Operations: Practices and Pharmacies — Can’t We All Just Get Along?

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By Shirley Grace [2]

Between big chain pharmacies, mail-order pharmacies, and forgetful patients, practices these days are inundated with prescription paperwork. Rapport with pharmacies may be at an all-time low. Here are some tips for reducing the burden — and improving relations.

U.S. physicians wrote 1.6 billion prescriptions in 2004 — more than five prescriptions for every person alive in America that year, sick or not.

That’s a lot of meds, to be sure. It’s also a lot of time-consuming phone calls and faxes between the pharmacies and your practice, right?

Half of these drug orders require at least one communication between the prescriber and the prescription fulfiller, whether it’s a drugstore, pharmacy, online company, or direct-mail program. Questions about restrictive insurance formularies, nonexistent dosage forms, and indecipherable handwriting, among others, all spur conversations for which you and your staff have little, if any, time. Then there are the endless faxes from pharmacies, alerting you to soon-to-expire patient prescriptions.

While there’s no way to eliminate communication with medication providers (and you wouldn’t want to, anyway), you can reduce it. By streamlining the process at your end with tighter policies, better patient education, and efficient use of technology, you can turn irritation into collaboration.

Overflowing with problems
Communications between physicians and pharmacies tend to bog down in predictable ways, forcing the parties to engage in “games” no one wants to play. These can include:

**Telephone tag.** Although a smooth, efficient experience benefits all parties, a considerable amount of prescription follow-up seems to occur anyway. “The pharmacist calls. You’re seeing patients. You finally call back. They’re busy,” says family physician Jim King, who heads a six-physician practice called Prime Care Medical Center in Selmer, Tenn. “It takes up a significant amount of time.”

He says the bulk of these phone calls result from restrictive insurance formularies. “Patients have many different copays. There’s no way any physician can know all the formularies,” he says. “So you write a prescription, and when the patient gets to the pharmacy, it’s not covered on their plan.”

Direct-mail pharmacies take back-and-forth telephoning to the next level, much to King’s annoyance. “I’ll get faxes back from the mail-orders asking me to change the medication because it’s cheaper for the insurance company,” he says. “They’ve got special arrangements with certain drug companies. It may be swapping from one name brand to another name brand. That involves several phone calls and conversations.”

**Hide-and-seek-the-chart.** Many pharmacies make it a policy to alert doctors of soon-to-expire prescriptions. They do this by sending a fax. In theory, this sounds good because then a staff member can call the patient and schedule a time to come in and discuss renewing the prescription.

In reality, though, this practice strangles your office’s fax machine and wastes precious resources. Think about it: A fax comes in to report that Mr. Grossman’s blood pressure medication prescription will lapse next week. The receptionist passes the fax off to a nurse, who pulls Mr. Grossman’s chart and sees that he actually came in two days ago and so has already received his renewal prescription.

Nothing of value actually happened here. And it cost $12 to $15 for the chart pull. What if this scenario happened, say, 10 times a day? That’s as much as $150 in wasted staff time, not to mention the paper and toner used for nothing.

To some extent, the pharmacies are just doing this to try to retain customers, says Greg Anderson, a healthcare consultant at Woodland Hills, Calif.-based Top Tier Consulting. But consumers sometimes get confused about the difference between a refill and a renewal, or they miscount the number of refills remaining. “[Faxing] is a way to deal with the number of phone calls [pharmacy] staff have to...”
place to track down busy physicians, because a patient is standing in line, waiting for his refill,” he says.

Then again, for whatever reason, says Anderson, “many of the pharmacists feel compelled to call and question what the MD prescribes. This takes more time and typically irritates an MD greatly.” **The disappearing act.** Physicians often leave the exam room to write a prescription. This closes a window of opportunity to explain the medication. What are the side effects? Number of refills? Why is it in the patient’s best interest to follow the drug regimen?

**Keeping up with the e-Joneses.** With small practices still slow to adopt technology, many physicians remain unaware of how high-tech applications, such as an EMR or e-prescribing software, can facilitate getting the proper meds to a patient. King’s practice, which switched to e-prescribing software a few years ago, champions taking the plunge. “We saw a tremendous amount of improvement,” he says. “It cut down on phone calls. It cut down on medical errors.”

**Crack the code.** Handwritten prescriptions heighten the risk of callbacks from pharmacists and cause thousands of medical errors every year. It should be noted here that the long-held belief that all physicians have terrible handwriting is not true. Although studies have proven that about one-third of physicians have illegible handwriting, this is the same rate as the whole population. However, physicians are clearly in a profession where graphological exactitude is critical to others’ well-being.

**Who’s on first?** The physician and the pharmacist have a clear duty to direct patients to the correct medication and to try to persuade the patient to take it (about an 18 percent success rate, claims King). But patients play a part, too. They should know the difference between a refill and a renewal (a distinction that surprisingly escapes some patients). They should keep careful documentation of all their medication, and not ask for a renewal by saying, “I need more of that pink pill.” They have an obligation to read all materials doctors or pharmacists hand out regarding a prescribed medicine, and to call in if a drug does not seem to work, makes symptoms worse, or causes unpleasant side effects. Patients also need to arrange for periodic rechecks. “Some may not understand,” says King, “why they need to come in and see us for a renewal.”

**Calming the waters**
So clearly, problems with prescription communication fall on all sides. You can’t control the world, but you can keep the follow-up phone calls to a minimum by adhering to more accurate and efficient prescription-writing policies before the prescription leaves the practice.

First and foremost, success depends largely on knowing what your patients are taking. Make it a hard-and-fast policy that patients bring their actual medication bottles with them for an exam, or at least a detailed list of all current drugs, including name, dosage, type, initial fill date, and total number of refills. You could create this form yourself and hand it out to your patients. Instruct patients to list nonprescription drugs, homeopathic remedies, and vitamins. When patients bring the list in the first time, make a copy of it and keep it updated in their charts. This will cut down on phone calls from your pharmacist about possibly dangerous drug interactions because you’ll be able to determine a drug therapy yourself that works with the patient’s current medication regimen. And, if you’re in a group practice at which patients typically see multiple doctors, you’ll be instantly up-to-date on anyone’s medication history.

Impress upon the patient (in a nice way, of course) that it is “the patient’s responsibility to track their use of the medication and to allow the lead time necessary for a refill authorization between [you] and the pharmacy and/or the need to make an appointment before a refill can be authorized,” says Anderson.

You won’t be able to totally eliminate back-and-forth calling. Some prescriptions are complicated or involve controlled substances, and are, therefore, particularly subject to confusion. But you can head this off, says Anderson: “From my physician contacts, I have been told that with really complicated prescriptions, they know it will save time and hassle for all if they call the pharmacist directly and tell [the pharmacist] what they want.” For controlled substances, although you can call in the prescription, you must also supply a written prescription, which the patient must present to the pharmacist at pick-up time.

You can control the barrage of phone calls by consolidating your supply lines. In other words, “streamline the number of pharmacies or pharmacists a doctor has to deal with by building relationships with preferred pharmacists and referring patients to them,” suggests Anderson. There are some 40,000 drugstores and pharmacies in the United States, employing about 112,000 pharmacists. “Most physicians I know find two or three pharmacists that they get to know and who learn how to work with the doctor over time.” You won’t want to override patient preference, of
course, but the more you can deal with pharmacies that “get” you, the smoother your communication will be.

Alternatively, you can attack the problem from another angle: Cut down on the actual number of visits necessary to have a drug refilled. This is particularly handy for those on maintenance medication, says King. “If I have a patient on a chronic medication I know he’s going to take daily, and it’s not a scheduled drug, I’ll go ahead and give him a year’s worth of medication.”

Be careful with this, though. “A lot of docs use refills to make sure patients come in,” says King. You’ll have to weigh the options for each specific patient, and whether you’d really need to see him regularly. King says he feels it’s very important that patients stay on a maintenance drug regimen uninterrupted: “The problem I have is that if a patient can’t get in or his doc is out of town, then he’ll be without medication for a few days.” This could be a minor inconvenience or have serious consequences, depending on the medication.

And don’t forget about your employees. First of all, you’re probably not answering the phones — they are. Do you really know how many phone calls and faxes come in every day regarding prescriptions? Michael Burger, the director of clinical product management at Sage Software Healthcare Division, thinks not. “If you were to ask a doctor, ‘How many calls do you get from pharmacists each day?’ the doc will probably say none. But you can be sure the doctor is paying someone to field those phone calls.”

What can you do about this? First, dedicate one phone line to prescription refill and pharmacist requests, and task a staffer — preferably a nurse — to work this line. Then set up protocols for prescription renewals or refills. “I have certain guidelines that I follow. I allow nurses to renew certain prescriptions — not scheduled meds or narcotics,” says King. “For most prescriptions, I’ll have them authorize the renewal but schedule a follow-up appointment.”

Choose your telephone point person carefully — you’ll want to have someone who can deal with overworked pharmacists and grouchy patients alike. “You need very good people who are well trained and know the practice policies associated with refills and who can politely deal with the volume and types of calls they receive from patients and pharmacies,” says Anderson.

You might also consider taking the e-plunge. Yes, that means technology, specifically, e-prescribing — a software application for physicians to send prescriptions straight to a pharmacy, after prescrubbing the proposed medication orders for indications, contraindications, allergies, and drug interactions. In essence, e-prescribing offers a higher quality of patient care, fewer troublesome prescriptions for the pharmacist to process, and peace of mind for you that you’ve done your job to the best of your ability.

“It can manage all of the patient’s prescription information like you can’t with paper records. It’s always accessible,” says Burger. You can add in formulary information so the patient gets what you want him to get, and you can ensure that it’s covered under his insurance, he says. “E-prescribing makes the scripts cleaner when they go out, and when there is a reason for the pharmacy to contact the prescriber, there’s a facility.”

This facility depends on what sort of software resides at each end of the prescribing conduit. If you send a patient’s prescription for Warfarin to a pharmacist who also uses electronic data interchange, or EDI, technology, the pharmacist can download the drug order quickly, with no worries about legibility. You’ve already checked it for interactions, but let’s say your patient felt too embarrassed to divulge that she recently saw a psychiatrist, who prescribed an antidepressant. She had this prescription filled at the same pharmacy. Immediately, a significant drug interaction warning pops up. The alert goes straight back to you, at which point you can choose the treatment direction you want to take for your patient.

It works even if a pharmacy does not have e-prescribing set up but you do. “On the prescriber’s side, the transaction looks the same,” says Burger. “If the pharmacy has no EDI, it gets converted to a fax. [The medication] is safer for the doc to prescribe because the prescription has already been checked, and the pharmacy will more likely fill the prescription because it’s coming in prescreened.”

Either way, the chance of medical errors is reduced (although more so when both sides have set up an e-prescribing facility). Communication back to you would come in an electronic form, not a paper one or through a phone call, saving on resources. Burger says that “50 percent of communications are faxes. The overhead back and forth is tremendous. This way, there’s less clogging of communication.”

Technology adoption in healthcare still lags in the United States, especially for small practices, partly because of the prohibitive cost. But even with the comparatively lower price tag for e-prescribing software, Anderson estimates e-prescribing adoption to be between 5 and 18 percent.
Still, he points out, e-prescribing software is a good place to start if you’re leery about investing in technology. His company, Sage Software, offers the EMR system Intergy, which has e-prescribing built into it. But you can buy a stand-alone e-prescribing software package for much less. Of course, Sage hopes you’ll eventually want to upgrade. “If you’re not ready to invest in an EMR, we’ve got some incremental things you can do,” says Burger. “When you’re ready to make the switch up, we hope you’ll choose us, and we can offer a smooth migration path.”

Burger claims that Sage’s 4,000-odd Intergy clients all use the e-prescribing facility embedded in the company’s EMR, which represents, of course, an excellent in-house adoption rate, although it is true that most full-blown EMRs from any vendor have e-prescribing software.

Like physicians and pharmacists, payers benefit from high-tech prescribing, as the software will suggest using the lowest formulary listed under the patient’s insurance plan, meaning the one with the lowest cost.

Patients benefit, too. How many prescriptions go missing before they even get presented to the pharmacy clerk? And medication errors stemming from bad handwriting, which occur at an alarming rate of 1.5 million per year, are prevented.

In the end, anything you can do to streamline this most important exchange is good. But give automation a serious look if you don’t already use it. “E-prescribing will save time and money and reduce the cost of communications when necessary,” says Anderson. “Coupled with the EMR, a complete online capability will help to ensure that all information necessary to make the correct clinical decision regarding a refill and other necessary follow-up will be realized.”

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