WELCOME TO THE 2ND ANNUAL
IDAHO INTEGRATED BEHAVIORAL HEALTH NETWORK
CONFERENCE
Integrated Clinical Pharmacy in Team Based Care

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April 27th, 2019
Course Description

Team based care is evolving. Pharmacists have been a part of team based care in a variety of ways for the past 20-30 years however are still working within the private secret to expand these roles. This course will dive deeper into why integrated pharmacy is important along with many different opportunities for how this model can look.
Disclosures

- Nothing to disclose
Learning Objectives

1. Explore why integrated pharmacy is important
2. Discuss important factors that play into being able to provide integrated pharmacy including provider status and barriers to implementation
3. Review models for how pharmacy is integrated within team based care
Outline

1. Why Integrated Pharmacy?
2. Role of Pharmacy and Models of Delivery
3. Outcomes
4. Barriers and Solutions
Why Integrated Pharmacy?
Why Integrated Pharmacy?

- Medications are the most common treatment modality for chronic conditions in an ambulatory care setting
- 70% of physician office visits (in patients >45 yo) results in medications being prescribed
- ~50% of adults are taking 4+ medications for chronic diseases
- Incorporating pharmacists within a team shows:
  - Reductions in BP
  - Lowered LDL
  - Improved A1c
  - Lower hospitalization rates and mortality

Why Integrated Pharmacy?

- Number of office visits are projected to increase:
  - 462 million in 2008
  - 565 million in 2025

- United States will need 52,000 additional primary care providers by 2025
  - Escalates current shortage problem
Role of Pharmacy and Models of Delivery
Collaborative Disease Therapy Management

- Comprehensive Medication Management/Collaborative Disease Therapy Management/Chronic Disease Management
- Requires Collaborative Practice Agreement
- Initiate, modify, and monitor drug therapy
- Assess response to therapy
- Order labs
- Counsel and educate about medications
- Usually integrated within ambulatory care clinic setting via face to face visit or telephone
Collaborative Disease Therapy Management

- Services often include:
  - Diabetes management
  - Hypertension management
  - Annual Wellness Visits
  - Transitions of care
  - Tobacco cessation
  - Asthma/COPD
  - Pain
Mr. MB comes to clinic today with complaints of back pain. Upon check-in, patient’s BP is 163/93 mmHg recent A1c is 10.3%
Scenario 1

- PCP address patient’s back pain
- Start a basal insulin
- Nurse visit for BP technique
- Increase one BP medication
- RTC 3 months
PCP: Katie – do you have time to see a patient for his BP and new start insulin? RN checked his BP technique, it’s good. BP today 163/93 mmHg, on 3 meds. Also A1c 10.3%, on metformin.

a. Yes, who is the patient? Let me know when you’re ready
b. I have time for an introduction
c. Not right now, please place a consult
Scenario 2 With Warm Handoff

PCP: Katie – do you have time to see a patient for his BP and new start insulin? RN checked his BP technique, it’s good. BP today 163/93 mmHg, on 3 meds. Also A1c 10.3%, on metformin.

a. Yes, who is the patient? Let me know when you’re ready
b. I have time for an introduction
c. Not right now, please place a consult
Scenario 2

- Initiate, modify, and monitor drug therapy
- Assess response to therapy
- Order labs
- Counsel and educate about medications
- The above done via:
  - In person
  - Telephone
  - Telehealth
Patient Case

PharmD involvement

30 min PCP spent on back pain

PharmD meets with patient after

PharmD visits regularly with pt on DM and HTN

3-6 month f/u, BP at goal, A1c decreased to 7/8%
Patient Case

PharmD involvement

30 min PCP spent on back pain

PharmD meets with patient after

PharmD visits regularly with pt on DM and HTN

3-6 month f/u, BP at goal, A1c decreased to 7/8%

No PharmD involvement

30 min PCP appt spend on back pain

Schedule another PCP appt in 1 mo for HTN and DM

Adjustments made to BP and DM meds at PCP f/u

At 3-6 mo PCP f/u, BP at goal, A1c decreased by 0.4%
Provider Status

- Types of services provided within integrated pharmacy models fall under medical benefit
- What does “Provider Status” mean?
- Collaborative practice agreements delegate prescriptive authority
Federal Provider Status

- Inclusion for pharmacists as providers under Medicare Part B

- 2015 and 2017 legislation:
  - Payment for services that are
    1. Furnished by a pharmacist in a medically underserved area
    2. Would otherwise be covered under Medicare if furnished by a physician
    3. Under a pharmacist’s scope of practice in their respective state
  - Payment is 85% of physician fee schedule
State Level Provider Status

- States have taken on “provider status” in different ways

- Common Components:
  - Payment for specific services (e.g. hormonal contraceptives, naloxone, nicotine replacement, travel medicines, immunization) or payment for “any service under a pharmacists scope of practice.”
  - Expansion of scope (to included drug administration, prescribe certain medications, immunize, order/interpret tests, etc.)
  - Inclusion in medical networks as providers under the medical benefit
State Level Provider Status

- Idaho doesn’t prohibit provider status within pharmacy law
- Continue to have limitations with payers paying for services
- Not recognized at the federal level (Medicare)
## Collaborative Practice

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<td>Drug Therapy Agreements</td>
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<td>Licensed Practitioners</td>
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<td>With Scope of Practice</td>
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Ideal Model

- **Scope of practice or collaborative practice agreement**
  - Keep it broad when clinically appropriate
  - Credentialing/privileging
  - Implement peer review process

- **100% of time dedicated to patient care activities**
  - No operational tasks such as order processing, insurance formulary reviews, prior authorizations, inventory checks
Ideal Model

- Full ancillary support
  - Patients should have same support seeing a pharmacist provider as they would seeing a physician, NP, or PA
  - Schedulers should perform scheduling (not pharmacists)

- Structured schedule with appointments
  - 50 appointments per week (mix of face to face, telephone, video)
  - 4 hours per week unscheduled population management time
  - 4 hours per week administrative time to perform unscheduled patient care and meet with interdisciplinary team
Models Within Idaho

- Practices within the state started in the 1990s
  - VA practice started with lipid clinic
  - Private practices started in 1998 which was when first pharmacist prescriptions were written Contents of a collaborative practice agreement

- Length of appointments vary by practice
  - 15-90 minutes

- Patient populations
  - Majority diabetes
Models Within Idaho

- Structure of visits vary
  - Independent
  - Combined visits where 2/3 time with pharmacist and 1/3 time with pharmacist-provider pair
    - Benefit of provider education and combined documentation

- Post discharge care coordination and follow up

- Ratios vary by practice
  - VA - 1 clinical pharmacy specialist to 3600 patients
  - St. Luke’s - 1 ambulatory care pharmacist to about 10-15 providers
Billing

Agreements with clinic practice:

- Contract billing to receive percentage of total billing
- Compensation set at dollar amount per patient
- Improvements to quality measures, move towards value based care

Billing through insurance:

- Can bill independently for transition of care codes, annual wellness visits, certain DM education, and incident to
- Otherwise billing must be done under a recognized provider’s name
Information Resource

- Medication reconciliation
- Polypharmacy reviews
- In depth medication counseling
- Vaccination questions
- Medication side effect profile reviews
- Population health review
- Basically...any medication related question!
Patient AB is experiencing an increase in sweating. Can you see if this is medication related?

Patient CD is on quite a few medications and seems unsure of exactly what they’re taking. Can you talk to them?

Is patient EF a candidate for Pneumovax?

Patient GH is here for an appointment today and is new to the VA. They are on candesartan for their HTN. Candesartan is non-formulary. Do you have any alternatives?

What medication would you recommend for patient JK?
Collaborative Disease Therapy Management

Collaborative Disease Therapy Management

Information Resource

Population Cases

- How do we manage our population of diabetics?
- What about the hypertensive patients on our panel?
- We are not meeting lipid measures, how do we fix that?
Population Cases

Incorporating pharmacy within your team is going to require a lot of communication/discussion about roles

- Nurse Care Manager also sees patients for chronic disease states
Population Cases

- Team meetings:
  - Diabetes
  - Hypertension
  - Pain
  - Lipid measures
- Shared Medical Appointments
- Nurse protocols
  - Hypertension
  - Insulin titration
Opiate medications are not always the right choice for chronic pain. Stress can negatively affect how you experience pain. Here's how to request disability accommodations at school.
Team Based Care
Team Based Care - Interprofessional Practice

**Multidisciplinary Team**
- A team of professionals who care for patients independently. Care is subdivided and handled by each professional separately.

**Interdisciplinary Team**
- A team of professionals who coordinate care of patients. The team shares responsibility for patient goals and outcomes.

**Transdisciplinary Team**
- A team of professionals who understand each others’ knowledge/skills and approach to enable seamless collaborative decisions on all of the patient’s problems.

Team Based Care - Huddle

- Team leader – designated or situational
- Review schedule and priorities
- Scrub patients at least 1 day prior
- *Where are you stuck?* How can we help each other out?
- How do our projects overlap?
- We are all a part of the team
- Get to know each other
- PROACTIVE
Interprofessional education occurs when two or more professions learn about, from, and with each other to enable effective collaboration and improve health outcomes.

Team Based Care – Interprofessional Case Conference

- Identification of high utilizers

- Interprofessional team:
  - Nurse
  - Primary Care Provider
  - Pharmacist
  - Social Worker
  - Psychologist

- One hour weekly meeting
  - Group discusses case and offers advice to improve care
  - Care plan determined
**Models**

ACCESS: Access to pharmacists who provide comprehensive services

Patient Centered: Bringing care to patients where and when they want it

Team Based: Pharmacist integrated with team

Quality: Team based population management

Team Based Care to Remote Locations

Salmon, Idaho

Banking and Healthcare
Telehealth
Telehealth Equipment

Telehealth Cart Patient Side for Exam

Desktop Unit on Provider and Potentially Patient Side
Team Based Care
Team Based Care
What Is Pain?

"An unpleasant sensation and emotional response to that sensation".
American Academy of Pain Medicine

PAIN is COMPLEX.
The central nervous system consists of the central and peripheral nervous system. It is considered a network that conveys pain stimulus within the body. Involves a series of electrochemical exchanges.
Billing

Medicare

- To be billed must be real-time, interactive, face-to-face
  - Consultation
  - Office visit
  - Pharmacologic management

- Store-and-forward visits are not covered if there is no direct patient contact

Medicaid

- Check state and insurance
Billing

- Ensuring payer coverage
  - Maintain patient safety and privacy
  - Protect patient-pharmacist relationship
  - Enhance communication and coordination of care

- Billing codes for telehealth
  - Q3014 rooming code on patient side
  - GT modifier on provider side
Outcomes
Quality Outcomes

- Decrease blood pressure
  - Improve A1c
    - Improve lipid measures
Quality Outcomes

San Diego Veterans Affairs 2006
- Poorly controlled DM 16%
  - vs 49% Medicaid
- Controlled BP 76%
  - vs 53% Medicaid
  - vs 47% Medicare
  - vs 60% commercial plans
- LDL goals achieved 62%
  - vs 36% Medicaid
Quality Outcomes

The Asheville Project

Cardiovascular/Lipid
- Improved blood pressure
- Improved lipid goals
- Decreased cardiovascular events
- Increased medication use 3x, but decreased medical costs by 46.5%

Diabetes
- Improved A1c
- Lower total health care costs
- Fewer sick days
- Increased satisfaction with pharmacy services

Asthma
- Severity improved
- Emergency action plans increased from 63% to 99%
- ED visits decreased from 9.9% to 1.3%
- Hospitalizations decreased from 4% to 1.9%
- Direct cost savings averaged $725/patient/yr
Telehealth Quality Outcomes

Northwest Telehealth Hub

◦ A1c reduction 2.4% (p<0.0001)
◦ BP reduction 27/11 mmHg (p<0.0001)
◦ Lipids
  ◦ 82% on target statin
◦ Tobacco cessation
  ◦ 42% quit
  ◦ 39% reduced

Cost Savings Outcomes

Veterans Affairs 1999
- For every $1 allocated to clinical pharmacy services, approximate $4 benefit
- $368,000 savings per pharmacist

Veterans Affairs 2007
- Tobacco cessation program estimates annual savings of $691,200
- Net cost benefit to VA $551,200
Access Outcomes

- Number of pharmacist provider visits
  - Increase patient access

- Provider time saved
  - Conducting part of a visit to allow more throughput
  - New patient calls

- Convert or off-load appointments
  - Also allows for higher acuity billing

- Next available appointments

- Wait times

- Provider satisfaction/burnout
Barriers and Solutions
Barriers

- Provider understanding of value
- Provider confidence in ability/knowledge
- Compensation
- Provider fear of lost income
- Initial investment of time and energy to implement
- Pharmacist desire to provide services
Telehealth Barriers

What are barriers to implementing telehealth for integrated pharmacy?
## Telehealth Barriers

<table>
<thead>
<tr>
<th>PERCEIVED BARRIERS</th>
<th>REAL BARRIERS</th>
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<tbody>
<tr>
<td>Lack of patient acceptance</td>
<td>Access to electronic medical record</td>
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<tr>
<td>Lack of patient understanding</td>
<td>Licensure – need to be licensed in each state</td>
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<tr>
<td>Concern for quality of care</td>
<td>Need informed consent</td>
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<tr>
<td>“Elderly people won’t like it”</td>
<td>Need a back up plan</td>
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<tr>
<td>HIPAA</td>
<td>Need an emergency plan</td>
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<tr>
<td>Taking jobs/Outsourcing</td>
<td>Scheduling</td>
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<tr>
<td>Lack of awareness</td>
<td>Pharmacy reimbursement?</td>
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## Telehealth Barriers

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<tr>
<td>Access to electronic medical record</td>
<td>Insurance company can contract MTM services with pharmacists who have access to the medical record</td>
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<tr>
<td>Licensure</td>
<td>Ensure pharmacist licensure in each state working in</td>
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<tr>
<td>Informed consent</td>
<td>Obtain verbal consent and document</td>
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<tr>
<td>Back up plan</td>
<td>Have telephone number in case of technology failure</td>
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<tr>
<td>Emergency plan</td>
<td>Make sure MTM pharmacist is aware of local emergency number</td>
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<tr>
<td>Scheduling</td>
<td>Utilize resources to schedule appointment with pharmacist and patient, may need patient reminder</td>
</tr>
<tr>
<td>Lack of pharmacy reimbursement</td>
<td>MTM pharmacist may contract services with insurance company ensuring payment under pharmacy benefit, more concerns within medical billing</td>
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Questions?