Workforce Innovations in Complex Care Series: Integrating Community Pharmacists into Complex Care Management Programs

June 22, 2017, 12:00-1:30 pm ET
For Audio Dial: 800-238-9007
Passcode: 759661

Made possible with support from Kaiser Permanente Community Benefit and the Robert Wood Johnson Foundation
Questions?

To submit a question, please click the question mark icon located in the toolbar at the top of your screen.

Answers to questions that cannot be addressed due to time constraints will be shared after the webinar.
Welcome & Introductions
Agenda

- Welcome and Introductions
- Cultivating an enhanced community pharmacy network to serve complex beneficiaries
- Q&A
Meet the Team

Rachel Davis, MPA
Associate Director for Program Innovation
Center for Health Care Strategies

Caitlin Thomas-Henkel, MSW
Senior Program Officer
Center for Health Care Strategies

Meshie Knight, MA
Program Associate
Robert Wood Johnson Foundation
Non-profit policy center dedicated to improving the health of low-income Americans
Select Complex Populations Initiatives

**Complex Care Innovation Lab**

Multi-year national initiative, supported by Kaiser Permanente Community Benefit, focused on improving care for low-income individuals with complex medical and social needs

**Transforming Complex Care**

Two-year multi-site pilot demonstration, funded by the Robert Wood Johnson Foundation, aimed at refining and spreading effective care models that address the needs of high-need, high-cost patients
Building a Culture of Health in America

Meshie Knight, MA
CULTURE OF HEALTH ACTION FRAMEWORK

ACTION AREA 1
MAKING HEALTH A SHARED VALUE

ACTION AREA 2
FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

OUTCOME
IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY

ACTION AREA 3
CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

ACTION AREA 4
STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS
Cultivating an Enhanced Community Pharmacy Network to Serve Complex Beneficiaries
Today’s Speakers

Joe Moose, PharmD,
Director of Strategy and Luminary Development,
Community Care of North Carolina and Co-Owner,
Moose Pharmacy

Trista Pfeiffenberger, PharmD, MS,
Director of Quality and Operations,
Community Care of North Carolina
Improving care through shared knowledge

Trista Pfeiffenberger

June 22, 2017
Disclosures

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The research presented here was conducted by the awardee. Findings might or might not be consistent with or confirmed by the findings of the independent evaluation contractor.
CCNC’s Statewide Network Infrastructure

14 Networks

Each network has:
- Medical Leadership
- Local Case Managers
- Pharmacists
- Psychiatrist

Each Network:
- NCQA Accredited for Complex Case Management
- Clinical and Operational Leadership

Population Management:
- 1.6 million Medicaid Patients
- 300,000 Aged, Blind, Disabled
- 150,000 Dually Eligible
- Care Management and Practice Support
- Convene hospitals, health department, social services, community resources
- Pregnancy Medical Homes
- Behavioral Health Integration
The Medical Neighborhood

- Care Teams
- Clinic Team/PCP
- Quality Improvement Teams
- Ongoing Medication Coordination and Optimization
- Prospective and Retrospective Quality Data
- Home Health/Rehab/ Skilled Nursing
- Community Resources
- Pharmacy
- Specialty Providers

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Documented Success of CCNC Model

Absolute percentage difference between actual and expected rates for CCNC enrolled vs. unenrolled.
Going Beyond Utilization
Medication Chaos Reigns
(Problems are Opportunities)
Beginning of Network Pharmacist Program. 1 of the 14 networks had a community pharmacy partner from the very beginning…

…Other local collaborations developed, and providers and care managers recognized community pharmacy as an especially important resource for complex patients…

…The “Special Provision” project demonstrated it could be coordinated on a larger scale…

COMMUNITY PHARMACY ENHANCED SERVICES NETWORK

Why community pharmacy?

High risk patients with multiple chronic illnesses see their physician 2-3 times per year but see their community pharmacist 20-35 times per year.
# Enhanced Pharmacy Services

- Medication Synchronization | Adherence Packaging
- Home Delivery | Home Visits
- Point-of-Care Testing | Collection of Vital Signs
- Nutritional Counseling | Smoking Cessation
- Compounding | Long-Acting Injections
- 24-Hour Emergency Services | Multi-Lingual Capabilities
Community Pharmacy Enhanced Services Networks

Core CPESN Services
Provide a minimum set of enhanced services including, but not limited to:
• Medication reconciliation
• Clinical Medication Synchronization
• Adherence Packaging
• Immunizations
• Complete Medication Reviews with Chronic Care Management

Core CPESN Services
• Ability to integrate with and augment Managed Care coordination and care management infrastructures
• Establish an ongoing professional relationship with the patient
• Provide in depth review of patient education regimens to identify opportunities to optimize therapy
• Work with providers and other health care professionals to resolve any concerns with the patient’s medications
• Contribute to development of a patient-centered care plan
• Provide care coordination and additional motoring between provider office visits for patients, especially those who are non-adherent to medications and/or are medically complex
• Engage in clear, clinically-relevant communication with the provider and care team
CPESN Pharmacy & Care Team Integration

- PRIMARY CARE PROVIDER
- PATIENT
- CARE MANAGER
- CPESN PHARMACY
Care Team Collaboration

Care managers and CPESN pharmacies can work together to address:

• Barriers preventing optimal medication adherence
• Health literacy challenges, cognitive deficits, or lack of caregiver supports that require pill box fills, special packaging, or special labeling
• Other specialized medication-related needs that could be fulfilled by a CPESN pharmacy (e.g., labeling for non-English speaking patients, naloxone kits, etc)
• Patient understanding of special instructions for administration or storage (e.g., insulin out of the fridge beyond one month, not taking inhalers properly)
• Complexity of treatment regimen versus patient’s health literacy (e.g., carb counting to determine sliding scale insulin dose is not realistic for all patients)
Making the CPESN Model Financially Viable

Option 1: Pharmacy Benefit

Drug Benefit

Better Outcomes

Non-Drug Benefit

Option 1: Pharmacy Benefit

Option 2: Medical Benefit

Pharmacy

Medical and other care team members
CPESN℠ Networks from the Pharmacy’s Perspective

Joe Moose, PharmD
June 2017
It’s Not Just About Star Ratings

The reality of what is coming... or what may already be here...

Single = ACE-I Prescribed and Taken

Home Run = BP < 140/90

Grand Slam = Patient Hospitalization Avoided
Refocusing on What Matters

Documenting what you did to get paid

- Sharing what you did to help others care for your patient
- Sharing what you found to aid in care delivery
- Sharing Patient Aspirations
- Sharing what you plan to do next with the patients so others are aware
A Day In The Life Of:
Adherence Techs
Inputting Techs
Clinical Pharmacist
Dispensing Pharmacist
Cashiers
Delivery Drivers
**Adherence Technicians**

8:30-9:30 AM – Identify patients for phone calls. Attributed patient noted in profile.

9:30 AM-1:30 PM – Call patients-Drug Therapy Problems (DTPs) identified in adherence and medication list discrepancy. DTPs input in Pharmacy Home & added to Pharmacy Management System (PMS) DTP queue via MTM Actions. *Advise pharmacists on complex medication list and therapeutic considerations.*

1:30-5:00 PM – Process patient medications-primary DTPs during this part of the day will be system failure (insurance reject, Prior Auth. required) DTPs input in Pharmacy Home and added to PMS DTP queue via MTM Actions. Help with DTP queue as allowed.

**Inputting Technicians/Counting Technicians**

8:30 AM-6:00 PM – Run queue for the day. DTPs identified in adherence and medication list discrepancy.

11:00 AM-6:00 PM – DTP follow up queue in PMS. Call patients, physicians offices, insurance, etc. and comment on progress in Pharmacy home and PMS, close out in PMS when resolved. Assist pharmacists with inputting matrices for Comprehensive Initial Pharmacy Assessments (CIPAs).
Clinical Pharmacists

8:30-10:00 AM (day of attribution list receipt) Make sure attributed patients are uploaded in PMS CIPA queue.

8:30 AM-6:00 PM
• Identify patients newly eligible for CIPA
• Identify patients who need follow up based on CIPA queue/DTP queue
• Contact patients and complete documentation in pharmacy home
• Date of next CIPA should then be assigned in PMS CIPA queue
  • Patients with no DTP’s or low priority DTPs should be assigned a CIPA follow up date of 1 year
  • Patients with more issues should be assigned a sooner follow up date based on pharmacists discretion
• DTPs should be input in PMS DTP queue for stores to follow up

Dispensing Pharmacists

8:30-9:30 AM – Work on DTP follow up queue (calling physicians, calling patients)

9:30 AM-6:00 PM – Identify DTPs while dispensing. DTP score of 75 warrants checking in Pharmacy Home for completed CIPA within a year/DTP resolution.

If no CIPA, notify cashier or delivery drive and attempt to do one on the fly if time permits or schedule one.

Notify cashier if RPh needs to speak with a patient to address DTP when patient comes in store

Have delivery driver call patient when he arrives at patient home to address DTP

Scheduled CIPA should be added to Pioneer CIPA queue. If dispensing pharmacist is unable to complete, then clinical pharmacist will complete
Cashiers

8:30-9:30 – Tag bags for potential face to face CIPAs from report given by pharmacist or technician

8:30-6:00 PM – Schedule CIPA for pharmacist at point of sale if no time to do “on the fly” CIPA

Notify staff if attributed patient chooses not to get a drug at register or if brought back by delivery driver

Delivery Drivers

Call pharmacist or technician after arrival at patient home per pharmacist/technician request

Act as a bi-direction conduit for info (Community Health Worker- Role)

Apply screening scripts

Share any compelling social/health status changes with pharmacist

Notify technicians of new phone numbers of any points of contact for patient (extended family, neighbor) for difficult to reach patients.

Notify cashier of address change so it can be changed in PMS
• What is the best phone number for us to reach you and a neighbor’s phone number?
• Are you having any problems with any medications?
  • If patient replies YES → Stop and call pharmacy
• Have you had any new medications added since the last cycle?
  • If patient replies YES → Stop and call pharmacy
• Have any medications been stopped by your doctor?
  • If patient replies YES → Stop and call pharmacy
• Did the doctor change the directions or dose of any medications?
  • If patient replies YES → Stop and call pharmacy
• Have you stopped or changed any medicines on your own?
  • If patient replies YES → Stop and call pharmacy
• Did you stop taking medications this month because of a hospitalization or vacation?
  • If patient replies YES → Stop and call pharmacy
• How much medication do you have remaining?
  • Record the amount remaining
Comprehensive Initial Pharmacy Assessment (CIPA) Work Flow Process

- **Attribution List received by pharmacy**
- **Request PCP med list, specialist med list, etc.**
- **Review PH to ensure patient not reviewed recently**
- **Complete Matrix in PH noting any non-clinical DTPs**
- **Complete CMR with patient/caregiver**
- **Call patients to schedule Face-to-Face CMR or complete CMR via telephone**
- **Review Matrix entered in PH, noting clinical DTPs**
- **Complete CMR Summary Note and Publish all Materials**
- **Work with healthcare team to resolve any DTPs**

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Summary of Moose Pharmacy
Key Learnings

• Frequently discuss initiative with entire team to create a culture of providing value-based care
  • Frequent Team Meetings
  • When you stop talking about it, staff resume “old” practices
  • Encourage everyone to work at the top of their degree

• Be efficient at dispensing medications

• Complex patients require time away from the workflow
  • Invest in resources when appropriate to assist with workflow

• Relationship building is key to successful intervention
Thank You

For more information, Contact Joe Moose at jmoose@cpesn.com
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In Case You Missed It…

- Webinar Series: Parts I and II
  - Using Community Health Workers and Volunteers to Reach Complex Needs Populations
  - Community Paramedicine: A New Approach to Serving Complex Populations

- Additional Resources
  - Integrating Community Health Workers into Complex Care Teams: Key Considerations
  - Integrating Community Health Workers into Care Teams: Lessons from the Field
  - Community Paramedicine: Taking Care into the Home for Complex Populations
  - The Business Case for Community Paramedicine: Lessons from Commonwealth Care Alliance’s Pilot Program
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