Oncology practices recruit pharmacists for efficiency, savings

Changes to the way the federal government pays physicians for services and supplies have prompted some community-based oncology practices to hire pharmacists to do more than prepare hazardous drugs, according to people knowledgeable about cancer care and its finances.

“The larger groups have made the move to work with pharmacists,” said Mary Lou Bowers, a health care consultant in oncology at The Pritchard Group LLC in Rockville, Maryland. Before joining Pritchard, she held a similar position with the Pritchard Group LLC in Rockville, Maryland. Before joining Pritchard, she held a similar position for eight years at ELM Services Inc., also in Rockville.

Signs of a trend. Bowers estimated that 70–80% of large oncology practices, having at least eight oncologists on staff, employ pharmacists and pharmacy technicians.

Although large oncology practices constitute less than 40% of the oncologist work force, they conduct about 40% of the oncology business in the country, she said.

Congress’s Medicare Payment Advisory Commission, during visits to five metropolitan areas and states in 2004 and 2005, found several community-based oncology practices with pharmacist employees.

The commission had conducted the visits as part of its assignment to examine the effect that congressionally mandated changes to the payment system were having on Medicare beneficiaries’ access to chemotherapy services. Those changes included paying 85%, instead of the longtime 95%, of the average wholesale price for physician-administered medications in 2004. The next year, payments changed to 106% of the average sales price—reportedly a value just a little higher than the actual price paid by physicians.

Hiring a pharmacist to buy and prepare medications for the practice and recommend drug products on the basis of price and clinical effectiveness was one action that the commission said oncologists had undertaken to reduce costs or improve efficiency, according to a report released in January 2006.

“It used to be relatively easy to make money in community practice,” said Susan B. Goodin, director of pharmaceutical sciences at The Cancer Institute of New Jersey in New Brunswick. The facility is 1 of 39 National Cancer Institute (NCI)-designated comprehensive cancer centers in the country. “Reimbursement was good; let the good times roll.”

“With the changes that have occurred in the last two years,” she continued, “I think they’re all starting to see that there’s certainly more challenges and in order to make it, you’re going to have to . . . learn how to optimize therapy but not give up [good] outcomes. And certainly it’s what pharmacists have been doing for years.”

One group’s rationale. Oncologist Michael J. Nissenblatt of Central Jersey Oncology Center, P.A., said he recently hired a local hospital’s oncology pharmacist for the practice’s two sites.

“She does absolutely everything,” Nissenblatt said of Eileen Peng, who now works full-time with the six oncologists.

In just the first week, he said, Peng suggested that the practice start buying lympho-philized i.v. immune globulin (IVIG) so that patients could resume receiving the treatment in the office. The oncologists had been sending patients to a hospital outpatient department because the practice lost about $1000 with each infusion of a ready-to-administer IVIG product, he said. Now a pharmacy technician prepares the doses for office use.

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What Nissenblatt said he gained foremost by hiring a pharmacist was an employee who was “as familiar with the protocols as we were but was at a heightened level of awareness about the interactions of the drugs with patients’ other comorbidities and medications.”

The oncologists, he said, wanted someone on whom they could rely to recommend dosage adjustments for patients with renal dysfunction and help ensure the relatively safe administration of cancer treatments known to have toxic effects on the heart or lungs.

In addition to advising the oncologists about drug regimens, Peng was hired to oversee the preparation of injectable cancer treatments by a pharmacy technician, thus freeing up the oncology nurses from drug preparation and administration, Nissenblatt said.

“We felt there would be a win–win–win situation for everybody if we had a pharmacist,” he said. “That is, we would improve the accuracy of treatment for our patients, we would improve the quality of our nursing for our patients, and at the same time we would improve our level of knowledge by the doctors about each of the protocols and make sure that they were absolutely perfect.”

Economics pushes strategy. Goodin, at The Cancer Institute, said she knew of community-based oncology practices in addition to Nissenblatt’s that had hired pharmacists to do more than prepare medications. Some of those practices hired their pharmacists to focus on therapies and continued to have the nurses prepare the drug infusions.

“But I think the bigger issue,” she said, “is really this reimbursement [challenge] and using pharmacists to help them optimize product selection for reimbursement.”

Goodin said she had recently spoken with a Philadelphia oncology practice that had hired a pharmacist to oversee drug purchases and therapies and help optimize the billing.

“The upsurge has certainly been in the last five years,” she said, and more so in the past year.

Many of these oncologists, Goodin said, have joined forces rather than continue in solo practice and, in building a larger practice, remember the positive interaction they had with pharmacists during a medical fellowship or in a health system.

“They realize . . . the value that a pharmacist has brought to them from a clinical standpoint but also from an economic standpoint,” she said.

Good for patients. Bowers, the health care consultant, said some of the large community-based oncology practices have added “retail pharmacies,” with the office pharmacist filling prescriptions for oral oncology and oncology-related medications, as well as mixing the drugs for infusion in the office.

This arrangement, she said, is a convenience to patients who may have trouble obtaining these specialty medications at regular community pharmacies, and it is a recognition of the movement in cancer treatment from injectable to oral medications.

Goodin said that 85% of all cancer care now occurs at facilities other than NCI-designated comprehensive cancer centers and academic medical centers. “It occurs out in the community,” she said.

With more pharmacists working in community-based oncology practices, Goodin said, “This is a continued opportunity for pharmacists to have a positive impact on patient care.”

—Cheryl A. Thompson
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Telepharmacy project aids North Dakota’s rural communities

In 2000, North Dakota found itself in the midst of a pharmacy services crisis. The national pharmacist shortage had hit the mostly rural state particularly hard, said Howard C. Anderson Jr., executive director of the North Dakota Board of Pharmacy.

Newly graduated pharmacists were being lured to larger cities in other states where community pharmacy chains were offering big salaries and other incentives, leaving few pharmacists to take the place of those who were retiring in small, rural communities, Anderson lamented.

More than 25 rural community pharmacies in the state had recently closed, and 12 more were on the verge of shutting their doors.

North Dakota’s rural hospitals, many of which had only one pharmacist or relied on contracted pharmacists who worked part-time at the facilities to keep inpatient pharmacies operating, were also challenged by the pharmacist shortage, Anderson said.

After contemplating several options, he said, the board decided to explore telepharmacy as a potential solution to address the predicament.

The North Dakota board spent the next several months reviewing various telepharmacy proposals and models, Anderson said, and worked on developing new rules and regulations that would support implementation of the practice, meet federal requirements and national accreditation standards, and ensure patient safety.

The College of Pharmacy at North Dakota State University (NDSU) soon joined the effort and applied for and received a federal grant from the Health Resources and Services Administration (HRSA) Office for the Advancement of Telehealth to pilot telepharmacy in the state.

North Dakota’s telepharmacy project, which recently started its fifth year of the

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