Collaborate with your Pharmacist to Improve Patient Care

Building better practices for tomorrow with resources available today…

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American Pharmacists Association Foundation

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Presentation Objectives

Provide strategies for engaging pharmacists as a key influencer with patients in medication management including:

• Reviewing the impact that can be achieved by using pharmacists in BP control, adherence, and medication management
• Looking at barriers to pharmacist's action such as payment reimbursement and provider status
• Discussing strategies that the state health commissioner and chronic disease prevention staff can use to connect and have meaningful engagement with pharmacists at the state or local level in BP control and medication management
• Identifying a list of resources at the state and national level that can be accessed
The APhA Foundation Mission

“To improve health by inspiring philanthropy, research and innovation that advances pharmacists’ patient care services.”

- Designing innovative solutions for health care delivery…
  - Collaborating
  - Innovating
  - Transforming
Where we’re going…

• Empowered patients
• Increased collaboration
• Enhanced safety
• Improved outcomes
• Reduced costs

“The best way to predict the future is to invent it.” - Alan Kay
What’s the best way to get there?

• Put patients first
• Optimize medication use
• Improve communication
• Manage information
• Increase collaboration

“Interdisciplinary care is the best way to invent a preferred future for health care.”
National Distribution of Provider Groups – Solving Access Challenges

HPSA: Health Provider Shortage Area
Pharmacists’ Patient Care Services

• State practice acts empower pharmacists to provide clinical services.

• The lack of pharmacist reimbursement limits patient access to certain health care services and the contributions pharmacists can make to health care and outcomes.

• Integrating pharmacists into health care teams will improve health outcomes and greatly benefit specific populations, especially those with chronic disease such as diabetes and cardiovascular disease.
Advancing Service Delivery in Pharmacy Practice…

Health Promotion
• Health Risk Assessment
• Immunizations
• Oral Health
• Wellness Programs

Health Management
• Asthma
• Cardiovascular Disease (Dyslipidemia, Hypertension)
• Coagulation Disorders
• Congestive Heart Failure
• Depression
• Diabetes
• Osteoporosis

…all with MTM

Selection Criteria:
- High prevalence
- High risk
- High cost
- Problem prone
Our Research and Innovation Continuum

www.APhAFoundation.org/our-work

… “Incubating Care Innovation”
Creating the Basis for a Preferred Future
Typical Patient Adherence

Improved Outcomes

397 patients collaborate with pharmacists & physicians in 12 states from March 1996 through October 1999 (24-months of patient care)

% Achievement

- **Persistence**: 93.6%
- **Compliance**: 90.1%
- **Treatment to NCEP Goal**: 62.5%

Historical Control Comparison: L-TAP vs. Project ImPACT

Health Promotion: Improved Risk Identification and Referral

- 11 community pharmacy screenings, 487 patients
- 75% were at high or moderate risk for future fracture
- Patients referred to primary care and/or specialty practice physicians
Demonstrated Outcomes

• Process of Care Models
  ✓ Adherence
  ✓ Alzheimer’s
  ✓ Diabetes
  ✓ Depression
  ✓ Hyperlipidemia
  ✓ Hypertension
  ✓ Osteoporosis

• Economic Savings (per patient per year):
  ➢ The Asheville Project: $1,622 - $3,356
  ➢ Patient Self-Management Program: $918
  ➢ Diabetes Ten City Challenge: $1,079
  ➢ Project ImPACT: Depression: $983
Compelling Evidence

• Systematic review and meta-analysis\textsuperscript{1}:
  • Pharmacist engagement in interdisciplinary health care with physicians and other providers can improve patients’ health considerably.

• Surgeon General’s Report\textsuperscript{2}:
  • Recognition of pharmacists as health care providers, clinicians and an essential part of the health care team.
  • Provides the evidence health leaders and policy makers need to support evidence-based models of cost-effective patient care that utilizes…our nation’s pharmacists…

• Access to U.S. Population\textsuperscript{2}:
  • More than 60,000 community-based pharmacies employ greater than 175,000 pharmacists across the United States.

\textsuperscript{1} Med Care. 2010;48(10):923-33.
\textsuperscript{2} J Am Pharm Assoc. 2013;53:e132–e141.
• Asheville
  • Started in 1997, 1 geographic area, 2 employers
• Patient Self-Management Program \((n=256)\)
  • 2002 to 2005, 5 geographic areas, 9 employers
• Diabetes Ten City Challenge \((n=573)\)
  • 2006 to 2008, 10 geographic areas, 29 employers
• Project IMPACT: Diabetes \((n=1,836)\)
  • 2011 to 2013, 25 geographic areas, disproportionately affected populations
  • Framework for spread – 2015 and beyond…
Consistent Clinical Outcome Improvement

• Three APhA Foundation programs with pharmacist-led patient credentialing interventions showed statistically significant improvements in patient outcomes

  • Patient Self-Management Program for Diabetes \((n=256)\)
    • Mean A1C decreased from 7.9% at initial visit to 7.1%
    • Mean LDL-C decreased from 113.4 mg/dL to 104.5 mg/dL
    • Mean systolic blood pressure decreased from 136 to 131 mm Hg

  • Diabetes Ten City Challenge \((n=573)\) \(^2\)
    • Mean A1C decrease from 7.5% to 7.1%
    • Mean LDL-C decrease from 98 to 94 mg/dL
    • Mean systolic blood pressure decrease from 133 to 130 mm Hg

  • Project IMPACT: Diabetes \((n=1,836)\) \(^3\)
    • Mean A1C decrease from 9.0% to 8.2%
    • Mean LDL-C decrease from 98.6 to 91.4 mg/dL

\(^1\) J Am Pharm Assoc 2005;45:130-37.
Patient Self-Management Credential

Meeting patients where they are to improve self-management of diabetes

• PSMC for Diabetes:
  • 3 domains, 3 achievement levels

• IMPACT of the PSMC:
  • Identify patient’s strengths and weaknesses
  • Target self-management education
  • Enhance efficiency and effectiveness of care delivery
  • Risk stratification for additional services
## HEDIS Indicators in PSM Solutions Model

<table>
<thead>
<tr>
<th>Indicator</th>
<th>HEDIS 2003</th>
<th>PSMP</th>
<th>HEDIS 2007</th>
<th>DTCC</th>
</tr>
</thead>
<tbody>
<tr>
<td>A1c Testing</td>
<td>85%</td>
<td>100%</td>
<td>88%</td>
<td>97%</td>
</tr>
<tr>
<td>A1c Control (&lt; 9)</td>
<td>68%</td>
<td>94%</td>
<td>71%</td>
<td>91%</td>
</tr>
<tr>
<td>Lipid Profile</td>
<td>88%</td>
<td>100%</td>
<td>84%</td>
<td>92%</td>
</tr>
<tr>
<td>Lipid Control (&lt; 100)</td>
<td>31%</td>
<td>49%</td>
<td>44%</td>
<td>63%</td>
</tr>
<tr>
<td>Flu Shots</td>
<td>48%</td>
<td>77%</td>
<td>55%</td>
<td>81%</td>
</tr>
<tr>
<td>Eye Exams</td>
<td>49%</td>
<td>82%</td>
<td>49%</td>
<td>65%</td>
</tr>
</tbody>
</table>

J Am Pharm Assoc. 2005;45:130-137.
### Average Annual Costs to Employer for Participants

<table>
<thead>
<tr>
<th>Year</th>
<th>Baseline</th>
<th>Year 1 Actual</th>
<th>Year 2 Actual</th>
<th>Year 3 Actual</th>
</tr>
</thead>
<tbody>
<tr>
<td>Year</td>
<td>$9,035</td>
<td>$8,913</td>
<td>$8,802</td>
<td>$7,490</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>$0</td>
<td>$414</td>
<td>$268</td>
<td>$240</td>
</tr>
<tr>
<td>Medication</td>
<td>$1,667</td>
<td>$3,045</td>
<td>$3,748</td>
<td>$3,093</td>
</tr>
<tr>
<td>Medical</td>
<td>$7,368</td>
<td>$5,454</td>
<td>$4,786</td>
<td>$4,157</td>
</tr>
<tr>
<td>Total costs</td>
<td>$9,035</td>
<td>$8,913</td>
<td>$8,802</td>
<td>$7,490</td>
</tr>
</tbody>
</table>

*for 63 patients with baseline, 1st, 2nd and 3rd year results. Note: ADA total annual health care costs incurred by people with diabetes were $13,243 in the baseline year compared to $2,560 for those without diabetes.

**Yr 3 savings Per Patient from projected Costs = $6,250 from Baseline Costs = $1,545**
DTCC Satisfaction Outcomes

Patient Satisfaction with Overall Diabetes Care
*Initial vs. 6 Months*

- **Patients Ranking Overall Diabetes Care as 8 to 10**
  - Initial: 67.1%
  - 6-month: 90.2%

Patient Satisfaction with Pharmacist-Provided Diabetes Care at 6 Months

- **98% of Patients were Satisfied (4) or Very Satisfied (5)**
Patient-centered, team-based care produces statistically significant clinical outcome (A1c, LDL-Cholesterol, TC, and TRG levels) and process (monitoring, exam, vaccination) improvements in medically underserved populations in 25 communities across 17 states.

Demonstrates that pharmacists providing customized care empowers people to improve their health... in a variety of settings, for a myriad of patients, in differing stations of life!

## Knowledge Achievement and Associated Clinical Outcomes

<table>
<thead>
<tr>
<th>Baseline Achievement Level</th>
<th>Baseline A1c (%)</th>
<th>Final A1C (%)</th>
<th>Change</th>
<th>P value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Beginner (n = 622)</td>
<td>9.3</td>
<td>8.3</td>
<td>-1.0</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Proficient (n = 721)</td>
<td>8.9</td>
<td>8.2</td>
<td>-0.7</td>
<td>&lt;0.001</td>
</tr>
<tr>
<td>Advanced (n = 324)</td>
<td>8.5</td>
<td>8.0</td>
<td>-0.5</td>
<td>&lt;0.001</td>
</tr>
</tbody>
</table>

Risk Stratification Potential for Improvement

Population Health Management 2014;0069.
Sustainability

- One year following the end of data collection:
  
  **96%** of communities are still providing diabetes care services  
  
  **100%** of communities still have pharmacists integrated into healthcare teams

- True sustainability and scalability requires:
  - Widespread payment for pharmacists’ services
  - Expansion of interdisciplinary care models
  - Quality- and data-driven decision-making

Collaborative Practice
Centers for Disease Control and Prevention
CDC/APhA Foundation Collaboration
Primary Goal and Key Objectives

- Goal – Create effective principles and translational tools to expand the implementation of innovative practice models whose success has been demonstrated

- Project Objectives:
  - Convene Consortium
    - Bring key thought leaders together for informed dialog
  - Draft Model Language
    - Develop consensus on model principles and language
  - Create Translational Tools
    - Enhance implementation of model policy by targeted audiences
  - Strategic Outreach to Key Stakeholders
    - Distribution of model policy and translational tools nationwide
Seven key themes identified for successfully implementing and creating infrastructure for empowering collaborative, interdisciplinary care.
Pharmacists’ Patient Care Services

• Include the broad array of services that every pharmacist can provide based on their scope of practice, local privileges, and practice setting

• Can include patient care services such as medication review, lab interpretation, disease screening, patient assessment and counseling, continuity of care, medication reconciliation, and referral as well as selecting, initiating, administering, monitoring, modifying, or discontinuing medication therapy

• Exact scope of what pharmacists’ patient care services can encompass depends on each state’s practice act; therefore, initiating, modifying, or discontinuing medication therapy may be pursuant to physician authorization or the use of collaborative practice agreements
Collaborative Practice Agreements

- Used to create formal relationships between pharmacists and physicians or other providers
- Define certain patient care functions that a pharmacist can autonomously provide under specified situations and conditions
- Many are used to expand the depth and breadth of services the pharmacist can provide to patients and the health care team
- When a CPA is in place, a licensed health care provider makes a diagnosis, maintains ongoing supervision of patient care, and refers the patient to a pharmacist to provide patient care functions as authorized by the provider
- These functions can include any or all of the pharmacists’ patient care services described above

Note: CPAs are not required for pharmacists to perform many patient care services (e.g., medication reviews, patient education and counseling, disease screening, referral).
Consensus Recommendations

1. Use consistent terminology and language that is readily understandable by all potential audiences
2. Allow health care providers who enter into the CPA to define the details of each agreement
3. Create and expand an infrastructure that embeds pharmacists’ patient care services and CPAs into care, creating ease of access for patients
4. Incentivize and facilitate the adoption of electronic health records and the use of technology in pharmacists’ patient care services
5. Encourage pharmacists to maintain strong, trusting, and mutually beneficial relationships with patients, physicians, other providers; encourage them to promote pharmacists’ patient care services
6. Properly align incentives based on meaningful process and outcome measures for patients, payers, providers, and the health care system.
7. Examine and redesign health professionals’ practice acts, education curriculums, and operational policies to create synergy, promote collaboration and optimize support staff

Consensus Conclusions

• Pharmacists deliver many patient care services to sustain and improve health.

• In an era of health care reform, advancing the level and scope of pharmacy practice holds promise to improve health and reduce costs for care.

• Published evidence supports the role of pharmacists as essential members of the interdisciplinary health care team and emphasizes that pharmacists are well positioned to perform medication- and wellness-related interventions that improve patient outcomes.

• The consortium participants’ seven recommendations provide methods and infrastructure for empowering collaborative, interdisciplinary care.

Translational Tools from the CDC

• The APhA Foundation worked in partnership with representatives from the CDC Division of Heart Disease and Stroke Prevention to take the key recommendations from and develop an easy-to-understand tool kit for four target audiences (published by the CDC):
  • Resources for Pharmacists
  • Resources for Physicians, Nurses, PAs, and Other Providers
  • Resources for Government and Private Payers
  • Resources for Decision Makers
Inventing a Preferred Future

Collaborate Your Way to Success
Advanced Service Delivery in Pharmacy Practice…

Health Promotion
• Health Risk Assessment
• Immunizations
• Oral Health
• Wellness Programs

Health Management
• Asthma
• Cardiovascular Disease (Dyslipidemia, Hypertension)
• Coagulation Disorders
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…all with MTM

Selection Criteria:
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- High cost
- Problem prone
Medication Therapy Management

• MTM Definition
  • A distinct service or group of services that optimize therapeutic outcomes for individual patients

• MTM Core Elements
  • Medication Therapy Review (MTR)
  • Personal Medication Record (PMR)
  • Medication-related Action Plan (MAP)
  • Intervention and/or referral
  • Documentation and follow-up

• Payment for MTM Services
  • CPT Codes: 99605, 99606, 99607
  • Medicare Part D Plans
A simple solution for taking your medication as prescribed

Approximately 69 million Americans take three or more prescriptions per month, requiring multiple trips to the pharmacy. Many consumers say they miss doses of their medication because they forget to refill their prescription before they run out.

Missed or skipped doses of medication cause 125,000 deaths every year and account for 10 to 25 percent of hospital and nursing home admissions.

You can reduce your trips to the pharmacy and improve your ability to take medications as prescribed through medication synchronization (med sync) programs now being offered by some pharmacies. Med sync allows you to pick up all of your ongoing prescription refills at the pharmacy on a single, convenient day each month and work closely with your pharmacist on sticking to your medication regimen.

Be sure to ask your pharmacist if the pharmacy’s med sync program includes a proactive call a week before each of your appointments or “sync date” at the pharmacy to review your synchronized medications, and make sure he or she is aware of any additions, changes, or deletions to your medications. Keeping your pharmacist aware of any changes to your medications resulting from doctor or hospital visits is important in maintaining optimal results from your prescriptions. Your pharmacy will then proactively refill your medications, relieving worries of missed refills or running out of your medications. You will build a relationship with your pharmacist that will help you take your medications properly and regularly, which leads to overall better health. Your appointment is also an ideal time to review other pharmacy-provided health services with your pharmacist, such as a review of your vaccine history to schedule any missing or due vaccinations.

Med sync is especially helpful for people who take multiple, monthly medications such as those with chronic illness or the elderly, as well as caregivers or family members responsible for helping them manage their prescription refills.
Inventing a Preferred Future…

Align the Incentives, Improve the Outcomes, Control the Costs™
Let’s Start with Hypertension…

• Patient blood pressure measurements are readily attainable
• Pharmacists’ patient care services can sustain and improve cardiovascular health
• Compensation for services is possible through an MTM integration
• Enhance existing revenue model through ABM MedSync adherence improvements
• Documentation that contributes to understanding of the value pharmacists bring to the team
• Be a part of CMS/CDC Million Hearts initiative…

https://MillionHearts.APhAFoundation.org/
Every day pharmacists across the United States are helping patients manage their blood pressure. In an effort to demonstrate how the pharmacy profession is contributing to cardiovascular health and the Million Hearts™ campaign, these pharmacists and their staff are invited to participate in the Pharmacy Blood Pressure Challenge. Participating pharmacists can log their patient outreach, education, and intervention activities on the form below:

Practice or Pharmacist NPI: 
Activity Date: 4/29/2016
Minutes spent on this activity:

Interaction Type:
- Select one or more:
  - Blood pressure taken
  - Patient education
  - Prescriber intervention

Action Taken:
- BP within limits, no action taken
- BP out of limits
- Refer to physician
- Patient instructed to seek immediate help

Patient Questions:
1. When was the last time the patient had his/her blood pressure taken?
   - Within the last year
   - More than 1 year ago
   - Never

2. Is the patient currently being treated for high blood pressure?
   - Yes
   - No

3. Did the patient know that this pharmacy provides blood pressure readings and other clinical services before this screening?
   - Yes
   - No

Share an experience with us

Submit

* Fields with an asterisk are required.
Health Care Delivery Collaborations

Common Goals to...

• Improve patient care
• Increase communication between and among patients / providers
• Increase availability of objective measures
• Reduce total cost for care over time

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- Benjamin Bluml, R.Ph.  bbluml@aphanet.org