Transforming Patient Care
Paramount Issues and Opportunities in Pharmacy Practice

ARKANSAS ASSOCIATION OF HEALTH-SYSTEM PHARMACISTS
ANNUAL FALL SEMINAR – OCTOBER 2, 2014

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Disclosure Information

SPEAKER: Paul W. Abramowitz, Pharm.D., Sc.D. (Hon), FASHP
Chief Executive Officer, ASHP
TITLE: “Transforming Patient Care: Paramount Issues and Opportunities In Pharmacy Practice”
MEETING: Arkansas Association of Health-System Pharmacists
Annual Fall Seminar – October 2, 2014

I have no relevant financial relationships to disclose.

Objectives

Practice Model Change
New Methods of Care

- Discuss future pharmacy practice models and new methods of care delivery to improve outcomes of care
- Describe a focus on the full continuum of medication therapy and pharmacy-driven transitions of care to eliminate silos of care

Defining and Advancing Ambulatory Care Pharmacy Practice

- Discuss the need for pharmacists to be members of all ambulatory healthcare teams, and the role they play in improving care outcomes, providing primary care, and reducing healthcare costs
- Describe key factors and models for ambulatory care delivery and integration models
- Outline ASHP’s efforts to date to help advance ambulatory care practice through practice model change and education
Obtaining Provider Status for Pharmacists

- Yes, it is important
- Pharmacists Interdependent Prescribing
  - Optimizing Patient Outcomes
  - Discuss increasing pharmacist prescribing privileges to improve the delivery of healthcare

Objectives
- Describe the importance of and process for pharmacists to obtain provider status at the federal, state, and local levels
- Provide an update on the efforts of the Patient Access to Pharmacists' Care Coalition (PAPCC)
- Discuss ways in which members and affiliates can get involved to rally congressional support of H.R. 4190
- Discuss ways to enhance the public’s understanding of the vital role of the pharmacist in their care

Practice Model Change

New Methods of Care

What is a Practice Model?
- Defines important types and levels of patient care services
- Allows for:
  - Application of best practices
  - Standardization of care
  - Judgment of pharmacist and individual patient needs
Imperatives for Practice Model Change

- Medication use and its outcomes are far from optimal in the U.S.
- Admissions and readmissions to hospitals due to medication therapy are too high
- Provision of primary care and management of chronic disease is inadequate to meet needs
- Wellness and prevention do not receive adequate attention
- Estimated waste in the healthcare system each year = $765 BILLION
- Estimated cost of medication-related hospital admissions each year = $198 BILLION

Current Silos that Exist in the Pharmacy Practice Continuum

- Lack of effective transition-of-care mechanisms
- Less than optimal division of responsibilities

INTER- and INTRA- Professional Care

Principles for Practice Model Redesign

- Health care will become increasingly inter-professional, team-based
- Medication preparation, distribution, and dispensing should be more centralized and automated
- Vast majority of pharmacists’ time must be spent providing direct patient care in all settings
- Need for a well-trained technician workforce to provide more complex medication-use roles
- Increased definition & standardization of pharmacy direct care services offered for all patients is necessary
Every patient should receive a comprehensive pharmacotherapy plan.

Expect the public to insist on additional requirements for credentialing and privileging of pharmacists in general & specialty practices.

More and more pharmacists will be practicing in clinics.

Collaborative practice will evolve to include greater pharmacist responsibility for prescribing as part of coordinated health care teams in all settings.

Primary care and adherence must receive a much greater emphasis by pharmacists.

ASHP's vision is that medication use will be optimal, safe, and effective for all people all of the time.

IMPROVING HEALTH – OPTIMIZING OUTCOMES

"Expanded pharmacy practice models in collaboration with the physician or as part of a health team improve patient and health system outcomes and optimize primary care access and delivery."

-- Dr. Regina M. Benjamin, U.S. Surgeon General (Ret)
Defining and Advancing Ambulatory Care Pharmacy Practice

Early Pharmacy Ambulatory Clinic Practice

- **1960s – Indian Health Service**
  - Began refilling prescriptions, based on medical record information

- **1979 – Greifenhagen and Pearlman**
  - Created a system to screen ambulatory patients with:
    - Respiratory disorders
    - Dermatologic complaints
    - Hypertensive concerns
  - Established protocol where pharmacist:
    - Interviewed and examined patients
    - Ordered lab tests and developed treatment plan
    - Referred patient to physician for confirmation of pharmacist’s treatment plan

- **1981, 1982 – Helling**
  - Developed principles/constructs of family practice pharmacy services

- **1985 – Gray et. Al**
  - Researched benefits of pharmacist-managed anticoagulation clinics
  - Findings of clinics:
    - Therapeutic prothrombin times were effectively maintained
    - Reduced the incidence of hospitalization; 0.048 days per year in pharmacist group versus 3.22 days per year in physician group
    - Reduced hospitalization costs per year by $211,776.00 for 26 patients treated

- **1987 – Veterans Affairs (Cheung et. al)**
  - Developed a multi-institutional pharmacy system; including inpatient and ambulatory care practices

- **1989 – Koecheler et. Al**
  - Identified six prognostic indicators
  - Quickly identify ambulatory patients who may benefit from pharmacist monitoring
Ambulatory Clinic Practice of the Future

- **2014 and beyond** – Many more pharmacists will be working in ambulatory clinics:
  - Embedded in clinics and/or pharmacist-directed clinics
  - Criteria-based patient selection
  - Allocation of physician, pharmacist and nurse time

- Clinic Locations:
  - Hospital and health-system clinics
  - Patient-Centered Medical Homes (PCMH)
  - Community medical centers
  - Community pharmacies
  - Physician office practices

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**ASHP Ambulatory Care Summit and Conference**

- March 3-4, 2014 – Dallas, TX
- Consensus-building process
  - 40-member consensus panel
  - Domains
    - Defining ambulatory care pharmacy practice
    - Patient care delivery and integration
    - Sustainable business models
    - Outcomes evaluation
    - Iterative process with large group (>400) all participated
    - Followed by survey to all members

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**Outcomes**:

- 25 Visionary and forward-thinking recommendations
- High percentage of participant agreement
- Percentage of ASHP member agreement

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Major Recommendations:

- Defining Ambulatory Care Pharmacy Practice
  - Recommendation 1.5: Pharmacists who provide ambulatory care services should articulate and promote a standardized pharmacist patient care process

- Patient Care Delivery and Integration
  - Recommendation 2.2: Pharmacists who provide ambulatory care services must collaborate with patients, caregivers, and healthcare professionals to establish consistent and sustainable models for seamless transitions across the continuum of care

- Sustainable Business Models
  - Recommendation 3.4: Services provided by pharmacists who provide ambulatory care services should achieve a set of quality and cost measures, be supported by payment model(s), and be valued by demonstrated improvements in patient outcomes

- Outcomes Evaluation
  - Recommendation 4.6: At every level (community, state, national), pharmacists who provide ambulatory care services should participate in healthcare policy development related to improving individual and population health outcomes

ASHP’s Next Steps:

- Proceedings published - AJHP 8/15/14
- Mobilize the profession
- Create tools and resources to assist in implementation
- Advocacy efforts to achieve Summit recommendations
- Ambulatory Care Conference – 2015 Summer Meetings
What **YOU** Can Do at Your Hospital?

- Make the healthcare and business case
- Start with establishing transitions of care pharmacy services
- Identify clinics and patients where drugs are a major component of care of ambulatory care
- Pilot new clinic services
- Expand based on successes

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Obtaining Provider Status for Pharmacists

*Yes, It is Important*

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What is Provider Status?

- Being listed in section 1842 or 1861 of the Social Security Act as a supplier of medical and other health services
- Becoming a “provider” in the Social Security Act means that pharmacists can:
  - Participate in Part B of the Medicare program
  - Bill Medicare for services that are within their state scope of practice to perform

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Provider Status is About Patients

- Achieving provider status is about giving patients access to care that improves:
  - Patient safety
  - Healthcare quality
  - Outcomes
  - Decreases costs

Why is it Important for Pharmacists?

- Absence reduces visibility ➔ Implies secondary role ➔ Impedes care provision
- Extensive documentation of need and improvement in outcomes, safety, cost, and access when pharmacists provide clinical services
- Pharmacists practicing in clinics and the expansion of services offered in community pharmacies will require financial support
- Need for pharmacists to provide primary care and manage chronic disease
- Inappropriately aligned incentives constrain pharmacists
- Section 1861 of the SSA remains the reference point for which practitioners are eligible to participate in current, new and emerging delivery systems, and payment models (e.g., ACOs and Medical Homes)

Who Has Provider Status Now?

- Physicians
- Nurse practitioners
- Physician assistants
- Certified nurse midwives
- Psychologists
- Clinical social workers
- Certified nurse anesthetists
- Speech-language pathologists
- Audiologists
- Registered dietitians
- Physical therapists
What is House Resolution 4190?

- Introduced by Representatives Guthrie (R-KY), Butterfield (D-NC) and Young (R-IN) March 11, 2014

- Bipartisan bill; over 100 congressional cosponsors include two physicians: Reps. Roe (R-TN) and Bera (D-CA)

- Refers back to state scope of practice

- Applies to medically underserved areas, populations, or shortage areas
  - Represents a large part of the U.S.
  - Urban and rural areas

H.R. 4190 Specifics

- Amends Section 1861(s)(2) of the Social Security Act to include:
  - Pharmacist services furnished by a pharmacist licensed by state law
  - In setting located in and defined in federal law:
    - Medically underserved area
    - Medically underserved population
    - Health professional shortage area

- Why does H.R. 4190 only cover under medically underserved communities?
  - Help meet unmet health care needs
  - Increase access
  - Improve quality
  - Decrease costs

- Why this approach?
  - Provides a foot in the door; limits opposition and bring down legislation costs
  - Other health professionals have taken a similar approach (e.g., Nurse Practitioners and Physician Assistants)

Where are the Medically Underserved Communities?
**Patient Access to Pharmacist’s Care Coalition (PAPCC)**

- **Formed January 2014**
- **Group of more than 20 organizations representing patients, pharmacists, pharmacies and other interested stakeholders**
- **Drafted H.R. 4190 to expand medically-underserved patients’ access to pharmacist services consistent with state scope of practice**

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**Why Do Pharmacists Want Provider Status When Fee-For-Service is Going Away?**

- Traditional fee-for-service is not the model of the future
- However, Social Security Act (SSA) remains the reference point for eligibility to participate in:
  - Delivery systems
  - Payment models (see ACO example)
- Pharmacists need to be listed in the SSA to fully participate

**Does H.R. 4190 require pharmacists to be residency trained, Board certified, or possess other credentials?**

- No. H.R. 4190 requires pharmacists to be licensed by a state
  - State legislature and board of pharmacy, health care organizations, and private health plans determine requirements
  - Examples:
    - CA: “Advanced Practice Pharmacist”
    - NM: “Pharmacist Clinician”

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**Why isn’t ASHP calling for credentialing requirements given that ASHP started pharmacy residencies and supports Board certification?**

- ASHP supports these concepts, but they do not belong in federal law
  - Credentialing and privileging requirements are for states and organizations to decide through:
    - State pharmacy practice acts
    - Private health plan requirements
    - Credentialing and privileging requirements by hospitals and health systems

**What will a pharmacist provider be referred to when H.R. 4190 is signed into law?**

- Pharmacist
- No need to create a new category of pharmacist in federal law
State Scope of Practice

• Provider status at the federal level will only allow a pharmacist to:
  o Participate in the Medicare program
  o Bill for services that are within their state scope of practice

• State scope of practice will determine what pharmacists can actually do in terms of the provision of service

• As provider status at the federal level is achieved, continued efforts by states to ensure scope of practice for pharmacists is sufficiently robust will be vital

How Can State Affiliates Support H.R. 4190?

• Urge co-sponsorship of H.R. 4190; focus on state members:
  o Energy and Commerce Committee
  o Ways and Means Committee

• Seek Senate sponsors for companion bill
• Organize in-state/in-district meetings with elected officials and/or staff
• Coordinate hospital/health system facility tours
• Reinforce/supplement ASHP Grassroots Calls to Action
• Profile Member Advocacy in Newsletters, etc.
• Attend Campaign Fundraiser & other Events
• Recruit individual health systems to support of H.R.4190
• Solicit the support of other state-level health professions

How can YOU support H.R. 4190?

• Visit elected officials/staff in your home district
• Encourage your colleagues to get involved
• Utilize social media to talk about provider status; share ASHP material and updates
• Attend political rallies, town halls, and fundraising events
• Write editorials or op-eds in local newspapers
• Congressional leaders listen when constituents speak
• Educate your patients and the public
• ashp.org/providerstatussteam
Enhance the Public’s Understanding of the Vital Role of the Pharmacist in Their Care

https://www.youtube.com/watch?v=152dfad7Iv4&feature=youtu.be

Optimizing Patient Outcomes
Evolution of Collaborative Drug Therapy Management (CDTM)

Changing the Scope of Practice - Maximizing What Pharmacists Can do for Patients

Pharmacist and physician, working together with other members of the healthcare team, and forming a strategic partnership to optimize patient outcomes with medications.

- Changing delivery of care model as it relates to prescribing*
  - Current model: Vertical Dependent
  - Proposed model: Horizontal Interdependent
Proposed Horizontal Model:

- Makes initial diagnosis
- Treats and monitors patient

**PHARMACIST**
- Based on physician diagnosis, selects & designs drug therapy regimen
- Writes prescription or medication orders
- Reviews and monitors patient's drug therapy for efficacy and adverse events
- Changes medication orders, consulting with physician and nurse as needed

**OUTCOME**: Improved outcomes and reduced costs. Better utilization of physician, nurse, and pharmacist's time.

Existing International Models

- **U.K.**
  - Able to prescribe all drugs for any medical condition within their competence

- **Canada** – Effective October 2012, Ontario:
  - Independent prescribing based on a collaborative relationship
  - Initiate therapy for smoking cessation
  - Emergency prescribing
  - Renew and adapt prescriptions
  - Administer injections or inhalation (for education and demonstration)
  - Administer the flu vaccine
  - Quebec allowing pharmacists to prescribe medications that do not require a diagnosis, i.e.:
    - Antimalaria medications for travelers

- **Australia**: Currently in development
  - National prescribing competencies
  - Scope of practice

Final Thoughts

*Putting it All Together*

We need to educate the public as to the role of the pharmacist in patient care.

Pharmacists in different sites of care must work together to provide the full spectrum of care.

We need an increased emphasis on care basics, such as adherence, design of affordable drug therapies, elimination of unnecessary drug use, chronic disease management, wellness, and primary care.
Final Thoughts
Putting It All Together

There should be an increased pharmacy presence in clinics, medical homes, ACOs, etc.

Our models of practice must change significantly to achieve the above.

Staying focused on what is right for the patient will always be our best strategy.

References

1. IOM, 2012, Best Care at Lower Cost.
References

17. Legislative change in Quebec gives pharmacists expanded authorities. Can Pharm J. 2012;145:7