

Assuming Action From Managed Care-to-Provider Communications

There is a great deal of communication between managed care groups and providers, among them drug-utilization review (DUR) messages, alerts, profiles, formularies, benefit materials, and educational materials. An underlying assumption is that managed care communications improve the treatment of individuals and groups of patients. Yet if practitioners don't know, understand, or agree with these assumptions, then there really is no communication, and therefore there is no action leading to improved care.

Assumptions are dangerous, especially when communications are unidirectional and the goals of both parties have not been reconciled. Clearly, messages must be important, identify supporting information, offer an action plan, and do all this in short sound bites. Just as clearly, however, practitioners must see the value in action. If all patient messages are left to the discretion of individual practitioners, how will the patient be sure of receiving at least a minimum standard of care?

One prerequisite for ensuring action is that everyone agrees on its importance. To achieve mutual agreement, a single reference point is critical. Recently, the JMCP Editor received from the U. S. Pharmacopeia (USP) its Guiding Principles *Supporting Appropriate Drug Use at the Patient and Population Level*. The USP sets standards to ensure the quality and appropriate use of medicines and health care technologies. These standards, which are enforced by the U.S. Food and Drug Administration (FDA), are accepted worldwide. Guiding Principles is the work of a USP advisory panel of nationally recognized DUR experts; it was adopted by the USP in March 2001. The association with the FDA provides an appealing way to ensure consensus.

As a basis for discussion, the Guiding Principles could be the reference point for reciprocal agreement on principles and requirements for action on behalf of the

patient. If there is agreement on the standard principles for practitioner communication, there is a basis for patient-centered action. What is of interest here is the issue of bi-directional communication, standards for that communication, and methods for achieving action. These guidelines do provide a basis for discussion, even though they do not address issues of degree, i.e., the intensity of messages, the severity of problems requiring communication, and the depth of discussion required in any setting.

I would like to stimulate a dialog about these issues: is there a basis for agreement that the Guiding Principles (reprinted below) provide fundamental principles for managed care organization-to-provider patient-centered communications? Can the utility of DUR messages, educational interventions, health care maintenance messages, prevention alerts, etc., be improved by agreements for communication based on clinical imperatives? Letters to the Editor provide a forum for such a dialog. I encourage you to send me your comments after you review the guidelines.

• USP Guiding Principles Supporting Appropriate Drug Use at the Patient and Population Level

Appropriate drug use encompasses drug selection, professional monitoring, and patient compliance. It includes efforts toward recognition/diagnosis, prevention and treatment of illness, including achievement of intended outcomes. Appropriate drug use also includes steps to ensure that: (1) drug selection is optimally adjusted to the needs of individual patients; (2) patients are appropriately monitored for the result of therapeutic intervention and adverse events; (3) patients are adequately educated and the treatment program is communicated to all concerned; (4) steps are taken to ensure, for individual patients and for the whole population or population group under consideration, that both over- and

underutilization are adequately scrutinized and addressed; and (5) necessary interventions occur when drug use is shown not to be appropriate.

Recognizing that appropriate drug use is essential to good health and beneficial to both individuals and society, the following principles should guide drug selection and use from the individual patient and population perspective.

1. Drug selection for individual patients is based on the proper assessment of diagnosis, stage, severity, and duration of the disease, disorder, or condition and patient characteristics. The best available scientific evidence should be the basis for drug selection at both the individual and population levels.
2. Successful therapy for individual patients is based on consideration of non-drug therapies, all relevant approved drugs, and medically accepted uses not included in FDA-approved labeling when supported by scientific evidence, and established medical practice. At the population level, all relevant therapeutic options should be considered.
3. Optimal therapy for the individual patient takes into account the variation anticipated in drug response due to individual variations in pharmacodynamics, pharmacokinetics, co-morbid condition(s), allergies, and/or the presence of concurrent therapies. At the population level, drug selection must take into account anticipated drug response variation by assuring access to an adequate range of well-designed therapeutic alternatives.
4. Drug selection for individual patients takes into account the anticipated side effects of a specific drug. At the population level, scientific studies have demonstrated that the use of certain drugs in particular patient groups may

Perspectives

- increase the likelihood of undesirable outcomes in those patients. If the risk of adverse drug reactions exceeds the expected benefits, use of such drugs in these patients should be discouraged.
5. Dose, regimen, drug formulation, and route of administration may affect the achievement of therapeutic goals for individual patients. Accordingly, at the population level, access to an adequate range of formulations or guidelines for preparing needed formulations (e.g., compounded preparations) is necessary for prescribers to consider patient variability.
 6. Communication of the treatment program to the patient, his or her representative, and involved health professionals, as well as its inclusion in the patient record, is essential to achieving therapeutic goals for the individual patient. Communication must be two-way, with health professionals providing information about the use of medicines and patients informing health professionals about their use of herbals, over-the-counter medicines, and other matters. Communication tools should include providing patient-specific written and oral information. At the population level, evaluation of effectiveness of educational information and compliance with the treatment program is necessary. Information about individuals in population-level data is also privileged and confidential as specified in applicable standards and statutes.
 7. Individual patient therapy should undergo continuous monitoring by health care providers to ensure adjustments (alternate dosage regimen, drug formulation, and route of administration, alternate drug) or discontinuance of drug use can be made, as necessary, to achieve specific therapeutic objectives for the patient. At the population level, treatment monitoring should aggregate and evaluate data to improve the quality of care and to determine whether satisfactory outcomes are achieved for the use of drugs in specific health conditions, particularly those involving significant public health consequences (e.g., AIDS, tuberculosis, and antimicrobial resistance).
 8. When alternative drugs or therapies have similar expected risks and benefits, costs may be an appropriate determining factor in choosing drugs for an individual patient. At the population level, access and coverage decisions for pharmaceutical products should be based on analysis of overall health care costs and outcomes, rather than impact on the pharmaceutical budget alone.

I am interested in hearing your thoughts. Please comment by e-mail c/o jmcpre-view@mitchellpetersen.com or snail mail to "Letters to the Editor of JMCP," 1775 Jamieson Avenue, Suite 210, Alexandria, VA 22314.

Finally, beginning with the next issue of JMCP, I will assume the role of chair, Editorial Advisory Board. I look forward to continuing to influence the Journal and thank all who helped it grow in my tenure as editor-in-chief.

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