T O P I C S

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Evolution of Consulting Pharmacy and Medication Management

By Joe Litsey, Pharm.D. CGP

Consultant pharmacy has been a staple in nursing homes for over 40 years. In this article we will explore the past, how the practice of consulting pharmacy has evolved over these four decades, and how it might be structured to improve patient outcomes in the future. To better understand the role of a consulting pharmacist, it is important to define and understand certain terms that are routinely used in the industry. These terms include: Drug Regimen Review, Medication Regimen Review, Consultant Pharmacist, Senior Care Pharmacist, Medication management

Drug Regimen Review (DRR) is a process conducted by a pharmacist that can occur either prior to dispensing medications or at a later time. The goal of the DRR is to ensure that optimal patient outcomes are achieved from the drug therapy.[1] Simply, the DDR is evaluating drug use. This "evaluation" became known as the DRR when the process became a federal mandate for nursing facilities in 1974. As the years passed, the process and expectations evolved and "Medication Regimen Review" (MRR) was introduced into the vernacular as this was thought to be a more accurate description of the process. In addition, the term MRR removed the perceived negative connotation linked to drugs in certain circles, such as: "the war on drugs," "just say no to drugs," etc. "Medication Regimen Review" was perceived to be much more positive. In 2006 the process of DRR was officially renamed MRR when the Centers for Medicare and Medicaid Services (CMS) made broad sweeping changes to their interpretive guidelines.

CMS defined Medication Regimen Review as:

A thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences associated with medication. The review includes preventing, identifying, reporting, and resolving medication-related problems, medication errors, or other irregularities, and collaborating with other members of the interdisciplinary team.[2]

According to the American Society of Consultant Pharmacists (ASCP), a Consultant Pharmacist is defined as: "a pharmacist who is paid to provide expert advice on the use of medications by individuals or within institutions, or on the provision of pharmacy services to institutions." Consulting pharmacy originated in the nursing home setting many years ago and reimbursing a pharmacist for their cognitive services was a progressive idea back in 1974. Today consultant pharmacists are practicing in a wide variety of other settings such as post-acute, assisted living, hospice, home care, community-based care, prisons, etc. Because of the changing practice settings, the term "consulting pharmacist" is being replaced with "Senior Care Pharmacist." Senior Care Pharmacists are skilled health care professionals who have specialized training in the medication-related needs of seniors no matter in what setting they reside.

The rationale for having a pharmacist routinely review the medication therapy of patients residing in long term care (LTC) facilities is to improve the overall medication management of the patients and the institutions in which they reside. Many definitions of medication management exist depending on the organization defining. However, I believe it can be broadly defined in simple terms. Medication management is "all things pertaining to medication use." This includes medication evaluation, which involves evaluating each medication's indication, administration, monitoring parameters, dose and duration of therapy. Also included in medication management is the handling

of medications, which encompasses such things as ordering, procurement, storage, and accountability. The consultant pharmacist, therefore, exists to improve medication management for individual patients as well as institutions.

In the early years of consultant pharmacy, pharmacists were often forced into the consulting role as part of the responsibilities packaged with being the LTC pharmacy provider. Pharmacists were fulfilling the federal requirement, but the quality of the work was anything but consistent and the term "expertise" was loosely applied. My introduction into consultant pharmacy was consistent with this generalization. My initial training was offered by a pharmacist who owned his own LTC pharmacy and did a little consulting work "on the side". His version of consulting pharmacy was grabbing the past month's Medication Administration Record (MAR) and looking for "holes" in the MAR (medications not signed out as given) and to audit medication storage areas for out of date drugs. Once this process was completed, he reported the number of "holes" and the number of expired medications found to the director of nursing and administration. The quality of the facility's medication management was measured by comparing numbers from previous months to current month. Certainly, there is value in these types of audits; however, they are not cost effective uses of a consultant pharmacist's time. Quality must be measured through outcomes. Shifting focus of the MRR from simply fulfilling the compulsory components to legitimate medication use concerns will improve patient outcomes and can be a cost effective investment for LTC facilities.

The federal requirement for the MRR was considered by some in the LTC industry as an unfunded mandate. At the time, pharmacies could afford to offer extensive services to LTC facilities at little to no charge while still achieving acceptable margins due to favorable drug costs and reimbursement rates from Medicaid and Medicare. Pharmacies had the incentive to charge a nominal fee for consulting services to capture the majority of the provider pharmacy business even though this is a direct violation of the federal anti-kickback statute: 42 U.S. Code § 1320a–7b[3]. Despite this violation, the practice continued and became so widespread that in 2010 CMS proposed a rule change requiring LTC facilities to contract with a consultant pharmacist that is independent from the provider pharmacy. CMS rationalized that the proposed rule change was needed because daily MRR quotas had rendered the process perfunctory and was not yielding intended outcomes or providing expected beneficiary protections against unnecessary medication use. CMS charged foul by citing the potential conflict of interest on the part of the pharmacist who were providing consulting services to the LTC facility while also employed by the LTC provider pharmacy. CMS stated:

We are greatly concerned with financial arrangements that involve payments from pharmaceutical manufacturers directly or indirectly to LTC pharmacies and LTC consultant pharmacists for encouraging physicians to prescribe the manufacturer's drug(s) for residents. The impact of these financial incentives is heightened when, as permitted under State law or by the State Pharmacy Board, LTC facilities sign agreements with LTC pharmacies permitting the consultant pharmacists to make medication switches. These types of arrangements may result in incentives for the LTC consultant pharmacist to make recommendations that conflict with the best interests of nursing home residents. Any such arrangements have the potential to directly or indirectly influence consultant pharmacist drug regimen recommendations. As a result, the arrangements bring into question the ability of the LTC consultant pharmacists to provide impartial reviews of the residents' drug regimens, which in turn raises concerns regarding the quality of those reviews and potential impact on resident health and safety.[4]

After much debate, the proposed rule change was never implemented as it was determined this change would cause a massive disruption for much of the LTC industry. Instead, CMS strongly encouraged the LTC industry to voluntarily adapt the following:

- Separate contracting for consulting services from dispensing and other services.
- Payment by LTC facilities of a fair market rate for consultant pharmacist services.
- Disclosure by consulting pharmacist of potential conflicts of interest (i.e. the execution of an integrity agreement).
- Collect data on the number, type and outcomes of consultant pharmacist recommendations to develop performance measures to assess the effectiveness of the consultant pharmacist.

Even though these proposed rule changes were not implemented, they had a profound effect as LTC facilities and pharmacies were forced to examine their relationships and overall objectives, thus, putting the focus back on the patient.

The Accountable Care model is designed around the principle of performing a task that improves patient outcomes while simultaneously reducing the overall cost of care. The pioneers of consulting pharmacy were ahead of the curve as they were tracking drug therapy problems and outcomes well before this became the standard. Today there are over 43.1 million adults aged 65 and older in the United States; by 2040, that number will rise to 79.7 million. Seniors represent just over 13% of the United States population[5], but consume 40% of prescription drugs and about 35% of all over the counter drugs.[6] The need for quality senior care pharmacists has never been greater and consultant pharmacy continues to evolve in concert with our overall health care system.

As chronic disease increases, so does the use of medications to manage these diseases. On the flip side, the more medications taken by a patient the greater the risk of medication related adverse effects. On average, individuals 65 to 69 years old take nearly 14 prescriptions per year while individuals aged 80 to 84 take an average of 18 prescriptions per year. Adverse drug reactions and nonadherence are responsible for 28% of hospitalizations of the elderly, and 36% of all reported adverse drug reactions involve an elderly individual.[6] Poor medication management has been recognized and generally accepted as a leading cause of hospital readmissions. As penalties for hospitals intensify for sub-optimal readmission rates, and as skilled nursing facilities brace for their own version of hospital readmission penalties, it only makes sense to engage pharmacists to address these medication management problems. Medication management problems are not being properly addressed by our patchwork of health care workers applying Band-Aids to our bullet holes. If we want to fix our medication management problems we need the right people with the right set of skills leading the way.

Beyond medication regimen review, the consultant pharmacist could be leveraged by the LTC industry to develop medication policy and procedures, and to establish formularies and standing orders. Through collaborative practice agreements with LTC facilities, medical directors and individual providers, pharmacists could be allowed to manage individual patient's medication therapy. Consultants also could be involved in fall prevention programs, psychotropic medication monitoring and assessment programs, antibiotic stewardship programs, and transitions of care. Finally, pharmacists could be involved in developing medication regimens specifically designed for a patient's personal lifestyle, not the other way around.

Medication management is a significant factor contributing to unnecessary hospital readmissions. The majority of medication errors occur during times of transitions. Approximately half of hospital related medication errors and 20 percent of adverse drug events are due to poor communication at transitions.[7] Sixty percent of post-hospital discharge adverse drug events can be prevented or improved with intervention.[8] Improved discharge procedures have been shown to have a major impact on preventing these events.[9] Recently, CMS has proposed further rule changes to their interpretive guidelines.[10] Many of these new proposals will require further involvement of a pharmacist during transitions of care. Proposed changes include requiring each new admission to have a MRR completed at the time of admission, a Prospective Medication Review (PMR). Additional changes include documented medication reconciliation for all patient discharges and participation in antibiotic stewardship programs. Consultant pharmacists will need to demonstrate their ability to perform these tasks effectively and efficiently and new business models will need to be developed to comply with the new requirements. Collaborative agreements will allow pharmacists to improve transitions of care through direct communication with the hospital allowing medication handoffs to occur directly between pharmacies which will immediate identification of medication related concerns. This will reduce medication errors and adverse drug events and will expedite the availability of medications for patients newly admitted to LTC facilities. Pharmacists can improve the LTC discharge process through proper medication reconciliation and medication evaluation. Many LTC discharges happen late in the afternoon and if it happens to be on a Friday in January it very well may be 20 degrees below zero.

Undoubtedly, these circumstances result in picked up from the pharmacy after LTC discharge as other priorities take president for the patient. Comprehensive discharge programs that involve medication reconciliation, evaluation, counseling, delivery of the medication product, and patient follow up services after discharge are needed. A pharmacist-led successful "meds to beds" program including these important services will undoubtedly improve overall medication management and significantly reduce hospital readmissions. This collaborative work will allow hospitals and LTC facilities the peace of mind that their patients will be going home knowing how to take their medications, when to take their medications, why to take their medications, and will have the medication product in hand. Pilot programs have shown promising results. For example, nine skilled nursing facilities in greater MN participating in a pharmacy led "Care Coordination" program, including: Prospective Medication Reviews for all new admissions, medications never being consulting pharmacy services, discharge counseling at time of discharge back home, and two follow up phone calls .

Internal tracking results have yielded reduced facility drug spending on Medicare A admissions and an overwhelmingly positive response from patients when evaluating the discharge counseling and follow up phone calls.

Health care collaboration and direct patient care needs will continue to redefine consultant pharmacy and the pharmacy industry in general. Leveraging pharmacists to provide comprehensive medication management services will lead the way to further health care reform. Shifting medication management work upstream by focusing on education and prevention programs gets us on the right track for achieving the triple aim of health care: improving the patient experience, improving patient health, and reducing per capita cost.

Important timelines in consulting pharmacy history	
1954	Nursing homes receive Federal funding if they meet certain requirements
1967	Conditions of Participation - Facilities must meet Medicare and Medicaid standards
1969	American Society of Consultant Pharmacists (ASCP) founded
1974	Monthly Drug Regimen Review required in all skilled nursing facilities
1980	Guidelines to Surveyors - Guidelines for DRR
1990	OBRA 87 Implemented
1993	OBRA 90 Implemented
1999	Beer's List and other quality measures added to interpretive guidelines
2006	DRR now called MRR
2012	Partnership to improve dementia care - goal of reducing antipsychotics used in SNFs 25% by year end 2015 and 30% by year end 2016
2015	Further proposed rule changes - many focused on quality during transitions of care (coined "The Mega Rule")

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Joe Litsey has worked with Thrifty White Pharmacy as a consultant pharmacist/senior care pharmacist for over 15 years.

President's Letter

By: George Schoephoerster, MD

This will be my last President's Letter for my term as president of the Minnesota Medical Director's Association. This role, over the last 2 years, has given me the opportunity to interact with many of the providers and organizations involved with the challenging task of providing quality care to the frail elderly of Minnesota. Being president fills one's time with annual meeting planning and representing the organization in a number of opportunities for which expertise in the geriatrician's perspective is essential. I will review some of those opportunities.

One endeavor I have referenced in a previous letter has been an effort to reorganize our annual educational sessions, through a couple of grant opportunities, both of which unfortunately fell through for us. We currently are pursuing a third grant opportunity with the American Gerontological Society, this time with a rural focus. There were discussions with the Minnesota Department of Health about antibiotic stewardship in the long term care environment. There will be follow up to that exploration as a breakout session on Friday afternoon at our annual conference. There have been meetings at Stratis Health of the Minnesota Partnership to Improve Dementia Care, both at the state and national level. Minnesota has done quite well as a state in decreasing the inappropriate utilization of antipsychotics. Some organizations, however, are struggling. There are discussions underway to figure out how to best help those facilities in improving the quality of their care.

Over the last 2 years, I have - somewhat independently - pursued a couple of interests of my own: promoting quality geriatric care, regardless of the setting, and, pursuing care provided to those with dementia. I have remained active in the ACT on Alzheimer's Coalition, mostly through the education of providers and community members, and by assisting in the development tools that can help in improving the quality of care we all provide. Most recently, I have become involved with Dr. Bob Kane's "Rethink Tank," (new name pending) that will be exploring how we can improve the quality of care, and - more important - the quality of life of the frail elderly. I personally believe that there are some key constructs that will guide such an effort. We need to help our patients (and, probably more importantly, their families) move from the medicalization of the end of life (a term of Atul Gawande in *Being Mortal*) to get to a patient-centered approach, where the goal is no longer to repair a frail, and at times, unfixable body, but to help a patient (and their family) to explore how that person's life had meaning, the family values they upheld/developed, and how to put closure on the key relationships that sustained them through it. How to accomplish that under the watchful eye of regulation remains the challenge. We will be spending Friday morning at the annual conference exploring just that with three speakers: Where did LTC come from? Where is it heading? How will manpower issues and regulations have an impact on that as we transition from quality of care to quality of life?

It has been an honor to serve as your president. I believe that much has been accomplished, but I have only been able to scratch the surface. Unfortunately, I still had to maintain a job to make house and car payments! However, I do hope that the transition to immediate past president allows me to continue to promote quality geriatric care and dementia care. I also hope to put more energy into the exploration of expanding MMDA into a support organization for everyone who cares for the frail elderly, whether their practices are urban or rural, black/Latino or Scandinavian, academic center or solo clinic, research oriented or clinically-based, primary care oriented or specialty-based. The health of future Minnesotans depends on the ability of each one of us to be the best that we can be, hopefully with the help of a well-developed support organization for all of geriatric care. So long! Have a pleasant journey through your own medical practice. I am hopeful our paths will continue to cross.

Minnesota Nursing Home Quality Update- October 2015
Top "Missed Opportunities" for Minnesota Nursing Homes

Stratis Health recently analyzed nursing home Quality Measure (QM) data to determine where there are the greatest opportunities for improvement in Minnesota. The 379 Minnesota nursing homes had a total of 23,868 missed opportunities, based on six months of assessments that ended in April, 2015. Five of the 13 long-stay QMs account for 69.9% of all missed opportunities. These measures are:

- Incontinence (23.4%)
- Activities of Daily Living (ADL, 14.0%)
- Use of Antipsychotic medications (13.8%)
- Chronic Pain (9.7%)
- Weight Loss (9.0%)

There are currently 210 (over 55%), of Minnesota nursing home participating in the Centers for Medicare and Medicaid National Nursing Home Quality Care Collaborative (NNHQCC). Free education related to these and other topics are being offered to participating homes by the Lake Superior Quality Innovation Network (represented by Stratis Health in Minnesota). Please encourage nursing homes where you are practicing to participate in the NNHQCC and support them in their quality improvement efforts. Nursing homes can join the collaborative by completing this participation agreement. For questions about the NNHQCC contact Kristi Wergin.

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Inside

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Manuscripts should be emailed to rlobeck@mnmeddir.org and cdwighttownes@hotmail.com. The first page should include the title and a 50 to 60 word abstract. Manuscripts should range around 1800 to 3000 words.

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