Managed Care Forum

Helping primary care providers with appropriate, cost-effective prescribing

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Our college of pharmacy sends students to primary care practice sites for clerkships. The practitioners are more than satisfied with the students’ chart review and patient interaction, but they need assistance on a more global level. One site that has entered risk-sharing agreements with a local managed care organization (MCO) has requested help in managing its per-member-per-month (PMPM) utilization costs and formulary compliance. How can we help the practitioners manage their drug use and prescribing patterns?

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Risk-sharing agreements like the one you describe often involve incentives for reaching a PMPM cost threshold. As a resident in managed care pharmacy practice and preceptor for pharmacy students in ambulatory care clerkships, I created and implemented a pilot project to evaluate the effect of academic detailing on prescribing by primary care practitioners. The practitioners (two physicians, a nurse practitioner, and a physician assistant) at one of our clerkship sites had lost capitation dollars at the end of a one-year risk-sharing contract, because PMPM costs had exceeded the threshold set in the contract. One of the practitioners asked the pharmacists for help in reducing costs, and this request led to the pilot project.

The primary care practice site where the project was implemented serves primarily Medicaid patients. The project involved creating and implementing a series of guidelines that combine therapeutic and formulary coverage concerns. The guidelines cover the 10 most common diseases in patients at the site, as determined through a random review of 300 patient charts: hypertension, viral upper-respiratory-tract infections, type 2 diabetes mellitus, asthma, osteoarthritis, allergic rhinitis, otitis media, gastroesophageal reflux disease, hyperlipidemia, and gonorrhea or chlamydia. The most common, rather than the most costly, diseases were chosen because the goal was to incorporate both cost control and proper disease management, tailored to the specific practice site. Health plans often institute guidelines for diseases that are costly to treat because expensive drugs are used, but placing restrictions on drug use may not reduce the overall cost of treatment.

The guidelines were implemented in December 1999. They consist of easy-to-follow therapeutic algorithms constructed from currently accepted clinical practice guidelines from the Joint National Committee on Prevention, Detection, Evaluation, and Treatment of High Blood Pressure (sixth report), the American Diabetes Association, and the American College of Rheumatology, as well as several guidelines from the Institute for Clinical Systems Integration and the National Guidelines Clearinghouse. The formulary coverage portion consists of a list of all or most of the indicated agents for each disease, along with dosage information and the formulary status of the agent for the three MCOs most frequently encountered at the practice site. Data such as relative cost and formulary status were taken verbatim from each plan’s current formulary. The least costly agent or agents in each class are highlighted in yellow. The trade name for each drug is typed in italics, and the generic name is placed before the trade name if a generic equivalent is available. All of this information is contained in a binder at the site.

The sixth-year doctor of pharmacy students on clerkship rotation at the site visit the clinic daily and provide regular reminders to prescribers about the guidelines. The students are considered members of the health care team. As the students’ preceptor and the managed care resident, I handled questions and therapeutic issues pertaining to the guidelines.

This two-year pilot project is part of a study that melds academic detailing and cost conservation in an attempt to promote prescribing that is appropriate as well as cost-effective. Because multiple MCOs are involved, no PMPM cost threshold was set. Instead, the average costs for all three plans before and after guideline implementation will be compared. In addition to costs, the percentage of generic products prescribed and the numbers of emergency room visits and inpatient hospital days will be analyzed.

Cost-effective disease management will become especially important as more practitioners enter risk contracts. Projects such as this may be useful when incentives are offered for reducing PMPM costs to a certain threshold.

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