A Call to Action: Ambulatory Care in Illinois

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Ambulatory Care Pharmacy: Current Status in Illinois

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The speakers have no conflicts of interest to declare.

How do you define "ambulatory care pharmacy practice" (ACPP)

How do you think patients or other health care providers define ACPP

Do ACPP have the following responsibilities:

- Ability to prescribe medication and manage disease via CDTM • YES/NO
- Ability to order, interpret and monitor medication related tests • YES/NO
- Monitor response to drug therapy, adverse medication related effects and adherence • YES/NO
- Provide information about the patient's diseases and related medication therapy and offer strategies for improvement • YES/NO

Defining Ambulatory Care Pharmacy Practice

- "The provision of **integrated, accessible** healthcare services by pharmacists who are **accountable to addressing medication needs**, **developing sustained partnerships** with patients, and practicing in the context of family and community"
- "Accomplished through **direct** patient care and **medication management** for ambulatory patients, **long-term relationships**, **coordination of care**, patient **advocacy**, **wellness** and **health promotion**, **triage and referral**, and patient **education** and **self-management**."
- "May work in both an **institutional and community-based** clinic involved in **direct** care of a diverse population"

https://www.bpsweb.org/bps-specialties/ambulatory-care/

Defining Ambulatory Care Pharmacy Practice

- Must attain and maintain appropriate competencies and credentials
- Inter-professional patient care team members
- Specific examples of Scope of Practice/Responsibilities
- Patients should have access to, and have an opportunity to be evaluated by, ambulatory care pharmacists across the continuum of ambulatory care

Am J Health-Syst Pharm. 2014; 71:1390-1

Defining Ambulatory Care Pharmacy Practice

- Physician perspective
- Formal consensus statements lacking from medical organizations

POSITION PAPER

Pharmacist Scope of Practice

American College of Physicians–American Society of Internal Medicine*

Ann Intern Med. 2002;136(1):79-85.

American College of Physicians – American Society of Internal Medicine

- "non-physicians" and "physician extenders"
  - pharmacists, nurse practitioners, and physician assistants
- Described 5 "position statements" both supportive and critical of expansion of the scope of pharmacy practice
- Reimbursement issues
- Liability issues
- Call for research
  - Effects of pharmacist and physician collaboration on physicians' time with patients
  - Studies examining the outcomes of a community-based pharmacist system

Ann Intern Med. 2002;136(1):79-85.

American Medical Association

- Steps Forward campaign
- Encourage physicians to include a clinical pharmacist and/or a pharmacy technician in their ambulatory care team

Collaborate with pharmacists to improve patient outcomes.

Embedding Pharmacists Into the Practice

https://www.stepsforward.org/modules/embedded-pharmacists

Physician Position Statements on Pharmacy Scope of Practice

1. ACP-ASIM supports research into the effects of pharmacy automation and the move to the PharmD degree on pharmacy practice.
   - Moving from prescription provider to pharmaceutical care provider.
   - Collaborative drug therapy – need for pharmacists to access patients, medical records, knowledge and skills, documentation, and compensation.

Ann Intern Med. 2002;136(1):79-85.

Physician Position Statements on Pharmacy Scope of Practice

2. To improve patient safety and reduce medical errors, ACP-ASIM supports physician-directed pharmacist-physician collaborative practice agreements **limited to** pharmacist involvement in patient education and hospital rounds.

3. ACP-ASIM **opposes** independent pharmacists prescriptive privileges and initiation of drug therapy.
   - Little evidence supporting pharmacist prescribing or initiating drug therapy
   - Pharmacists do not have access to complete medical histories
   - Pharmacists do not have the exposure and experience to diagnose and prescribe medications for patients.
   - "Clearly and area that should remain under physician authority."

Ann Intern Med. 2002;136(1):79-85.

Physician Position Statements on Pharmacy Scope of Practice

4. ACP-ASIM supports the use of the pharmacist as immunization information source, host of immunization sites, and immunizer, as appropriate an allowed by state law.

5. ACP-ASIM reiterates its support of its 1990 therapeutic substitution position. ACPE-ASIM resolves to work with pharmacists in designing therapeutic substitution policies that ensure the highest level of patient care and safety.

Ann Intern Med. 2002;136(1):79-85.

How do PATIENTS define ambulatory care pharmacy?

- Supportive of chronic disease management programs as long as pharmacist is trained
  - Lack of awareness of pharmacist traning and credentialing
- Pharmacists are easier to access in the community setting
- Expect frequent communication with physician regarding treatment plans
- ”Doctors should diagnose and pharmacists should prescribe – they know their drugs, know interactions, so I want their opinion, knowledge.”

CMAJ Open 2017

How do PAYORS define ambulatory care pharmacy?

- Part D Medication Therapy Management (MTMP) program requirements and information.
- **Requirements for Medication Therapy Management Programs (MTMP):** Under 423.153(d), a Part D sponsor must have established a MTM program that:
  - Ensures optimum therapeutic outcomes for targeted beneficiaries through improved medication use
  - Reduces the risk of adverse events
  - Is developed in cooperation with licensed and **practicing pharmacists** and physicians
  - Describes the resources and time required to implement the program if using outside personnel and establishes the fees for pharmacists or others
  - **May be furnished by pharmacists** or other qualified providers
  - May distinguish between services in ambulatory and institutional settings
  - Is coordinated with any care management plan established for a targeted individual under a chronic care improvement program (CCIP)

https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.html

Ambulatory Care Pharmacy: Defining our Practice

- ASHP Ambulatory Care Summit (2014)
  - Program designed to advance patient care by building consensus in:
    1. Defining and advancing ambulatory care pharmacy practice
    2. Patient care delivery and integration
    3. Sustainable business models
    4. Outcomes evaluation

Ambulatory Care Pharmacy: Current Status in Illinois

- Practice assessment tool created by ASHP to help administrators and practitioners evaluate current practice
- Individualized recommendations provided upon completion of tool
- Data compiled nationally by ASHP

Ambulatory Care Pharmacy: Current Status in Illinois

- Ability to prescribe medication and manage disease via CDTM
  - RPh: 2 of 5 = yes (nationally 56.9%), Administrator: 7 of 8 = yes (national 64.9%)
- Ability to order, interpret and monitor medication related tests
  - RPh: 4 of 5 = yes (nationally 70.7%), Administrator: 8 of 8 = yes (national 77.7%)

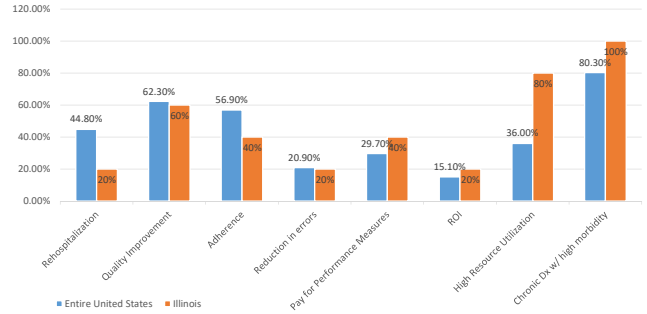
Data from the ASHP Practice Advancement Initiative Assessment Ambulatory Care Tool (May 2017)

Ambulatory Care Pharmacy: Current Status in Illinois

- Monitor response to drug therapy, adverse medication related effects and adherence
  - RPh: 5 of 5 = yes (nationally 92.9%), Administrator: 8 of 8 (national 90.5%)
- Provide information about the patient's diseases and related medication therapy and offer strategies for improvement
  - RPh: 4 of 5 = yes (nationally 91.6%), Administrator: 8 of 8 (national 90.1%)

Data from the ASHP Practice Advancement Initiative Assessment Ambulatory Care Tool (May 2017)

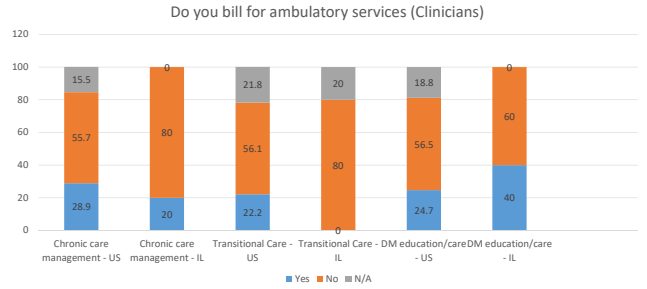
Ambulatory Care Pharmacy: Primary Drivers for Pharmacist Care



Data from the ASHP Practice Advancement Initiative Assessment: Ambulatory Care Tool (May 2017)

Ambulatory Care Pharmacy: Billing Practices

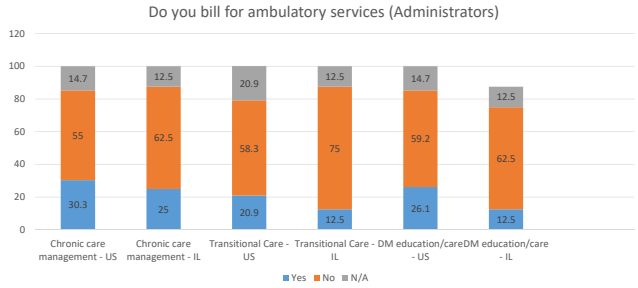
US: n= 239
IL: n=5



Data from the ASHP Practice Advancement Initiative Assessment: Ambulatory Care Tool (May 2017)

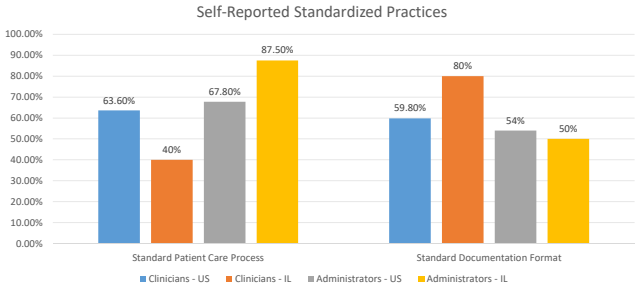
Ambulatory Care Pharmacy: Billing Practices

US: n= 211
IL: n=8



Data from the ASHP Practice Advancement Initiative Assessment: Ambulatory Care Tool (May 2017)

Ambulatory Care Pharmacy: Standardized Practice



Data from the ASHP Practice Advancement Initiative Assessment: Ambulatory Care Tool (May 2017)

Ambulatory Care Pharmacy: Current Status in Illinois

- Given the relatively low respondent numbers in dataset– not dramatically different from national averages in scope of practice, billing or standardization
  - However, nationally ambulatory care practice = consistently inconsistent
- Difficult to measure demographic details of ambulatory care pharmacists in Illinois
- Potential current barriers to standardization
  - Limited consistency in exact roles and practices between organizations
  - No delineation of “ambulatory care practice” details in pharmacy practice act
- Where do we go from here?

Ambulatory Care Pharmacy: Closing the Gap in Illinois

- Areas to address to align with best practices
  - Move towards universal training and credentialing in ambulatory care pharmacy
  - Consistent practice goals and expectations
  - Improved practices in billing and utilization of cost effective practice
  - Outcomes assessment
  - Increase research and data surrounding benefits of pharmacist involvement
    - Physician time
    - Patient outcomes
    - Cost savings and/or revenue generating?
  - More consistent message and increased visibility to patients and other healthcare providers

Ambulatory Care Pharmacy: Your Current Practice

- Among the group at your table
  - Have everyone provide a brief summary of your current clinical practice
  - As a group – discuss what are the main differences between the ambulatory care sites
    - Pharmacist responsibilities
    - Common chronic or acute diseases managed
    - Support staff/Resources
    - Billing practices
  - As a group – discuss
    - What elements of your current practices work great
    - What elements would you like to see changed
    - Any current practice changes in progress to improve your clinical practice

Challenges and Success on the National Level

Mary Ann Kliethermes, BS, PharmD, FAPhA
Brooke L. Griffin, PharmD, BCACP

The speakers have no conflicts of interest to disclose.

Unless otherwise stated, images obtained from https://pixabay.com/

Learning Objective - Pharmacist

- Interpret, from a national perspective, current health care challenges and sustainable opportunities for pharmacists in ambulatory care settings.

Can you explain what you do to your parents?

A. I struggle
B. I easily can

Which term do you believe best describes pharmacist patient care services?

A. CMM
B. MTM
C. Medication Optimization
D. Medication Management Services

Is Ambulatory Pharmacy Patient Care Services Heading to a Perfect Storm

Terminology Issues

Medication Management Services

Pharmaceutical Care

Wicked Challenges for Ambulatory Pharmacy Practice

What is it we do? What is our philosophy care

Roles

Accountability

Responsibility

Are all pharmacists alike?

Listening to what others are saying…

- How do I find a pharmacist that will meet my needs? How do I find a pharmacist like you? *Medical Director of a Physician Group*
- "I fought to get a pharmacist, but the ones we have are not like the ones I trained with?" *Physician Board member of a large health-system*
- What is the intervention? There's definitely a need for it, but I need to know what I'm buying." *CMO of National Insurer*
- "We need consistency in the practice of CMM. Unless we train them, we are unsure whether they truly know what CMM is." *Director of CMM in a large integrated health system*

Terminology: Words Used in Pharmacy Literature to Describe Patient Care Services

Courtesy of Dr. Patrick Clay and his student

Alphabet Terminology Soup

MTM

CMM


CMR


TMR

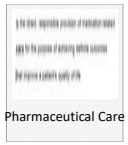

DRP/MTP


PPCP

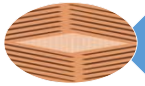

MED REC

MM


Clinical Pharmacy


Pharmaceutical Care

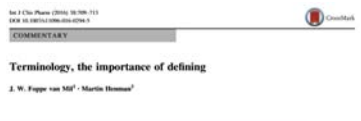
Why is terminology important?


Users of our services understanding and perceptions


Attribution of value


Developing evidence base for value

Raising this issue to (inter)national discussion


Terminology, the importance of defining

Harmonization of Terms for Clinical Pharmacy: If It Walks Like a Duck…

BY JERRY BAUMAN

UIC alumni publication 2016

Get the medications--and the name-- right: Comprehensive Medication Management by Katherine H. apps, president, Health2 Resources blog

Terminology Is Important *Written by Daniel Aistrope, Pharm.D., BCACP Director, Clinical Practice Advancement ACCP Report 7 2016*

"Despite pharmacists confirming that they are engaged in CMM and despite the existence of several guideline documents, standards of practice, and definitions of CMM in the literature, a consistent approach to CMM is lacking." *ACCP CMM project*

Where Are Other Countries

Medicines optimisation: the safe and effective use of medicines to enable the best possible outcomes

NICE guideline [NG5] Published date: March 2015 Uptake of this guidance

Medication Management
Medication management involves patient-centred care to optimize safe, effective and appropriate drug therapy. Care is provided through collaboration with patients and their health care teams.
Canadian Pharmacist Association*

Medication Management Services

Spectrum of patient-centered, pharmacist-provided, collaborative services that focus on medication appropriateness, effectiveness, safety and adherence with the goal of approving health outcomes.

JCPP press release: https://naspa.us/wp-content/uploads/2018/03/Press-release-MMS-2018-1.pdf

Are we all alike?

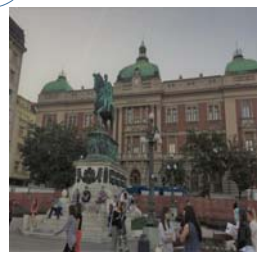
Agree on an axiom:
Pharmacists and Patients are different

Flaws with all being the same

Penguins are black and white
Some old TV shows are black and white. Therefore, some penguins are old TV shows

Are the assumptions correct and more importantly safe?

Does it stifle or discourage innovation?
Is it wise use of resources?



Essentials of a Patient Care Practice:
Providing Medication Management Services

- A philosophy of practice

The Why

- A patient care process

The What

- A practice management system

The How

What is your Philosophy of Practice?

What is your philosophy of practice?

Ideas to Address the Challenges
The Population Health Pyramid

- Image removed due to copyright.

Image credit: https://www.linguamatics.com

Pharmacist Services through a Population Health Lens?

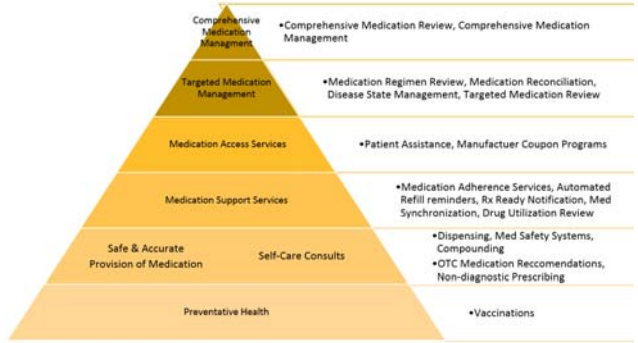


Figure 1: Optimization of Health through Pharmacist Provided Services

Image Credit: HAIMM, MN Health System Collaborative. Reprinted with permission

Medication Management services

Required for each bucket: highly reliable standard services provided in a consistent and standard way to produce consistent and expected outcomes.

Pharmacist Patient Care Process

Defining the Services

- What are the discrete services and the range of services?
- Where and how do they fit on the continuum?
- What are standard, consistent elements of each discrete service?
- What skills, knowledge and credentials are desirable for a provider performing the services in each bundle of discreet services?

Successful Ambulatory Care Practices in Other States

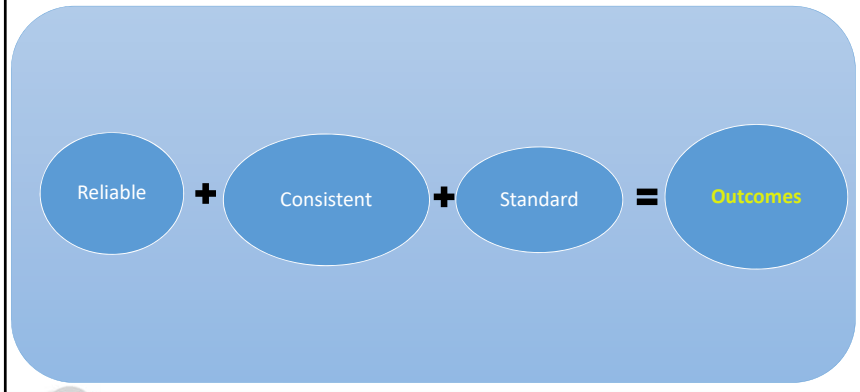
In states with successful ambulatory care practices, which of the following is the greatest contributor?

A. Designation as a legal health care provider
B. Optimized pharmacy practice for scope of practice
C. Payment for services in State Insurance Code
D. Governmental Advocacy
E. Physician Champions

Successful Ambulatory Care Practices in Other States

- Why Successful?
- Why Sustainable?
- What are the Opportunities?
- What have they Defined?

Quality of Services



Documented Support

American Medical Association
- Embedding Pharmacists Into the Practice
- https://www.stepsforward.org/modules/embedded-pharmacists

Report to the US Surgeon General
- Giberson S, Yoder S, Lee MP. *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice*. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011.

CDC
- Partnering with Pharmacists in the Prevention and Control of Chronic Diseases
- https://www.cdc.gov/dhdsp/programs/spha/docs/pharmacist_guide.pdf

American Academy of Family Physicians
- "The AAFP supports arrangements where the pharmacist is part of an integrated, team-based approach to care. The AAFP believes that independent prescription authority for pharmacists will further fragment the American health care system and will undermine the national goals of integrated, accountable care and models such as the PCMH." https://www.aafp.org/about/policies/all/pharmacists.html

Pharmacist Contributions in the Literature[1]

MDs can see more patients	Reduce Hospitalizations	Improve Outcomes for Various Disease States	Prove ROI
Nichol A, Downs G. The pharmacist as physician extender in family medicine office practice. J Am Pharm Assoc. 2006;46:77-83.	In patients with DM or HF[4]	Geisinger Health System: Providing a One-Stop Shop for Medication Management." AHIP Innovations in Medication Therapy Management APhA Document https://cdn.ymaws.com/www.chronicdisease.org/resource/resmgr/cvh/pharm_&_hc_puzzle.pdf	Reducing total annual health expenditures exceeded the cost of providing MTM services by more than 12 to 1[2] Significant reduction in per member per month cost and controlled spending growth overall[3]

1. The Patient Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes RESOURCE GUIDE https://www.pcpcc.org/sites/default/files/media/medmanagement.pdf, Accessed 7/5/18
2. Isetts BJ, Schondelmeyer SW, Artz MB, Lenarz LA, et al. Clinical and economic outcomes of medication therapy management services: The Minnesota experience. J Am Pharm Assoc. 2008;48:203-211
3. Isetts, Brummel, Ramalho de Oliveira, Moen-Medical Care-Nov 2012
4. Viswanathan et al. JAMA Intern Med. 2015;175(1):76-87.

Someone Should Write a Meta-Analysis!

Two teams tried…

1. Pharmacists' Effect as Team Members on Patient Care: Systematic Review and Meta-Analyses
   - Reviewed 298 articles
   - Ambulatory, community and inpatient teams
   - Small number of pharmacists in some studies
   - Majority did not report power or sample size analyses
   - Pharmacist activities varied so greatly that it was challenging to associate interventions with outcomes
2. Medication Therapy Management Interventions in Outpatient Settings: A Systematic Review and Meta-analysis
   - Reviewed 44 articles
   - "evidence was insufficient to determine the effect of MTM interventions on most evaluated outcomes (eg, drug therapy problems, adverse drug events, disease-specific morbidity, disease-specific or all-cause mortality, and harms)."
   - Authors stated there was "inconsistency and imprecision that stem in part from underlying heterogeneity in populations and interventions."

1. Chisholm-Burns MA, et al. US Pharmacists' Effect as Team Members on Patient Care: Systematic Review and Meta-Analyses. Medical Care, Vol. 48, No. 10 (October 2010), pp. 923-933
2. Viswanathan et al. JAMA Intern Med. 2015;175(1):76-87.

Unanswered Questions

Gaps in Practice, therefore gaps in the literature:

- Standardization in practice
- Definition of the pharmacists' role
- Difference in professional credentials and experience
- Difference in resources and funding
- Undefined value

Jorgenson et al. International Journal of Pharmacy Practice 2014, 22, pp. 292–299

What can we do in Illinois?

Which states have successful Ambulatory Care models?

Washington: History

- 1979 CPA in Pharmacy Practice Act
- 1993 Health Services Act – includes compensation for "every category of provider"
- 1994-2012 - numerous attempts for pharmacist compensation
  - Insurers stated they were in compliance by paying professional dispensing fees
- 2013 Attorney General informal opinion that pharmacists are health care providers and must be compensated
- 2015 – SB 5557 – pharmacists as medical providers requiring compensation under major medical insurance for pharmacists providing health services contained in benefits

Washington: Getting There

2000's

2 pharmacists published results:

-Lowered per member per month drug costs (use of generics and OTCs)

-Increase of 15% of patients with controlled BP

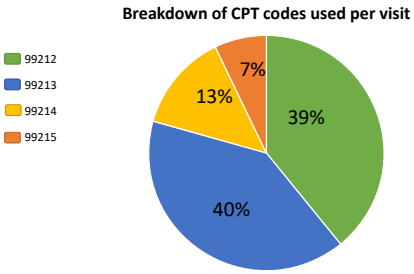
-Avoided $450,000 in hospital costs by initiating an outpatient DVT program

Devine EB et al. Strategies to optimize medication use in the physician group practice: the role of the clinical pharmacist. J Am Pharm Assoc. 2009;49:181–91.

Washington: Currently

Productivity Review

YTD August data



CPT Code	Visit Volume
99212	11,120
99213	11,436
99214	3,832
99215	2,032

*** Does not include linked visits or shared medical appointments*

Permission courtesy of Amanda Locke, Virginia Mason

Washington: Currently

- Patient financial services available
- Marketing tools to educate patients on pharmacist role

Permission courtesy of Amanda Locke, Virginia Mason

Minnesota: History

- Pharmacy Practice Act
- (1) interpretation and evaluation of prescription drug orders;
- (2) compounding, labeling, and dispensing drugs and devices (except labeling by a manufacturer or packager of nonprescription drugs or commercially packaged legend drugs and devices);
- (3) participation in clinical interpretations and monitoring of drug therapy for assurance of safe and effective use of drugs, including the performance of laboratory tests that are waived under the federal Clinical Laboratory Improvement Act of 1988, United States Code, title 42, section 263a et seq., provided that a pharmacist may interpret the results of laboratory tests but may modify drug therapy only pursuant to a protocol or collaborative practice agreement;
- (4) participation in drug and therapeutic device selection; drug administration for first dosage and medical emergencies; drug regimen reviews; and drug or drug-related research;
- (5) participation in administration of influenza vaccines to all eligible individuals six years of age and older and all other vaccines to patients 13 years of age and older by written protocol with a physician licensed under chapter 147, a physician assistant authorized to prescribe drugs under chapter 147A, or an advanced practice registered nurse authorized to prescribe drugs under section 148.235, provided that:
- (i) the protocol includes, at a minimum:(A) the name, dose, a contraindications and precautions to the vaccine;(D) the proc advanced practice registered nurse;(F) a telephone number a and time period for which the protocol is valid;(ii) the pharma for the administration of immunizations or a program approv
- (iii) the pharmacist utilizes the Minnesota Immunization Infor when administering influenza vaccines to individuals age nine
- (iv) the pharmacist reports the administration of the immuniz
- (v) the pharmacist complies with guidelines for vaccines and does not need to comply with those portions of the guideline issued by a physician licensed under chapter 147, a physician drugs under section 148.235, provided that the order is consi

(6) participation in the initiation, management, modification, and discontinuation of drug therapy according to a written protocol or collaborative practice agreement between: (i) one or more pharmacists and one or more dentists, optometrists, physicians, podiatrists, or veterinarians; or (ii) one or more pharmacists and one or more physician assistants authorized to prescribe, dispense, and administer under chapter 147A, or advanced practice nurses authorized to prescribe, dispense, and administer under section 148.235. Any changes in drug therapy made pursuant to a protocol or collaborative practice agreement must be documented by the pharmacist in the patient's medical record or reported by the pharmacist to a practitioner responsible for the patient's care;
(7) participation in the storage of drugs and the maintenance of records;
(8) patient counseling on therapeutic values, content, hazards, and uses of drugs and devices;
(9) offering or performing those acts, services, operations, or transactions necessary in the conduct, operation, management, and control of a pharmacy; and
(10) participation in the initiation, management, modification, and discontinuation of therapy with opiate antagonists, as defined in section 604A.04, subdivision 1, pursuant to:
(i) a written protocol as allowed under clause (6); or
(ii) a written protocol with a community health board medical consultant or a practitioner designated by the commissioner of health, as allowed under section 151.37, subdivision

Minnesota: Getting There

2005: Coverage of pharmacist MTM (CMM-level) services for Medicaid and state employee health programs with positive results; the state has expanded eligibility to more patients

Fairview Example

- 1997: Introduced CMM approach
- Included:
- collaborative practice agreements
- coordination with expanded care teams
- utilization of patient data to ensure economic and clinical outcomes are identified and met
- Helped ACOs meet quality and financial benchmarks

Park Nicollet Example

- 11 Pharmacist Providers at 15 Ambulatory Clinic sites, 1 PGY1 Resident, 1 Patient Outreach Coordinator, and 1 FTE Pharmacist Leader
- 2017 Med Management Data
  - >5k Patients, >9k Encounters
  - >13k Med Related Problems (76% Resolved)

Brummel A Lustig A, Westrich K. "Best practices: improving patient outcomes and costs in an ACO through comprehensive medication therapy management," J Managed Care Specialty Pharm. 2014;20(12):1152-1158

Minnesota: Currently

Park Nicollet HealthPartners

ACO ESRD Costs- Patients with a MTM Visit in 2016

ACO members utilizing pharmacists:	2016 Five months experience	Part A Medicare Costs Per Patient Per Month	Part B Medicare Costs Per Patient Per Month	Admits per 1,000	ER Visits per 1,000
No	**ESRD Control (24)**	$ 34,705	$ 3,998	**1,083 (26 admits)**	1,292 (31 ER Visits)
Yes	**MTM ESRD (17)**	$21,770	$3,144	**353 (6 admits)**	1,000 (17 ED Visits)
	Difference between Control and MTM Intervention	**$12,935**	$854	20	14

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"The statements contained in this document are solely those of the authors and do not necessarily reflect the views or policies of CMS. The authors assume responsibility for the accuracy and completeness of the information contained in this document."

South Carolina: Physician Productivity

Provider	2013 Payment/ Work Day	2014 Payment/ Work Day	% Increase Payment/ Work Day	2013 Q2 Visits/Day	2014 Q2 Visits/Day	% Total Referrals to PharmD
MDA	$2,741	$3,499	27.7%	24.2	25.0	46%
MDB	$3,100	$3,701	19.4%	31.1	31.2	9%
MDD	$2,602	$3,385	30.1%	23.5	23.7	27%
MDT	$2,582	$3,000	16.2%	23.5	24.8	11%
MDV	$2,878	$3,177	10.4%	24.0	22.7	7%
AVERAGE	$2,781	$3,352	20.6%	25.3	25.5	100%

Contributing Factors:
1. **Fee Increase November 2013**
2. **More New Patient Visits**
3. **More Complex Visits**

20.6%

Original Research Kennedy Pharmacy Innovation Center

Permission courtesy of Bob Davis, The Kennedy Center

Other States

California[1]

- 2014: SB 493 declared pharmacists to be health care providers who have the authority to provide health care services
- AB 2084: if enacted, would allow for provision of CMM services for certain high-risk Medicaid patients

Tennessee[2]

- 2017: Pharmacists as Providers" (HB 405/SB 461) gives Tennessee pharmacists formal recognition as providers through managed health insurance issuers, including reimbursement and inclusion in medical networks, as providers of care

North Carolina[3,4]

- 2000: Clinical Pharmacist Practitioner (CPP) Act, authorizes CPPs to implement drug therapies as outlined by a CPA
- 2013: NC Chronic Care Act, includes provisions for CMM for certain publicly funded beneficiaries

1. http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_2051-2100/ab_2084_bill_20160217_introduced.htm
2. https://www.pharmacist.com/article/new-tennessee-law-formally-recognizes-pharmacists-providers
3. GetTheMedicationsRight.v22final-5.20
4. NC Chronic Care Coordination Act http://www.ncleg.net/Sessions/2013/Bills/House/PDF/H459v3.pdf

In states with successful ambulatory care practices, which of the following is the greatest contributor?

A. Designation as a legal health care provider
B. Optimized pharmacy practice for scope of practice
C. Payment for services in State Insurance Code
D. Governmental Advocacy
E. Physician Champions

Discussion

-What elements can we take from other successful states?
-What is the first thing we should tackle in Illinois?

https://pixabay.com/en/group-team-feedback-confirming-1825510/

Acknowledgements and Additional Contact Information

- Park Nicollet
  - Kristen.Kopski@parknicollet.com
  - Park Nicollet Health Services ACO website
  - http://www.parknicollet.com/About/accountable-care-organization
  - Gena.Graves@parknicollet.com
- Centers for Medicare & Medicaid Services
  - Questions regarding the Next Generation ACO Model can be directed to CMS NextGenerationACOModel@cms.hhs.gov

Ambulatory Care Clinical Pharmacists Role in Value-Based Payment Models

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Disclosure

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Learning Objective - Pharmacist

Evaluate the impact of ambulatory care clinical pharmacists on clinical and economic outcomes in value-based payment models.

What services are you interested in providing at your site?

What outcomes are you measuring to demonstrate benefit?

What implementation challenges have you encountered?

What sustainability challenges have you encountered?

Advocate Medical Group Southeast Center

Advocate Health Care's ACO is one of the largest in the country

- Over 250 clinic locations in the Chicago metropolitan area

ACO = Accountable Care Organization

Payer Mix

Medicare Advantage Full Risk	59%
Medicare Shared Savings Program	19.4%
Commercial Full Risk	11.3%
Commercial FFS	8%
Medicaid	1.8%
Self-Pay	0.4%

FFS = fee-for-service

Outcomes-Based Reimbursement Model

Capitated Reimbursement

- Medicare Advantage and Commercial Full Risk
  - Incentive for keeping the patient well
- Medicare Shared Savings Program

Incentive to focus on preventative health care

- Meet performance measures
- Prevent hospitalizations
- Decrease cost

Outcomes-Based Reimbursement Model

Breeds team-based model of care

- Utilize clinical pharmacist for:
  - More frequent follow-up
  - Timely medication titration
  - Improvement in performance measures

Outcomes-Based Reimbursement Model

99211

- Internal tracking tool to measure number of individual visits

90036

- Patients seen the same day as their physician
- "No charge" office visit

Identifying the Need

Heart failure (HF) transitions of care

313	• Number of patients hospitalized for HF exacerbation (HHF) in 2008 that were readmitted within 30 days for a subsequent HHF
$2.4 million	• Estimated risk cost for 30-day readmissions for HHF
36%	• Percentage of these patients that had a repeat HHF in the one-year period following readmission for HHF

Clinical Pharmacist Services

Initially designed as HF clinic

- Decrease hospitalizations
- Initiate and optimize GDMT for HF
- Improve medication adherence
- Reduce medication costs for patients

Expanded collaborative care

- Diabetes
- Hypertension
- Hyperlipidemia
- Asthma
- COPD
- Post-hospital follow-ups

→ All Internal Medicine Chronic Disease States

GDMT = guideline-directed medication therapy

Clinical Pharmacist Services

Collaborative Practice / Practice by Protocol

- Develop and implement an individualized patient care plan
- Initiate, discontinue and titrate medications
- Provide medication reconciliation and education to improve adherence
- Order and interpret laboratory values
- Monitor safety and efficacy
- Identify barriers to adherence
- Arrange appropriate medical referrals

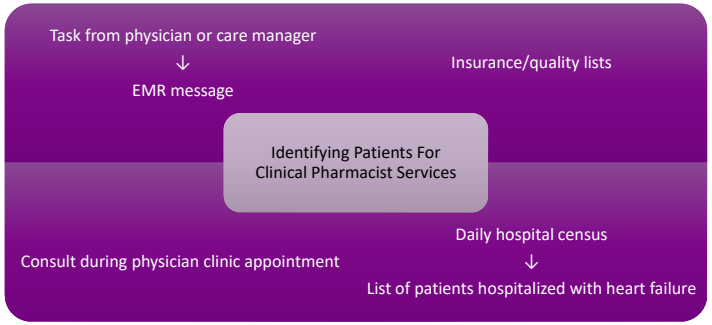
Educate

- Patients, physicians, medical staff, pharmacy students and residents

Clinical Pharmacist Services

8 to 16 patients scheduled daily	• Initial visits and post-hospital follow-ups: 60 minutes • Follow-up visits: 30 minutes • Utilize students and residents
Visit type	• Face-to-face independent • Shared visits with physician
Available at any time for physician consults	• Establish care during physician visit to improve visit adherence with PharmD visits
Communication	• Electronic medical record • Shared office space
Limited availability due to demand	• ~5-15 new referrals each week

Referral Process



Pilot Program Data from Clinical Pharmacist-Managed Patients with Heart Failure

Patients with HF managed by Clinical Pharmacist, November 2009– August 2010 (n = 111)	
Inpatient admissions in the 10 months pre-PCMH implementation	63 (57%)
Inpatient admissions in the 10 months post-PCMH implementation	30 (27%)
Average Cost per HF admission	$8,500
Potential Cost Avoidance for patients based on pre/post-PCMH implementation	$280,000

HF = heart failure; PCMH = patient-centered medical home

Pilot Program Data from Clinical Pharmacist-Managed Patients with Diabetes

Patients with DM managed by Clinical Pharmacist, May 2010 – November 2011 (n = 153)			
	Baseline	Study Period Conclusion	Change
Average A1c (%)	9.2 (±2.6)	7.7 (±1.7)	-1.5
Patients with A1c < 7%[a]	25 (16%)	49 (32%)	24 (16%)
Average LDL (mg/dL)	97 (±30.6)	81 (±25.6)	-16
Patients with LDL < 100 mg/dL	81 (53%)	103 (67%)	22 (14%)
Average SBP (mmHg)	143 (±22.1)	129 (±17.9)	-14
Average DBP (mmHg)	77 (±10.6)	70 (±10.8)	- 7
Patients taking ACEI or ARB	110 (72%)	133 (87%)	23 (15%)
Patients taking statin	92 (60%)	121 (79%)	29 (19%)

[a]*Before American Diabetes Association guidelines created less stringent, individualized goals*
ACEI = angiotensin-converting enzyme inhibitor; ARB = angiotensin receptor blocker; DBP = diastolic blood pressure; DM = diabetes mellitus; LDL = low-density lipoprotein; SBP = systolic blood pressure

AMG-SE Quality Metrics Dashboard

DM Management, aged ≥ 65 years	2009 Results (%)[a]	2013 Results (%)	2014 Results (%)
Annual Eye Exam	35	71	75
Annual Foot Exam	71	86	84
A1c Performed	80	93	96
A1c < 8%	32	84	80
A1c > 9%	41	9	11
LDL Performed	78	94	93
LDL < 100 mg/dL	40	63	65
LDL > 130 mg/dL	39	19	16
HTN Control (< 140/90 mmHg)	62	91	91
Nephropathy Testing	85	98	100

[a]*Before the clinical pharmacist managed patients at the center*
AMG-SE = Advocate Medical Group Southeast Center; DM = diabetes mellitus; LDL = low-density lipoprotein; HTN = hypertension

AMG-SE Quality Metrics Dashboard

Generic Medication Use	2009 Results (%)[a]	2013 Results (%)	2014 Results (%)
Generic medication use	80	92	92
Generic statin use	75	96	96
Heart Failure Management	**2009 Results (%)[a]**	**2013 Results (%)**	**2014 Results (%)**
Appropriate medication: ACEI or ARB	74	88	95
Appropriate medication: BB	82	80	83

[a]*Before the clinical pharmacist managed patients at the center*
ACEI = angiotensin-converting enzyme inhibitor; AMG-SE = Advocate Medical Group Southeast Center; ARB = angiotensin receptor blocker; BB = beta-blocker; HF = heart failure

Implementation Challenges

Gaining physician support

- In-services at physician meetings
- Coordination with physician schedules

Workflow inconsistencies at different centers

- Shared visits
- Physicians' needs
- Collaborative practice limitations

Sustainability Challenges

Workload

- Challenging to sustain with growth and demand

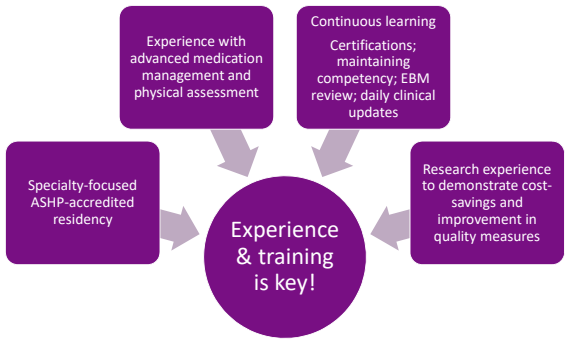
Team expansion and cross coverage

- Variability in skill sets among team members
- Maximize skill sets based on training
- Communication with patients and health care team

Shared faculty member

- Multiple responsibilities
- Same accountability as full-time employees

Professional Development



Questions and Discussion

- What services are you interested in providing at your site?
- What outcomes are you going to measure (or measuring) to demonstrate benefit?
- What implementation challenges have you encountered?
- What sustainability challenges have you encountered?

Worksheet

Ambulatory Care Pharmacy: Your Current Practice

Among the group at your table:

1. Have everyone provide a brief summary of your current clinical practice

2. As a group – discuss the main differences between the ambulatory care sites

- Pharmacist responsibilities

- Common chronic or acute diseases managed

- Support staff/Resources

- Billing practices

3. As a group – discuss

- What elements of your current practices work great

- What elements would you like to see changed

- Any current practice changes in progress to improve your clinical practice