The Minnesota pharmaceutical care project

Department of Health's prescription fraud report

Credit for Learning questions on adverse drug reactions

Lack of pharmacy support for OTC medicines?

Health promotion in pharmacies: an evaluation
A WELCOME REVIEW

When Frank Dobson was appointed Secretary of State for Health in the new Labour Government, we described him as a plain-speaking yokelishman with a down-to-earth approach (P7, May 10, p65). He has been demonstrating these personal characteristics recently with his remarks about National Health Service charges (P7, June 21, p856).

His statements have caused a fair amount of controversy — not least because they are seen by some as a breach of election pledges — but they are to be welcomed none the less. What he said was that NHS charging policy was under review, which should mean that, as well as new charges being considered, existing charges will be re-examined.

One of the policies that need reviewing is that of prescription charges. The charge has risen ahead of the rate of inflation for many years, so much so that now, at £3.65 per item, it is nothing less than a form of taxation.

But the charge is an unequal burden: the great majority of prescriptions are dispensed free, since they are covered by exemptions of one sort or another. And those exemptions have remained largely unchanged since 1968 when they were brought in on an interim basis.

The high basic charge leads to fraud (see also below) and deters people from taking all of the medicines that their doctors want them to take.

The exemption scheme itself deserves close examination. There are obvious anomalies — a diabetic patient does not pay charges for any prescribed medicines, regardless of whether they are to treat diabetes or not. However, a sufferer from another chronic condition, asthma, pays for all treatment, unless exempt on other grounds.

The Royal Pharmaceutical Society's policy remains that prescription charges should be abolished. This has been its position ever since charges were first introduced by the Labour government in 1912. The Society does not want any barriers to be put in the way of people receiving the medicines they need.

Since abolition of charges does not seem to be on the political agenda at the present time, at the very least the general charge should be reduced and a more rational system of exemptions brought in. As a letter from the President to the Secretary of State for Health makes clear (see p982), this is something that the Society would be more than happy to discuss with the Government. Mr Dobson's remarks indicate that the Society should not have to wait too long.

PROSCRIPTION FAULT

A great deal of attention has been paid of late to the issue of prescription fraud. In November, 1994, a suggestion was made that £20m was being lost to the National Health Service through such practices as pharmacists destroying prescription forms for low-cost items after the patient had paid a charge (P7, November 5, 1994, p633). The Audit Commission was said to be producing a report.

Later in the year, the commission duly reported, but no further light was shed on how the figure of £20m was arrived at (P7, December 13, 1994, p784). However, the report seemed to suggest that, where there was fraud, pharmacists were not playing a leading role in it. Patients falsely claiming exemption seemed to be the main problem.

Subsequently, the Department of Health and the Welsh Office funded a study to assess the scale of prescription fraud and to make recommendations. That study has now been completed and the study team's report was published last week (see p690).

The first thing that needs to be said is that the report does not provide any further evidence on the level of fraud by pharmacists. Indeed, it points out that contractor fraud is difficult to quantify and makes it clear that where there is fraud by practitioners it is very much a minority activity.

Most of the study team's efforts were devoted to analysing the prescribing and payment process, identifying opportunities for fraud and then making recommendations to deal with the problem areas identified. There are 100 recommendations.

In relation to patient fraud, a key recommendation is that the prescription charge system should be reviewed and simplified. The high charge must be a strong reason for fraud. Another key recommendation is that charge evasion should be a criminal offence. At the moment there is no such deterrent.

Another proposed deterrent would involve pharmacists in more work and would require the setting aside of an agreement made with the Government when the prescription charge exemption scheme was first brought. That was that pharmacists would not be expected to check entitlement to exemption. If one of the report's recommendations is acted on, patients would be asked to provide proof of entitlement when they claimed exemption. Where they could not provide such proof, the prescription would still be dispensed without charge, but it would be submitted for pricing in a separate bundle, so as to facilitate later checking. The report recognises that this would add to the pharmacist's workload, and suggests that payment should be negotiated. Pharmacists are already acting as unofficial tax collectors and would take some persuading to perform such a policing role.

So far as practitioner fraud is concerned, one of the recommendations is that test prescriptions should be put into the system where there is cause for concern. This would seem to be reasonable. The vast majority of contractors are law-abiding and would have nothing to fear from such an approach. It is only the dishonest who would be likely to be called to account.

Fraud by pharmacists is to be deprecated. The President of the Society has made it clear that the profession supports the need to deal with it (see p692). Indeed, where fraud is detected, the profession has a reputation of taking an uncom­ promising view. In all of the 10 times of National Health Service fraud referred to the Statutory Committee over the past six years, the name of the pharmacist has been removed from the register. Pharmacists in general would not want things any other way.
Pharmaceutical care was defined by Douglas Hepler and Linda Strand as the responsible provision of drug therapy for the purpose of achieving definite outcomes that improve a patient's quality of life (Ann J Hosp Pharm 1990; 47:533-41).

Linda Strand, who is an associate professor in the College of Pharmacy at the University of Minnesota, now says that that definition was incomplete. The definition she now espouses—and it is the one that has been developed at the Penn's Institute of Pharmaceutical Practice within the college—is that pharmaceutical care is "a practice in which the practitioner takes responsibility for a patient's drug related needs and holds himself or herself accountable for meeting these needs".

Professor Strand places great emphasis on the word "practice". A pharmacist working to this new definition处方writes all the medicines that a patient is taking, from whatever source, assesses them for reasonableness and effectiveness in the light of the patient's condition, develops a care plan and follows up progress on a regular basis.

Linda Strand and Douglas Hepler, who is based in the University of Florida, now find themselves on divergent paths. While Strand and the Peters Institute have been developing the total therapy concept, Hepler has been working on therapeutic outcomes monitoring on a one-disease-at-a-time basis, beginning with such common conditions as asthma, diabetes, angina, hypertension and hyperlipidemia (J Am Pharm Assoc 1997; 37:145-8).

Professor Hepler described the basis of the institute's philosophy of pharmaceutical care in a long interview with me.

She emphasized that the pharmacist's real focus was the patient. Pharmacists had to assume responsibility for providing a service of real value and in a way that they could be paid for it. It was much more than simply providing a product. Pharmaceutical care was a practice, just like any other health practitioner's practice. It had a philosophy, a patient care process and a management system. If there was a difference between pharmaceutical care and clinical pharmacy it was that pharmaceutical care had a management system and clinical pharmacy did not. Clinical pharmacy was on a periphery of a system that was essentially dispensary and being managed as such. Pharmaceutical care was a practice in which practitioners took responsibility for defining a patient's needs and held themselves accountable for that. This was very different to the 1990 definition. In that definition the only thing that people seemed to have caught on to was "outcomes". But outcomes meant nothing out of the context of a practice.

Why was pharmaceutical care needed?

The philosophy started with the assumption that a profession was only justified if it contributed to the solution of a unique set of problems. Drug-related morbidity and mortality fulfilled that description. They required expertise of a professional nature. Drugs could make people sick as well as better. And there was also this idea of preventive therapy. That was why a rational approach was needed through pharmaceutical care.

But pharmaceutical care did not mean that drug usage was lessened. On the contrary, it had been found that about 20 per cent of patients needed additional drug therapy.

The responsibility of the pharmaceutical care practitioner was to ensure that there was an indication for every item of drug therapy and that any drug used was the most effective and the safest and that the patient was compliant.

Patients' needs were there, whether pharmacists recognized them or not. Many patients had problems with their drug therapy. Society had yet to create a professional to meet these needs.

Did money spent on pharmaceutical care lead to savings elsewhere?

Data showed that half of all patients entering a pharmacy had a drug therapy problem that needed to be addressed. If not dealt with, it could lead to unnecessary costs, from wasting money on ineffective therapy to hospitalization. The unnecessary costs...
had been estimated at between $1,000 and $25,000 per patient. But drugs were by far the cheapest form of therapy — perhaps compared with the costs of surgery, psy-
chotherapy, etc. It had not been possible in the Minnesota project to gather data on avoidance of physician or hospital costs as a result of the practice of pharmaceutical care — nobody had the necessary data — but its absence did not mean that pharmaceutical care should not be progressed. Insurance companies and other health care providers should not want their patients to be tak-
ing unnecessary or ineffec-
tive drugs.

What progress had been
made with pharmaceutical care and what could be done
to take the concept further?

In seven years, according to Professor Stend, the advo-
cates of pharmaceutical care had changed the profession’s mission and direction. But
really to achieve change, progress had to be made on a broad front. It was no use fo-
cusing on one issue at a time.

To change a profession, they had to change regula-
tions, reimbursement, edu-
cation, practice, patient expectations, relationships with other health care profes-
sionals, the physical structure of pharmacies and the attitude of the pharma-
cacist. This was a tough task.

There was no single key that would unlock the whole system. Pharmacy was frag-
mented. The way forward could be to teach students pharmaceutical care as a prac-
tice. This was what other profes-
sions did. Pharmacists
would also have to provide the service first, then seek payment afterwards.

The Minnesota concept of pharmaceuti-
cal care worked because it set out to find problems and solve them. It would un-
derstandably be more difficult to adopt, but the practitioner might not be a pharmacist.

The institute was developing a curricu-
um to teach pharmaceutical care, but it
would not be restricted to pharmacists, al-
though the institute was not interested in creating a new professional. For the foresee-
able future, the people who underwent the course would practice in pharmacies.

There was great resistance to change in the profession. But pharmacy needed to con-
vert from “dispensing” to “dispensing and practice”, where pharmaceutical care was the practice and dispensing was a component of the service. And pharmacists would have to build a practice on patient care at a time, just as physicians and dentists built their practices. As things stood now, phar-
cists did not know how many patients

would be prescribed and the dispensing model would continue. The necessary changes were not great — they mainly con-
cerned the area for patient interview — and pharmacies would not necessarily look much different from how they looked now.

To build a practice, pharmacists would have to start from the beginning. But the

good news was that a practice model had now been defined and pharmacists who were sufficiently knowledgeable could carry it out. So building a practice was not as diffi-
cult as it sounded. It was mostly the mind-
set of the pharmacist that was the hurdle.

There was no assurance that pharma-
cists would do it. They would if they decided to act like a proper profession. But if they did not, the only certain way would be to re-
quire pharmaceutical care by regulation. Whichever way it was achieved, there would be a need for reimbursement systems paying for defined services.

Minneapolis College of Pharmacy shares a building with
the College of Nursing.

What was the pharmaceutical care process?

Essentially, it was assessing a patient’s needs, using resources to meet those needs and then following up to make sure that what had been done by the pharmacist was benefi-
ticial to the patient. The responsibilities were to ensure that all of a patient’s drug therapy was appropriately indicated, effec-
tive, safe and able to be compiled with by the patient — in that order. If a pharmacist counselled a patient to be compliant without establishing that a drug was truly indicated, he or she was part of the problem, not the solution.

The care process was connected fully to the philos-
ophy. It comprised three steps: assessment of a pa-

tient’s drug therapy needs, a personalised care plan that identified these needs and a follow up evaluation to make sure these needs had been met. The whole process needed to be fully recorded. Pharmacists could not inter-

face with people’s lives with-
out full documentation.

Those steps had not, in fact, been invented for the purposes of pharmaceutical care. They were part of every single health care practitioner’s patient care process in the world.

The resources needed to provide the service were a qualified person and a suit-
able physical environment (a drug store and a reference source, spaces for the patient to wait and to talk to the pharmacist and a patient care dispensing system).

The next step was to build the practice and demonstrate the value of the service. There was yet little real understanding of the process. This was partly the

institute’s fault, because it had not published much. It would be cor-
recting that deficiency soon.

Would some pharmacists specialise in par-
ticular areas of therapy?

In medicine there were generalists and spe-
cialists, both essentially using the same process, starting with diagnosis and going through to treatment and follow-up. There could be specialist pharmaceutical care pharmacists addressing a restricted group of drug therapy problems in depth. When the generalist pharmaceutical care pharmacist felt he could not help a particular pa-

tient he could refer him on to the specialist. Once the problem had been assessed, the patient would be referred back to the general-

ist.

The institute had developed the practice of pharmaceutical care as a generalist prac-
tice in the community because that was where patients spent most of their time.
The project

Robert Cipolle: a lot of unique date

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The average time for an assessment was about five minutes. A lot could be achieved in that time if the pharmacist was systematic.

Dr Cipolle said that patients usually knew why they were taking particular medicines (though they might not use the precise medical terminology). If they did not, that could be a major problem. How could a counselled patient who did not know why they were taking a particular medicine. Because of the community setting, with people making frequent visits, pharmacists did not necessarily have to get all the information all at once. In the last resort, the pharmacist could ask the physician.

Once problems had been identified, solving them was not usually difficult. And once problems had been identified and resolved then the matter of compliance could be dealt with.

The whole process was recorded on computer software using standard terms as far as possible, to facilitate data analysis.

Initially, the idea had been to develop a pilot project, expand to a large number of sites and then develop a computer program to document patient care undertaken. But it had become evident very quickly that a computer program was needed in its own right, it simply had not been feasible to record the necessary data on paper. As a result, a program had been developed (by Health Outcomes Management Inc, a local company which had already produced programs for medical practitioners) in the first six months.

The program was designed to help pharmacists care for large numbers of people over long periods of time. It had a relational database and could be searched for any variable or combination of variables. The latest version had been internationalised to allow use in South Africa (by a health insurance company). A Windows version was due in the autumn.

The first screen shows a patient entry matrix which on one hand is a number of options, including a screen for recording patient demographic details, and facilities for recording care plan details, interventions and evaluations. There are 150 standard treatment protocols for all principal disorders stored within the program. Dr Cipolle

pharmaceutical care is a face-to-face business. Pharmacists have to be close enough to people to touch them to care for them

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THE PRACTICES

Mr. Frakes said that in the United States, physicians often did not keep records of patients' medication and people often did not use the same physician twice in a row. For many, the pharmacist was the only professional they usually used. This was why the personalized pharmaceutical care plan created by the pharmacist and given to the patient was so valuable. It listed the medicines that the patient was taking, the reasons for taking them, the dosage regimen, the prescribers, the intended outcomes and arrangements for follow-up. Brief general information was also given about the conditions being treated. Over-the-counter medicines were covered as well as prescription medications. A summary chart was provided to be kept in a wallet or purse.

Mr. Frakes noted that, in general, patients were taking twice as many drugs as recorded in a pharmacy patient medication record system.

As well as being of value to the patient, the patient could show their care plan to their physician or any other health professional treating them.

Twenty-five patients had signed up for pharmaceutical care at the pharmacy so far. One recent recruit had been found by the pharmacist to have dangerously high blood pressure and had decided to change doctors because his then physician had decided he did not need to be treated. On changing doctors, his treatment had started. The patient paid a fee for pharmaceutical care.

There were several major benefits. One was getting patients interested in pharmaceutical care and another was getting that care paid for. Payment had been made to pharmacists during the Minnesota project, but nothing had been established since. Until a payment system was established it would only be practised in pockets on a local level.
basis. The federal government had mandated patient counseling, so there were precedents for government action. A further hurdle was getting pharmacies to take up the system. The computer software had been available for some time, but there were still not many users. But Mr. Frakes declared: "Pharmaceutical care is so right I can't believe it won't pop up." Good medicine was a good idea and health maintenance organizations should be promoting it, but unfortunately their main interest was in getting the patient's premium. No one seemed to see that many treatments with medications were not working. Insurers needed to be convinced that the service provided by pharmacists could be so much better. For $10 a month per patient, pharmacists providing pharmaceutical care could do everything that needed to be done. This was not a lot, considering the amount of money spent on ineffective drug treatment. A small amount of money was needed to solve a large problem. The most likely route forward would be to convince health insurance companies that pharmaceutical care was worth paying for because it improved the quality of therapy. The professional organizations needed to be promoting the process. They should also be educating the public about the value of pharmaceutical care. All the data they needed would be in the forthcoming book about the proposal.

When they had started it all, they had not known whether pharmacists could fulfill the new role. The Minnesota project showed that they could. The tools had been developed for pharmaceutical care. All that was needed now was the will and the means.

**White Bear Lake**

The Bel-Aire pharmacy in White Bear Lake is owned by leading Minnesota pharmacist Lowell Anderson, a former president of the American Pharmaceutical Association. The pharmacy did not take part in the Minnesota pharmaceutical care project, but one of the pharmacists who now practices there, Mr. Tony Bose, did. Mr. Bose took the course arranged by the College of Pharmacy and helped in the creation of the pharmacy tool (see p750) and in the process of converting the pharmacy to pharmaceutical care.

Mr. Bose told me that a lot of patients did not expect pharmaceutical care and, even if they accepted the need for it, were concerned about whether their health insurers would pay. Payment was, indeed, an issue. For the present, it was up to the individual pharmacist to make arrangements for a health maintenance organization to pay for pharmaceutical care or risk the patient to pay. There had been some success with individual insurers, but many did not know how to deal with the matter. They were not accustomed to pharmacists operating in such fashion.

So far, about 25 patients had been enrolled for pharmaceutical care. They did not necessarily have their prescriptions filled at the pharmacy. Forms had been developed to obtain medication information from other pharmacists used by the patient. Other pharmacists were willing to pass on such information. Patients were using in-store leaflets and by placing information in prescription bags.

**Sites in Britain?**

Professor Standards said that the institute would welcome the opportunity to work with British community pharmacists in the development of pilot pharmaceutical care sites in Britain. She can be reached at the Peters Institute of Pharmaceutical Care, College of Pharmacy, University of Minnesota, 3-169 Health Sciences Unit P, 109 Harvard Street SE, Minneapolis, MN 55455-0931 (Fax: 612 625 9983).

The Bel-Aire Pharmacy is being converted for pharmaceutical care thoughts he had. Mr. Bose emphasized that support personnel were essential. Without them, pharmaceutical care would fail. Pharmaceutical care pharmacists had to be freed from the routine of dispensing. But pharmacists could not excuse themselves from pharmaceutical care on the basis that they did not have enough time. When they had done some time and motion work in pharmacies operating in the traditional manner, it had been surprising how much time pharmacists spent on things that did not need their skill and training.

On the question of privacy, Mr. Bose said that he did not believe it was right for the pharmacist to work with the patient in a totally closed-door environment. Patients should be assured of privacy without such physical separation from the rest of the premises.

He had no doubt in his mind that the pharmaceutical care model developed in Minnesota was the way to go. If pharmacists began helping patients in this way they would be making use of their skills and the whole process would snowball. It could develop into a situation where the doctor diagnosed and the pharmacist handled the treatment. As more and more pharmacists practiced pharmaceutical care and suggested changes in treatment to benefit the patient, the more physicians would come to value their judgment. He was already beginning to notice such a response locally.

The Peters Institute

The Peters Institute of Pharmaceutical Care takes its name from two former graduates of the Minnesota College of Pharmacy, William and Mildred Peters, both highly successful practitioners, who made a bequest to the college for the purposes of pharmacy education. Its director is Professor Robert Cappel, a former dean of the college. As well as Professor Standard and Professor Merck in the pharmacy, the institute was recently joined by Professor Lawrence Weisert, emeritus dean of the college, and Dr. Janet Norman, a research fellow.