For years, the VA health system has suffered under the yoke of bureaucracy and institutional mind set. But reform is underway—and pharmacy offers a shining example of how the agency is striving to embrace innovative methods for improving patient care and achieve greater cost efficiencies within the system.

Bloated, inefficient, and out-of-control: These are adjectives some critics have used to describe the American health care system. Similar—and perhaps even less flattering terms—have also long been hurled against the federal institution charged with providing medical care to the millions of Americans who have served their country: the Veterans Health Administration (VHA).

It's no surprise, then, that as debate about reforming the nation's health system heated up in 1992 and 1993, the VHA also came under swift attack. The agency had come under fire before; its long history of troubles had prompted numerous cries for reform over the years. Some critics even urged doing away with the VHA altogether, claiming that veterans would be better served if they obtained their medical care through private sector facilities, which...
were perceived to provide higher-quality services to beneficiaries at a lower cost to taxpayers.

But entirely dismantling a long-revered—aht, bureaucratic—institution such as VHA is a highly charged, politically risky undertaking. So Congress, which authorizes VHA, chose the more palatable approach: reform. In late 1994, Kenneth Kizer, M.D., became the new undersecretary for health within the Department of Veterans Affairs. By March 1995, Kizer submitted to Congress a new VHA reorganization plan, called “Vision for Change.” The plan aimed to radically revamp the way VHA operates and delivers health care by streamlining the system. The restructuring would, in theory, foster new relationships and coordination among providers, place new emphasis on the importance of primary care, improve patient satisfaction, and save taxpayers millions of dollars each year.

Congress said “yes” to the new plan, which is ambitious in scope. Under the program, VHA is reorganizing its system of 172 hospitals and more than 530 outpatient centers, clinics, and nursing home facilities into 22 so-called “veterans integrated service networks” (VISNs). Network directors—not hospital administrators—have strategic planning and budget responsibilities over all medical facilities in the network. Directors also have new flexibility to use their authority and resources to meet local community needs. VISNs range in size from five to 12 medical centers each. Gone is the old four-region system, under which each VHA region had broad oversight and control over roughly 40 medical centers. The new program officially took effect on October 1, 1995.

The VISN program is still in its infancy, and only time will tell whether the VHA will succeed in overcoming the obstacles that for years have stifled innovative approaches to delivering high-quality, cost-efficient care. One thing certain is this: as the VHA moves away from a hospital-based system to one that stresses outpatient care—and places new emphasis on improving medical outcomes and patient satisfaction—pharmacy is sure to assume a more visible and vital role.

In this article, I will describe how the VHA’s pharmacy system operates, how it is changing, and how it is bringing pharmacy into the “mainstream” of coordinated health care delivery.

**HOW VHA EMBRACES MANAGED CARE CONCEPTS** —

The idea of integrating pharmacy services within a larger system of care is not new to VHA. “We’ve had elements of managed care pharmacy in place for years,” explains John Ogden, director of pharmacy services for Veterans Affairs Headquarters, Washington, D.C. For example, for decades VHA has had formularies and mail service programs in place to provide prescription medications to eligible veterans and dependents on a large scale, he says.

What’s changing is the process involved, Ogden says. Not only is VHA working to streamline the operating systems in place to create new efficiencies—it is also moving pharmacists away from the traditional role of filling and dispensing medications. Today, VA pharmacists are more directly involved in the total care process by becoming part of the primary care “team.” Like other providers in the system, pharmacists are embracing new techniques and interacting more directly with patients and other care givers to better coordinate and monitor care—and maximize patient outcomes.

**MAIL-SERVICE PHARMACY: A STEP TOWARD INTEGRATION** —

The VHA system has relied on mail-service pharmacies for distributing drugs since the early 1960s, Ogden says. Eligible veterans and dependents prescribed drugs by a VA physician or other authorized caregiver could send their prescriptions to the appropriate VA center, which would process the prescription and deliver it to the patient via mail—saving patients the inconvenience of having to drive to the nearest VA facility to pick up the medication. Patients were encouraged to use this route rather than get prescriptions filled at a non-VA-affiliated community pharmacy because of the “tremendous cost differential,” Ogden says.

For efficiency, VA’s mail service facilities relied on available technologies, such as medications in unit-of-use packaging. “But there wasn’t much dispensing technology available for the high-volume prescription workloads in the 1970s and 1980s,” he recalls. Historically, each of the VA’s 172 medical facilities processed prescriptions via mail, except for several centers in Southern California, which consolidated their mail-service operations in the 1970s.

In the late 1980s, things began changing. Mail-service pharmacy business in America “was going great guns,” Ogden recalls. Several vendors, in fact, approached VHA, offering to assume the agency’s mail-service functions. VHA pharmacy officials visited a number of these companies to see what they could offer in the way of further streamlining the agency’s pharmacy operations.

Surprisingly, what the VHA officials found was that using an outside mail-service pharmacy would be “cost prohibitive” for the agency, Ogden says. Even though many of the companies offered the latest in technology, the process at the time was highly “labor intensive.”

VHA efficiency is not an oxymoron, Ogden contends. He cites these statistics as an example to prove his point: In 1980, the VHA system dispersed roughly 37 million prescriptions. Ten years later, it dispensed 56 million prescriptions, 51% more—with no additional staff, he says. New technologies, automation, local management, and re-engineering of the pharmacy process all played a role in increasing productivity within the system, Ogden says.

But there were problems, Ogden concedes: Distribution. Too many staff people were devoted to this process, consuming resources. So in 1993, VHA embarked on the task of consolidating

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its mail service for outpatient pharmacy. Today, four consolidated mail outpatient pharmacies (CMOPs) operate nationally, and three more will be running soon. When they are all in place, centers in Kansas, Texas, and California will process mail prescriptions west of the Mississippi, while centers in Massachusetts, Illinois, Tennessee, and South Carolina are planned to handle the Eastern United States.

Already, VHA has learned some valuable lessons from operating the first four consolidated sites—and is applying this knowledge in getting the next three sites up and running. Stephen Boykin, national program manager for the CMOP program at the VA Medical Center in Martinsburg, W. Va., cites several examples of these in an article in the November 1995 issue of Federal Practitioner, a magazine for health care professionals working in the VA, Department of Defense, and the Public Health Service. Some of these include:

- The VHA identified several design faults and is correcting and redesigning these. VHA personnel found, for example, that total recirculation of plastic totes containing the drug product is essential for smooth operation of the system. Using computer-simulation models assists in this process.
- Automated equipment at CMOP facilities can process 10,000 prescriptions in eight hours, indicating that VA can process its entire mail-service prescription workload from nine to 10 sites. The Kansas facility processes 10,000 prescriptions each day in a 10-hour workday with partial staffing.
- Vendors can provide faster printers with greater clarity at costs similar to those of dot-matrix printers. All new CMOP sites will use these advanced printers for prescription drug labels and other documents.
- VHA is contracting with an outside vendor to provide clear, ultraviolet light-resistant prescription vials that will allow drug products coming off the dispensing machine to be inspected without the need to remove the bottles’ caps. This will lower labor costs by reducing the time needed for staff to check prescriptions at each mail facility.

The VHA's goal is to have one full-time employee on staff for every 50,000 prescriptions filled—a goal that's already being met by most of the CMOP centers, Ogden says.

FORMULARY CONSOLIDATION: AN OLD SYSTEM ADOPTS NEW APPROACHES

As with the mail-service program, VHA is consolidating its formulary operations to better improve patient care and reduce costs. This streamlining parallels VHA's move from a hospital-based to network-based system. Rather than have formularies operating out of each of the VAs 172 medical centers, VHA by April of this year will have pared back the number of formularies to 22—one for each VISN.

The new system will offer several advantages. Ogden says. From a patient-care perspective, beneficiaries will have the same therapeutic regimen at each facility or provider within a given VISN. Providers—whether primary care physicians, specialists, nurse practitioners, or pharmacists—"will all be working off the same medical record," allowing for better coordination of care, he says.

The consolidation also will give VHA better negotiating leverage with drug manufacturers, because the smaller number of formularies allows each to purchase drugs in greater volume, Ogden says.

The advantages of this system—long used in the private sector—would not have come to fruition had the VHA not taken steps several years ago to streamline its drug-distribution system. VHA always has purchased drugs in bulk quantities at discount rates from manufacturers. But those cost savings were generally wiped out because VHA operated under the military's outsourced procurement policies. Under that system, VA was required to purchase huge stockpiles of pharmaceuticals based on prescription usage the preceding year. This system was highly inefficient, laden with layers of hidden markups and fees—and often resulted in long waiting times for patients needing medications.

In response, VA in late 1991 began a pilot prime vendor project to streamline the distribution and procurement process. Three wholesalers were chosen to provide pharmaceutical products to 33 VA medical centers. This allowed VA pharmacies to place orders electronic-
ly directly with the vendor; payments were made with each order.

The project was successful in reducing costs, boosting refill rates, and improving overall customer satisfaction. Today, all VA pharmacies procure pharmaceutical products via the new system. Several other federal agencies, including the Department of Defense and the Indian Health Service, are following VA's lead by exploring similar prime vendor systems.

INTEGRATING CARE AND EXPANDING THE PHARMACIST'S ROLE

Most of the operational changes within VA's pharmacy system in recent years have occurred independently of each other, Ogden notes. But that does not negate the combined effects these changes are fostering toward a more integrated approach to delivering care.

For example, under VA's prescription mail service, the database is located "where our patient accesses the system," Ogden says. All of the patients' caregivers within the VA system have access to that data under one roof. By contrast, most mail order services operate off site from where providers actually treat patients, making provider access to patient prescription data less readily available.

For years, "clinical pharmacists have been recognized as part of the clinical care team" within the VA system, Ogden says. "Pharmacists are out there seeing patients in the clinics, and putting [prescription and patient] information in the database," he says. New developments are expanding the pharmacist's role further. For example, VA recently approved a new policy that authorizes VA medical facilities to grant prescriptive authority to clinical pharmacist specialists, advance-practice nurses, and physician assistants who complete certain training.

Many VHA pharmacists also are moving away from their traditional roles of filling and dispensing prescriptions to assume other responsibilities in the areas of pharmacotherapy, patient outcomes, and patient education and compliance, Ogden says. This is a natural outgrowth of the automation and processing efficiencies that have decreased the need for pharmacists to perform those tasks—freeing them up to assume greater responsibilities in the patient care arena. It also ties in with VHA's new emphasis on primary care teams, in which pharmacists and other caregivers work together closely to coordinate patient care. Not all VHA facilities have adopted this team approach, but all networks are expected to move in that direction by October 1 of this year, the date VA has set for implementing its primary care services system.

ADDITIONAL INITIATIVES

Other improvements are underway in VHA. Here are just a few examples:

▲ In October, VHA launched a pilot test of a rules-based drug-use software program at three sites. Later this year, VHA will determine whether the software can assist in better managing patient care and controlling costs. Specifically, VHA will determine whether the program—which will incorporate pharmacy and medical data—helps providers effectively identify patient populations at risk of drug interactions, drug–disease conflicts, inappropriate dosage and durations, and drug duplications. Pharmacists, physicians, and quality management staff will participate in the pilot. The software was developed by PharMark Corporation, Rosslyn, Va.

▲ VHA is developing new programs to assist pharmacists in assuming expanded, outpatient team roles. Staff from the VA Pharmacy Service in Hines, Ill., the University of Illinois at Chicago College of Pharmacy, and the Veterans Affairs Headquarters Pharmacy Service developed an ambulatory care certificate program for federal pharmacists. Roughly 50 VA pharmacists completed the program in 1994–95. Similar educational programs are being offered this year.

▲ A total of 10 VA centers will participate in a study to be conducted by University of Colorado School of Pharmacy researchers beginning this spring. The two-year study, "Implementation of Pharmaceutical Care in Veterans Affairs Medical Centers Utilizing Managed Care Principles," will assess, among other things, the impact pharmacists have in providing care to ambulatory patients. The study's goal is to ensure more appropriate use of medications and medication compliance, identify actual or potential drug-related problems, and develop patient-specific pharmaceutical care strategies, including outcomes assessment of patients and their pharmaceutical therapy. The study is being funded through a grant from Pharmacia & Upjohn.

Institutions are generally slow to embrace change. But VHA has taken some positive steps in this direction. "The VA system is not immune to what's going on in the American health care system," says Ogden, who believes that the VHA today in many ways is "a microcosm of the evolution of integrated health care in this country." Further consolidation and downsizing within the VA will likely be end results of the changes underway, Ogden concedes. But another result will be the continuing growth and refinement of the pharmacist's role as a key player in the health care delivery team. VA pharmacists are fortunate to have a running start in this area. ■