800 city employees have enrolled in the program to date. Preliminary data indicate that "the patients are getting better care, the city is paying less for health care, and Anthem is able to lower costs for a self-insured client," Malinowski said. Although final study data still are being analyzed, he expects they will show a "really nice" return on investment.

Frannie McGowan, Clinical Program Development Manager for Kroger, is equally enthusiastic about the program and the opportunities it offers to pharmacists. "It's all about helping patients take charge of their own health," McGowan said. "Instead of just telling patients what to do, we're helping them set and achieve goals that they identify as important." McGowan had primary responsibility for conceptualizing the pharmacy protocols and processes—"the first time something like this had been attempted in just a large chain pharmacy," she noted.

The Asheville Project initially included only 12 community and hospital pharmacy clinics. For the Pharmacy Coaching Program, a ZIP Code analysis was performed to identify the Kroger locations most convenient for the participants; pharmacists at all of those stores were recruited for the program. McGowan needed to address a number of practical concerns, including how to centralize as many aspects of the program as possible (e.g., communication, documentation, scheduling) and ensure that participants would have as similar a coaching experience as possible at each Kroger location.

Partnership success factors. Like the WPQC, the Pharmacy Coaching Program collaboration benefitted from existing relationships among the eventual participants. Kroger became a major partner in part, McGowan explained, because "I already knew many of the other players from Employer Health Care Alliance meetings." McGowan encourages pharmacists to become more involved in community organizations that include multiple stakeholders: "Pharmacists know what pharmacists can do, but employers and MCOs don't necessarily know what we can do. We need to get out of our pockets of comfort and take advantage of social opportunities that allow us to spread the word about our services and capabilities."

The Pharmacy Coaching Program also benefitted from having all program stakeholders involved from the beginning, on essentially equal footing. Novartis served an early facilitator role, bringing the groups together and providing the services of a project manager. Thus, said Malinowski, none of the primary stakeholders was "running the show," so no group felt subservient to the others.

Malinowski offered special praise for City of Cincinnati Risk Manager Chuck Haas. "He was a real champion of this program from the start," observed Malinowski. "It's critical to have someone like that—waving the flag and rallying support—in all organizations, but especially on the employer side."

Unexpected challenges. The Pharmacy Coaching Program met some resistance early on from an unanticipated source: primary care physicians. The backlash began almost immediately after physicians were notified about patients' enrollment in the program. "They were concerned that we were taking patients away from them," both Malinowski and McGowan recalled. Much of the resistance was defused through one-on-one meetings with the physicians, emphasizing the program's goal of multiple groups working together to improve the health of city employees. The program stakeholders also arranged a seminar with presentations by both John Miall and a physician who had participated in the Asheville Project. That seminar "went a long way in alleviating apprehension," said Malinowski. "The speakers shared data showing that patients in the Asheville Project actually visited their primary care providers more frequently, not less frequently." In retrospect, both Malinowski and McGowan would have included some primary care physicians in the initial planning phases of the program to prevent misunderstandings.

Patient interest in the program was lower than expected initially, despite widespread promotion and the many incentives offered for participation. As tends to be usual, McGowan

noted, the most motivated patients were the first to enroll. Recruiting some of the less motivated patients—patients who might benefit most from the pharmacist coaching—"remains a continuing challenge."

Illinois Pharmacists Association/University of Illinois at Chicago College of Pharmacy/Medco Health Solutions, Inc./State of Illinois/Mirixa

The Illinois Project is a relatively recent (December 2009) entry into the managed care/community pharmacy partnership arena. The program is targeting State of Illinois employees who meet the following criteria:

■ Take medications used to treat diabetes, cardiovascular conditions, pulmonary conditions (e.g., asthma), or neurological conditions (e.g., depression, migraine)

■ Have potential adherence problems or have not been prescribed evidence-based therapies for their condition

A network of 84 community pharmacists is working to close these "gaps in care" by providing face-to-face counseling to eligible employees and coordinating care with physicians.

According to Michael Patton, Executive Director of the Illinois Pharmacists Association (IPhA), the Illinois Project—also known as SOCR$_X$ATES— had its genesis in a series of informal conversations about how pharmacy could help to reduce rising health care costs in the state and position pharmacists as providers of patient care. The conversations were spurred by IPhA's participation in the Diabetes Ten City Challenge; IPhA served as pharmacy network coordinator for the Chicago employers.[36,37] With Illinois facing ongoing budget deficits and looking for ways to hold down costs, targeting state employees "seemed like a good place to start," Patton said.

Medco Health Solutions, Inc., joined the partnership in its role as PBM for the State of Illinois. Using its proprietary "clinical engine," Medco analyzes prescription drug records on a daily basis and identifies state employees with potential adherence and omission gaps. When possible interventions are identified, Medco transmits electronic alerts to participating pharmacists in real time via the MirixaPro Web-based clinical platform. Participating pharmacists also use MirixaPro to document their interventions and bill Medco for their services. In addition, Medco is demonstrating its commitment to the partnership by funding all program development costs.

Specialized training for Illinois Project pharmacists was conducted by the University of Illinois at Chicago College of Pharmacy. All pharmacists are required to complete a series of Web-based educational modules that review the targeted conditions, as well as a module addressing long-term medication adherence issues that can be barriers to care for patients with these conditions. The pharmacists also attend a live program designed to bring together the online material with case studies, motivational interviewing training, and other activities.

Approximately 1,400 state employees with an estimated 2,500 gaps in care were eligible for the initial pilot phase of the Illinois Project. During the first 6 months of the program, participating pharmacists addressed about 1,300 of those gaps.

Partnership success factors. Initial feedback from the pharmacists and patients involved in the Illinois Project has

been positive, according to both Patton and Bill Strein, Medco Vice President of Provider Relations. A number of pharmacists told Patton that patients who had been getting prescriptions filled at several different locations now were having all of their prescriptions filled at the program pharmacy. Strein reported that some participating pharmacists already have begun offering similar counseling services to all of their patients on a cash-pay basis.

Unexpected challenges. The pharmacists currently participating in the Illinois Project are mostly independent community pharmacists. The decision to limit initial recruitment to this group was a practical one that was based on the efficiencies associated with "dealing with decision makers directly, rather than having to work through a corporate office," Patton explained. However, the fact that the pharmacy recruitment letter was sent by Medco and Mirixa engendered quite a bit of reluctance among these pharmacists. "There was almost a foregone conclusion that the program would be negative," Patton shared. "The letter probably would have been better coming from IPhA, not the pharmacy benefits manager." Strein concurred, advising anyone interested in developing a similar program to anticipate the need to overcome unfavorable perceptions that community pharmacists might have about MCOs.

Strein is hopeful that the Illinois Project will contribute to a reversal of opinion. "It's not just about the bottom line," said Strein. "MCOs really do care about patient safety and adherence to prescribed medications."

Cub Pharmacy/Prime Therapeutics

Inadequate understanding of what managed care is and the role it plays in patient care may contribute to negative perceptions of MCOs and PBMs among community pharmacists.[1,38] In a recent exploratory study conducted at one pharmacy school, nearly three-fourths of the PharmD students surveyed indicated that they understand little or nothing about the functions of PBMs, and most of those students rated PBMs unfavorably.[38] A new partnership between SUPERVALU and Prime Therapeutics seeks to remedy this problem by introducing community pharmacy residents—who usually are in their first postgraduate year—to the world of managed care pharmacy.

Nationwide food and drug retailer SUPERVALU currently offers accredited community pharmacy residencies at three Jewel-Osco sites in the greater Chicago area and one Cub Pharmacy site in Minneapolis. A new residency at ACME–Sav-On in the Philadelphia area is a candidate for accreditation. Each residency is affiliated with a nearby pharmacy school (University of Illinois College of Pharmacy, Midwestern University College of Pharmacy, University of Minnesota College of Pharmacy, or Temple University School of Pharmacy). Residents engage in a wide range of activities at both their community pharmacy site and the affiliated university; they also spend time at SUPERVALU corporate headquarters in areas such as operations and training/recruiting.

According to Monica Brands, director of the Cub Pharmacy

residency program, the idea to have community pharmacy residents also receive managed care experience first arose during an accreditation site visit in 2009. "The topic came up during our discussions with the survey team—'Wouldn't it be great to really round out the resident's experience in this way?'—because the current standards for community pharmacy residencies include goals and objectives for elective managed care experiences," Brands explained. "We were all intrigued by the possibilities."

April Shaughnessy, Director of External Relations for AMCP, put Brands in touch with Jeremy Schafer, Residency Program Director for Prime Therapeutics (a PBM that is owned jointly by 12 Blue Cross and Blue Shield plans, with headquarters in the Minneapolis suburb of Eagan, MN). When Brands broached the possibility of having the Cub Pharmacy resident complete an elective rotation at Prime Therapeutics, the timing turned out to be perfect. "I had just finished the development work on our own managed care pharmacy residency, so I knew what was involved," Schafer said.

Brands and Schafer hammered out the specifics of the pilot rotation during a series of telephone calls and e-mail exchanges. They decided that a 2-week rotation would be optimal: long enough to be of value, but not so long that it would interfere with resident's primary activities. As they worked together on the rotation structure and content, they focused on the aspects of managed care that have a direct impact on community pharmacy practice. "We wanted the resident to understand the reasoning behind the things we do, and how the decisions we make affect patients," said Schafer. "We also wanted to include practical things like why drugs are added to or removed from the formulary." Schafer arranged for the resident to spend time with key personnel in formulary development and operations, use management, government programs, networks, clinical review, and MTM services departments.

The first resident completed the elective rotation in April 2010, and from all accounts, the pilot was an unequivocal success. "Our resident couldn't stop talking about it," Brands said. "When she came back to the pharmacy, not a single week went by when she didn't apply something she had learned at Prime Therapeutics." In particular, the resident's newfound knowledge of managed care practices improved her interactions with patients and enabled her to provide better explanations of health plan policies. Both parties were so pleased with the outcome of the pilot that SUPERVALU is exploring managed care rotations for its other pharmacy residents; Prime Therapeutics is considering adding an elective community pharmacy rotation to its managed care residency, so the resident "can see how everything they've learned gets implemented," noted Schafer.

Partnership success factors. Brands credits Schafer with much of the success for the pilot rotation. "He put together such a stellar curriculum—I don't know if the rotation would have been as valuable otherwise," said Brands. Schafer, in turn, acknowledges the commitment and preparation of his Prime Therapeutics colleagues. "Everyone was so enthusiastic and organized, and they had such great ideas for helping the resident learn about their areas," he said. Schafer recommends

that community pharmacy residency programs seeking to replicate this rotation focus on selecting a managed care partner with a demonstrated record of teaching. Before the first pharmacy resident arrived, Prime Therapeutics already had experience hosting both student pharmacists (for advanced pharmacy practice experiences) and summer interns. Thus, the company was accustomed to providing learning experiences in various departments, and many existing materials were easily adapted for use in the residency rotation. As Schafer noted, "The last thing you want is for the resident to go back to the community pharmacy and say there wasn't much to do."

Unexpected challenges. As in other collaborations between MCOs and community pharmacists, the participants in the Cub Pharmacy/Prime Therapeutics partnership encountered unanticipated roadblocks. Most prominent were delays introduced by the resident's employment status. "The resident was employed by SUPERVALU, but while she was here at Prime Therapeutics, she needed to function in some ways as our own employee," Schafer explained. The resident's "guest" status brought up unexpected issues related to computer access, security, and mandatory preemployment screening, among others. Schafer's advice to other MCOs and PBMs: "Start your planning *way* in advance. It probably will take a lot more time and discussion to bring someone on board than you think." Fortunately, thanks to plenty of teamwork and problem solving, "everything was ready for the resident on day 1," reported Schafer.

Walgreens/Humana Inc.

Arguably, few initiatives have done more to advance pharmacists' role in direct patient care than the pharmacist-administered immunization movement.[39] Pharmacists currently are authorized to administer influenza vaccines in all 50 states, the District of Columbia, and Puerto Rico; in many states, pharmacists also may administer other vaccines such as pneumococcal, zoster, and hepatitis B.[40] As of June 30, 2010, more than 120,000 pharmacists have been trained to administer immunizations.[40]

Ed Cohen, Senior Manager of Immunization Clinical Services for Walgreens, sees pharmacy-based immunizations as the embodiment of "everything we've been talking about for so many years." In Cohen's view, immunization services provide the ideal transition from a product focus to a service focus. "The vaccine—the product—is treated in the same way that a prescription drug would be," Cohen explains. "But the pharmacist also must interview the patient and interact in a way that exemplifies pharmaceutical care."

Ironically, these very characteristics have created billing and reimbursement challenges to an extent that many pharmacists have offered immunization services on a cash-pay basis only. A partnership between Walgreens and Humana Inc. is seeking to address challenges such as these by making it as easy and convenient as possible for Humana members to receive their annual influenza shot. (Beginning with the 2010–11 influenza season, the CDC Advisory Committee on Immunization Practices recommends routine influenza vaccination for all persons 6 months or older.[41])

"We're trying to get our members to 'do the right thing' for their health, and immunizations are an important part of that," said Sherri Cohmer, Director of Medicare & Commercial Clinical Pharmacy Programs for Humana. "We make a special effort to ensure that members are aware of the pharmacy option for getting vaccinations. Walgreens has been a leader in this area, and they have locations everywhere that we have members." Walgreens is one of the largest chains to offer immunizations; in just 5 years, the company's immunizations network has expanded to encompass more than 24,000 trained pharmacist immunizers in more than 7,500 stores.[42] Walgreens was honored with a 2010 National Influenza Vaccine Summit Immunization Excellence Award for its efforts during the 2009–10 influenza season and H1N1 pandemic.

Humana has endeavored to ease the administrative burden for pharmacists and facilitate billing for immunizations so patients don't have to pay cash. "It took some time to change our infrastructure," Cohmer stated, "but now pharmacists can bill us online using the point-of-sale claims processing system for the vaccine alone, vaccine administration alone, or the combination of vaccine plus administration."

Walgreens has developed a number of marketing materials to help health plans such as Humana spread the word about the pharmacy influenza vaccination option. These materials include cobranded mail tip-in sheets, newsletter copy, and website banner ads for the health plans, as well as workplace posters, paycheck stuffers, and e-mail templates for large employer groups. At the store level, Walgreens uses reader boards, in-store signage, and large format banners to welcome Humana health plan members.

Conclusion

Despite their perceived differences, MCOs and community pharmacists share many common goals. Among these goals are ensuring safe and appropriate patient care, improving the cost-effectiveness of medication therapy, and helping patients obtain the best possible therapeutic outcomes. The partnerships profiled in this article provide evidence that these goals are not beyond reach.

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Assessment Questions

Instructions: The assessment test for this activity must be taken online; please see "CPE processing" below for further instructions. There is only one correct answer to each question. This CPE will be available at www.pharmacist.com no later than October 31, 2010.

1. **Payers began to embrace managed care as an alternative to indemnity insurance during which decade?**
   a. 1960s
   b. 1970s
   c. 1980s
   d. 1990s

2. **Which of the following is mentioned in this article as a managed care strategy for influencing the appropriateness of drug therapy?**
   a. Copayment
   b. Drug use review
   c. Step therapy
   d. Therapeutic interchange

3. **In the APhA/National Association of Chain Drug Store model framework for medication therapy management (MTM) services, which of the following core elements of MTM service delivery is a document for patients to use in tracking progress for medication self-management?**
   a. Medication therapy review
   b. Personal medication record
   c. Medication-related action plan
   d. SOAP note

4. **According to the AMCP/American Society of Health-System Pharmacists consensus document** *Sound Medication Therapy Management Programs,* **which of the following represents a specific operational aspect of a quality MTM program (as opposed to an important overall feature)?**
   a. Evidence-based medicine
   b. Flexibility for broad application
   c. Interdisciplinary, team-based approach
   d. Services tailored for setting and cultural differences

5. **The Current Procedural Terminology billing codes for pharmacists allow billing for MTM services in increments of**
   a. 5 minutes.
   b. 10 minutes.
   c. 15 minutes.
   d. 30 minutes.

6. **In the Wisconsin Pharmacy Quality Collaborative, which of the following activities would be compensated as a Level 2 service?**
   a. Creating a medication-related action plan for a patient
   b. Discontinuing a medication that represented duplicate therapy
   c. Making a dose adjustment based on renal function
   d. Recommending addition of an evidence-based medication to a patient's regimen

7. **The Pharmacy Coaching Program for employees of the City of Cincinnati is modeled after which of the following programs?**
   a. Diabetes Ten City Challenge
   b. Project ImPACT: Hyperlipidemia
   c. Senior PharmAssist
   d. The Asheville Project

8. **To be eligible for the Illinois Project, State of Illinois employees must be taking medications from certain categories and**
   a. Be willing to meet with a pharmacist on a monthly basis.
   b. Have potential adherence problems or be missing evidence-based therapies.
   c. Incur annual drug costs that exceed $3,000.
   d. Take more than eight medications.

9. **In the partnership between SUPERVALU and Prime Therapeutics, the optimal length of the managed care rotation for the Cub Pharmacy community pharmacy resident was determined to be**
   a. 1 week.
   b. 2 weeks.
   c. 1 month.
   d. 5 weeks.

10. **One of the biggest hindrances to immunization partnerships between managed care organizations and community pharmacists has been**
    a. Billing and reimbursement challenges.
    b. Low patient interest.
    c. Resistance from primary care physicians.
    d. The fact that pharmacists are not authorized to administer vaccines in all states.