

# Program gives pharmacists more clout in patient care

By Julie Appleby, *USA TODAY*

LOS ANGELES – On this city's Skid Row, where the down-on-their-luck come for food, shelter and a second chance, pharmacist Steven Chen bustles into a small examining room at a community clinic. He sits down next to Floyd McLucas, who has diabetes.

The two talk for more than 25 minutes about McLucas' medication, his diet and his recent blood sugar test results. Chen then suggests that McLucas, 58, a former truck driver who lives at a nearby charity mission, begin taking a drug to lower his cholesterol.

What's unusual about the encounter is not only the amount of time Chen is able to spend with McLucas, but also that Chen is a pharmacist with the authority to order lab tests, add or change medications, and otherwise help oversee patient care.

Both men are part of a program underway at a handful of federally funded health centers across the country, which aim to show that more directly involving pharmacists with patients can improve care and lower the cost of treating patients with chronic illnesses such as diabetes, asthma and heart disease.

During more than two years, patients with diabetes referred to the pharmacist program at the [JWCH Medical Clinic at the Weingart Center](#) on Los Angeles' Skid Row showed an average drop in blood sugar levels of 3.7 percentage points, a significant drop. Lowering blood sugar levels can help patients avoid some of the serious complications of diabetes. Blood pressure levels for the participants also fell significantly to near-normal range.

At another community clinic – The El Rio Community Health Center in Tucson – a group of diabetes patients referred to its pharmacist-overseen program had lower blood sugar levels after six months than counterparts getting standard care.

Results like those could help lead to more such efforts, as both government health programs and private insurers look for ways to control some of the most costly diseases. Preventing the complications of diabetes, including blindness, limb amputations, heart disease and stroke, could not only save lives, but also reduce hospitalization and other medical costs for insurers, program proponents say.

"This is the future of the practice of pharmacy," says Jimmy Mitchell, director of the office of pharmacy affairs at the federal Health Resources and Services Administration (HRSA), which granted start-up money for the Los Angeles program and 17 others.

## **Insurance roadblocks**

More than 40 states allow such collaborations between pharmacists and doctors. But because many insurers don't directly pay pharmacists for patient care, such efforts are mainly found in programs run by a few state Medicaid agencies, as well as the Department of Veterans Affairs, the Indian Health Service and federally funded community clinics, which accept all patients regardless of whether they have insurance or money.

"We've been fortunate in that we've combined some profits from the pharmacy department to pay for this, and we have a foundation that seeks private donations to our program," says Tony Felix, pharmacy director for the El Rio center.

A big change came when Congress passed the Medicare Modernization Act of 2003, which created a drug benefit for Medicare patients and said for the first time that pharmacists can be paid by insurers for counseling certain chronically ill Medicare patients who spend at least \$4,000 a year on drugs.

"That was a turning point for community pharmacists to be recognized as health care providers," says Edith Rosato, senior vice president of pharmacy for the National Association of Chain Drug Stores.

The new rules come as retail pharmacies are expanding services – one way to boost foot traffic in their stores – to include more medical services, going beyond offering flu shots to offering other types of vaccinations or having specially trained pharmacists fit patients for medical equipment such as wheelchairs.

Still, most pharmacists in busy drugstores don't have the time or the space for longer disease-management sessions.

"Retail pharmacies are not usually conducive to this type of thing," says Bridget Eber, national practice leader for pharmacy benefits at benefits consulting firm Towers Perrin.

Humana, like some other insurers, runs disease-management programs for members with chronic conditions such as diabetes. Because the insurer does not have its own medical clinics, it has asked its network of 60,000 retail pharmacies if they would provide such counseling and get paid for it.

## **Independent pharmacies take lead**

So far, just short of 7,000 pharmacies have signed on, many of them independent pharmacies rather than the large chain drugstores, says William Fleming, Humana's vice president of pharmacy. He attributes the low sign-up rate to a reluctance of pharmacies to set aside retail space for private counseling areas.

"In pharmacy school, we're all taught that you want to be more than a provider of pills," Fleming says. "Pharmacists want this opportunity, and it's in front of them now. It's up to the retail pharmacy community to seize this opportunity."

Rosato, who notes her group has worked closely with Humana, says it's also up to insurers to broaden the number of patients for whom counseling services are provided. As it stands, a retail pharmacy may see only a handful of patients who qualify under the restrictive Medicare rules, often not enough to justify making wholesale changes in store practices.

"We want to serve not just the chronically ill Medicare patients, but to expand the concept across the entire population," Rosato says.

To get employers and insurers to pay for such services, pharmacists must show that the programs improve care and lower costs. Rosato says that, initially, many such programs may show an increase in the amount spent by insurers on prescription drugs. But, over time, she says, savings are had through reduced hospitalizations and complications.

### **Treating homeless patients**

Key to cost savings and improved health is to get chronically ill patients to consistently take their medications and follow other guidelines set by their doctors.

At the Weingart Center, pharmacist Chen spends a good deal of time discussing those issues with McLucas, who has followed the guidelines and is doing well, with low enough blood sugar readings that Chen tells him that he won't need to go on insulin.

Savings can come in other ways, too. The program helped the center increase the use of a low-cost government purchasing program and free programs offered by drugmakers, which resulted in about \$1 million annually in savings.

On the day in mid-August that he met with McLucas, Chen had about 20 patients booked, but only about half showed up. That's just one of the challenges the medical staff faces in dealing with patients who are often homeless, between jobs or just out of jail.

The pharmacist program, run in conjunction with the University of Southern California School of Pharmacy, lets doctors refer some of their complicated, high-risk patients to the pharmacists, who generally have more time to spend with them. Chen left a medical practice in Beverly Hills to teach at USC and offer his time to the Weingart Center program.

Sometimes, the pharmacists even make home visits. Chen visited a diabetic patient who wasn't improving, despite having a good supply of insulin and clear instructions to store it in a refrigerator.

He arrived at the patient's address only to find a mostly empty lot. Confused, he went next door and asked about his patient. The neighbors said, " 'He lives right there,' " says Chen, who went back, poked his head inside a wood pile and saw a camper shell.

"In the middle of the lot was this refrigerator. It wasn't plugged in, and there was no door," says Chen. "There was the insulin, baking in the sun."

From then on, the patient had to come to the clinic more often because they could not give him extra supplies of insulin.

Not having a refrigerator or a kitchen is a problem for a lot of his diabetic patients, who must carefully control the sugars and carbohydrates they eat.

"I talk about eating fresh fruits and vegetables with my diabetic patients, and they said, 'We don't have refrigerators,' and they ask what they can store in their rooms that would be good for them," Chen says.

The average income for a clinic patient at the Los Angeles center is \$2,500 a year, Chen says.

"It's been a humbling experience for me," Chen says. "We're all just two steps away from being these patients."

### **Gaining doctors' acceptance**

The USC program began in 2002, when federal agency HRSA granted start-up money to the university's School of Pharmacy to expand pharmacy programs in three clinics, including the Weingart Center. After receiving additional money from private donors, USC has expanded the programs to eight clinics in Los Angeles.

The majority of the networks set up diabetes-management programs run by pharmacists, with most of the patients having multiple health problems, such as diabetes and high blood pressure, says a review of 18 networks completed in late 2004 by analysis firm Mathematica Policy Research.

The report called the results "striking" for patients in the program at least six months: One key reading of blood sugars dropped significantly, and the percentage of patients with optimal blood sugar levels nearly doubled to 37% from 18%. Even so, most of the results occurred in the first six months; patients generally leveled off but did not improve further.

Trouble finding money to continue programs led many of the networks to discontinue or cut back, with only 11 remaining at the time the report was completed.

Another challenge at some centers was getting doctors to agree to allow pharmacists an expanded role.

"Six of the 29 health centers with disease-management programs had little or no success generating physician support," the report says.

Chen said doctors initially were a bit skeptical about the role pharmacists would play in directly caring for patients.

"Most physicians didn't quite understand (at first)," Chen says. "They wondered, why are you changing the prescription or the dosage? At first, they wanted us to talk with them before making changes, so we did. After a while, the doctors said, 'We don't need you to talk with us.' "