Local Acts

Public health is such a broad concept that it can be easy to forget how it plays out in countless actions taken every day at the local level. It is the job of local public health officials to identify and characterize threats to the health of their communities—and then respond. Innovation and creativity can reap rewards, not just in one jurisdiction, but in the many others that follow suit. The goal of *Local Acts* is to provide a peer-reviewed forum for describing and sharing important and uniquely effective local health efforts.

This first submission comes from my health department in Baltimore, where we treated the implementation of Medicare Part D as a potential public health emergency. Our initiative helped many vulnerable city residents maintain access to essential medications. It also created a path in our city between emergency preparedness and regular health department activities—a path that, if traveled frequently, should yield benefits for both.

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A PUBLIC HEALTH RESPONSE TO IMPLEMENTATION OF MEDICARE PART D

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The 2003 passage of the Medicare Modernization Act established the Medicare prescription drug program known as Medicare Part D.[1] Among its provisions, the legislation mandated an abrupt transition to Medicare Part D on January 1, 2006, for those low-income seniors and disabled individuals previously receiving drug coverage through state Medicaid programs.

In advance of the scheduled transition date, federal, state, and city officials supported an array of activities to reach out to affected patients. Nonetheless, several warnings led Baltimore City officials to be concerned that technical problems could lead to a disruption in care for the approximately 20,000 disabled and low-income seniors (so-called "dual eligibles") who would transition from Medicaid drug coverage to Part D.[2] For example, in December 2005, the U.S. Government Accountability Office issued a cautionary report suggesting that "the complex process for transitioning dual-eligible beneficiaries on a single day with no overlap could create difficulties ensuring that prescriptions for some members of this vulnerable population are filled."[3]

To respond to this challenge, Baltimore City designed and implemented the Medicare Part D Surveillance and Response Initiative.

INITIATIVE SUMMARY

The Baltimore City Health Department planned the initiative with the city's Commission on Aging and Retirement Education (CARE) and city pharmacies. On December 21, 2005, the city released a four-part plan:[2]

1. 24-hour surveillance based in the 98 pharmacies in Baltimore City. Using the city's 311 call system, faxes, and internet, pharmacists would notify the Health Department of patients having problems with Medicare Part D.
2. Immediate intervention from the Health Department. Staff would provide real-time advice to pharmacists on Part D billing procedures and could draw from a $50,000 reserve fund for medications when all other options were exhausted. The Health Department also planned to provide fax updates to pharmacies with advice on how to handle common problems with Medicare Part D.
3. Patient follow-up by CARE. All patients identified through surveillance would be referred through a follow-up computer database to CARE, which would provide assistance with enrolling patients in drug plans within 72 hours. CARE would continue to provide follow-up intervention for as long as necessary through short-term case management.
4. Monitoring of emergency department visits by seniors for hyperglycemia. This outcome measurement was chosen based on the experience of the medical problems suffered by evacuees from Hurricane Katrina when their supply of medication was disrupted. Measures were from December 29, 2005, to May 31, 2006.

Information on the initiative was distributed to pharmacists by fax, internet, and phone, as well as through personal visits to 58 pharmacies. Updates were provided at http://www.baltimorecitymedicare.org.

Evaluation of the initiative began soon after implementation on January 1, 2006. In January 2006, the Health Department assessed the percentage of successful transfers from the 311 line to the Health Department, fax transmission rates to pharmacies, percentage of referrals receiving follow-up from the Commission on Aging and Retirement Education within three business days, and numbers of prescriptions authorized by the Health Department. In March 2006, the Health Department surveyed randomly selected city pharmacy staff to assess pharmacy staff awareness of the program, efficiency of methods of communication between pharmacies and city government, and motivating factors contributing to participation or lack of participation in the program. Of the 50 pharmacies randomly selected, staff at 33 (66%) responded to the survey. The Institutional Review Board at the University of Maryland considered the survey to be exempt from review.

OUTCOME AND EVALUATION

Pharmacist participation

From January to September 2006, pharmacists reported 164 patients requiring assistance with the Part D transition. These reports came from 60 different pharmacies in 20 ZIP Codes in the city. While 124 reports came in January and February (75%), reports have continued to come each month, and the initiative is ongoing.

Seventy-three percent of pharmacists and staff surveyed (24 out of 33) were aware of the city's efforts and possessed at least an adequate knowledge of how and when to use the initiative. Sixteen of the pharmacists had made no reports of problems with Medicare Part D. Of these, 11 reported that they were able to resolve problems through the insurance company, nine reported lack of knowledge about the initiative, and eight reported that they encountered no problems with Part D. Only two pharmacists surveyed reported that logistical issues kept them from reporting cases.

Problems in Medicare Part D

Sixty-seven reports involved patients who previously had drug coverage through Medicaid or state pharmacy assistance but were charged high co-payments by their Part D plans instead of the mandated cap of $5 per prescription. Fifty reports involved patients who previously had drug coverage through the Medicaid program but were not automatically assigned as planned into Medicare Part D. Two reports described problems with the plan formulary (Figure 1).

Health Department response

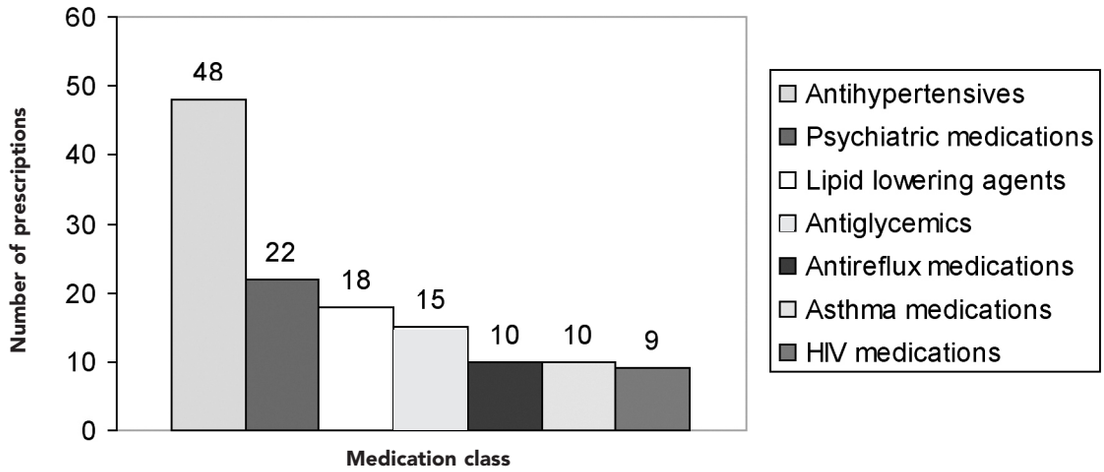
Health Department staff handled 89 calls and 76 faxed reports. An assessment in January found that there were five failures in transferring pharmacy calls from the 311 call center to the Health Department by the end of the second week. Analysis of the failed transfers showed that they typically occurred when the pharmacy officer was busy with another caller. In response, the Health Department developed a Blackberry e-mail back-up system. Subsequent follow-up demonstrated that the e-mail system in conjunction with the 311 call center allowed 100% of requests for assistance to be received immediately and handled by Health Department staff.

In 102 cases, Health Department staff provided technical assistance to pharmacists to assist with Medicare Part D. In 67 cases, Health Department staff

Figure 1. Common problems in Medicare Part D

Problem	*Example*
High out-of-pocket charges for low income patients	Baltimore City received a report that an 80-year-old man, previously receiving pharmacy benefits through Medicaid, was being substantially overcharged for eight essential medications including medications for blood pressure. The Baltimore City pharmacy officer on-call authorized $168.28 to cover the medications. A case manager from the city Commission on Aging and Retirement Education followed up with the patient and ensured he was properly enrolled.
No coverage for low income residents	Baltimore City received a report of an 84-year-old woman who had been dropped in the transition of her drug coverage from Medicaid to Medicare Part D. She urgently needed medication for hypothyroidism, asthma, and cardiac arrhythmia. The Baltimore City pharmacy officer on-call authorized $234.54 for her medications. The Commission on Aging and Retirement Education then followed up and scheduled her for an enrollment session at a local senior center.
Medications not covered by plan formulary	Baltimore City received a report of a 32-year-old mentally disabled woman, previously on Medicaid pharmacy assistance, who was automatically enrolled into a Part D plan that did not cover all of her medications. The Baltimore City pharmacy officer on-call authorized $47.50 for her medications. The Commission on Aging and Retirement Education then helped her change to an appropriate plan.

Figure 2. Most common types of medications authorized by Baltimore City Part D Initiative, January–September 2006



provided authorization for medications at a total cost of $15,148.89. The most common types of drugs covered were anti–hypertensives, psychiatric medications, anti-cholesterol drugs, and diabetic drugs (Figure 2).

The Health Department faxed city pharmacies nine times with technical advice on Medicare Part D on behalf of Baltimore residents. The faxes offered key strategies in how to successfully enroll patients in Part D plans, such as 1-800 numbers and instructions on how to enroll patients in a backup pharmacy plan.

The Health Department also sent advocacy letters to the leadership of 12 different Medicare Part D plans on behalf of 36 Baltimore residents. These letters explained the problems experienced by pharmacists and requested immediate attention by the plan. All of the plans contacted the Health Department for further details on the cases and followed up with the local pharmacist for resolution of the cases.

CARE follow-up

The electronic follow-up database permitted transfer of information from the Health Department to CARE. From there, all patients identified through the surveillance system received outreach and case management. CARE case managers contacted 90% of patients reported by pharmacies with 72 hours to provide extensive follow-up assistance with Medicare Part D enrollment and overall benefits eligibility assessment. One hundred fifty-six of the referrals were Medicare beneficiaries who received enrollment and other assistance. Individuals who were not eligible for Medicare Part D plans were linked with other resources.

Monitoring of hyperglycemia

The number of seniors presenting to a major area emergency department with hyperglycemia (blood glucose >300 mg/dl) was tracked and compared to data from corresponding months in the previous year. In comparison to 2005 data, no consistent trend was evident in the numbers of seniors presenting to the emergency department with hyperglycemia. The overall proportion of seniors with hyperglycemia presenting from January to May did not differ significantly between 2005 and 2006 (3.5% in 2005; 2.5% in 2006; χ^2 p-value=0.30). This lack of increase in hyperglycemic presentations supports the conclusion that at a public health level, seniors had preserved access to medications over the initial months of transition (Figure 3).

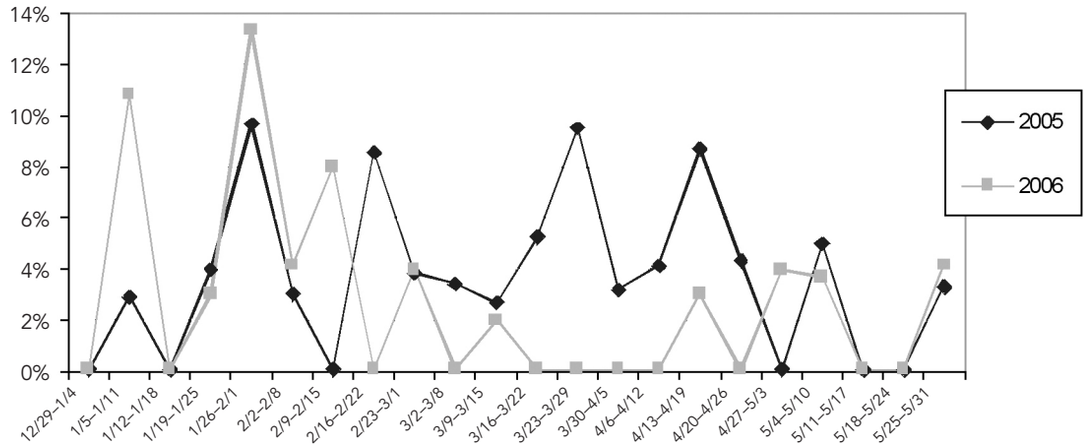
Cost

In addition to staff time, the initiative cost $40,000 for extra caseworkers at CARE, approximately $15,000 for medications, and approximately $5,000 for electronic fax, copying, and other expenses.

DISCUSSION

Reliable access to prescription medications is essential to an effective, functional health care system. Medicare Part D, while providing financial protection for many city residents, isolated others without the resources to navigate a complicated system. The abrupt transition for over 10,000 vulnerable residents represented a potential public health crisis. Persistent glitches indicate reform is still needed at the federal level.

Figure 3. Percentage of seniors presenting to Baltimore area emergency departments with glucose levels >300, 2005–2006



Baltimore City's initiative protected vulnerable residents from loss of access to essential medications. The key reason for its success was collaboration. At one level, city agencies with different responsibilities (including the 311 call system, the Health Department, and CARE) collaborated in the development of a seamless surveillance and response system. At another level, the city collaborated with pharmacies to identify and support some of the most vulnerable residents of the city. Information technology, including the development of an electronic follow-up database, was an essential spark to this collaboration.

The initiative's approach to surveillance and response has applicability to other public health challenges. Such a system could detect early markers of a bioterrorist incident, for example. If many patients with similar symptoms requested certain medications from pharmacists, that information could be reported to the Health Department.

Based on its experience with Medicare Part D, Baltimore City implemented another surveillance and response initiative during the heat wave in the summer of 2006. The Health Department invited area emergency departments and physicians to report information on patients in urgent need of energy assistance. The Health Department then relayed information to the energy assistance unit of the Housing Department by means of an electronic database. Through the end of August, the energy assistance initiative led to 75 home visits by energy assistance staff to vulnerable city residents. (Personal communication, Baltimore City Department of Housing staff, August 24, 2006.)

The greatest challenge in these efforts is to provide confidence to community partners—pharmacists, physicians, and others—that alerting the Health Department to problems is worthwhile. While the Medicare Part D initiative received reports from 60 pharmacies, no reports were provided by the other 48. While the pharmacy survey found that some pharmacists were able to solve problems on their own, others still did not know about the initiative.

Future efforts should invest further in outreach to community partners and research should be directed at the factors influencing their participation. It is hoped that repeated successful efforts such as the Medicare Part D Surveillance and Response Initiative will lead to increasing engagement in these activities over time.

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REFERENCES

1. Medicare Prescription Drug Improvement and Modernization Act of 2003, Pub. L. No. 108-173, 117 Stat. 2006 (Dec. 8, 2003).
2. Baltimore City. Medicare Part D Surveillance and Response Plan [cited 2006 Sep 29]. Available from: URL: http://www.baltimorecitymedicare.org
3. Government Accountability Office (US). Contingency plans to address problems with the transition of dual-eligible beneficiaries from Medicaid to Medicare Drug Coverage [cited 2006 Sep 29]. Available from: URL: http://www.gao.gov/new.items/d06278r.pdf