Milestone 2 Action Group: Medication Management

Presenter: Rachel Wallis & Jackie Crain, TransforMED (AR faculty)

Moderator: Rose Langdon, TMF Health Quality Institute

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Hello, everyone. I'm Rose Langdon from TMF Health Quality Institute. And welcome to the interactive meeting of the Medication Management Action Group. As a reminder, any statements about the quality or utility of any product or vendor made in this presentation, is an expression of the opinion of the person making the statement only and is not an opinion or endorsement of the Center for Medicare & Medicaid Innovation, TMF Health Quality Institute, or the host of today's presentation. We look forward to your participation in today's session. And now we'd like to know where each of you are located across the seven regions. And, as you know, to do this, please click the arrow on the left side of your screen in the annotation toolbar and indicate your location on this map by clicking your location. We've got people from all over! I think all— all regions seem to be represented and that is absolutely wonderful. Excellent. I think we're gonna have a great conversation today. Um, with all the participation that we have. Now please click on the arrow again, to turn it off to avoid accidental annotation during the presentation. Now keep in mind that this session is your action group live session. We want to be as interactive as possible using chat, polls and the forum. The more activity we have, the more learning we have. What we'd like you to do now, is go to the top of your participant's screen, and you'll see a chat bubble. And click on that and chat to us the response to this question: "What issues are you dealing with now at your site regarding medication management? We will be responding to each of these, as you are entering them. I'd like take a minute now to introduce you to the facilitators for today's session. Rachel Wallis and Jackie Crain are representing the Arkansas region. They're joined by our subject matter expert, Marie Smith. And our peer faculty who are Marie Stacks and Alison Gray from the Little Rock Family Practice, as well as David Bounds, and Gina Garrison from the Albany Medical College Faculty Group Practice. And I'd like to know, turn the microphone over to Rachel Wallis.

Thank you so much, Rose. Welcome everyone to the Medication Management call today. Thank you so much for taking the time out of your busy day to join us. We know how valuable your time is. And we are really appreciative of you joining us today. We look forward to the conversation and the rich discussion that we're going to have. And, I just want to remind you of what Rose just said— that this your call. This is your time to express your concerns or barriers or solutions that you may be experiencing in regards to Medication Management in your practice. So, we do have a couple of presenters today and they're going to share with you some very valuable information. But we will also have some time for open discussion and dialogue but, with those presenters, and among yourselves. So thanks for joining us. So this is what we're going to discuss today. Before we get started, though, I would like to just review what the last sessions were about. You may remember when we met the last time we

split into two groups and we talked about startups of Medication Management— really incorporating the pharmacist into the team to truly deliver team-based care, and really integrated care management. Between the last call and this call, there's been a little bit of [inaudible] on the forum, but not much. Uh— we talked a little bit about adopting team-based protocols, and identify the triggers or the characteristics of patients that makes them qualified for meeting medication management. And, so, there were some questions that were put out there on the forum, and, also, there was a great link published by one of the practices for billings, the resources around medication management. So if you haven't gone out to the forum, please do so. There is some very valuable information that's being posted up there. Additionally, we are also posting some pre-work for the calls or in-between work between each of the medication management calls. And it's really just to help prepare you for the next call. And to prepare you for the discussion. And, we're also there in the forum to help you overcome some of your barriers and put proposed potential solutions. So the planned discussion today is medication management workflows in primary care, but Rose has already done so, and I haven't seen anything sent to the chat box. I like to ask, is this what you want to talk about today? Are there other things? So, we're going to talk about workflows and how to incorporate the pharmacist into the workflow but if there's other things you'd like to have the agenda, please chat those in now. And whenever we switch to the discussion, we'll be sure to hit on those topics. I'm gonna move on as you're typing. But, we definitely want to get your feedback. So little bit of follow-up from the last session: there was a learning assignment as I stated previously on the forum and some pre-work there and some forum questions. We will continue to work through this type of learning assignment, pre-work, articles in question, between each of the calls; because we really want a lot of the work in this discussion take place on the forum— not just during these calls. So, again, if you haven't gone to the medication management forum and subscribed to the updates, please do so. If you have questions about how to do that, please reach out to your regional learning faculty. Or you can reach out to Jackie or I and we'd be happy to help you do that. So there's three ways to participate today. We prefer that you use your telephone, we like to hear your voices. So, if at any time, you would like to verbalize a question, please raise your hand, and we'll unmute you so that we can chat with you. You can also use the chat function which is a little bubble in blue at the top of your screen. If you'll click on that and put it into "All Participants" or to the panelists, we'd be happy to chat with you. And then, you can just listen. So you may be at the point to where you're just getting started, and you don't really know what to share. And you don't really know if you have anything to add and you just want to listen to the insight that is being given during the call. You can definitely do that. And then think about the steps within your own team that you could take on Monday to implement some things you may have learned. So, with that, we want to get right into the presentations. And I want to turn the ball over to Dr. Alison Gray, PharmD, and Marie Stacks, they're with Arkansas Family Practice. Marie and Alison, if you take a few minutes and talk to us about who you are, and tell us what you're doing, and then, just let me know when you'd like us to advance the slides, and we'll do so.

Okay, sounds good. This is Alison. I am the pharmacist at the Family Practice Clinic. The clinic has about 12 doctors, three care managers, four health maintenance, full-time employees, we use Allscripts Touchworks and we're an independent group practice. Next slide, please. Okay. So I was just gonna start with a short recap of what I talked about last time we had the action group. So I started about three

months ago now. And, during my start-up, I actually worked with different physician teams. So I met with each team I spent one day with each team. And for half the day, I worked with the nurses. And the second half of the day, I worked with the physicians. And it was really helpful to work with the nurses because it gave me a lot of insight into their— into their workflow and their responsibilities, as well as finding out different areas that I could possibly be assisting them. And one thing that I have noticed with the nurses is that they have lot of prior authorization they have to deal with. So that's an area that I'm working on now, and continuing to work on to see whether I can try to reduce that. You know, working with the physicians to possibly adjust their prescribing habits so that we are, you know, catering to our patients and making sure that the drugs we're prescribing match their insurance coverage. And then working with the physicians was helpful. Number one, just to sort of start that relationship with the physicians, get a better understanding of how they work with their patients, and, then— so to finding out which physicians were more enthusiastic about my presence, and which ones weren't quite used to working with the pharmacist. So, some of them were very interactive asking me lots of questions. Whereas, other ones just preferred that I sort of stand off to the side and just observe. So it was good for me to experience that and know which— which physicians sort of were more enthusiastic about me and which ones are not. But, overall, it just really helped to work with the team and, you know, I was new, so being able to interact with everyone and just have a chance to get to know everyone was what was really helpful. So once I had completed that, it really had given me a good idea of where I needed to go next, so what I needed to do to start my own services. So, right now, I'm putting together protocols for each service, which I'd like to develop. I've completed three protocols at this time, and they're written protocols— it's the jargon the Arkansas Board of Pharmacy likes to use. And my warfarin protocol, that one is completed and it has been approved by the physicians and then my MTM and diabetes ones are also complete and I'm hoping to actually meet with the physicians this upcoming Thursday to get that approved, as well. So, just to speak to a little bit about my work from protocol. So once I've finished, we had that completed. Actually, could we just change that over to my table of contents? Perfect. Thank you. Do I scroll down, or do you need to scroll down?

Hey, Alison, real quick, if you guys would like to see it all on one page, there is a little magnifying glass at the top-right hand of this document. You can click on that to change the view.

Okay.

Alison, they won't see if you scroll down. They will have to scroll down themselves.

Okay. Perfect. Okay, sounds good. So this is the front page of my warfarin protocol. I changed my table of contents just slightly since I've submitted this. But this sort of gives the idea of the clinical framework of what I've put together in my protocol. So, I felt that it's really important that the physicians know exactly what I'm going to be doing. That they know the information that I'm going to be talking to their patients about. And, you know, especially when it comes to making adjustments to medications and any sort of changes in procedures then the more explicit you can write it, the clearer that it is then, the easier it is for the physicians to understand what I'm going to be doing. And then I find that they can trust me a little more because then they don’t have as many questions. So that's what I tried to do with my warfarin protocol. And it's gone over very well. The—the physicians were very pleased with it.

They— I gave them about a week to look at before I met with them. And they proved it in— in the meeting. And so now I get referred patients. Right now I'm seeing complicated patients. So it's usually those that are having trouble staying within their INR range. Then, the physician will either give me a task through Allscripts, or they will give me a piece of paper that states the patient's name and such. And that's how I get the referral and then I will contact patient and set up an appointment so that I can meet with the patient and start to monitor their INR. So that's been really good. Since I haven't had a chance to prove my other protocols, I'm not seeing as many of these diabetes patients or MPM patients. But I'm sure that once I get that approved with the physicians, it will be in the forefront of their mind. And, hopefully, the will think of me when they have complicated patients that they encounter. So that's— that's my protocol. Just another thing I wanted to mention about that was depending on the state that you're in, so something that I've learned that I've had to sort of beef up my protocol a little bit is including the necessary legal components of the protocol, so um— being very specific about um— you know— having my name and the practice. And, you know, having all the license information. So that it's more of a— a legal document. So, everyone has to sign it at the end of the document with everybody's license. You know, just to make sure that it is official. As well as making sure that um— there's a statement in there saying when the protocol has to be reviewed. So for Arkansas, it has to be reviewed annually. As well as having a statement that says that the physician can, um— pull out of the protocol at any time. So, if a physician is not comfortable with me managing their patients, they can, you know, um— say that they don't want me to be doing that. So just making sure that that's in there as well. But, again, it could be different for different states. So, just making sure that the pharmacist is aware of what are the necessary components of the protocol. So, that's where I am right now. Um, one of the barriers that I think that I faced um— being a new pharmacist here— some of the physicians had never worked with the pharmacist before. So those are the ones that have not been quite as interactive with me. But I feel that the more I can work with them, then the easier it will get, and the more trust that I can develop. But those that have worked with pharmacists have been very enthusiastic. One of my doctors here asks me questions all the time. You know, asks me to do projects, I put together um— drug charts. You know, all the different drugs for certain disease states. Sort of cheat sheets for them. Um— I'm been working on immunization schedules and things like that. So, it sort of just depends who you're working with. And, lastly, so for the future, I am working on my protocols, continuing to develop more. Hoping to flush out my practice a little bit more with these protocols that will be approved in the future. As well as, I'm really hoping to start to get into pre-visit planning. Being able to work with the doctors instead of target those high-risk patients. So that I can, whether it be an actual visit or chart review, before the doctor sees the patient so that I can identify any changes that need to be made. And, um— if you have any questions I can do that.

Thanks, Alison, so much for sharing. If, at this time, you have a question for Alison, please feel free to raise your hand or type that in the chat. And while you are thinking of your questions, Alison, I will just ask, um— Tanya, I don't know if you're out there— Tanya Walker. If you're out there and you want to unmute. I know that Tanya was having problems getting her physicians to buy into the notion of the pharmacists on the team. Alison, what advice would you give to Tanya? And Tanya, if you want to have this conversation with Alison at this time, we can unmute your line. Um— and you can ask a specific

question if you'd like, but what advice would you give to the pharmacists that are trying to incorporate pharmacists getting that buy-in with the provider?

Well, I think for me, um— being able to find a need. One of my biggest things when I started at the practice and I could see that the physicians were little bit hesitant with having me there was I really didn't want to disrupt workflow. I didn't want to, you know, be something that they needed to change in their workflow. But, I'd rather be an addition when they— when they needed me. So trying to find those areas of need. And then, really with those protocols, you know, trying to show the physicians what I know. Um— because the more that they know then I feel that the more they can trust me when I care for their patients. So that's what I've been doing right now.

And, Rachel, I think, too, Alison actually had an advantage when she came in the door because a lot of the buy-in had to be done before we actually even started to search for a pharmacist. So the physician had to buy into the idea for us to even start the search.

Got it. All right. That's great, Marie. I think that is—that is something to note that if they are involved in the front end of the notion of a pharmacist that maybe they will buy in a little easier than if it somewhat appears to be forced on to them. Which, we know, sometimes, that's not the best approach. Um— very quickly, Tanya, I don't see you chiming in there, so I may have answered your question for you. But, if you'd like to add to that, please do so. Um— Tammy. Tammy, raise your — I see you on the line. I noticed that you posted up on the forum. Thank you so much for doing that. I know you're just getting started with med management. Would you like to share any similarities that you see as to how Alison has been incorporated that you're experiencing or any questions of Alison of how she's gaining buying in?

And Tammy if you could raise your hand, we could unmute you. That would be wonderful. And Jeff, if you could unmute Tammy? Thank you.

Thank you, I appreciate you putting on this action group. It is something that we are wanting to incorporate more. Our problem was more out getting the doctors on board to trusting a pharmacist, and we also have limited time with the pharmacists. They — the ones we contracted work in a hospital. And, they do participate by helping us with our patients who meet a criteria that we have designed in the hospital prior to discharge, but, getting them to come here is not a problem. It's getting the referrals made and then also patients to be compliant with following up with a pre-planned visit.

Okay. Thank you, Tammy. Can you tell me little bit about what those characteristics are for having the pharmacist work with patients in your practice?

Yes, our doctors wanted to focus on two certain disease processes, initially. They chose CHS and COPD. And also patients who are, have complicated medication regimens or polypharmacy. And are also high risk. So, these are patients that we are targeting. Also, if there happens to be a patient that we've discovered is not taking their medications correctly or needs further teaching or assistance than those patients are also then referred.

Wonderful. Thank you, Tammy. Thank you so much for unmuting and talking with us.

Thank you.

You're welcome. Alison— real quick before we move on to the next presenter— so I see that you're working with the protocol for warfarin right now, and that's probably the biggest trigger you have for getting patients referred to you, but are there others that maybe it's just, gosh, a quick referral within the practice at the time of the visit? Do you get any of those?

I'm not getting too many of those. I have had a few diabetes referrals. But beyond that, at this point, I'm not getting too many. I had one of the physicians that give me a referral for polypharmacy elderly patient who was on I think more than nine medications. But, beyond that, I haven't really been seeing patients outside of the warfarin.

Okay. And so, do you keep a registry, Alison, of what warfarin patients you're following?

Yes, I do.

Okay perfect. All right. Well, thank you so much. I don't see any other questions at this time, Alison. So what we're going to do is move on and then after the next presentation we'll have plenty of time for more discussion. So all right. Is David and Dr. Gina Garrison. I'm going to turn this over to you all. If you could just tell us a little bit about yourself and your practice, and then just let me know if you'd like for me to advance the slides or to your protocols.

Thank you so much. Good afternoon, everyone. Again, my name is Gina Garrison I'm a PharmD and I've had the pleasure of working with the Albany Medical College faculty group in Latham, New York, for the past 15 years. My primary position is as a full-time faculty member in the Department of Pharmacy Practice with Albany College of Pharmacy and Health Sciences. We have an affiliation agreement with Albany Medical College and Albany Medical Center. And that allows us to have this as our practice site. And with that, I am taking approximately anywhere from 12 to 14 students every academic year at the site. So when I'm talking about my services, I'm referring to those provided by myself, as well as my students. Being a full-time faculty member, I'm sort of in a different position. I'm not there to be revenue-driven. This is really of value added. It was a great decision back15 years ago, by our Practice Director, Dr. Elizabeth Higgins, to merge this relationship with the two colleges, if you will, the Medical College and the Pharmacy College. So little bit about what we do there, we have nine medical providers. And among those we have two physician assistants, and then, also, we have 16 medical residents who are in various stages of their four-year training, in combined internal medicine and pediatrics. So a lot of what I'm focusing on here with the primary care initiative— we do focus that on the adult population. So I'll be referring to that today. And we all use Allscripts Touchworks. And we have two nurse care managers who we work very closely with— who really are tremendous resources. And it's really a great team effort. If you want to advance to the next slide, please? Thank you. So I'll be honest. As I was hearing Alison talk, I think it's interesting to hear the two different types of timelines. So, I've been there for 15 years. And so in preparation for today, I was thinking back and reflecting on the startup piece. We— I'll be honest, the provider buy-in, 15 years later, still stands out in my mind as a challenge. It

certainly was something that wasn't easy at first. Most of the providers I had worked with— were working with, weren't aware that a PharmD could be clinical. They were more familiar with pharmacist working behind a counter at a retail store. So they weren't really as sure— they weren't really understanding the types of things we could provide. So for— to speaking to what Alice was referring to— the two examples. Certainly, we can help with drug information, some patient counseling, but I think that when start getting into medical decision-making and looking into treatment options, they were a little bit more surprised that a PharmD would be able to have a conversation with them and talk about treatment plans and so forth. We were more utilized upfront for things like prior authorizations, can you call the pharmacy? Could you confirm this information? And we've transitioned now into much more higher order cognitive services. The workflow, as it is, so as I mentioned, I'm a full-time faculty member funded by the College of Pharmacy. So this, I also have I'm sort of volunteer faculty, if you will, at the site. So because of that, I'm not there full-time. But my students are scheduled to be there full-time most years— excuse me—most weeks during the academic year with a couple of weeks off during the summer. I mentioned that because when the students aren't there, as soon as I get back, I hear how much they've missed us. And so it's interesting when you take away a service, you realize how much you need it. So what's interesting there I think, too, is that it's pretty unique we have pharmacy students helping. And, you know, when I'm not there, the physicians basically are working as their backup preceptor. The students are not doing anything independently, necessarily. But they are offering a fantastic opportunity to be part of the team. And that inter-professional relationship building continues. I should be clear, the students are in their sixth— excuse me— the end of their program. So most of them have done two years of pre-pharmacy work and four years of pharmacy school. So they're in that last year right before they become a pharmacist. So they're advanced students, and they're able to do a lot of what we're expecting of them when they get their license. So what do they do day-to-day? I do have some workflow documents but, before I get into those, I just want to give you a brief overview. Similar to what Alison was talking about, I also sort of break the day into different sections, if you will. So, what we have is in the mornings, we have assisting the nurses with doing the medication history on our more complicated patients. So we'll write on the schedule that the pharmacist, or the pharmacy student, will be going in and taking the medication history. And then, as part of that, for patients that are most complex we'll be doing some pre-appointment reviews and the students will have an opportunity to look at the medical record. See what types of questions they want to ask the patient. See where there may be discrepancies and need for medication reconciliation. So that all occurs before the physician comes in to visit. Also, a part of that, the students are prepared to make any therapeutic recommendations. For example, after they've taken the medication history, they might notice that a patient's on a drug and they haven't had some recent blood work to monitor for potential side effects. At that point, they'll be able to talk with the provider, before they go in and see the patient, and just go through a list of things they've noticed. And the providers, for the most part, are pretty open to that. I'll admit sometimes that's one of the pieces that if the schedule is little bit behind, or a little rushed, they might not get to a full-on discussion. But as time allows, it really does help to serve to improve the patient care. And, you know being in an environment where we have residents, medical students and pharmacy students is really that inter-professional team. So, in the afternoon, it's a little bit different. This is where we've probably had an accumulation of several phone calls that came into the office and nursing triages to us which ones they'd like us to call the patient back on. And by "us" I mean myself and

the pharmacy students. I usually have two or three at any given time. We also have consults that come through, and when I say "consults" I really just mean informally. They'll go into Allscripts and they'll send us what we call a "task" electronically. It might be, you know, patient's not tolerating rhis meds. Can you recommend something else? Or insurance isn't covering it. Could you help us write an authorization letter? We also get consults to call patients back. And go through things like tobacco cessation counseling. Or could you do a full med history on every cholesterol drug they've ever taken and what their reactions are because we're trying to find a drug to use and we can't seem to. So that's really the break down between the morning and the afternoon. Again, the mornings being more seeing patients, and helping with med histories, and talking to the physicians before the group visits, excuse me, before the visits and in the afternoon, more follow-up. As far as documentation and the workflows that we have here, you may want to go ahead and look at those. They're sort of simplistic, but they may help to give— you know, they say a picture is worth 1,000 words. So this is a workflow that we created just so that everyone knows what everyone is doing in the office. The first one that's displayed now is the history taking role, so that's what we do in the morning. And then, you know, of course, if there is the patient that occurs in the afternoon, we're— we're flexible with that predominately in the morning. So as you can see, there is an opportunity there where we're able to have the students look for any— what we call "medication-related problems" and they work very closely with the nursing staff. Notice the medication history is very thorough. Not only are we listing their drugs, but any over-the-counter products which a lot of times patients forget to tell us they're taking. We also can prime the visit for the provider by asking about any side effects, what refills do they need today, any questions about their medications. And often the providers are comfortable, if there are any patient education needs, we go ahead and give it right on the spot. We have some patients, who when they make their visit, they ask if they can be scheduled on a day that the pharmacist is there. Or can they be sure to have a pharmacy student in the visit. So that's how well-received this has been. I don't know if it'll be helpful to maybe switch to the second workflow? If you want to take a look at that? That's something— that's control. Thank you. Thank you. So this is more the workflow for what we call "tasks." And again, that's a term we use in Allscripts. But, essentially, whether it's on paper or electronically it's a request for some assistance. This can come from one of our providers, and we do get a lot from our medical residents. They rely on is very heavily sometimes more so than the attendings. As well as the nursing staff. Anytime they get a call to the office, and it has to do with medications, they involve us. And so, the task comes forward. The student has an opportunity to look into some possible answers. If they're not comfortable with answer, they contact me. I'm always available electronically or face-to-face when I'm at the site. And one of the things that we have, is we don't have the opportunity for students to write on the record, so we do revert back to the requester to go ahead and document what transpires at the end of that process.

I think on the slide we were moving along, and the last bullet there was on measurements. So I think it would be helpful to mention here right now we are in the early phases. A lot of what we're tracking is really quantitative data, just how many patients we are assisting. And we are able to utilize a couple of processes in the medical records to do that. As far as, you know, other types of measurements that are more qualitative in nature, we're continuing to explore that. I'll admit that's a very lofty task. But certainly important. And, I guess, the last thing I wanted to mention was also building off what Alison

has mentioned. We also are involved with various projects and practice management issues as they come about. For example, a new immunization comes out that's been recommended for adults, and how are we going to integrate that into the practice and do we check with payers, and is everybody covering it? Newer anticoagulant drugs came out, what types of patients should be getting it. So we do in-services on these items. And we meet with the medical director to make more practice-wide— being involved with those practice-wide decisions.

All right. Thank you so much, Dr. Garrison, for that presentation. And, as always, if there's anyone that has a question, please raise your hand for Dr. Garrison and her group. Or feel free to use the chat. Very quickly, I would— I think it's pretty amazing to me, Dr. Garrison, to hear that you've been at this for quite some time. And Alison, pretty new at it, but you're stilling running into a lot of the same problems with provider buy-ins. While we're waiting for hands to come up, and I see a few, is there a suggestion that you might have to the group as to how to get that provider buy-in that's worked for you in the years you've done this?

Certainly. You know I have to say, too, I think the provider buy-in has a lot to do with, you know, what is it that you're trying to improve. I know that was mentioned earlier. What are your areas of need? For me, though, I guess to build the inter-professional rapport, it's certainly complex; but, for me, I also find that when you impact a patient and they go back and they tell the provider how great it was, how much they valued it, or when the physician might see the documentation in the record and how thorough we were able to provide patient education and respond to drug information needs. I think that those types of illustrations of what we have to offer really are the best way to build that rapport. I think there's only so much you can tell someone. They need to figure it out for themselves. And the ways that we do that are by demonstrating what we do well and documenting it. So— and I see— I hope that helps a little bit, that I see that— um— there's also a good question of how do you make the impact when, perhaps, you're not there full-time. There's a question about a pharmacist— if you're only there for two days a week, how can we make the best impact? To become— you know— more involved? I— I think that, at least for me when I first got there, I was coming straight out of residency training I had done my residency in the VA system— who has a very different approach. And I thought it was helpful, at that point, to give an overview of the types of things I've done, and the types of things that I could offer. And outlining those for the providers. And, I think that if they see that menu and then they choose the types of things. For example, they say "oh, we have a lot of patients who need to help smoking— to quit smoking. We see you're certified in that." Great. And then, let them decide on how they want to do that. I'm also going to say, David you're here as our Practice Director. Do you want to comment on that as well?

Yeah. I think just any set of medical patients or whether they're in a home, whether it's a pharmacist— I have two RN case managers, Karen and Stacy, is to really just let them— everybody work at the peak of their license. I think showing that value, you know, it does take some time to develop with that. But I think that once it's been demonstrated, everybody in the whole practice sees that and that’s again from the attendings to the residents. We have all different kinds of students, nurses, etc. And, you know, the reality is that it’s generally gonna decrease the amount of work on some those other people as well. Because, like Gina said, you know, we have her and two to three other students that can also assist. And

then, the patient feedback is typically, you know, unbelievable. I can't believe somebody would take the time out to go over that with me. I can't believe someone's making that phone call to me. You know, patients don't expect that. And again, when that kind of feedback gets back to the attendings, um, you know, they— it's in their best interest and they want to just keep that ball rolling because it's more help for their patients, it's more help for them. You know, you have patients who are getting their questions answered. You know, all those different things show that value, and, yes, it does take a little bit of time, but I think— um, it's— it's been well worth it. And, you know, all these things were well in place before I got there. But I've, you know, my experience has been nothing but just— just fantastic. And, like Gina said, the couple of weeks that we don't have them, I would definitely say that there are missed by everybody in the practice. So —

Thank you, David. Alison and Marie, is there anything else that you like to share to that question about how to make an impact when the pharmacist is only available two days a week?

So. Go ahead.

Go ahead. That's fine.

I was just going to say, Alison— this is Marie. And Alison is actually split between our two sites. Monday, Wednesday, Friday she is at our West clinic. And Tuesday, Thursday, she's at Central. And one of the things is that our patients know they can go to either location. And it simply keeps Alison at the forefront of physicians' minds even though she's in our office, she's able to walk around and kind of talk to them. But, I mean, that's kind of how we keep her active with our patient population at both sites. I don't know if that answers the question. [Laughter]

No, I think that's helpful, Marie. I think it's important to hear that she's there and visible to the providers. I think that's a challenge when they're only in the office a couple of days a week. And they tend to be forgotten about, maybe.

Um-hum.

So I think that's a good point. And yes, Maurice, yes. You have your hand up. I like to hear your input on this or any other comments you may have.

Thank you. So this, um, I have a couple of questions to ask. One is, I know that both presenters talked about some of their pearls about getting prescriber buy-in? I'm also sensing that at least, I think— Gina, your practice, you mentioned you had nurse care managers, and perhaps Alison you did too. Can you talk a little bit about how you worked with the nurse care managers to get their buy-in because I think they can be such a great referral source.

es, I'm happy to comment on that. And thank you for your point. You're spot on with that. You know, I think right from the beginning, you know, the Medical Director, Dr. Swaram, and our Division Head, Dr. Lindstrom, when they hired our nurses, you know, I remember the day the nurses came through to interview. They introduced us, they said, "Here's the pharmacy office. These are the pharmacists." And, you know, "this is the pharmacist and the pharmacy students." And so right at the day of their interview,

we were a part of the process. And then, after they came onboard, they were told by the providers, you know, if you have any drug questions, you can go to the pharmacy office and they'll help you. And so we, immediately, they recognized that we were there as a resource. And, so, and, you know, the proximity of our office that— we're physically right next to each other, which is great in the design of the office. So— um— we each have our own separate office with telephones. And, um, I can just tell you it's the most positive— it's a very positive working relationship because— um— we all have the same goal. And that is, you know, patient care is number one. And so, we tried to sort of always lose all of our labels and the barriers that we have between our two different types of disciplines. And it's just a great inter-professional approach. I do think that, you know, one of the things that really helped with that transition, it may be helpful to others starting in this venue, um, is having an opportunity for the nurses to— the nurse care managers to understand what pharmacy has to offer. You know, for example, all those calls they get about patient who is in "x" scenario or "y" scenario, and sharing some workflows or review articles that have a great chart that they can follow. You know, switching patients that are on anticoagulation right around the perioperative period is a great example. They get those questions a lot. We help them. And it made their job easier. And we're all able to make sure that every patient gets the appropriate care and follow-up.

Do you have anything else to add?

This is Marie Smith. I have one other comment I could make about the potential ways to get provider buy-in. One of the examples we had here, we placed a pharmacist in a new— a newly placed pharmacist in a fairly qualified health center. So a pretty large and very sophisticated primary care center— was we used and they had never had exposure to a clinically-trained pharmacist, and had most of their interaction with a retail pharmacist who was in the lobby of their building. So rather traditional model. We actually used— um— educational sessions so these were for all noon conferences. We would make sure that on a regular basis, on a monthly schedule the pharmacist was giving some type of a timely educational case study or a new drug update, or something like that. So from an educational standpoint, all the providers and other health care professionals and staff in the practice had a better understanding of the knowledge base of the pharmacist. We also volunteered if there were committees in that practice, like this practice happened to have a pharmacy and therapeutics committee. They had a patient education committee, an antibiotic stewardship committee. So we actually have the pharmacist get involved in some of those activities so that they could kind of roll up their sleeves. And work on practice issues that were affecting the practice with regards to medication use. And then, probably, I think the— Dina mentioned this— one of the most important ways that the practice providers had a better understanding was to really look at the thoroughness and the level of action for the recommendations in the notes. So depending on how you're documenting, it sounds like most people are probably are on an electronic health record today. It's really important that there's feedback from the providers about how useful and how actionable those notes are. Because that seemed to be one way we could measure the extent to which they felt comfortable and, and getting information that's gonna help them— and— from a time efficiency standpoint. So those are just some thoughts.

All right. Thank you so much, Marie, for that. I hope that was very helpful. On that note, if there are things that maybe we haven't really focused a whole lot on, that was presented by the presenters today,

and we haven't brought up that you'd like to discuss. With their little nugget, maybe that Alison or Gina discussed briefly, but you want to further investigate or further talk about, if so, please let us know. This is your group. We can talk about any topic related to medication management, provider buy-in, anything that goes along with med management that you would like to discuss today. Again, we want to make this actionable and valuable for you because you're spending your time on this. So there's some questions that are—that are coming out in the chat. And I hope you guys can see the chat. If you can't there's a little blue bubble at the top of the screen. And you can click on that and see what's coming down from the chat. I'm just reading through these quickly to see if there's anything that's coming from practices. As I'm doing so, please feel free to chime in or raise your hand. We would love to hear from you. And so Gina and Alison and Marie, I was trying to capture on the whiteboard some of the little nuggets of provider buy-ins, and so, looking at that list, I gleaned from you conversations that educational sessions— I think that was a great idea of having a way to keep the pharmacist at the forefront and giving little pieces of information to the team, showcasing the pharmacists' abilities. I think that's great. I think Alison, you did a great job of sitting in with the nursing staff and the doctors and trying to learn what the practice was about to try to get that buy-in. I think that was a good approach. And then, I liked Marie as you said, looking back at the notes and making sure the providers thought the notes were actionable and valuable. And more of the other things that maybe the participants might like to ask questions of in this area or add to this list. And while you're thinking about that, I see we've got a couple of hands up. So Tanya— Tanya Walker, if we could we could unmute Tanya's line? Tanya, feel free to chat away.

Hi. Actually, this is Sheila. Tanya couldn't make it. I'm one of her care managers.

Hi, Sheila!

How are you?

I'm well.

I just wanted to make a comment. I've been listening to some great ideas. But, I really do love the idea of the educational session at noon. That's when a lot of the docs are gathered together, of course. And I think that would be a really big impact for our clinic here to get more involved. Like I said, there're only here on Monday and Tuesday. And they come to us, and, you know, we tell them the high risk, the polypharmacy— the issues we're having. But a lot of times, the doctor doesn't see that interaction. And for them to come face-to-face with the doctors I think is just a really good idea. For that to happen, actually.

Thank you, Sheila. Can I ask a question of you?

Sure.

Um, I had spoken to Tanya, recently, about the difficulty she was having getting the pharmacist to work with the high-risk patients. That the providers were feeling a little hesitant to give the pharmacists the freedom to intervene with their very delicate patients.

Yes.

Have you made any progress on that?

You know. Well, just this week, I know the pharmacist, yesterday, went in with several of the patients and just spoke with them. You know, they're just on a lot of medicines. And I know one of our physicians came to me to let him know that he was finished with that patient for that pharmacist to go in. He didn't know she had already been in there. But, I saw a little bit of that "hey, I know they're here now. Let's get 'em in here to see the patient." Which a lot of it I think they just forget. I hate to say that, but, I think they forget they're here— those couple of days. And they can really use 'em for a lot of things that would take a load off their plate as well. It's just a matter of getting them out there and getting 'em seen. I think it's a part of our issue here.

Yeah. I think you're right. And so, I love the idea that has been thrown around today about how to increase awareness of the pharmacists' abilities. So, I hope, at some point, you're going to utilize that noon session. I think that is probably something for everyone on the call today to think about. If that's a possibility for your practice. Sheila, real quick, one thing that we had talked to Jeanie about was maybe asking the pharmacists and the doctors if they can work together on the moderately high-risk patients so that they could gain trust and into working on the high-risk patients. Did that— is— are you guys working that way? Or are you just trying to work with those high-risk patients?

Right now, I think we're— excuse me—on the high-risk, but Tanya has mentioned that to me. So I don't know how far she's gotten with that. I honestly don't have a good answer for that. But I know she has mentioned that. And I think that's a great idea to get them to do that. And I think our pharmacists and our doctors know each other. They're all from the same hospital. And I think they trust them. It's just, again, a matter of remembering they're here. And— um— kind of giving them, as you say, these tasks of things that the pharmacist could do that would help the doctors. I think they just do. They forget that they're available.

Right. All right. Well, thank you so much for raising your hand and chatting today with us, Sheila.

Thank you.

I do have a question here. Yes. Yes, thank you. From Jan. And Jan asks if CPC money can be used to pay for pharmacists? Absolutely, Jan. You can definitely budget for a pharmacist's time for your CPC efforts, and, of course, integrated care management. Whatever time you are utilizing that pharmacist, if you're going to hire them, if you're going to contract with them, absolutely. You can use CPC money for that. And if you have a follow-up question, please raise your hand. We would love to chat with you about that. Or you can continue to use the Q&A. With that, I would like to do just a brief poll. As you all are thinking about other questions. So I think that there was an interesting comment made about who was referring for a patient to get med management. So raise your hand if you are solely depending on the doctors who refer for med management. If the doctors are the only ones that can suggest med mManagement, raise your hand. I just want to get a feel for— for that. So not— not very many. So if your nurses or your care managers can "refer" to Med Management, raise your hands. All right, a lot of

hands going up there now. All right. So that's interesting. So those of you that raised your hands stating that the care manager could start that workflow, would you be willing to discuss that with us? If you're not willing to discuss, click on your hand again and your hand will go down. If you're willing to tell us how that works, keep your hand up, and we'll unmute your line. I see a couple people there. Lisa. You're at the top of my list! Lisa, would you mind sharing with us what that workflow looks like with your care manager referring?

Oh, sorry. Yes. We can take referrals from physician assistants and they can start to share so that we can cover the advanced providers.

Oh. I'm sorry. Can I interrupt? Can you tell me your background and who you're with, please?

Yeah. Um— I am an ambulatory care pharmacist with Providence Medical Group. And I practice in Portland, Oregon. Is that enough background? Or—

That's perfect. Thank you. I just wanted some context. [Laughter]

Yeah, so we have CDPM or collaborative drug therapy in place for multiple climate conditions. And we can under our Oregon law, the PCP on the patient scanner does have to be the one who approves the CTM before we can start it. However, the— the patient who may benefit from our services that can be caught by a PA, nurse practitioner, case management, we have a behaviorists as well, or IDs in our clinics, and so they just send us a little FYIs through our electronic system. And say, I think this patient would really benefit from PharmD involvement. And then it allows us to do a chart review and go to the PCP and decide if we would like to do a one-time review of medications with some suggestions that PCP can follow-up on. Or if we really need to do full on collaborative management where we are really taking over the medication decisions and doing the follow-up on our own.

Okay. Thank you so much, Lisa. So help me capture this really quickly. Who refers to you? I'm sorry, I was multitasking and didn't get that.

Physician assistants, nurse practitioners, case management, our case managers—

Uh-huh.

And also our behavioral health.

Oh, great!

Behavioral health interventionists, their BHIs, their initial. But, they are psychologists by training.

Wonderful! So that's interesting. And so, what types— what types of referrals do you get from behavioral health? If you can go into that? I'm just intrigued by that.

We have collaborative therapy. We have a CDTM in place. We have collaborative drug therapy management agreement in place for depression. And we also have— that gets engaged and then our BHI, they— because they are not psychiatrists, they don't prescribe or do medication management.

They actually work with our patients more on. It tends to be on motivation, adherence, maybe stress. Sort of like a grief crisis short-term situation. And so they often can identify patients who maybe are just struggling with making healthy lifestyle decisions and seeing it as medication. Adherence plays a role in that or if it's appropriate for us to get involved with that answer. Those tend to be more in my experience for the one-time reviews for just maybe sitting down with the clinical pharmacist, or having a conversation with someone to go over why they're on certain medications and what benefit is there can be really helpful.

Wonderful! All right. Well, thank you so much for sharing, Lisa. I really appreciate your willingness to share. If there's any questions for Lisa, please chime in and we'll— Lisa, we'll keep you open so in case you want to make any other comments, you can. Charlotte. Look at— I will unmute you, Charlotte. Who refers to med management in your practice? And please tell me what your discipline is and where you're located. Oh. Charlotte took her hand down. Maybe she wasn't wanting to share.

All right, Kimberly. You're up next. Kimberly Crosby?

Hi! Can you hear me okay?

Yes, ma'am.

Then you probably hear my phone ringing because that's the way it goes. You know? [Laughter]

I understand.

Well, I'm a PharmD. And I worked with a physician practice with a university. So I am faculty with the College of Pharmacy and then adjunct faculty with the School of Community Medicine Department of Family Practice. And our physicians use a referral system in our electronic health records to refer patients to me for individual appointment. So if I— if they would like like diabetes education, our management or a medication review specific for a patient, they will usually refer those through that system. But we do also get a lot of— or I do also get a lot of referrals or questions about patients from our— both our case managers, our nurse case managers. And then, just our nurses and clinic, so if something comes up if there's a medication question or if there's a patient they see and they think "you know, this one's not doing well. This patient isn't doing well. They need to go see someone." I've noticed a lot of those. Nurses will refer a patient over. And often they'll— they'll send it directly to me. Or they'll talk to the resident and say, "hey, you know, why don't we have this patient go see Kim Crosby. Because she really doesn't seem to understand whatever disease state it is or whatever. And then we do have a warfarin clinic that I manage and in that patients— those patients are referred from our providers again through that EHR referral system.

That's awesome. All right. Interesting. So, I love to hear the various workloads dependent upon your setting, Kim. You're in a residency program, is that right?

Right. Yes. It's an academic center and we do have a residency program for family medicine residents. So we— do get—I mean— get a lot of referrals from the residents. We also get a lot of referrals from the attendees as well. So it's a nice mix of referral.

That's awesome. Kim, how long have you been you doing is?

Well, I've been at this clinic for about five years. But they've had a PharmD at that clinic— clinical pharmacist of some type at that clinic since probably '99/2000? So they're— they're familiar with the practice of what a clinical pharmacist can do for them and what kind of services can be offered. I think we're all learning how to make— how to collect data and how to document what we do for this CPCi project. But, but may— or— we've had a referral base. We've been involved with the education of patients and management of patients since about 2000, probably.

Okay. Wonderful. Wonderful. Pretty advanced program there. Thank you for sharing. I want to be cognizant of time. We only have about 5 minutes remaining. And so for this time, I want to do just a couple things— very quickly. Thank you all so much for sharing today your feedback, either planned or unplanned. We really appreciate it. That's what these calls are about. We're looking to prepare for the next learning session call for this particular group. And we have a couple of questions for you. So if you could take just a second and click on your arrow and answer these next couple questions for us. The one is: Do you know your state's regulation for the ability to develop collaborative drug therapy programs? If you know it, "yes." If not, "no." Using your arrow. All right. Looks like there's a few of you that do not. Marie Smith, if you're still— I see you still out there. Where might the practices go— and I think we're going to post this on the forum— so practices can go to the forum. Marie, is there anything that you would like to comment about knowing your state's regulations?

Sure. Thank you. I think we have a document that we were going to have posted from— and, if you want to see it, in advance of that, if it's not up there yet— there's actually a great document from the Centers for Disease Control, CDC, that did kind of an overview, an issue brief and a map of the United States. The only thing I would say is that it's a little bit dated. So, just be aware that. It doesn't get a lot of detail. So, as— I think Alison pointed out early on, it really is important that you talk to pharmacists in your state. Maybe your state pharmacists' organization? Your State Board of Pharmacy or Commission of Pharmacy should have information that they can share with you that's very specific to your state and what the requirements are. Because it will vary. But around 47, 48 states now have some level of collaborative drug therapy management regulation that do allow pharmacists to do collaborative drug therapy protocols.

All right. Thank you, Marie. And I just looked, and that information is already on the forum. It's in the Medication Management Forum. So please go out to the Collaboration site and pull that link down and there's that and multiple other links related to this that Rose and Marie collaborated on and posted for everyone to view. So thank you all. Keep your arrows going because we're going to do one more thing before we wrap up. Do you currently have a CDT program in place in your practice? All right. I see lots of nos. All— okay guys thank you for answering that. So I'm— I'm going to ask you one more thing. If you are interested in exploring this type of program further through agreements and things of that nature with more information please click on your hand icon. Raise your hand. I want to get a feel for if this is something that you all— we, we think it's something that's valuable to discuss maybe at one of our next calls? But I want to get the feedback from you all, real-time. If you would like to further explore the notion of collaborative drug therapy, please raise your hand. All right. We've got several coming in. All

right. So it seems like our notion was correct. That would be a hot topic. So great. All right. Thank you all. You all have been wonderful today. It's been a great presentation. And— as, I just want to remind you to go out on to the forum. Go out, post up your questions. Post up your barriers and solutions. That's where we want to really take the work of this group. And we want the calls to be where we discuss and brainstorm and share best practices. So the forum is out there. If you have trouble navigating, please let us know. Please reach out to your learning faculty or TMF. We're all here and happy to help you. Thanks so much again. And I've got one more announcement to make and that's the next action group. It's February 17, at 2 p.m. Eastern time. And it looks as though we're really going to focus in on integrating and doing collaborative drug therapy and really integrating this team and the documentation that comes out of that. So integrated care planning, integrated medication therapy planning, all of those things that really make the entire team work together. And, also, patient-facing. So how does it look to the patient? Does it look like you all are really working together? Or does it look siloed? So that's our notion. Please go out to the forum. Let us know if that's the right notion. Let us know that's what you want to talk about. Is there something else? We want to know about it. So with that, I apologize. I kept you over just a couple of minutes. I'm going to turn it back over to Rose for last-minute announcements.

And, wow, I have to say this has been a great group. And thank you for attending. As you complete the session, please indicate the practice you are representing. And if you have multiple attendees, make sure that you contact your regional representative to get them credit. Thank you and we look forward to dis— this continued discussion in the February live session. Have a great day.