VIEWPOINTS

Strength-based Advocacy: Making a Difference Through Teaching, Research, and Service

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The implementation of the Medicare Part D benefit has stirred the emotions of both the academic and professional pharmacy communities. With the inclusion of a small provision within the Medicare Modernization Act (MMA), a whirlwind of activity has been initiated. To many, the medication therapy management (MTM) provision is a panacea: recognition of the pharmacist’s role in medication management and the payment system to compensate for it. Many pharmacy organizations and individuals see MTM as the opportunity for pharmacy to shine in the context of care delivery. However, shortcomings of the law and implementing rules, lack of programmatic definition to guide the drug plans, and dependence on drug plans to explicitly include and cover pharmacist face-to-face patient interaction have failed to quell the expectations of a large portion of the profession. The cries of “pharmacists must be paid for delivery of services before they will provide them” have been answered with only the potential of payment for delivering unspecified services to an undefined population of patients at a payment level yet to be negotiated with drug plans.

The hollow nature of the harangue that “we must be paid before we provide services” provides little or no incentive for federal, state, or local policymakers to respond to the “payment for services” mantra. Academic pharmacy has actually created programs and care delivery models, but they are not reflected in the advocacy efforts of the profession. Advocating for both the academy and the profession through examples with significant associated outcomes, academic pharmacy is making inroads into the policy world. The strength of the effort is the continued allegiance of the academy to the principles outlined in the papers of the Commission to Implement Change.1-4 The tradition-breaking dedication of the academy to educating a health care professional competent and committed to the delivery of pharmaceutical care is carrying the profession further than it realizes.

Strength-based advocacy depends on bringing to the policy table positive examples of change: academic pharmacy has developed clear strengths that are now positioning the academy for effective advocacy efforts. The policy agenda important to academic pharmacy which focuses on teaching, research, and service, is moving the profession of pharmacy towards the shared vision of a care environment in which the pharmacist is inextricably linked with the prescriber and patient in medication decision making. The downstream events associated with poor prescription drug decisions could be ameliorated to a large extent with the placement of the pharmacist directly at the side of the prescriber and patient as the prescribing decisions are made. The issues of medication safety, misuse, adherence, and the very need for the prescription could all be modified to result in improved patient care if a pharmacist was part of the renewed calls for patient-centered, team-based care. Let us be honest, this type of practice is already a reality. There are physician practices that employ a pharmacist to improve patient care through this type of model. Members of the American Association of Colleges of Pharmacy (AACP) are developing academic detailing programs with self-insured employers. Colleges and schools have developed successful telemedicine and shared-position programs that ensure continued access to comprehensive pharmacy services in rural communities. The Department of Health and Human Services authorized a series of important demonstration projects that created similar practice plans within community health centers. As an indicator of success, some of these projects have continued beyond the funding period. The pharmacist is being paid, but where are these examples in the advocacy efforts of the profession?

The AACP is increasing the awareness of how colleges and schools of pharmacy are leading the way in creating a health care professional that is essential in the prescription drug use decision-making and medication management
processes. Through a strength-based advocacy agenda, AACP is bringing to the attention of policymakers the positive results of our members’ activities. In the context of the current issues important to both the academy and the profession, let us compare the respective approaches.

**Medicaid**

AACP supports the concepts of drug comparative effectiveness. The concept is supported through congressional appropriations to the Agency for Healthcare Research and Quality. Comparative effectiveness analysis was authorized in the MMA. Several of our colleges and schools of pharmacy are helping state Medicaid programs save millions of dollars annually utilizing this type of approach which leads to the development of preferred drug lists based on scientific evidence rather than cost.

The profession has advocated for a statutorily defined dispensing fee. A major concern here should be that to change the dispensing fee in the future it would literally take an act of Congress. It also adds costs to Medicaid and continues to muddle the dispensing aspects with the care aspects. This approach hamstrings state Medicaid programs from developing innovative programs. The total annual state expenditure for dispensing fees would not be available to possibly create a medication management program, such as the Asheville project for Medicaid patients.

**Patient Safety**

AACP supports the development and implementation of interprofessional health education programs. The small amount of funds Congress has annually invested in the Title VII health professions programs has, to date, been the only federal support of the interprofessional concept that is becoming recognized as the best chance to make significant improvements in patient care and safety. The too often overlooked and underappreciated benefits of Area Health Education Centers (AHEC), geriatric education centers (GEC), and Quentin Burdick Rural Health Program are providing the seeds for a recommitment to the mission of these programs across the broader health care policy arena. Several initiatives are under development that will create frameworks for interprofessional health professions education bringing improvements to the quality of patient care in the context of the IOM recommendation that “[a]ll health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, employing evidence-based practice, quality improvement approaches, and informatics.”

The profession recognizes that maintenance of competence is essential for pharmacists. Organizations have gone as far as discontinuing the use of the term “continuing education” to utilizing a more contemporary phrase “continuing professional development.” While the goals of continued competence are truly laudable, the framework in which this takes place remains rooted in the past, with the pharmacist as a stand-alone player with little or no connection to important health care decisions prior to the patient coming to the pharmacy counter.

**Professional Recognition**

AACP has developed a significant external outreach that is making a difference in the way the public views the role and capability of contemporary pharmacy graduates. Our colleges and schools of pharmacy are furthering this outreach by connecting with community partners who were unknown or underappreciated just a few years ago. The growth of the academic enterprise and the need for expanded experiential learning sites has created a need to look beyond the traditional sites. AACP members are actively engaged with community health centers, area agencies on aging, local public health departments, critical access hospitals, rural health centers, homeless clinics, and Medicare quality improvement organizations. All this activity improves the recognition of the pharmacist’s unique contributions to health care and safe and effective medication use across a wide public. It also increases the expectation by providers and patients that the pharmacist is there to assist them both with making the best medication use decisions and then continuing engagement in the process to provide the necessary management of the medication as long as the patient is taking it.

The profession publicly states, in a broad variety of venues, that only through payment by the Medicare program will recognition of the pharmacist as a health professional be complete. This position does nothing to recognize the valuable contributions that thousands of pharmacists are making to patient care on a daily basis. This position fails to take into account the innovation and commitment to change that is the ongoing work of the academic pharmacy community.

The examples could go on and on. We could compare and contrast the advocacy efforts of other health professions, other health professions educators, other higher education groups, etc. The result would be the same. The opportunity for continued advocacy based on the strengths of academic pharmacy will only increase. More and more policy makers and the public want to hear your examples of how you improve education and the public’s health through your teaching, research, and service. Share
your strengths with others. . . nobody else can do it more effectively.

REFERENCES