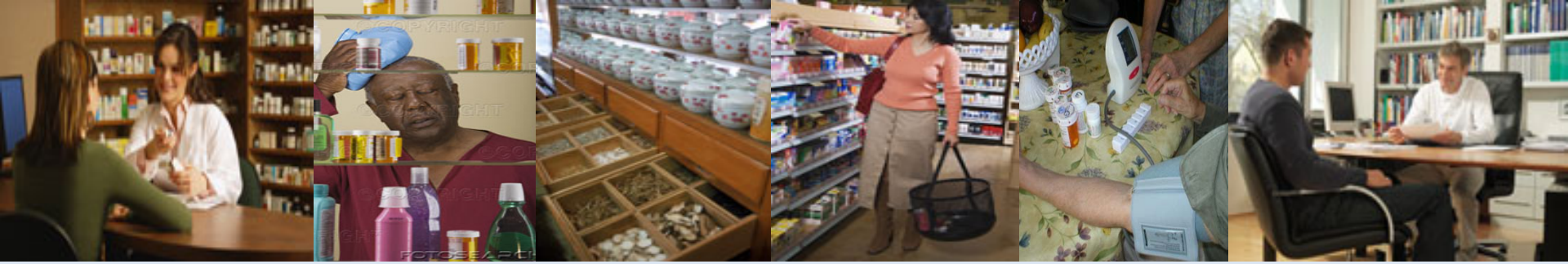

A Pharmacist Network for Integrated Medication Management in the Medical Home

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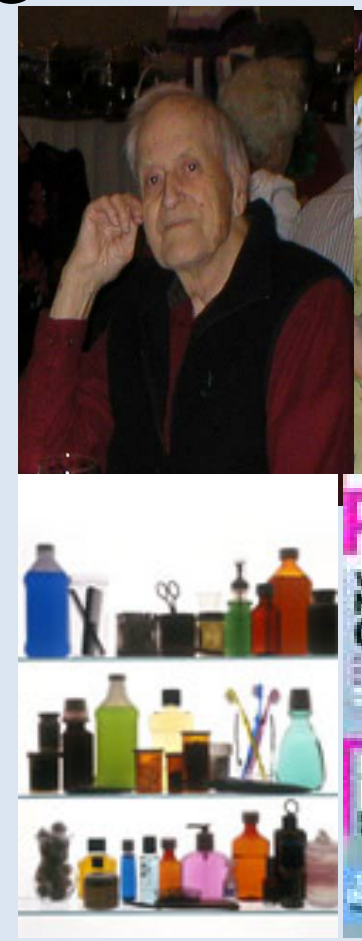
Third National Medical Home Summit

Philadelphia, PA March 14, 2011

Case Study for New Primary Care Model

- 90 yo WM, cardiac disease, post-CABG
- 7 chronic meds/day; adherent
- PCP + 5 specialists
  - Pharmacist-led anticoag clinic
- Multiple prescribers
- Motivated in self-management
- Care support system
  - spouse – "adherence coach"
  - 3 daughters – "care coordinator/navigators"
- Great access, insurance coverage



Has had multiple <u>preventable</u> medication misadventures /errors with care transitions, change in PCPs, specialist care – POOR CARE COORDINATION, HIGH COSTS

Primary Care Med Use and Safety Issues

- **Prescribing:** 71% of physician office visits recorded ≥1 prescription meds; 48% of US adults having 4+ prescriptions for chronic conditions
- **Medication discrepancies**: 24% prescription meds and 76% OTCs/herbals (reported as actual meds used at home) were not in EHRs; ~ 50% medication discrepancies due to discontinued meds
- **ADEs:** 175,000 visits/yr to US emergency depts for adverse drug events (ADEs) in the elderly; 32% adverse events leading to hospital admission attributed to medications
- **Care Transitions:** 49% patients had unexplained med discrepancies between home to hospital discharge; 29% patients had unexplained med discrepancies between hospital discharge and 30-days post discharge

Medication management is too critical and important to leave to any one person or profession…….primary care offers opportunities for interdisciplinary collaboration and teamwork for safe, evidence-based, cost-effective medication use

SOURCES: National Ambulatory Medical Care Survey: 2006 Summary. Natl Health Stat Report. 2008 Aug 6;(3):1-39. Health Affairs 28, no. 1 (2009): w1–w16; Intl J Med Informatics 2008:153–60; Ann Intern Med. 2007;147(11):755-765.; Arch Intern Med. 2006;166:565-571;JAMA. 2006;296:1858-1866.

Disparate, Fragmented Med Info Sources in Primary Care

EHR/Medical Charts
Primary Care, Specialists

Prescribing

Multiple Prescribers
Paper Prescriptions
E-Prescribing

PATIENT HEALTH RECORDS

PATIENT MED DISCUSSIONS

Medication Monitoring and Outcomes

MTM Services
Remote Monitoring
E-Consults w/ PCP

Rx Processing

Pharmacy Profiles
- Multiple Stores
- Mail Order

Rx Claims Paid
- Health Plan
- PBM

HEALTH INFO EXCHANGES

Patient Med Use at Home

Patient Self-Report
Caregiver/Family

Home Visits/Brown Bag Sessions
Webcam Med Reviews

HIE is a shared platform for centralized patient medication history , usage patterns, and outcomes that can be accessed by all health care professionals (and patients??)

Pharmacist Services in Primary Care

Collaborate with patients/families and providers to:

- ✓ Perform **comprehensive review of medication therapies**
- ✓ **Identify, resolve, monitor, and prevent** medication use and safety problems
- ✓ Optimize **polymedicine** regimens
- ✓ Recommend **cost-effective** therapies
- ✓ Design tailored **adherence and health literacy** programs
- ✓ Address **health disparities** - culturally and linguistically appropriate care
- ✓ Develop **medication action plans** for patients and caregivers
- ✓ Provide **medication recommendations** to all patient's providers
- ✓ Perform targeted medication assessments at **care transitions**

Enhance Access to Care

- ✓ Pharmacists can provide patient services in **multiple locations**
  - retail pharmacies, physician offices, outpatient clinics, home visits, worksite health centers, senior centers
  - pharmacist consults by tele-health connection

Medication Therapy Management (MTM)

Medication Therapy Management (MTM) is a "*systematic process of collecting patient-specific information, assessing medication therapies to* ***identify medication-related problems****, developing a* ***prioritized list of medication-related problems****, and creating a* ***plan to resolve*** *them."*

Pharmacists have the training and clinical expertise to ***detect, resolve, monitor, and prevent*** *medication discrepancies and medication-related problems across the continuum of care and at times of care transitions*

MTM is a component of:

- ✓ patient safety or risk management initiatives
- ✓ care quality improvement programs
- ✓ performance target or incentive programs
- ✓ cost optimization programs

True MTM is NOT:

- ✓ comparing 2 med lists for medication reconciliation purposes
- ✓ copying meds into a list to give to the patient
- ✓ outbound calls to see if patients have new meds or med problems
- ✓ adherence education, patient counseling, refill alerts and reminders

Pharmacist Patient Care - MTM Services

1 - Comprehensive review of a patient's current prescribed and self-care medications for actual usage and adherence patterns

TODAY, most primary care office med lists are INCOMPLETE or INACCURATE

- **Lack of skills in collecting comprehensive medication histories**
- **Poor documentation of medication info**
- **Poor patient recall or avoidance of truth on med use/non-adherence**
- **Cultural or health literacy challenges**
- **Discontinued medications not included**
- **Fragmented sources of medication info**

Missing Info…..OTCs, herbals, nutriceuticals, MD samples, indigent care meds, complex dose schedules, meds from other MDs/specialists, discontinued meds, adherence trends





Even with use of EHR and E-prescribing, most PC med lists are incomplete or inaccurate which diminishes the promise of improved medication safety and care quality

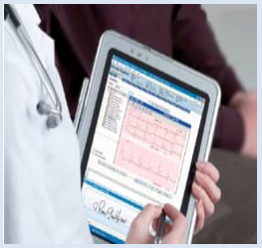
Pharmacist Patient Care - MTM Services

2 - Systematic assessment of each medication for appropriateness/indication, efficacy, safety, and adherence (in this sequence) to achieve optimal therapy goals

70-80% of medication-related problems in primary care

3 - Development of a personal medication care plan with patient self-management goals and medication management recommendations

4 - Documentation and communication of the care plan to the patient and all health-care providers for care coordination and follow-up between office visits



Incorporating Pharmacists in the PCMH

Workflow patterns that incorporate pharmacists in a direct patient-care role

- **Pre-visit planning**: meet with patient or reviews the patient medical chart and makes care plan recommendations that are shared with the primary care provider ***prior to*** the patient's primary care appointment
- **Coincident referral**: sometimes called a "warm handoff" as the pharmacist meets with the patient and makes care plan recommendations to the referring provider ***during or at the conclusion of*** a primary care appointment
- **Follow-up referral**: the provider refers the patient to the pharmacist for a separate, follow-up visit subsequent to the patient's primary care appointment; care plan recommendations are sent to the referring primary care provider ***between*** primary care appointments
- **Targeted consults:** the pharmacist initiates (or the provider requests) medication management services for selected patients
  - ✓ care transitions
  - ✓ lack of therapeutic goal achievement
  - ✓ high-risk medications for adverse events
  - ✓ complexity of medication regimens
  - ✓ multiple prescribers
  - ✓ poor patient adherence
  - ✓ presence of liver or renal dysfunction

Considerations for Pharmacist Integration in PCMH

Patient Selection (Who?)

Elderly patients, polymedicines, high-risk meds, high-cost therapies, complex regimens, lack of therapeutic goal achievement, health literacy and cultural issues, care transitions, frequency of med-related hospitalizations/ED visits, non-adherence

Locations (Where?)

Primary care offices, ambulatory clinics, worksites, home visits, senior centers, community pharmacies, tele-health, e-consults

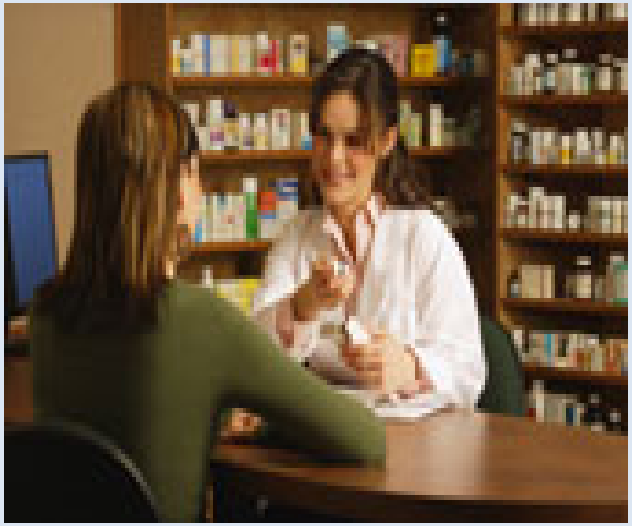
Integration Models (How?)

Employed model – pharmacist on PCMH staff
Embedded model – partnership between PCMH and pharmacy school clinical faculty
Referral/regional model – pharmacist serves PCMHs in geographic area
Contracted model – PCMHs/payers contract w/ network of credentialed pharmacists

Sustainable Payment Sources

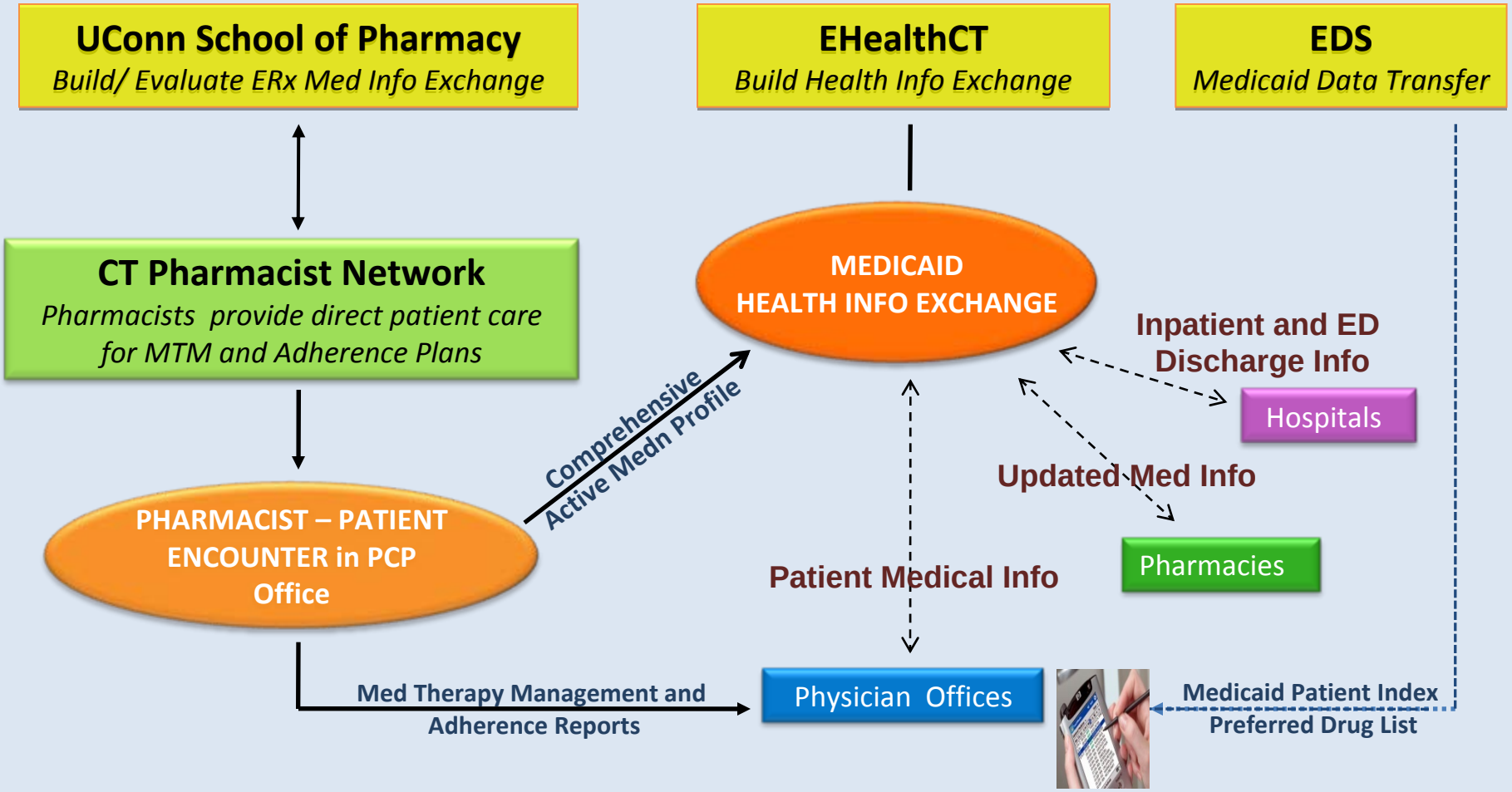
Fee-for-service (CPT codes for pharmacist MTM)
Global Payment/Care Coordination Payments
Performance Targets/Bonuses
Additional physician visits (w/complex medication patients seen by pharmacist)

CT DSS Medicaid Transformation Grant



CT DSS Medicaid Transformation Grant

Building a Medicaid HIE and ERx Med Info Exchange



PHARMACISTS NETWORK FOR EXCELLENCE

Subsidiary of CT Pharmacists Assn

NETWORK SERVICES

Negotiate Contracts

- Administrative and billing service
  - **Direct payments to Pharmacists**
- Coordinate network of pharmacists
  - **Competency/skill-based qualifications**
  - **Not dependent on pharmacists' workplace**
- Validate credentials of pharmacists involved
- Provide standardized pharmacist documentation tool
  - HIPAA compliant
  - Web-based , secure access
  - Standardized reports
- **Systematic approach to all services offered**

PHARMACIST MED'N THERAPY MANAGEMENT

- Pharmacist at Point-of-Care (Primary Care Office/Telemedicine)
- Perform Comprehensive Medication Review
  - Develop a Personal Medication Record
  - Assess Medication-Related Problems (MRPs)
  - Duplicate therapy/ Drug interactions
  - Adverse events and side effects
  - Adherence
- Develop Patient Medication Action Plan
- Document /Follow-up Plan
- Communicate with Primary Care Provider

CMS Medicaid Transformation MTM Project

- Demonstration project in 4 FQHCs, 20 providers
- Beneficiaries with 4+ chronic meds, >1 chronic disease, not disease specific
  - 3700 eligible beneficiaries, 88 enrollees, 401 encounters
- Initial and 5 monthly face-to-face patient-pharmacist visits between primary care provider appointments; avg=4.6 visits
- CT Pharmacist Network: specially-trained Pharmacists
  - met with Medicaid patients in PCP office
  - had full access to EHR
  - multiple medication data sources: pharmacy claims, EHR, patient visit to obtain actual med use at home
- Provide patient with comprehensive active med list + Medication Action Plan w/ self-management goals
- Communicate MTM recommendations to PCP via EHR

Key Findings: CT Medicaid Pharmacist MTM Project

1. **EHR and ERx adoption does not solve medication use/safety problems**
2. **Medication discrepancies** ~ **50%** related to discontinued medications
3. **Clinicians need actual patient medication use info not just admin claims or ERx data for clinical decision-making**
4. **CT Medicaid beneficiaries have complex medication regimens**
   - ✓ Medical conditions ~9-10, chronic medications ~ 15-16
   - ✓ Medication-related problems (MRPs)/ptnt: 10
     - **74% MRPs - medication appropriateness, effectiveness, safety (clinical decisions)**
     - **26% MRPs - patient adherence**
       - Needs additional medications (23%) – using evidence-based guidelines
       - Dose too low (16%)
       - Adverse drug event (16%)
       - Patient does not understand medication use instructions (11%) – esp. inhalers
5. **Took 4 pharmacist-patient visits to resolve 83% of identified MRPs**
6. **Medicaid Project – Success Drivers**
   - **Medical home model** – pharmacist seen as part of the health care team
   - Pharmacist **access to EHR** - complete medical info and lab data
   - Holistic patient MTM evaluation (**all comorbidities**, not disease specific)
   - **Intensity and frequency** of patient-pharmacist visits (initial, 5 monthly visits)
   - Pharmacist developed **Medication Action Plans** – promoted patient engagement
   - Pharmacist sent **MTM Reports** with recommendations to the patient's provider

Med Management in Primary Care

RESOLVING medication – related problems

- ~ 80% MRPs resolved in 4 monthly visits
- Pharmacists made ~ 60 recommendations to PCP for preventive treatment according to evidence-based guidelines
- ~ 75% MRPs were resolved in the patient-pharmacist encounters (did not require a PCP visit) with use of Medication Action Plans
- 28% improvement in achieving patient medication therapy goals between the first and last patient-pharmacist visits
- 83% PCPs made medication adjustment based on MTM reports

PATIENT ENGAGEMENT and TRUST

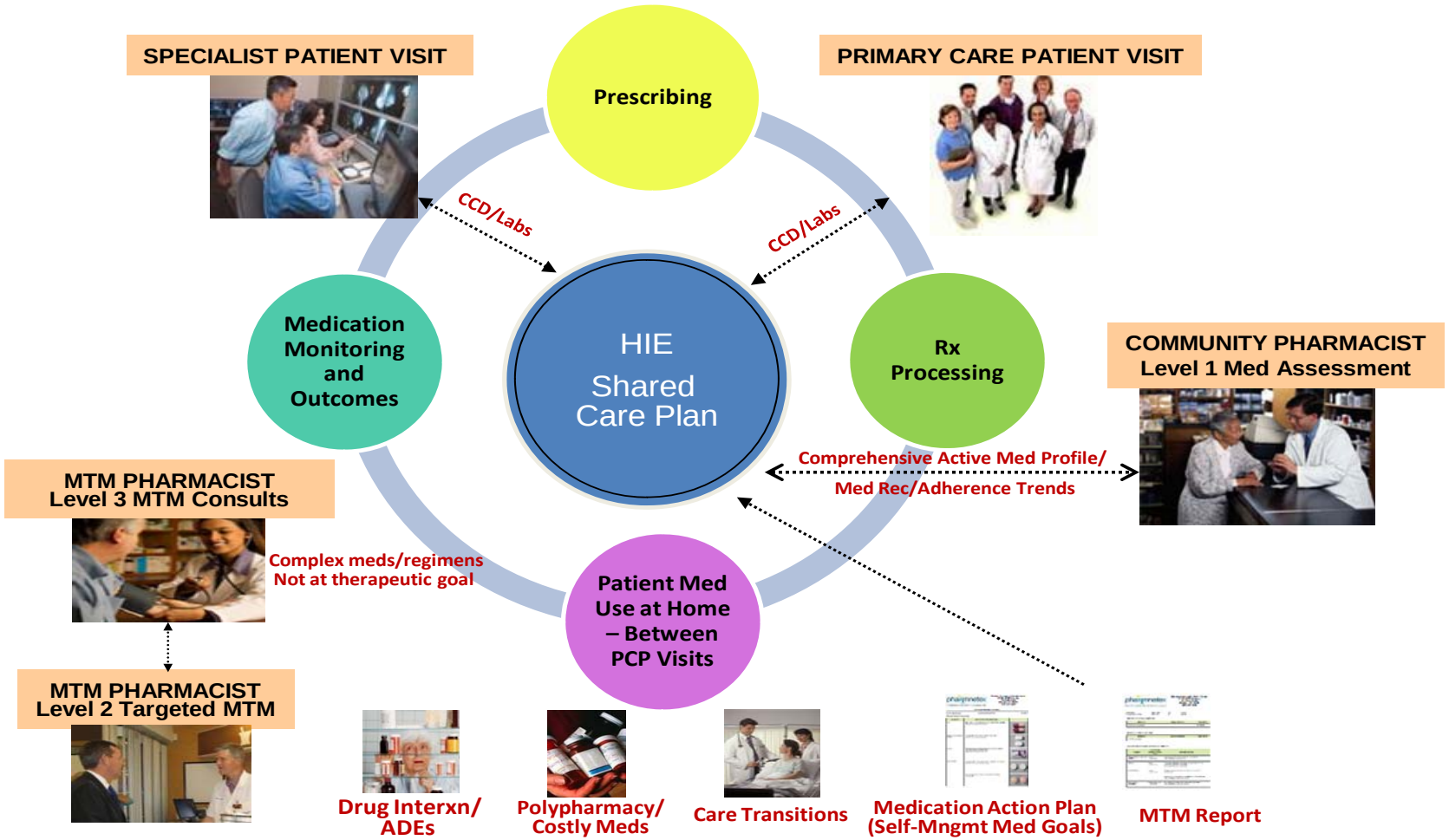
*"The most important part of meeting with my pharmacist was she **communicated with my doctor and then when we met we were all on the same page."***

*"These programs offer the patient the opportunity to **ask questions that are embarrassing** to ask the doctor."*

*"I get answers to questions that I could not get from a **busy pharmacist inside a store**."*

In a PCMH who should manage medication processes?
Required training/competencies?? MD productivity impact?

Medical Neighborhood Info Exchange Model



Resources

APhA/NACDS MTM Core Elements

http://www.pharmacist.com/AM/Template.cfm?Section=Home2&CONTENTID=15496&TEMPLATE=/CM/ContentDisplay.cfm

Patient-centered Primary Care Collaborative (Jul 2010)

Integrating Comprehensive Medication Management to Optimize Patient Outcomes: A Resource Guide

https://www.elbowspace.com/servlets/cfd?xr4=&formts=2010-06-30%2006:58:52.550887

Payment Reform to Support High-Performing Practice

https://www.elbowspace.com/servlets/cfd?xr4=&formts=2010-06-30%2006:47:34.445008

Pharmacists Role in Medical Home

Smith MA, Bates DW, Bodenheimer T, Cleary PD. Why Pharmacists Belong in the Medical Home. *Health Affairs* 29, no. 5 (2010): 906-913.

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