National: Medication Management

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Everyone, I'm Krystal Gomez from TMF Health Quality Institute. Welcome to our National CPC Webinar entitled CPC Milestone 2, Integrating Medication Management Services. I'd like to start off today's presentation with a few announcements. The slides for today's presentation will be available for download on the collaboration site. You can also download the slides directly from the WebEx environment today by using the top toolbar and selecting file, which will open a drop-down menu. Then select "save as" and then "document." Today's program is being recorded and will be posted on the Collaboration Site once transcripts have been completed. We appreciate the presenters' time and effort in preparing for and sharing their valuable knowledge. Any statements regarding their technology, products or vendors are expressions and opinions of the person speaking and not an opinion of, nor endorsement by, the Center for Medicare and Medicaid Innovations, nor TMF Health Quality Institute, nor the host of the program. As a reminder, all lines will remain muted throughout today's session. To submit questions, click on the Q and A tab on the right-hand side of your screen. I am delighted to introduce today's speakers. I would like to introduce our subject matter expert for today's presentation, Marie Smith. Marie Smith is a Palmer Professor and Assistant Dean for Practice and Public Policy Partnership at the University of Connecticut School of Pharmacy. In 2013, she was on faculty leave to work with CMMI, where she was on the CPC team and helped develop the Milestone 2 Medication Management Strategy. I am especially excited to announce that we will have two practices that will be sharing on today's Webinar. First, Angela Vinti, is a clinical pharmacist working at OHSU, Internal Medicine and Geriatrics. We also have Amy Stump, who is a clinical pharmacist from Associates in Family Medicine, PC. Now I'd like to hand over the presentation to Dr. Laura Sessums, who is a Decision Director for Advanced Primary Care at the Center for Medicare and Medicaid Innovation. Dr. Sessums.

Thank you Krystal. Hello again everybody. It's been a while, it feels like, since our last webinar, so I know many of you have been engaged in your regional learning sessions in the interim. And I'm very aware some of you all had some great sessions on medication management there in the region. But now that all of you have made your choice of an advanced primary care strategy under Milestone 2, I am pleased we'll be spending time today learning more about medication management. And the results are in from your Quarter 1 reporting. We had 78 practices choose Medication Management across the CPC. For all of you who chose Medication Management as your primary strategy and for those who didn't make this choice, but are considering the addition of a pharmacist and medication management capability to your practice, this webinar will review some wonderful opportunities to improve your patient's [inaudible]

and treatment outcomes, and at the same time, potentially reduce health care costs. In my own practice, I've seen many examples of the benefits of having an on-site pharmacist. One example is medication monitoring, such as with Coumadin, and I'm sure many of you have either experienced this or heard of the involvement of pharmacists with this kind of activity. Medication reconciliation, while that can be a fairly simple task that we do ourselves in the office, especially after care transitions, this can be really complex, given the change in clinical situation and perhaps multiple changes in medications and hospitalization or a nursing facility stay. Another really, really useful and important function for pharmacists is medication education and adherence. Say the patient is on a complicated regimen, such as CHF patients with episodic diuretic titration at home, or a diabetes patient titrating glucose meds, patients, especially those with limited English proficiency or perhaps low health literacy, and their care givers, who require additional time to review and understand the regimen, and perhaps need help making a medication list. Pharmacists can spend time with patients reviewing something, say how to use inhalers, how to take bisphosphonates, and the like. The sort of thing that's very difficult for providers to spend the necessary time doing. Two other aspects of having pharmacists in the practice, that I didn't think back when I first started down that journey some years ago, is physician advocation, one, and I found that pharmacists are often so comfortable with and have access to medication databases that I didn't have or wasn't familiar with, and the pharmacist could help with detailed evaluation of patient concerns about possible, but less common, medication side effects, help with sorting out medication interactions and the like, help with formulary questions, and then another one was assistance with prescribing quality improvements across the practice. Neither of those two things had I anticipated, but were terrific helps in improving the quality of care and patient safety. I'm sure each of you have thought some about how to start this work, or how to take the next step if you've already begun, and that will all be included in today's talk. I'm really pleased to have Marie Smith with us today. As you heard from Crystal, Marie is the national expert on the subject of medication management and primary care, and notably, was also the author last fall when she was with CPC of the survey of CPC practices, who had a pharmacist in the practice prior to Program Year 2014. She is going to provide you with some of the results of that survey, and obviously as a result of doing that survey, has a detailed understanding of what CPC practices have done with medication management prior to their choice of that under this option, under this year. So with that, I'll let Marie take it away.

Thank you Laura, very much, for that intro and welcome to everybody on today's call. As we heard, I'm going to spend a little bit of time talking about Milestone 2, the Care Management Strategy around integrating medication management services. And we are really very lucky today to have some pharmacists on the call with us. And so throughout the call, we're going to be asking them some questions as panelists as well, and I think they'll give you some good front-line responses to the topics we're talking about today. Just as a way of an overview, this is more of a slide that shows the Medication Management Milestone 2 goals, and the systematic approach to providing services, so it's here more as a place holder. I know most of you already know this. With regard to our time, we're going to talk a little bit in the beginning, I have a few background slides, and I'm going to go through rather quickly, around medication use and safety challenges we have today in primary care, care transitions and for readmission. Talk about team-based care models, which is part of the essence of CPC's program, and then there, as Dr. Sessums mentioned, we are going to talk about the key questions and focus most of

our time on the key questions that you'll see in your implementation guide and I'll weave into that discussion some of the results from the survey we did with pharmacists who were actively involved in CPC practices as of last fall. So we have two panelists, and Krystal, do you want to have —you have a few questions for our panelists, I think?

Yes, thank you Marie. So let's start off with Angela Vinti. Angela, can you tell us a little bit about you and your practice?

At OHSU Internal Medicine and Geriatrics Clinic, we are an academic facility. We have 68 providers, 24 of whom are faculty physicians, and 44 are resident learners, we have one nurse practitioner, five nurse care managers, a triage nurses, a host of medical assistance and administrative staff in the phone room. We have an active census of about 13,000 patients, meaning they've had one office visit within the last three years. I've been with the practice for about a year, and prior to that, the internal medicine clinic has had a pharmacist for about five years before that.

Thanks Angela. Now, how about you, Amy? Will you tell us a little bit about you and your practice?

Yes, thank you. So Associates in Family Medicine is a private practice family medicine office in Fort Collins, Colorado. So we're in northern Colorado, north of Denver. We have approximately 50 providers, and physicians, PAs, nurse practitioners, and about 70,000 patients that we care for in the area. We have clinics in three different cities across the front range here, and we have what, 8 clinical sites, where we have sort of small family medicine clinics. We have an urgent care, and we also run an employee health clinic for the local health system and school district. I've been here with Associates in Family Medicine for about, oh, 9 months-ish. And I'm the first pharmacist that they've had on staff.

10:11

Thank you. Now I'll turn it back over to Marie Smith.

Great, thank you. And you're going to hear from our panelists along the way. We have some questions that are interspersed, so they'll be coming back in to tell us a little bit about their practices some more. So this is just, again, a placeholder slide, a background slide, that I know most of you know. But if you're looking for some reference material, I thought this might be a good way to consolidate and talk about the places where you might go to find some information about some justification for adding a pharmacist, maybe looking at your own medication management practices in your work flow and practices in your settings. But it just shows that we actually have a lot of data that has been accumulated and reported out now about medication use and safety challenges in primary care and care transitions in readmissions. Both in terms of quality improvement opportunities, and also cost savings opportunities. This slide is actually a bill slide. So what you see here is a, what we tried to do in some of the work we've done in Connecticut, in our work in primary care settings, is to map primary care medication related problems to the medication use cycle. So the traffic you see now is really the starting at the top with prescribing, prescription processing, medication use by the patient at home, meaning what they really are doing at home, as opposed to maybe what was intended, or what you believe they may have understood, and then the cycle continues for medication monitoring outcomes, and then it becomes an iterative process. But it starts with the patient prescriber, interaction in the middle. So it's a

patient-centered model. Our work has shown that we actually map medication related problems in a study that we published in Health Affairs in April of 2011. We mapped, actually, what we were seeing for primary care medication related problems that were what we call upstream factors, and three quarters of the problems we were seeing in primary care related to prescribing practices or processes as well as medication monitoring and outcomes. The upstream factors are really important to us, because we believe that those are practices where the clinical teams and the approach that CPC is taking toward medication management really can address these head-on. So it has high impact value. The more upstream the problem can be addressed, the greater impact it's going to have for both quality and for cost savings. The other side of the cycle, we see what we call downstream factors. So these relate to patient behavior, health literacy, medication adherence issues, very important. I'm not trying to promote that one set of factors is more important or less important than the other, but it's important to designate them the way that we've done here in the graphic, as upstream and downstream. And the reason for that is because the gaps in safe and effective medication use, we find, are due to both clinician influence factors, those that are in the upstream category, relate more to clinician influence factors, and things that we can change in, as clinicians working with patients and families, and as well as the downstream factors. So it's both patient influence factors and clinician factors. And the other thing I've tried to use this slide a little bit to show you where some of the CPC milestones map out to, and there may be more reach for this, but today we're going to really focus more on those aspects that relate to Milestone 2, which is the care management for high-risk patients, even though CPC Milestones you see, 5, 6, 4 and 7, also relate to medication management issues. I wanted to also just before we get into our key questions, just give you another couple of references for dynamic clinical teams. As you know, the medication management milestone really promotes a team-based approach, and so there are two articles that I like to use when I'm speaking or in my teaching, and that is the Annals of Internal Medicine article that you see there, the position paper that they wrote in October of 2013, talks about dynamic teams. And I think it's important to note what they call the dynamic team, it's a team that really assembles around the needs of the patient, it's very specific to the patient's clinical needs and circumstances, and it's an inter-disciplinary team that you see has a whole host of health care professionals listed there. But what is unique about this is that this team comes together with training and skills that are needed to provide high quality and coordinated care services that are very focused on the patient's needs. The second article I like to reference is one that really is now ten years old, hard to believe that, but it's ten years old. It's from Kevin Grumbach and Tom Bodenheimer, who many of you I'm sure know, from the University of California, San Francisco, have done a lot of work in team-based care. And they talk about teams really do have complementary skills, and the skills of the team members should be very complementary to those of the physician, to address both quality improvement and productivity, as well as work flow processes. Just another background slide. I've had questions along the way, when I was at CMI, and then more recently talking about, you know, what really is the background training and expertise for pharmacists today? So I've included that there, again, for your background. I think it's important just to take away from this slide the message of the fact that a pharmacist's competency are very synergistic, with those of other health care professionals. On the right-hand side you can see the expertise areas. There's a lot of breadth and depth in the pharmacology sciences, pharmacotherapy, pharmacokinetics, and you can see the list there. But that's a curriculum that I believe is somewhat unique to pharmacists in terms of their depth and breadth throughout the year,

both didactically and in their clinical practice. This is a slide that I want to talk a little bit about. The value of what we're starting to see reported now, more and more, to the value of medication management services. And the example I've pulled here is really from Community Care of North Carolina. And two examples here, both of these examples have pharmacists involved as members of their inter-disciplinary care teams. The pharmacist does provide medication management services, focused primarily on high-risk, complex patient populations. The top bar, with the little info-graphic is really meant to just show you that they are now seeing a fairly strong directional trend that says when you have pharmacists involved in team-based care, they're seeing decreased patient admissions, preventable admissions, and also decreased emergency department visits. In the graph on the left, the line graph with blue and red lines there, is really —comes from their article that they published last summer, in Health Affairs, that looked at transitional care versus usual care, for high-risk patients, and the transitional care group did have very much an integrated model of pharmacists involved for medication management, and I commend you to go to that article for a lot more detail on how they did their care transition program. But the key message there was that the group of patients that were receiving transitional care and interdisciplinary team approach, were 20 percent less likely to experience a readmission during the subsequent year. So many times I'll get the question from people who have not worked with pharmacists in the past, and don't really have a knowledge of a lot of the literature in the best practices around medication management. The question is very simple. What is it? And what is involved in it? So I'd like to think of this, this graphic to help us think through the processes. And as you heard earlier, medication reconciliation is really one step. It, many times, is the beginning point of the step in medication management, but it's necessary, but not sufficient to really get to the complexities that we're talking about, that you're going to see, and that you're working with in your patient populations in the CPC program. So Med Rec is really the process we think of to identify discrepancies between medication list and everything from the medical record to what the patient reports to what they might bring in, if they bring in, and you are asking them to bring in a box or bag or whatever, of all their meds. Some of you may have access to pharmacy prescription filling histories, and then you'll also see on care transitions discharge summaries. And as you know, from a practical standpoint, every day, you hardly see these lists always identically matching 100 percent. So we want to first identify the discrepancies for the purpose of building and updating this complete, accurate, active, patient med list. Once we have that list built, or at least we think we've got a good handle on it, then the next step is really to optimize those medications. And this is a very systematic process that pharmacists are trained to do. They will assess each medication for its appropriateness, efficacy, safety and adherence. And we actually do that in that order. And you might say, "Well why?" The reason being is, I know there's a lot of focus today on adherence, and that's a really critical area we need to address, but philosophically, we look at really focusing on appropriateness, efficacy and safety first, because there's no sense in really making a patient, in developing a nice plan for them to be adherent to a med, if it really isn't the most appropriate drug for them or maybe the dosage is not as efficacious as it needs to be, or if they've had some kind of an adverse event or interaction. Then we really don't want to promote just adherence alone.

21:01

You'll see there in the rest of the bullets in that green box, some of the things that we look for in terms of detecting drug therapy problems, or looking to develop a medication action plan for the patient,

especially care transition. This is an important thing to look at, what medications do they remain on, which ones are new and have been added to their regimen, maybe there has been a change in dosing, or maybe they've even had discontinued medications. And many times, patients aren't really aware or thinking that what they heard at a visit or on discharge was to really stop a drug, and especially if they have remaining refills on a chronic —meds used for a chronic disease. They may still go and get those refills. They may have them sent to them or delivered to them maybe in their plan, and it's really important to reinforce if they're discontinued medications, make sure the patient really understands that. And then the last step in that optimization process is that any of those recommendations and changes that have any actionable recommendations are circulated and communicated to the primary care physician and any other prescriber that is involved in that patient's care. Medication coordination would be the next step, and again, this is really critical, as many of you know, at times of care transition or if someone really is being —a patient is being seen and has prescriptions written by multiple prescribers, they may be going to, you know, getting home health service or hospice service or dialysis services as well, and so there can be multiple ways that their medication regimens can change on a very quick basis, between —you know, before they come back maybe to their primary care visit, and that needs to be coordinated very closely. The other point under there, in the second bullet, is that many of you know, and if you're working with patients in a primary care environment, that today it's the exception that somebody uses just one pharmacy. Many patients will have multiple pharmacies, and it's hard to get a handle on where all their meds are being filled, even if you want to go, you know, and check with a pharmacist about what they currently are receiving. And the last step there is really critically important, and that is the monitoring step. And we sometimes, you know, in the plan we really focus more on the meds and the optimization of them, the coordination of them, but we really should also, at the time of prescribing, and certainly in making any changes in the regimen, make sure that there is a monitoring plan, if there are lab tests involved that they've been done and properly reported, and monitoring the patient as well for any symptoms or side effects or adjustments that they may have made at home, that need to be communicated back to the prescriber. So now we're getting to our key questions. So we've finished the background. We're going to go into the key questions. The first question really deals with what is comprehensive medication management, beyond medication reconciliation? So that last slide really gave you kind of the big picture of it. But I wanted to intersperse here the results that we were seeing from the pharmacists who were involved in about 19 practices in the fall of last year. I was able, when I was at CMI, to survey pharmacists in 19 practices. And this is the range of activities that you'll see here. So everything from managing chronic meds to educating patients, resolving drug therapy problems that were found, improving QI programs, improving med safety, achieving milestones is part of what they were doing. I think we heard earlier the importance of a pharmacist working in the practice to educate clinicians and staff members. There's a prevention role for helping to work with other professionals and the patients and maybe families, caregivers as well, about preventing drug therapy problems. So knowledge, especially with new prescriptions or changed prescriptions. And you can see the rest that are there. I also asked them to not only just tell me what they were doing, but of that list of 12 activities, to provide some idea from the pharmacist's viewpoint of where they thought the highest value was. And so you see them there, high being managing meds and educating patients, resolving problems to the lowest around controlling cost and care coordination. I don't think that's an indicator of the fact that those lower ones aren't important, but maybe I think they

just didn't do them as much. The only thing that I will say surprised me personally, based on my experiences, I think there's greater opportunities for managing meds at care transitions, and we'll talk about that a little bit later. Key question 2 really focused on how do you engage a pharmacist as part of your care team, and how do you go about doing it, in terms of what kind of an arrangement do you have with the pharmacist? So the survey, again, gives us a little indication of how people are doing it today. Most of the pharmacists who were involved in the practices and CPC practices were trained with advanced degrees, the PharmD degree, by the way, is the entry level degree today in our profession. They also had pharmacy residencies, or had some sort of specialty board certifications or some advanced certifications. So very highly trained in the clinical aspects of health care. And most of them had been practicing, if not in the CPC, had been practicing direct patient care in ambulatory settings for four plus years. In terms of, you know, the question of who employs these pharmacists, and how do you create the arrangements to have them work with your practices? You can see there's a real mixture there, so I think the message here is there's not one model that works across the board. Really you have to look at what your resources are in your own area, but you can see that a little over a third of them were actually employed by a school or college of pharmacy. Some had mixed employment in that they were partially employed or paid by the CPC practice, a pharmacy school, and even some hospitals or health systems, where part of that employment structure, and then about a fifth of them were employed solely by the CPC practice. Another question that we asked was how much time do you spend in a practice? And so about two-thirds of the pharmacists work between a quarter and a half FTE, some of them worked at multiple practices. I think there were two or three people I can think of who actually rotated around. They have a full-time job, but their job was really to work with three practices in a close geography. So they would rotate across practices. I think the main thing to think about is if you are using some type of a shared resource model, or have pharmacists who are in a group that is rotating through practices, it's really important for both the clinicians in the practice, as well as the patients in the practice, to maintain as much continuity as you can with the same pharmacist at the one location or practice site. Something to think about if you're looking to engage a pharmacist in your practice for the purpose of medication management. Here are some things to think about, in terms of qualifications, these would be everything from things you would do as you engaged any new clinician in your practice. This would apply directly to the pharmacist as well, so making sure they're licensed in your state, looking at what their background and experience is, how much of a direct patient care role they've had, how much of an inter-disciplinary, team-based experience they've had. In terms of where to find pharmacists, that seems to be a common question I hear today, this list is in no way meant to be rank ordered, but many times a school of pharmacy, a college of pharmacy in your state, the faculty there are really good resources. If they, themselves, can't be involved, and as you heard, we have some of our panelists today are involved in a faculty-based practice setting, if you, if they themselves aren't able to participate, they usually have a pretty good handle on where pharmacists are who have the right background, training. They keep in touch with former graduates, who might be looking to come back to a region or to change positions in a region. They also will know a lot about ambulatory care pharmacy residency programs in their state, and that's a good resource for finding pharmacists who might be interested in some of these positions as they become available.

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Hospital pharmacists are being utilized as well, and I know in some states the quality improvement organizations may have pharmacists on staff or, again, can be a good resource to keep you informed of where you might look for pharmacists. In terms of business arrangements, there are multiple models. Everything from like we heard, employed, contracted, a consulting basis, a shared resource base, I think it's important to note, I want —because I know there's been some comments and some questions I've received about, well, what about a model that includes pharmacy students? And pharmacy students can be really great; however, they need to be supervised. They are not licensed, they require supervision of a pharmacist, a faculty member, a preceptor, and so that's really important. They, alone, really should not be providing the kind of services we're talking about. They just really aren't trained, and aren't licensed, to be honest, to do that. In terms of fees, I put some ranges in there, if you're looking to do any contractual arrangements, that might be a good estimate for a benchmark you might be able to use. So peak question 3, how does the pharmacist on your team engage in patient care? So how are the patients coming to the pharmacist? You see these are responses, by the way, on these questions. Really the ones that are listed in your web application in the implementation guide. So if we look at how some pharmacists that responded to our survey, you see that a very high percentage of them, 93 percent, get referrals directly from CPC team members for patients that they believe have some complex needs that a pharmacist could help with. There are collaborative drug therapy agreements that are in place in 86 percent of the people —pharmacists, who responded. They involve e-consults, so this was a situation where the patient does not necessarily need to be present, but the pharmacist has access to the patient's electronic medical record, and they're referred by a clinician within CPC with a question that's very patient-specific. And there are times when actually patients are in the office, in the CPC practice, where clinicians may actually bring a pharmacist in or hand out the patient who can benefit from having a pharmacist work with the patient on medication management issues after the clinician visit has been completed. Either way, it's really the most critical thing here is to work it out in your work flow. It may not always look the same in your practice. I think as clinicians in a practice get more comfortable with having a pharmacist involved in their patient care processes. You'll see some of these models may actually involve more collaborative drug therapy agreements and that sort of thing. Regardless of what the process is, it's important that the pharmacist does have read/write access to the patient's chart, which I think in most cases in CPC is not going to be an issue. They need to look at and access it from background information as well as communication of any of their actionable recommendations to clinicians on the team. In terms of work flow analysis, think of the situations where pharmacists bring their unique skillsets and knowledge in therapeutics, pharmacoeconomics, they have a really good understanding and deep understanding of pharmacy systems and how the medication process works, but ultimately, they really are there to do two things. They should be saving clinician time within the practice, in terms of productivity and efficiency, as well as improving the outcomes that we see from the —for patients and families as well. Here are some ways I think of it in terms of looking for ways that you might want to kind of evaluate where to start. Look at your practice processes, they have listed some there. Clinician roles, and again, I think care transitions really create a great opportunity for inter-disciplinary care with regard to medication use and medication safety issues, and monitoring between any follow-up between visits. So now the panel of questions time. Maybe our panelists, Angela or Amy, can you talk about, in your own experiences in your practices about medication reviews? Are they retrospective or are they concurrent?

This is Angela. Actually they're both, and with respect to retrospective reviews, it's usually based off of a trigger. Either a referral, or a consult question, which is, you know, chart review, but there's no patient contact required, and then the medication reviews can also be concurrent, just like your previous slide has said, Marie, when the physicians pull you into a visit for a patient who is there at the point of care. Or thinking prospectively about how to help manage the patient's medications moving forward.

This is Amy, and I agree. The one thing that I also do is with the retrospective review, we have a lot of managed care contracts, and so we get these hot spotter lists, and lists of high-risk medications, and I work those. And so those are sort of retrospective because it's been triggered by, you know, the contracts that we have.

Great. Thank you. So we'll move on to question 4, and the fourth question is how are patients selected for medication management services beyond routine med reconciliation? And in terms of surveys, we heard, I think it was Angela, who talked about progress and triggers, so you see here, the survey that we had for the CPC practices really indicated a lot of different ways that pharmacists will get patients targets and triggers, everything from patients who have been identified as having complex med regimens, to adherence challenges, high-risk meds, lists of meds like with an elderly population, the Beers List. So many of you probably know about Beers List. So it's a patient's —I have some high-risk meds, warfarin, I think was mentioned earlier. If there's the presence of any adverse events or suspected adverse events or side effects, that might be another trigger. Patients who have cost considerations that may be affecting their adherence would be another mechanism, multiple meds from multiple prescribers, probably fits in, again, with the complex med regimens. Care transitions, we're going to talk about those in a separate question. And high-use, high-utilizers, so the hot-spotters, as I think it was Amy that mentioned would be another mechanism to identify patients. So panelists, Amy and Angela, you mentioned this a little bit, but anything else you'd like to comment on with regard to the process you see being most effective for referring patients to you in your practice?

This is Amy, and one thing I think is starting to work really well for us is our chair coordinators and our RN navigators, who are working with our highest risk populations, and they and I have been working together to help identify the patients that might need me the most, and so I'm starting to get a lot of referrals, not just from our providers, but actually from our navigators and our care coordinators. So I'm getting in touch with patients earlier in some instances than I maybe would be if I waited for them to see their physician.

Great.

And this is Angela, I would just comment that here in internal medicine, when I first started with the practice, they had been without their pharmacist for a year, and there was some thought that, you know, maybe a formal referral process within the EHR wasn't necessarily the, would create barriers to people accessing my services. So a lot of physicians can refer patients to me any number of ways. Either coming to find me in my office or wherever I am in the clinic, paging me, utilizing three different ways in the electronic health record, so I'm taking it from many different ways. And the hope is probably to formalize that process. Because there are, there are patients who truly do need a formal referral,

meaning an office visit or a phone visit with the pharmacist. But there are a lot of consults that come our way too, so it's kind of important to tease those out, and understand the expectations from the provider as to what they mean by referral.

Okay thanks, that gives us some good practical advice. This is just a summary slide here, for high-risk patient targets and triggers. So something to think about, that you might want to talk with the clinicians in your practices. Do you have a population of patients who really are on medications for a chronic condition and haven't achieved a therapeutic goal? Would that be a group that you would want to have a pharmacist involved with? We talked about high-risk medications for adverse events. You see a number of them there. Patients who have multiple care transitions within a six- or twelve-month period. And when I speak about care transitions, I'm thinking about really two types. One is the one we probably think about most often, and that is the patient who moves between let's say home and emergency room or urgent care clinic, or hospital, and home, or hospital and post-acute care for rehab, maybe long-term care, or home care. So we think of it as a setting change. Many times there are meds that are adjusted or changed or discontinued with a setting change, a care setting change, but I also, more recently, have become more aware of what I'm going to call changes around provider change. So gaps in PCP visits, maybe the patient has changed practices, maybe the provider has left the practice, or joined the practice, and it's really not so much a care setting change, but a provider change, that really can also give us a time when it might be really important to kind of do a timeout and make sure we have the most complete, active med list and what the patient's really understanding and doing at home.

40:44

And then complex med regimens are another one. So a little box there, it says think about these as factors in your risk verification approaches, don't use sole criteria for just the number of meds or the cost of meds. I know we've seen here in our own work with patients that if that list is generated, let's say by a health plan, for example, they tend to give you a list based on number of meds, or maybe cost of meds, with some threshold that they're using to generate a list of what they consider high risk patients. And we've seen patients who really needed the services and needed medication management services who were on two generic medications that had a severe adverse drug event, they weren't high cost, they only had two meds, but it was a good indicator of a patient who really did need some additional help and we were able to do that and prevent multiple cycling through the ED and hospitalizations for the adverse drug event that kept recurring. Question 5 is does your practice provide collaborative drug therapy management, and if so, for what conditions? This map of the US comes from, and I'm going to skip to the next slide because there's a reference there, it comes from this document that is boxed in blue at the bottom of the slide, so Centers for Disease Control and Prevention, they produced a really great document at the end of 2012, called Program Guide for Public Health Partnering with Pharmacists in Prevention and Control of Diseases. And it does a really nice job of identifying the states that have some type of collaborative drug therapy agreements in their scope of practice for pharmacists. So there are about 47 states where it is allowed. However, they vary very much, so you really need to make sure you understand what the agreements are and the level of practice that allows for collaborative practice in the state that you are in. It does —a collaborative drug therapy management agreement —does delegate authority from the physician to the pharmacist under very

prescribed circumstances. It talks about the functions, the procedures, any decision-making criteria that needs to be in place, but it can vary from prescribing in some states too, for certain classes of drugs or types of drugs, to responsibility for assessment, for ordering lab tests, or even administering medications. So it's important to know what really is happening in your state. So questions for our panelists again, we haven't talked much about billing, but can either of you share anything about the question around current billing requirements for services, and if so, how it's done, and if you are not doing it, if there's any discussion for billing in the future? Because I think sometimes the fact that pharmacists aren't recognized by some payers that have a mechanism to bill, sometimes can preclude practices from wanting to engage them. So can you —either of you, comment on that?

This is Angela. And I would completely agree with your last statement, Marie, about different payers not necessarily recognizing pharmacist services as being payable. So because we want to treat all patients across the practice fairly, we currently bill for my services, if we have a visit with the patient, as a 99211 CPT code. And the thought is, in the future, as health care changes, to hopefully progress to using pharmacist-specific CPT codes.

Okay great. And Amy do you have any comments?

Yes, so we're billing using the incident 2 physician referral method, and the information that was recently published, the letter that went from CMS to the American [inaudible] physician is kind of what has helped us to be able to strengthen that position, and so that's been really helpful. And then we also have some local health plans that are interested in paying for pharmacist services, so we're going to start some talks with them about possibly doing some contractual agreements to be able to pay for my services to take care of their members that are already part of our practice.

Great. And you know, you brought up a really good point, Amy, I did not go in and update my slides, but your comment is really well taken. It was just what, within the last two weeks? That there was a letter, a clarification letter, that AAFP, American Association, or Academy, I guess, of Family Physicians, asked CMS to give some clarification around billing using an incident 2 method, and so it sounds like that's been helpful for you then, Amy, to get a better understanding of that. And my understanding, from what I've seen —I've just seen the letter —is that the guidance was that it can be done as a billing, as an incident 2, using 99211. Is that what you're doing?

Our compliance is still kind of reviewing it, but they feel that it may have blessed us to bill at higher levels, and they're still looking into that.

Great. So I think that's a good point. But if you can ref —anyone can go in and just Google the AAFP letter, with CMS, to clarify pharmacist billing, you should be able to see the letter, and that may generate some internal discussions, as Amy pointed out. Question 6 is does your practice target care transitions for comprehensive med services, and what are these triggers? So this is really one I mentioned a little bit about this already, but you know, first thing is to look at, you know, what are your capabilities to monitor for multiple care transitions within a six-month or twelve-month, whatever time frame you think is critical for being that trigger, and then looking at gaps, not only in care setting, but also with provider changes in your practices. And our last question, the key question is kind of a

question that probably leaves a lot to be still worked on here, but it talks about process measures that can be used in the practice to improve medication effective and safety. I can tell you that I serve on a national pharmacy quality alliance, with a number of multi-disciplinary stakeholders in our work groups, and we are working very much on what are some measures that can be used and validated without getting too crazy and doing a lot in the way of creating more measure for burden purposes, but some meaningful measures. Measures around the gaps in care. And so these are some of the direction, I would say they're directional measures here, is to look at for patient clinical outcomes, one of the great measures you can look at is what percent of your patients are on chronic meds, for whatever conditions you want to focus on, who are at goal, and then which ones are not at goal? And then maybe working with those that aren't at goal becomes a good process measure that you can use in your practice to target patients as well. Improving practice efficiencies. Sometimes people will look at the use of pre-visit comprehensive med reviews for new Medicare patients, as an indicator, maybe a process measure, but an indicator of maybe who needs some work on just preparing for those visits and whether they're new patients, or existing patients, wellness, annual wellness visits, that kind of thing. There are several quality metrics, I know that we all know about, including the CPC metrics, the HEDIS, the Meaningful Use, the ACOs, or other quality measures you've got from other plans you work with. Financial impact, I think more people who have pharmacists involved in their teams are really looking at total cost of care around the impact on drugs, and utilization of medical services, and hospitals, and those sorts of things. We're all trying to optimize performance incentives related to medication use and safety. And then the last, these are process measures that pharmacists tend to use a little bit, maybe more than a primary care team, but you might want to think about, depending on what your pharmacists are using to document their metrics, and what their services are, to look at, you know, something around these four areas. You know, a simple one would be the number of active medication or, I'm sorry, collaborative drug therapy management agreements you have in place. Do you have any? Do you want to expand in that area? And you can just monitor what are those agreements over time. Is the pharmacist involved in developing and delivering medication action plans to patients and families? What kind of recommendations and how many recommendations over a period of time are they making to care team members? And ultimately, if you've got medication related problems that are being identified, what percentage of them are being resolved?

50:07

And how is the pharmacist interaction in that team helping to resolve in an efficient and timely manner any kind of problems, medication-related problems, that are identified? So questions, we have a couple closing questions here. For the panelists. How do you see medication management role in your practice growing in the future?

This is Amy. And one thing that I am really excited about is more strongly ruling out my collaborative drug therapy management agreement, and part of that will be rolling out a new anticoagulation clinic across all of our clinics, using some of our RNs, and then also for me to see more patients by referral for the CDTM with our diabetes management program.

Great, and Angela?

Similar to Amy, I have a couple of CDTMs in place right now, and more to come, so that's very exciting. Formalizing the referral process is going to be very helpful, so we're going to pilot that in a small work group within the clinic. I think for myself, being here for just a year, and being more reactive to physician's needs, I'm hoping in the future to be more prospective, and thoughtful, about identifying high-risk patients, similar to the way our nurse care managers have identified those who would benefit from having the pharmacist be the care manager, be in that primary care management role for the patient. As well as champion like quality improvement, prescribing habits for the docs, and the identifying clinic work flows here, that involve medications and need improvement, such as clinic stock and not wasting medications, as well as identifying protocols for in-clinic administration of meds and high risk situations.

Great, thank you. So we are running short on time, so I'm going to hand the microphone over to Krystal.

Hello everyone, we've had a few questions that have been submitted through the chat function. If anyone has any additional questions, please submit those through the Q and A tab. I believe we have time for one question, and any of the questions that are not addressed today will create a FAQ document and load it to the collaboration site. So one of the questions that we have, can you give examples of hospital pharmacists doing this work before patients are discharged? It seems like the pharmacist should be part of a medical neighborhood and collaborating with PCP and specialist teams.

So this is Marie, that certainly is happening today. It probably depends on your setting and location, but yes, pharmacists are, in some hospitals and health systems, actively involved in interdisciplinary teams, where they are spending the time from the time that the patient is admitted to the hospital, they're actually working very closely in a team environment to when the patient, as an inpatient, working with them on identifying medications and working with the team, they also will be instructive for the patient when they are discharged. Some of them are using models where you have a hand-off between the hospital pharmacist and the community pharmacist. So there are some good models. I would say that one place to look for the literature in terms of current practices would be, there are articles within the American Journal of Health System Pharmacists, and that seems to be where most of that work that's done is being published today.

This is Amy, and I would say, you know, I'm not working in a hospital setting per se, but I help with the medical neighborhood with my patients almost every day. I can think of many examples of where a patient may come in to see me, and they've recently been to nephrology or to GI or any other sub-specialists, and I might be the first one in our primary care office to learn about the changes, and get the med list right, or find out that something was stopped, and now we're worried about, you know, care of a primary care disease state that we're managing, and that there's just been some communication gaps. And so I think we all help with that as much as we can, because often times we find out about those things through our work as well.

And this is Angela. We do have, here at OHSU, which is the academic medical center for the state, located in Portland. I'm sorry if I didn't mention that earlier. We do have a care transition program, and the inpatient pharmacy side is very active in that role for, especially medication reconciliation, and

education for new medications, when the patients are discharged from the hospital. And I do have hand-off with that pharmacist on the inpatient side, to help transition the patients who reside with us as their primary care home for that transitional care.

Thank you. So quickly, we have three minutes, but we have one more question that I feel really needs to be addressed today. In clinic practice, do you see medication reconciliation being localized to a single person, or is it done by multiple parties who may touch the patient in the clinic setting?

This is Marie. I think that this is a good discussion to have in your practices, to have all the people who touch the patient for med rec purposes sit down and talk about what they each do, to look at more efficient work flows. I can tell you in our survey, this was a question that I didn't put up there, but it was one that I can tell you from the 19 practices we surveyed, there are multiple people who are doing this from the MA to nurses, to a pharmacist, to physicians, to nurse practitioners, so everyone is doing it. And I think first it should point out just a kind of a flag to say who is doing that? Talk to each other, find out what the efficient work flow is, and then decide what's going to work best in your own practices.

Thanks Marie.

I'm sorry Krystal.

Go ahead.

So here at OHSU, there has been an institution-wide initiative as to medication reconciliation and what each individual's role is in the process, from MA, to physician, to pharmacist, to nurse. And that has been really helpful in clarifying and from a pharmacist perspective, I can tell you that our MAs take a major role in identifying discrepancies in the patient's medication reconciliation process during rooming, and then if there are large discrepancies, where there are multiple discrepancies which requires some more teasing out, then they begin to involve me through a page or a consult.

Thank you. I believe that's all the questions, all the time for questions that we have today. I want to point everyone's attention to the screen just for a moment. There has been a change in the curriculum. The May 27th National Webinar is going to be on Milestone 6, Compact and Collaborative Agreements. And the June 10th National Webinar is now going to be on Self-Management Support with Virtual Site Visits. So there has been a slight change, and I wanted to point everyone's attention to that. Also I want to really thank everyone for attending today. I want to thank Marie Smith, our subject matter expert, as well as Angela and Amy, for representing the clinical pharmacists within CPC. We hope that you found this presentation informative. You can exit the session by clicking on the file menu option at the top left of your screen and select the option to leave the session. You will be taken to a post-webinar survey which needs to be completed in order to receive credit for this presentation. Thank you.

58:27