Collaborative Practice in Texas: Where are we and what does the future hold?

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Disclosures

• Nakia Duncan is an Advisory Board member for Daiichi Sankyo

• Erin Graves and Carolyn Alessi have nothing to disclose, no conflict of interest.

Learning Objectives

1. Discuss the concept and elements of collaborative practice including the current Texas rules and regulations & legislative landscapes in different practice settings
2. Compare and contrast collaborative practice within the inpatient setting, the outpatient setting and the long-term care setting
3. Discuss the challenges and opportunities of a collaborative practice
4. Evaluate the next steps necessary to achieving a collaborative practice

Current legislative & financial state in SNF/PAC/LTC

• 85th Texas legislature failed to pass meaningful legislation (HB2766 – Nursing Facility Reinvestment Allowance) that would have allowed nursing facility owners to put money to draw down federal dollars that TX loses which would have been applied to quality of care and to address shortfall between the costs of care & current reimbursements.

• THCA reports that 43 other states have other programs in place to supplement funding similar to that which was proposed in the last legislature. Medicaid reimbursement in TX is 2nd lowest in the nation & pays average of $6/hr. per resident for nursing services

• Low occupancy rates due to overbuilding combined with fixed costs→ staff turnover (90% or higher annually for all levels of nursing—one of the HIGHEST in the country)

• up to 85% of Texans requiring care & residence in nursing homes depend on some type of Medicare/Medicaid funding

• Texans over age 85 will quadruple by 2050 many which will require skilled or LTC

Texas, Physician: Patient

• 43,000 physicians: 23 million patients: not to mention population growth estimates over the next few years

• Texas ranking 45 th in the nation in the number of physicians per population

• 8 med schools, 5400 students and 6000 residents. We change in the past 25 yr; more retiring than graduating

• The lack of growth factors:

- Predictions of an oversupply of physicians by the year 2000 proved inaccurate
- Reduced federal graduate medical education (GME) support
- Reoccurring cuts in the state funding of medical schools and graduate medical education
- Texas is now one of only three states that does not pay for GME through the state Medicaid program: and

- Shrinking operating margins at teaching hospitals

- Texas ranks 2nd in total population but at the bottom in both number of med students and residents per capita. When compared with the top six most populous states, Texas falls to 4th in the ranking of both the number of medical students and the number of physicians in training (resident physicians) per capita

• THCA reports that 77% of nursing facilities reported allowable costs exceeded Medicaid reimbursement and HHSC consolidated budget indicated a shortfall of $862 million.

• 55% of residents have dementia (significant since those require more assistance with ADLs)

• IMPACT ACT 2014- 2% cuts for FY 2018 for any SNF that does not comply with quality data submission requirements with respect to the FY

• October 2016 – Mega Rule / largest rewrite since 1991 by CMS of conditions for participation for LTC in Medicare and Medicaid programs which include expansion of pharmacy services benefit requirements

• Projected shortage of more than 130,000 physicians by 2025 by the Association of American Medical Colleges

Current legislative & financial state in SNF/PAC/LTC—cont’d
Pharmacists

- Not recognized under Section 18611 of the SSA, thus not able to bill for medication management services
- Medicare Part D only means through which pharmacists may bill for select services and excludes full range with current practice limitations
- Consultant pharmacists services in SNF/PAC/LTC are unfunded but mandated by CMS (fee for service model with potential for change) for continued participation in Medicare & Medicaid & come out of owner/operators budget
- Experts in geriatric medication management, uniquely positioned to provide person-centered longitudinal coordination for medication management services
- Currently the service delivery for care has been historically dependent on resources of the medical and nursing team

Definition of Collaborative Practice

A formal agreement in which a licensed provider makes a diagnosis, supervises patient care, and refers patients to a pharmacist under a protocol that allows the pharmacist to perform specific patient care functions.

Collaborative Drug Therapy Management (CDTM): A collaborative practice agreement between one or more providers and pharmacists in which qualified pharmacists working within the context of a defined protocol are permitted to assume professional responsibility for performing patient assessments, counseling and referrals

Collaborative Practice in Texas

- Drug Therapy Management by a Pharmacist is DELEGATION TO PHARMACIST
- Should discuss terms and have them clearly described in any CPA that is executed
- Medical complexity of patients (numerous co-morbidities)
- Scalable, sustainable and profitable
- Nurse pharmacist acting under adequate physician supervision the performance of specific acts
- Lower reimbursement, this could be risk/cost shared model between practice setting and physician
- No initial cost at onset for either party except time
- FAQS?

Collaborative Practice – FAQs?

- Not likely to incur additional liability (pharmacists should maintain malpractice insurance)
- Should discuss terms and have them clearly described in any CPA that is executed
- Start with some basic administrative reductions & test the model (ie. PA approvals, dosage form changes, OTC formulary management/substitutions)
- Costs and Reimbursement
  - MO initial cost at onset for either party except time
  - Other states can bill Medicare Part B for possible added revenue stream for providers
  - Separate fee structure/business agreement between prescriber/pharmacist
  - Risk/cost shared model between practice setting and physician — this could be under Medicare Part B or under a business agreement based on a “pay for performance”/outcomes driven payment for service

Physician Needs /Challenges/Opportunities

Administrative burdens
- Labor intensive
- Framework drives revenue (moving to electronic medical records and e-prescribe—not necessarily a time saver)
- Access to patient records to address needs at office locations or SNF/PAC/LTC
- After hours practice — in addition to effect hospital site
- Prior authorizations / insurance formulary constraints
- Nursing turnover
- Ideas in healthcare operations across the continuum of care
- Limited reimbursement
- Rising medication costs (in hospital)
- Expensive of care — lack of universal health record, dumping of referrals due to demands on shortened length of stay and discharges
- Medical complexity of patients (numerous co-morbidities)
- Specific to LTC/FM — new CMS/Mega Rule effective September 2016, more demands placed on physicians & documentation requirements needed for documentation for drug therapy management services
- Long term service needs: decreased length of stay for psychiatric medications
- IPN/ASP program initiatives

Collaborative Practice cont’d

- Voluntary relationship between practitioners/providers
- Builds upon a patient centered relationship already in place between physician(s) and pharmacist & in a growing number of states between pharmacists and other health professionals, such as nurse practitioners
- The agreement has to be filed with the TX board of pharmacy & is specific to what functions can be delegated to the pharmacist & is determined by the physician & pharmacist
- Most often in context of authorizing pharmacists to initiate, modify or discontinue medication, or order lab test as part of drug therapy monitoring for chronic disease management
- Functions may / may not include ordering & interpretation of lab results
- Dosage form &/or dose changes based on resident’s clinical need
- Prior authorizations/ changes based on formulary, reimbursement limitations
- Progressive process as trust/integrity in the relationship develops

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Business Model
- Scalable, sustainable and profitable
In Texas, any licensed pharmacist in good standing is eligible to engage in a collaborative practice agreement with their physician colleague(s)?

True or False

Carolyn Alessi, PharmD, BCGP

Erin to introduce & give a brief bio/description

Hospital to SNF Pharmacy Practice Transformation involving Drug Therapy Management (DTM) / CPA Model

- Memorial Hermann TIRR Hospital / University Place SNF
- Pharmacist transitioned to shared roles/responsibilities between both hospital and SNF to meet the needs of the system
- Hours/schedule
- Outpatient Pharmacist Managed
  - Refill Clinic
  - Collaborative Practice Clinics

Memorial Hermann Health System

- 15 hospitals
- 2 acute care hospitals in the Texas Medical Center
- Level I trauma center
- Children’s hospital
- 2 free-standing rehabilitation hospitals
- Orthopedic hospital
- 12 community hospitals
- Retirement community (University Place)
- Independent Living
- Skilled nursing facility
- Nursing home
- Specialty Areas
  - A-Vascular Institute locations
  - McHewer Neuroscience Institute
  - Irving Sports Medicine Institute
  - Life Flight
  - Cancer
  - Imaging and surgery centers
  - Sports medicine and rehabilitation centers
- Outpatient laboratories
- Home care agency
- Hospice
- Adult Care & Infusion

TIRR Memorial Hermann At-A-Glance

Inpatient
- 134 beds
  - Teaching facility
  - UT School of Medicine
  - Baylor College of Medicine
- Affiliated with UT
- Provider care for adults & children ages 12 years with disabilities
- 24-hour 7 days a week in-house physician presence
- Ranked #2 in US News & World Report
- Ranked for 27 years straight

Outpatient
- Over 20 outpatient specialty clinics
  - 100 patients/month
  - Pharmacists Managed Refill Clinic
  - 70+ specialty visits
  - 20 pharmacists involved
  - Pharmacists Collaborative Practice Clinics
  - Anticoagulation
  - Dialysis
  - Bedside
  - Smoking Cessation
  - Genetic Testing (in progress)

University Place

- 60 skilled nursing beds
- 170 independent living apartments
- Memorial Hermann (MH) adult living community
  - Established in 1989 as part of vision of CEO Dan Wilford to provide overall continuity of care
  - Transitional rehabilitation care for patients who require short-term rehabilitation
  - Skilled nursing care and therapy following hospitalization
- Located on the campus of Memorial Hermann Southwest Hospital
- 2013 Post Acute Care Network
- TIRR partnership with University Place (UP)
- Collaboration under CEO to increase integration of post acute care services

Interdisciplinary team approach to the delivery of care
Mission Statement

Pharmacy Practice at University Place:

To improve transitions of care, enhance quality outcomes, patient safety, and provide cost effective medication management in the delivery of patient care.

Transformation Management

- Pharmacist becomes integral member of interdisciplinary care team with a working knowledge of the patients' clinical and medical status and interacts personally with other care providers.
- Team members take personal accountability & leadership for solving patient problems, achieving goals, & managing the patient's care.
- There is building of respect and trust, improved communication and continuity of care.
- Leadership buy-in and support crucial!

Goals

- Transitions of Care
- Acute, Post-Acute
- Improve Transition to Next Level of Care
- Enhance Quality Outcomes
- Patient Safety
- Effective & Efficient Management of Populations Served
- Improve Patient/Family Satisfaction
- Drive Economic Efficiency
- Meet all Regulatory and Accreditation Requirements

Critical aspects of new pharmacy practice model

- Clinical Specialist Pharmacist consultant on site minimum of 16 hours per week on two separate days
- Medication reconciliation for each new admission within 72 hours with appropriate changes to medication therapy done concurrently
- Increased frequency of drug regimen review for all residents
  - Medication therapy
  - Lab-monitoring (clinical surveillance tools/software)
  - Other appropriate parameters
  - Renal dosing
  - Psychotropic medications
  - Antimicrobial Stewardship

Q&A

T/F?

Leadership support is important when initiating a collaborative practice agreement.
Critical aspects of new pharmacy practice model

- Initiation of an interdisciplinary medication management team
- Pharmacist-led medication management rounds with attending physicians weekly
- Physician approved protocols to ensure maximum pharmacist involvement in patient care
- Implementation and monitoring of an antimicrobial stewardship program
- Education to nursing & prescribers
- Formulary management
- Dashboard for intervention tracking

Pharmacist-managed protocols

- Medication Reconciliation
- Medication Management Rounds
- Warfarin
- Vancomycin
- Renal Dosing
- IV to PO
- C. difficile testing
- Aminoglycosides
- Diabetes (pending)

Example CPAs

- Guideline Purpose
- Scope
- Guideline Procedure
- Dosing Nomogram
- Renal dosing
  - Non-dialysis
  - Dialysis
- Hepatic adjustments
- Age adjustments
- Administration
- Monitoring
  - Indication for trough/INR monitoring
  - Dose Adjustments
- Adverse Events
- Reference
- Signature lines
- Plan for periodic review

Challenges

- Warfarin Management
  - High level physician buy-in
  - Nursing confusion – who to call?
  - Order still under prescriber – hard to tell who is under protocol management
- Protocol Enrollment
  - Communication and notification of enrollment
- 1:1 relationship vs. trust of concept
- Creating additional support for nursing but have not completely taken off their plate
  - Not a 24/7 service

CPA: Inpatient TIRR vs Outpatient SNF

- Approval Process
  - P&T Committee vs. Individual Provider Approval
- Formulary
  - Inpatient – hospital based (no individualization)
  - Outpatient – patient prescription benefit vs provider pharmacy
- 24/7 Service vs Episodic in a SNF
Opportunities

- Better collaboration with acute care hospitals
- Ways to reduce re-admission/cost-sharing
- Better hand-offs from acute to post-acute (less errors)
- Provision of high cost medication/IV’s
- Better documentation tools
- Integration of medical records (communication between EHR)
- Meds to beds to ensure medication adherence in continuum of care

Outcomes from a Transformed Pharmacy Practice Model at Memorial Hermann UP

- $1 million estimated medication cost savings (Jan 2016 – Nov 2017)
- Intervention categories/costs aligned with MH system as of January 2016
- $48K in antimicrobial stewardship savings
- Approximately 50% decrease of drug disposal (wastage) monthly
- Impact of community pharmacy interventions
  - Par levels
  - Formulary Interchange Compliance
- Good catches
  - Transfer record discrepancies/errors
  - Missing IV antibiotics for osteomyelitis, double dose of paroxetine, therapy duration
- Antimicrobial stewardship (nitrofurantoin CrCl example)

Test Your Knowledge

What are some of the key components of a collaborative practice agreement?

- Purpose
- References
- Procedure
- All of the above

What are some potential outcomes from initiating a collaborative practice agreement?

- Improved transitions of care
- More cost-effective medication management
- Increased patient safety
- All of the above
Nakia Duncan, PharmD, BCPS, BCGP

Carolyn to transition to Nakia, background/brief bio/

UT Southwestern Health System

- 2 Hospitals
  - William P. Clements Jr. University Hospital
    - 800 million state-of-the-art clinical facility
    - Level 4 neonatal intensive care unit
  - Zale Lipshy University Hospital
- Advanced Comprehensive Stroke Center
- 5 Cancer Support and Care Facilities
- 15 Hospital Clinics
- Primary Clinical Affiliates with
  - Parkland Memorial Hospital
  - Children’s Health System

- Specialty Areas
  - Radiation oncology
  - Bone marrow transplantation/hematologic malignancies
  - Head and neck oncology
  - Neuro-oncology and neurological oncology
  - Infusion center
  - Kidney and Liver clinic
  - Pharm-Administrative and Implementation Support
  - Hematology and medical oncology
  - Medical oncology
  - Wound care

William P. Clements Jr. University Hospital

- Inpatient
  - Opened in December 2014
  - 460-bed hospital
    - 40 emergency treatment rooms
    - 16 labor and delivery rooms
    - 72 adult ICU rooms
    - 30 neonatal ICU rooms
  - Teaching Facility
    - #1 ranked hospital in Dallas-Fort Worth by U.S. News & World Report
    - Recognized as a Top Performer by The Joint Commission

- Outpatient
  - Over 10 outpatient specialty clinics
  - Pharmacist Managed Refill Clinic
  - Pharmacists Collaborative Practice Clinics
    - Oncology
    - Anticoagulation
    - Hypertension
    - Pharmacotherapy

Harold C. Simmons Comprehensive Cancer Center

- Founded in 1989 with focus on reducing impact of cancer on patient care
  - Central provider for oncology services in outpatient setting
  - Providing cutting edge therapies
  - Top specialists in the country
  - Clinical trials
  - Disease-oriented teams (DOTs)
  - Supports 11 DOTs
    - Breast cancer, gastrointestinal cancers, gynecologic cancers, gynecologic malignancies, head and neck, hematologic malignancies and stem cell transplant, lung cancer, melanoma, neurological cancers, pediatric cancer, sarcoma
  - Located on the north campus
  - NCI-designated comprehensive cancer (only one in north Texas)

Mission Statement

“To improve health care in our community, Texas and the world through innovation and education.”

“To educate the next generation of leaders in patient care, biomedical science and disease prevention.”

“To deliver patient care that brings UT Southwestern’s scientific advances to the bedside — focusing on quality, safety and service.”
Collaborative Practice Agreement

I. Purpose

This document is a written protocol for drug therapy management authorized by (Authorizing Physicians) and delegated to Nakia Duncan, Pharm.D, BCGP, BCPS (Pharmacist).

This protocol considers the qualifications and types of training of the pharmacist to manage the clinical situations expected in the delegation of drug therapy management outlined and complies with the Texas State Board of Pharmacy and Texas Medical Board regulations regarding drug therapy management by a pharmacist under written protocol of physicians.

II. Scope

This protocol for drug therapy management will be inclusive of patients at the University of Texas Southwestern Medical Center Dallas, who are referred to Palliative Care inpatient teams and the Hematology & Oncology Clinics for outpatient management of pain and associated symptoms. The type of patients managed through this protocol will include patients who are dealing with serious illness and are in need of symptom management associated with disease state.

Types of Drug Therapy

A. Drug/dose initiation or changes: includes initiation, discontinuation, changes in dose, changes in frequency, route of administration of medications in collaborative practice.

1. Ex. Initiate mirtazapine 15 mg at bedtime for appetite and anxiety.

2. Ex. Increase hydrocodone/APAP from 1 tablet q4hrs as needed to 2 tablet q4hrs as needed for management of pain.

B. Medication side effect management: includes preventive management of medication side effects and making medication adjustment due to unpleasant side effects.

C. Home Medication clarification or reconciliation: comprehensive examination of patient’s medications for possible interactions, lack of indication for medications, and assessment of home medications. Pharmacist will be able to answer questions in regard to use of medication and proper administration of drug.

D. Discharge planning: the pharmacist will ensure patients’ discharging medications are provided discharge counseling to patient in regards to management of symptoms of pain, constipation, nausea and vomiting, mood, insomnia/hypersomnia.

1. Patients will be provided education materials and counseling concerning medication regimens, and monitoring parameters.

2. Provide education for patient and healthcare professionals.

Non-pharmacological recommendations: Pharmacist will be able to use non-pharmacological recommendations to help manage symptoms such as pain, constipation, insomnia, hypersomnia, nausea, and vomiting.

A. Laboratory and Patient Assessment

Ex. "Chemistry 7 laboratory test" prior to next visit for adjustment to renally dosed medications.

B. Physical examination evaluation of a patient with chronic pain; especially pertaining to the mood status and opioid addiction.

C. Opioid Risk Assessment

Counseling around difficult medical decision making often within family units.

Referral to other services for disease management: Pharmacist will be able to refer patients to specialists for further help with disease management.

Quality improvement projects: pharmacist will be able to lead process improvement projects related to patient care.

Outcomes

Implementing the Hospital Ambulatory Model has:

- Increased patient satisfaction scores
- Identified more medication errors
- Reduced ED visits
Outcomes from established CPA’s show that they can do which of the following?

a) Increase pharmacist satisfaction
b) Decrease health care provider satisfaction
c) Increase readmission rates to ED
d) Decrease medication errors

Collaborative Practice = Possible SOLUTION to consider?

- Hospital, hospital-based clinic, or an academic health care institution opportunities are already available, University Place/TIRR and UT Southwestern both presented
- Other practice settings -- need to go through the state legislative process for a change in the current TAC/Board of Pharmacy rules & state operations code for physicians to expand drug therapy management to all pharmacy practice settings
- Value proposition to prescribers - DTM/CPA is not a requirement; practicing medicine in the industry is not getting easier but in many ways tougher

Collaborative Practice = Next Steps?

- If a solid relationship is already in place that both physician and pharmacist want to expand, consider going back and have seed level discussions with a prescriber/team member
- What initial elements would best be initiated (tried at my practice site to test the waters)?
- Do I need credentialing, extra education, certification to build integrity in practice with prescribers I work with?
- Build the proposition—reduced transitions, improved outcomes (patient satisfaction, reduced med errors, healthcare costs)
- Policy and advocacy involvement for legislative change(s)

Questions?

Resource:

Krystalyn K. Weaver, PharmD
Vice President, Policy and Operations - National Alliance of State Pharmacy Associations
Kweaver@naspa.us
https://naspa.us/resource/cpa/