Physician dispensing

An old idea is new again

reader take-away

- Understand the regulatory, legal and ethical issues surrounding physician dispensing
- Learn the benefits of physician dispensing and the hidden costs of prescription writing
- Find out physician dispensing's impact on an organization's revenue
- Review the steps for implementation and execution
- Get pointers on selecting a dispensing vendor

Faced with declining reimbursement for infusional therapies, Great Lakes Cancer Management Specialists (GLCMS) turned to physician dispensing to offset the loss. We quickly discovered that the dispensing-vendor landscape was limited, and few guidelines existed for product line development.

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Regulatory, legal, ethical issues

Most states permit physician dispensing, as long as providers adhere to state and federal regulations. Some states require a modest additional licensing process. Typical regulations:

- Limit physician dispensing to practice patients;
- Require adherence to labeling, record-keeping, packaging and secure storage requirements of good pharmaceutical practice;
- Mandate patients' freedom to choose where to fill a prescription; and
- Mandate that the physician provide a written prescription.

In addition, pharmacy benefit managers (PBMs) may require that prescriptions be filled by mail.

An on-site pharmacist is not required for physician dispensing. A doctor may designate

an employee such as a nurse or pharmacy technician to manage the task. Nevertheless, some payers deny physicians provider-class status for dispensing medications.

GLCMS leaders worried that physician dispensing might create a liability risk. However, our malpractice carrier saw no problem with our physicians dispensing unopened, prepackaged, single-unit-dose medications.

Physicians may believe that office dispensing presents a potential conflict of interest or even an ethical dilemma. American Medical Association (AMA) guidelines do not preclude office dispensing as long as state and federal regulatory requirements are fulfilled, the doctor prescribes only to his/her patients and allows them to fill prescriptions where they want.[1] (Many practices want to dispense free samples but often fail to realize that regulations governing dispensing also apply to free medications.) Recent AMA and Food and Drug Administration (FDA) recommendations discourage free sample distribution.[2,3,4]

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Hidden costs of prescription writing

Physicians are blind to the hidden costs of prescription writing. Phoning or faxing prescriptions to the pharmacist, call-backs for nonformulary drugs, inquiries because of illegible handwriting and mandated prior authorization for refills are great time wasters.

The average physician spends up to 60 minutes a day dealing with pharmaceutical issues for no revenue.[5] For every three physicians, there is usually one employee dealing exclusively with pharmaceutical issues. This employee is often a nurse whose salary and benefits may reach

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Selecting a dispensing vendor

GLCMS struggled to identify experienced vendors. It's exceedingly difficult to achieve profitability because of the high cost of packaging small unit-dose medications. As a result, there are few veteran companies and fewer still with large client bases. Oral medication dispensing is a complex task. A vendor must be licensed by the Drug Enforcement Agency and Food and Drug Administration as a pharmaceutical repackager. It must provide medications within 24 hours in repackaged, single-unit doses.

A vendor's software must:

- Be reasonably priced;
- Enroll the practice in literally thousands of prescription plans managed by national pharmacy benefit managers;
- Warn of possible drug interactions and allergy incompatibilities;
- Provide simple online drug preauthorization, accurate labeling, lot-number and batch tracking; and
- Manage both the on-site formulary and inventory.

The system should require no more than a desktop PC, a secure room and a locked storage cabinet. Practices should avoid any long-term contract. There should be no purchase minimums, and the vendor should offer credit for returned drugs with minimal restocking fees.

Vendor business models to generate physician revenue mandate careful review. In some models, the physician office bills and collects; in others, the office fills prescriptions, and the vendor bills and collects.

$100,000 annually. While electronic prescribing may ease legibility and calls to the pharmacy regarding nonformulary prescriptions, the physician does all the work and receives none of the revenue — while often paying for the e-prescribing system.[6]

Cost savings

Making dispensing physicians aware of drug costs creates an incentive to reduce them with generic substitution. Remember: Only physicians possess the ability to substitute therapeutically equivalent generic or brand-name medications. As a consequence, their generic use rates reach levels not attainable by any industry strategy. In 2004, the average generic prescription cost was $28.84; the national average brand-name retail prescription cost was $63.59.[7,8] GLCMS' vendor achieved a 75 percent generic substitution rate in 2004.

Payers and PBMs have long recognized that generic medications save money. Promotional activities have increased generic substitution nationally to 53 percent,[9,10] yet no program has attempted to align physician cooperation. Without direct physician involvement, increasing generic prescription rates is problematic, since current rates almost equal available generic substitutes.[11,12,13]

Think about it: With physician-dispensing prescription costs 50 percent below the

Many benefits come from physician dispensing

Patients often embrace the convenience of receiving their medications in the doctor's suite. Physician dispensing can address many problems:

- Waiting times for chronically ill patients;[1]
- Compliance with medications — Half of the 2 billion prescriptions filled each year are taken incorrectly: one-third of patients take all their medicine, one-third take some, one-third don't take any at all;[2] dispensing at the point of care improves patient compliance by reducing the no-fill rate and decreasing long-term health costs.[3,4,5,6]
- Cost of medications — A study funded by the National Institute on Aging found that middle-aged and older Americans with heart disease who cut back on their prescribed medications because of cost were 50 percent more likely to suffer heart attacks, strokes or angina than those who did not;[7]
- Pharmacists' limitation to generic substitution — Physicians can substitute therapeutically equivalent generic or brand-name drugs;[8]
- Inaccurate patient medication records — Pharmacists maintain full medication records on their customers, but accuracy is jeopardized because 30 percent of patients routinely switch pharmacists;[9]
- Drug-drug interaction and drug-allergy interactions — Alerts about these, as well as patient counseling information and automated refill processing, are mandatory features for both physician dispensing and retail pharmacies;[10] and
- Prescription errors — By avoiding pill counts and open bottles, and using bar-code labeling, physician dispensing is virtually without error compared with retail pharmacy error rates.[11,12,13,14]

notes

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national average and generic substitution 50 percent higher than the national average, the potential cost savings for payers and consumers is staggering.[14]

Revenue center

Physician drug-dispensing's impact on revenues reveals a different and unfamiliar dynamic. Dispensing oral medications is not a high-margin business. The net revenue generated depends on the number of scripts filled. The impact that low-volume, high-margin drugs have on profitability is nominal in comparison to high-volume, low-margin generic medications. Revenue generation depends more on the process (volume) than price (profit).

A typical physician can expect to net $6 to $8 per script from office dispensing. Forty patients a day and 1,000 scripts per month works out to $70,000 to $100,000 in additional annual income.

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Implementation and execution

Implementation of physician dispensing requires attention to detail before, during and after start-up. In general, the larger the practice, the more complicated the process. Location of the dispensing service mandates that it's visible and accessible to both patients and staff. Involve information technology staff for fax access and placement of computer connections, router lines and firewalls.

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Staff preparation starts with physicians. They must embrace this patient service and diligently refer all scripts to the dispensing staff.

Your vendor will suggest a provisional formulary. While most practices have a good idea of the medications they prescribe, they may not track the number of scripts written or unit sizes. To help define your preliminary formulary, designate an employee to register all scripts written in a two- to four-week period. Limit the initial inventory in number of medications and unit doses. Most vendors can supply reorders within 24 hours, so a lean inventory improves your profitability and lowers start-up costs. You can adjust your formulary based on the volume and type of prescriptions written.

Staff preparation starts with physicians. They must embrace this patient service and diligently refer all scripts to the dispensing staff. Large practices must agree on the formulary and common unit of use. Physician variance in script writing translates to higher inventory costs. Put a physician leader and an administrative leader in charge of the implementation process.

Inform patients of this new service. Launch a marketing campaign using letters, newsletters, office signage and pamphlets to announce it.

Success in physician dispensing rises when doctors write as many generic medications as possible. Because the majority of generics sell for less than the patient's deductible, dispensing becomes a cash-and-carry business. Patients are often willing to pay a premium over their deductible to avoid going to the drugstore. Success also depends on volume, rather than high-margin drugs ordered infrequently.

The competitive landscape for primary care physicians includes national retail phar-

macies, many offering mainstream primary-care services on a walk-in basis. Community physicians should take notice. Physician dispensing can present a competitive response to the changing health care landscape.

notes

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