

Indian Health Service: Paving the Way for Pharmaceutical Care

For more than three decades, pharmacists with the federal Indian Health Service (IHS) have practiced pharmaceutical care in its broadest form. In fact, some credit the IHS with having invented the very concept long before the term "pharmaceutical care" was coined.

Imagine being a practitioner in a remote rural area of the country where the local population has an unusually high incidence of tuberculosis and other infectious diseases, where infant mortality rates far exceed the norm, and where the typical adult can expect to live only until about age 45.

Unfortunately, those were the harsh realities faced by many Native Americans living on or near federal Indian reservations during the mid-1950s. The poor conditions prompted the U.S. government to take a fresh look at how it served the more than one million Indians and Native Alaskans entitled to receive government-subsidized health care under the terms of previous treaties. In 1955, authority for providing this care was removed from the Interior Department and vested with a new entity, the Indian Health Service (IHS), which would operate under the auspices of the

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federal agency then charged with overseeing health issues (what was later to become the U.S. Department of Health and Human Services).

Today, conditions for many Native Americans, while far from ideal, are much improved, thanks largely to the efforts of those dedicated health care providers who have worked within IHS. IHS pharmacists have played an especially vital role in promoting the health and well-being of their Native American patients. In fact, the unique challenges that confronted pharmacists and other care givers serving the Indian population were the primary catalysts that prompted the agency to adopt a new approach to delivering health care, one that bears a striking resemblance to many of the principles at work in managed care systems today.

This article will explore what makes the Indian Health Service, and its pharmacy division in particular, unique and look at some of the lessons it offers today's pharmaceutical care practitioners.

IHS: A CARE-GIVING CULTURE BORN OF NECESSITY

Providing even basic primary and preventive care services to people living in remote, isolated rural areas is a difficult enough task. Add to this equation severe poverty, illiteracy, and language and cultural barriers, and one gets a general picture of the many professional challenges that confront IHS care givers on a daily basis.

Forty years ago, providing pharmaceutical care to the Native American population was more a question of logistics than anything else. "Just getting medications out to people" was the primary function of the IHS pharmacist, explains Rear Admiral Richard Church, a commissioned officer in the Public Health Service, and associate director for IHS and director for the Office of Information Resources Management.

But as more Public Health Service pharmacists joined the IHS ranks, "they very quickly saw other needs and opportunities for providing direct patient care" other than simply distributing drugs, says Church, who has worked for IHS for 23 years, and is former chief pharmacist with the agency.

For example, pharmacists noticed that patients waiting in the clinics to see a doctor often had upper respiratory or other acute or chronic problems "that could be managed by drug therapy," he says. Before long, pharmacists got involved in screening patients for conditions such as diabetes and hypertension and, in some cases, provided basic primary care services, or what many pharmacists today refer to as cognitive services. Before long, a "team approach" to providing care developed within the IHS system.

Several factors contributed to the development of this care philosophy, Church explains. First, because of how the clinics were set up, pharmacists worked right alongside physicians, very similar to how a staff- or group-model HMO works today. Second, because of the remote locations of the clinics, providers formed close social as well as professional relationships with their peers, adding to the cooperative spirit. Third, because of the limited resources available, IHS placed a lot of emphasis on preventive care to stretch those resources as far as possible: Patients who could have some of their basic care needs met by pharmacists in some cases would not have to see the doctor, freeing up the doctor's time for those patients with more serious illnesses. Fourth, IHS pharmacists, because they operated under a federal program, were not subject to state pharmacy laws regulating pharmacy practice, and so legally could assume these and other added responsibilities not traditionally held by pharmacists.

As early as the 1960s, IHS adopted a policy of not allowing physicians

simply to give pharmacists prescription blanks to fill, even though "that's how pharmacy has always been practiced," Church says. Instead, IHS pharmacists routinely would receive the patient's medical record as well. When a patient comes in for a prescription, IHS pharmacists immediately know about his or her medical history, what conditions he or she suffers from, and the last date that individual visited the clinic. "You would not be able to be involved in patient management unless you have information about the patient," Church says. "In community pharmacy practice, you get that information only if you ask patients for it."

All of these practices adopted by IHS "predate anything you've seen in the (trade) press about pharmaceutical care," Church is proud to point out, noting that the term itself wasn't even in use at all until the late 1980s. "These are the kinds of things that have laid a real foundation for pharmaceutical care" as it is practiced today, he adds.

IHS PHARMACY: MORE THAN JUST AN ORDINARY JOB

The innovative practices implemented within the IHS system caught the attention of many young pharmacists just starting out in their careers. Captain Bill Boyce, R. Ph., IHS director of pharmacy services for the Chemawa Health Center in Salem, Oregon, is one of them. Boyce began his career with IHS in 1977, where he started out as a pharmacist assigned to the Fort Defiance, Arizona, IHS facility.

"When I arrived, I was quite surprised by the innovations occurring in such an isolated area," Boyce recalls. IHS then was providing services routinely that pharmacy journals of the time were describing as something that a large hospital might have experimented with recently. "We were very much part of the health care team."

Boyce recalls having a beeper and being on-call 24 hours a day in case of emergencies such as responding to a code or preparing an IV in the middle of the night. "We lived right by the hospital, and I was neighbors with the physicians I worked with, so it made a close community."

A typical day for Boyce would start at 7 a.m., if he were assigned to inpatient duties. He would review patient charts, checking to see if there were any changes in the patient's condition, then make rounds with the physicians, so he could answer any pharmacy-related questions they might have, or recommend changes in dosing levels where appropriate. He also would check patient records to see what medications were ordered in the night, and review the charts to determine whether a patient was admitted because of an adverse drug event.

Later in the morning, he would set up to begin distributing drugs in the outpatient department. Boyce, like other pharmacists working at the facility, would receive patient charts and review these prior to filling any prescriptions, enabling him to spot and prevent potential adverse drug interactions or contraindications.

Boyce recalls working with the Navajo Indians, many of whom suffered from tuberculosis. When a number of Navajos began developing liver problems, providers suspected hepatitis as the cause. But IHS pharmacists, in reviewing patients' medical records to look for a drug cause, determined that isoniazid was the culprit, and that the patients were having an adverse drug reaction that caused liver damage.

He recalls another situation in which a patient walked into the pharmacy requesting a refill on his hypertension medication. This patient was a truck driver who traveled a lot, so he had not been in to see a physician for approximately six months and was out of medication. Boyce noticed that this

patient had beads of perspiration on his forehead and seemed to have discomfort. He immediately took the patient's blood pressure. It was 205/158. The patient then was immediately referred to the clinic. This is a good example, he says, of how observation and pharmacy patient-focused care performed during a simple refill situation made a clear difference in a patient's life.

PATIENT COUNSELING: KEY TO THE PHARMACEUTICAL CARE PROCESS

Attention has focused recently on the issue of pharmacist-patient counseling, much of it negative. Last August, *U.S. News and World Report* magazine published an article that criticized pharmacists for failing to adequately counsel and warn patients of potentially adverse drug interactions. A year earlier, the Food and Drug Administration (FDA) proposed the so-called "MedGuide" rule, which would require pharmacists to dispense useful written information on prescription drugs to patients with each prescription filled. In December, a private-sector committee representing a broad array of interests drafted and submitted an alternative plan to the U.S. Department of Health and Human Services (HHS) for consideration. Other not-for-profit groups, including the National Council on Patient Information and Education, Washington, D.C., devote tremendous amounts of time and energy to raising awareness of the need for patients to receive more complete information about how to use their medications safely and effectively.

All of this flurry doesn't faze anyone at IHS: pharmacists there have been providing counseling to patients on a routine basis for decades. In fact, many pharmacy students and pharmacy practitioners in the private sector today turn to the IHS for guidance on best patient counseling practices.

Ever since the 1960s, IHS has made a system-wide effort to make sure each patient receiving medication at an IHS facility is adequately counseled on the proper use of that medication. "If patients are totally in the dark about their medications, then we are really asking for trouble," says Church, who adds that compliance is another big problem.

IHS has been way ahead of the private sector in dealing proactively with this issue, Church says. Many IHS facilities have separate counseling rooms where pharmacists can sit down with patients and privately discuss issues related to medication use. "We were dealing with a cross-cultural environment in which many patients did not speak English," Church says in explaining how the concept got started. "So we wanted to provide some degree of privacy for patients and respect for cultural differences."

Boyce recalls the language barrier as one of the biggest challenges he and other IHS pharmacists faced. Many elderly patients on the first reservation Boyce worked at spoke only Navajo. IHS used pictograms and local people to act as interpreters so patients would understand how to properly use their medications and be more comfortable asking questions.

IHS recognized the value of patient counseling so much that it began developing educational training programs for young pharmacists just starting their careers with the agency. "The students coming out of the universities were real weak in communication skills," says Boyce, an avid proponent of patient counseling who also was instrumental in the development of IHS' patient counseling training programs.

Word got around about the IHS counseling training program, and soon several pharmacy schools started requesting materials from IHS. IHS pharmacists thought it would be a great idea to package the training program

for pharmacy students nationally, but they weren't sure how to go about doing it.

That changed in the mid-1980s when Cecil Newsome, R.Ph., the federal representative for Pfizer, Inc., offered to fund the development of a training program based on IHS practices and distribute it to pharmacy schools nationwide. "We felt we really had something to offer the students," Boyce recalls. "Our original vision was to distribute it so faculty could use the parts of the program they wanted to" in their teaching curricula.

What resulted from this effort was the release of a videotape in 1990 instructing pharmacists on effective methods for counseling patients about their prescriptions. Today, the videotape, and two subsequently-produced videos—one on dealing with patient conflicts and challenges and one on patient compliance—have been widely distributed and are used to train practicing pharmacists as well as pharmacy students in the art of counseling.

Many retail and community pharmacists working today complain that their workloads, coupled with financial pressures, make it impossible for them to counsel patients. But that argument doesn't seem to hold water with IHS pharmacists like Boyce, who already have incorporated the practice into their daily routines.

"People often have a hard time understanding how simple patient counseling is, and how little time it actually takes," Boyce says. "I think it really gets down to a philosophy of what you as a pharmacist want pharmacy practice to entail." Boyce worries that many pharmacists practicing today eventually will be replaced by automated dispensing technology. Those who survive will be the ones who can offer patients something technology can't deliver, such as good counseling, he believes.

One common mistake pharmacists

often make when they begin to counsel patients is repeating to them "what they already know," Boyce says. For a new medication, "all you need to do is to verify the patients' understanding and fill in the information gaps that they have." One technique pharmacists can use to more effectively counsel patients is to ask three simple questions:

- What's the medication for?
- How do you take it?
- What did your doctor tell you to expect once you start taking the medication?

The third question is particularly important. Many patients simply aren't in a position to know for certain whether or not their medication is working properly, and many who don't get better even after taking their medicines as directed fail to follow up. Patients need to be told that if they don't see certain improvements within a certain time frame, they need to let their provider know.

Pharmacists also are obligated to tell patients when a certain drug may interfere with something they may be taking already, Boyce says. For example, a young woman who receives certain antibiotics should be told that those can lessen the effectiveness of birth control pills and be advised to take extra precautions to avoid pregnancy.

NEW CHALLENGES

Other developments currently underway within IHS could have implications for how pharmacy services are delivered in the future.

"We're in the process of big changes here, as many of the tribes are beginning to manage their own health care systems," explains IHS Chief of Pharmacy Viola Dwight. With the tribes

INDIAN HEALTH SERVICES: FACTS AT A GLANCE

- ▲ One of eight operating divisions that make up the United States Public Health Service (PHS)
- ▲ Employs approximately 500 pharmacists, about 400 of which are in the PHS Commissioned Corps. Roughly half of all pharmacists employed by PHS work for IHS.
- ▲ Provides health care services to more than 1.3 million Native Americans who live on or near federal Indian reservations in 34 states.
- ▲ Operates 115 hospitals and clinics, most of which are located in the rural Southwest.

now given authority over 30% of IHS' budget, "we are challenged to maintain the current level of programs."

Working with each tribe as a separate nation "presents some real challenges for us," adds Church. As more individual tribes begin to assume management for their own health services, that can alter many already established pharmacy practices that have existed for decades. Coordination of formularies, drug and supply purchasing arrangements, and standards of clinical practice are just some of the areas that will need to be addressed in the coming years. Another challenge is building the right kind of information systems "so we can better manage the care we deliver," Church adds.

In spite of these uncertainties, it's clear that IHS pharmacists already have laid important groundwork that will help determine the future course of pharmacy. "I believe we have had an impact on how pharmaceutical care is delivered around the world in the last few years," says Church. Perhaps the agency will continue to wield influence in the years to come. ■