think that’s a tribute to how the other professions feel about pharmacy and [its role].

Pharmacists need to “step up and volunteer” to participate in their community’s disaster-preparedness and response planning efforts, said Colleen M. Terriff, clinical pharmacist at Deaconess Medical Center in Spokane, Washington, and assistant professor on the Spokane campus of Washington State University College of Pharmacy.

She helps oversee Spokane’s Chempack program.

Students lend a hand. Terriff said she has involved pharmacy students in the stockpile program whenever possible.

“If there’s any way you can incorporate residents or pharmacy students to assist, it’s something new and different for them and intriguing,” she said. “This is not busy work, this is important work. I utilize the work force and energy of our pharmacy students to help me accomplish some of these projects that are never-ending.”

Former Deaconess pharmacy resident Jolie Duffalo, who recently completed a one-year residency program accredited by the American Society of Health-System Pharmacists, developed emergency medical treatment protocols, dosing guidelines, and training programs for first responders, and “quick information” guides for the hospital’s pharmacy and emergency departments about chemical-agent exposure for her residency project, Terriff noted.

All pharmacists and pharmacy technicians need to be aware of the Chempack program, said Terriff, who has recently been helping Montana establish its program.

“Each local community that receives Chempacks will need to have a point of contact, and that is where pharmacists either can take the lead or volunteer their input,” she said. “The CDC is handing the baton, and we just can’t drop it.”

— Donna Young

Proposed rule discusses Medicare medication management services

Health and Human Services Secretary Tommy G. Thompson announced in late July the release of the long-awaited proposed regulations to govern the new Medicare Part D drug benefit, including provisions that allow pharmacists to manage medication therapies for some Medicare beneficiaries.

Kathleen Cantwell, director of federal legislative affairs and government affairs attorney for ASHP, said her group is “pretty enthused” about the proposed medication therapy management regulations. “I think there’s nothing negative in this for our members,” she said.

The Part D drug benefit begins in January 2006. By law, organizations that deliver the new benefit must develop programs for managing therapies for targeted Medicare beneficiaries and pay pharmacists or other health care providers for performing that service.

Targeted beneficiaries are patients with multiple chronic conditions, such as asthma, diabetes mellitus, hypertension, high cholesterol, and congestive heart failure. To be eligible for the service, these beneficiaries must take multiple medications for their chronic conditions and be likely to incur high drug costs.

The proposed regulations ask for input on the development of requirements and guidelines for providers of medication management services, including current best practices for the programs.

During a July 26 media briefing in Washington, D.C., Centers for Medicare and Medicaid Services (CMS) Administrator Mark B. McClellan said CMS wants to receive comments on how “to give beneficiaries and fee-for-service Medicare access to disease management and care management services and how we can best integrate that with services that could be provided by pharmacists to educate beneficiaries and help them manage their medications effectively.”

Cantwell said ASHP will send comments to CMS about implementing medication management services. Public comments on the proposed regulations are due October 4.

“What we need to do is encourage CMS to provide a little bit more guidance for the prescription drug plans about what types of services they’re going to offer,” Cantwell said. “In the rule itself at this point, there’s not much guidance for the plans. It’s completely up to them to determine who are the targeted beneficiaries and how they are selected and what services will be provided.”

Pharmacy groups discuss medication management

The new Medicare Part D drug benefit mandates the provision of medication therapy management services by drug-benefit sponsors, but little detail is available from the Centers for Medicare and Medicaid Services (CMS) about what the services will be.

In regulations proposed August 3, CMS asked for comments about implementing medication management services—an issue that ASHP and 10 other national pharmacy organizations discussed during a meeting in May.

The stakeholders’ resulting agreement, dubbed the Pharmacy Profession Stakeholders Consensus Document, describes critical issues in medication management, including:

- The need to formulate a patient-specific treatment plan,
- The importance of monitoring therapy and identifying and resolving medication-related problems,
- The importance of educating patients about their therapy,
- The preference for face-to-face interactions between the pharmacist and the patient, and
- The need for adequate reimbursement consistent with contemporary health care provider rates.

The entire consensus document is available at www.ashp.org/gad/monthlyupdates/legislative/August_2004.cfm#MMA.
Cantwell encouraged pharmacists to send their own comments about the proposal to CMS.

"It will be important for our members to provide CMS a better understanding of what's actually happening in practice today," Cantwell said. "Medication therapy management services really are individualized patient care services. That's probably one of the things we were most excited about. The proposed rule specifically cites that they aren't talking about population-based therapies but individualized services."

Although the proposed rule states that CMS expects the bulk of medication therapy management services to be provided by pharmacists, it will allow "other qualified health care professionals" to deliver the services. Cantwell said that, despite that caveat, pharmacists are the best-qualified health professionals to provide higher-level medication management services.

CMS estimates that premiums for the new drug benefit will be about $35 per month in 2006 for a basic plan. Drug plan sponsors can offer so-called enhanced alternative coverage, including expanded medication management services, to Medicare beneficiaries for an additional premium.

Targeted Medicare beneficiaries will not be charged separate fees for basic medication management services, but premium prices can be set to reflect the availability of the services. Drug-plan sponsors can extend the services beyond the targeted beneficiaries but are not required to do so.

CMS expects that competition for enrollees will force drug-plan sponsors to create reasonably priced customized medication management programs that are attractive to targeted Medicare beneficiaries, a line of reasoning that mirrors the agency's strategy for implementing the Medicare-approved drug discount card program earlier this year.

"If you are more than a couple levels below the CEO, then I'm going to suggest to you that your effectiveness in the organization is too dependent upon communication in authority lines that go through too many people," said David A. Kvancz, speaking about the top-most pharmacist in a health system or hospital.

Kvancz became chief pharmacy officer at Ohio's Cleveland Clinic Foundation in late fall 2003 after six years as the pharmacist at the Cleveland Clinic.

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Hail to the chief . . . pharmacy officer

Chief executive officer (CEO), chief operating officer, chief financial officer, chief information officer, chief medical officer, chief nursing officer, chief privacy officer, chief compliance officer. Know what's missing from what some people call the C suite or the O-zone layer? Chief pharmacy officer.

But not everywhere, according to pharmacists close to a new trend in health-system management that places a pharmacist among an organization's top-level decision-makers.

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