## *Making It Real: Pharmacists Working in Collaborative Practice with Physicians*

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# Our Presenters

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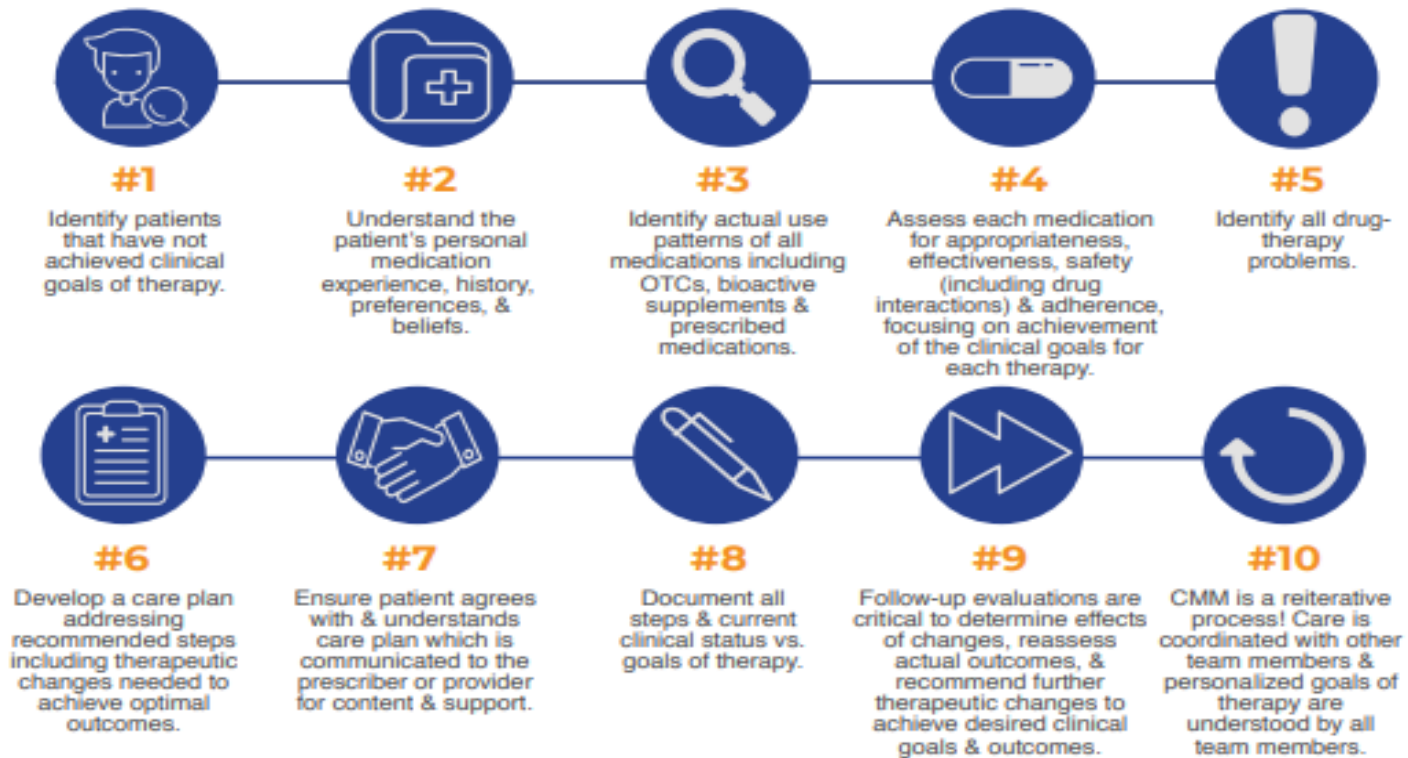Chair, Family and Community Medicine
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# Objectives

**1**   **Describe the foundational elements of CMM essential to ensuring consistency in implementation of the service in primary care.**

**2**   Discuss the value proposition of CMM and the importance of ensuring strategic alignment of the CMM service with the goals of the primary care practice.

**3**   Discuss current approaches and future directions to ensuring sustainability of CMM as an integral part of primary care.

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# Comprehensive Medication Management

A systematic approach to medications where physicians and pharmacists ensure that medications (whether they are prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended.

Integrating Comprehensive Medication Management to Optimize Patient Outcomes. Patient-Centered Primary Care Collaborative. Available at: https://www.pcpcc.org/sites/default/files/media/medmanagement.pdf. Accessed Oct 2020.

# GTMRx Ten Steps to CMM…*but HOW do you do this*

**#1**
Identify patients that have not achieved clinical goals of therapy.

**#2**
Understand the patient's personal medication experience, history, preferences, & beliefs.

**#3**
Identify actual use patterns of all medications including OTCs, bioactive supplements & prescribed medications.

**#4**
Assess each medication for appropriateness, effectiveness, safety (including drug interactions) & adherence, focusing on achievement of the clinical goals for each therapy.

**#5**
Identify all drug-therapy problems.

**#6**
Develop a care plan addressing recommended steps including therapeutic changes needed to achieve optimal outcomes.

**#7**
Ensure patient agrees with & understands care plan which is communicated to the prescriber or provider for content & support.

**#8**
Document all steps & current clinical status vs. goals of therapy.

**#9**
Follow-up evaluations are critical to determine effects of changes, reassess actual outcomes, & recommend further therapeutic changes to achieve desired clinical goals & outcomes.

**#10**
CMM is a reiterative process! Care is coordinated with other team members & personalized goals of therapy are understood by all team members.

Available at: https://gtmr.org/wp-content/uploads/2019/04/GTMRx-CMM-10-steps-PDF.pdf. Accessed October 2020.

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CMM in Primary Care
*Research Team*



Patient care process

Practice management systems

**Philosophy of practice**

**CMM Philosophy of Practice**

*Beliefs and Values that Guide the Delivery of CMM*

**CMM Patient Care Process**

*A common definition and approach to CMM delivery*

**CMM Practice Management**

*A common set of structures and processes for integration of CMM into practice*

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# Philosophy of Practice

*A shared philosophy of practice is a set of professional values and beliefs held within a discipline that serves to guide an individual practitioner's actions and behaviors and serves to instill trust in the care delivered.*

## *Guiding Principles*

- Meeting a societal need

- Assuming responsibility for optimizing medication use

- Embracing a patient-centered approach

- Caring through an ongoing pharmacist-patient relationship

- Working as a collaborative member of the health care team

Pestka DL, Sorge LA, McClurg MR, Sorensen TD. The Philosophy of Practice for Comprehensive Medication Management: Evaluating its Meaning and Application by Practitioners. Pharmacotherapy. 2018 Jan;38(1):69-79.

# *Making It Real...*



**Patient care process**

**Practice management systems**

**Philosophy of practice**

**CMM Philosophy of Practice**

*Beliefs and Values that Guide the Delivery of CMM*

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*A common definition and approach to CMM delivery*

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# The CMM Patient Care Process

*Establishing <u>a common language</u> for CMM is essential to ensure that the service is understood and valued as distinct from the care delivered by the patient's primary care provider, yet is complementary.*

*It also allows the interdisciplinary team of health care providers and staff to understand the ways in which various members of the team contribute to the patient care process for optimizing medication use.*

The CMM in Primary Care Research Team. The Patient Care Process for Delivering Comprehensive Medication Management (CMM). Available at: https://www.accp.com/report/index.aspx?iss=0718&art=3. Accessed Oct 2020.

# CMM Patient Care Process



- *Result of 2 years of research with best practices across the country.*

- *Created a Resource Guide for pharmacists and health care providers*

- *Created a CMM self-assessment tool for pharmacists*



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# Essential Functions and Operational Definitions of CMM

**I. Collect and Analyze Information**

1a. Conduct a review of the medical record to gather relevant information (e.g., patient demographics, active medical problem list, immunization history, admission and discharge notes, office visit notes, laboratory values, diagnostic tests, medication lists).

1b. Conduct a comprehensive review of medications and associated health and social history with the patient. You or a member of the interdisciplinary health care team member should:

1c. Analyze information in preparation for formulating an assessment of medication therapy problems.

**II. Assess the Information and Formulate a Medication Therapy Problem List**

2a. Assess and prioritize the patient's active medical conditions taking into account clinical and patient goals of therapy.

2b. Assess the **indication** of each medication the patient is taking by considering the following:

2c. Assess the **effectiveness** of each medication the patient is taking by considering the following:

2d. Assess the **safety** of each medication the patient is taking by considering the following:

2e. Assess **adherence** of each medication the patient is taking by considering the following:

2f. Formulate a medication therapy problem list. See Appendix A: Medication Therapy Problem Categories, Pharmacy Quality Alliance.

2g. Prioritize the patient's medication therapy problems.

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## III. Develop the Care Plan

3a. Develop a care plan in collaboration with the patient and the patient's health care providers to address the identified medication therapy problems.

3b. Identify the monitoring parameters important to routinely assess indication, effectiveness, safety, and adherence.

3c. Review all medication lists to arrive at an accurate and updated medication list.

3d. Determine and coordinate who will implement components of the care plan (i.e., patient, clinical pharmacist, other health care provider).

3e. Determine the type of follow-up needed.

3f. Determine the appropriate timeframe for patient follow-up.

3g. Determine the appropriate mode for follow-up (e.g., in person, electronically, by phone).

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## IV. Implement the Care Plan

4a. Discuss the care plan with the patient.

4b. Ensure patient understanding and agreement with the plan and goals of therapy.

4c. Provide personalized education to the patient on his/her medications and lifestyle modifications.

4d. Provide the patient with an updated, accurate medication list.

4e. Implement those recommendations that you as the clinical pharmacist have the ability to implement.

4f. Communicate the care plan to the rest of the care team. If you cannot implement a recommendation(s) on your own, reach consensus on where implementation is required by another member of the team.

4g. Document the encounter in the electronic health record (e.g., summary of relevant patient information, assessment, and plan, including rationale, monitoring, and follow-up).

4h. Arrange patient follow-up.

4i. Communicate instructions for follow-up with the patient.

## V.  Follow up and Monitor

5a. Provide targeted follow-up and monitoring (e.g., in person, electronically, or via phone), where needed, to monitor response to therapy and/or refine the care plan to achieve patient and clinical goals of therapy. Targeted follow-up includes, but is not limited to, quick check-ins to assess general status of care, monitor blood sugar or blood pressure, adjust insulin, check INRs, provide education.

5b. Repeat a comprehensive medication management visit at least annually, whereby all steps of the Patient Care Process are repeated to ensure continuity of care and ongoing medication optimization.[3]

5c. If the patient is no longer a candidate for CMM, ensure that a plan is in place for continuity of care with other care team members.

*The CMM in Primary Care Research Team. The Patient Care Process for Delivering Comprehensive Medication Management (CMM). Available at: https://www.accp.com/report/index.aspx?iss=0718&art=3. Accessed Sept 2019.*

# A Common Language for CMM

"Good checklists, on the other hand are precise. They are efficient, to the point, and easy to use even in the most difficult situations. They do not try to spell out everything--a checklist cannot fly a plane. Instead, they provide reminders of only the most critical and important steps--the ones that even the highly skilled professional using them could miss. Good checklists are, above all, practical.

They can help experts remember how to manage a complex process or configure a complex machine. They can make priorities clearer and prompt people to function better as a team."

— **Atul Gawande, [The Checklist Manifesto: How to Get Things Right](#)**

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# *Making It Real...*



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# CMM Practice Management

**Practice Management: The resources and supports needed to effectively and efficiently carry out CMM in a practice.**

## Organizational Support
- Leadership support
- Availability and adequacy of clinic space
- Fiscal resources to support service delivery

## Care Team Engagement
- Availability of support staff
- Interprofessional collaboration
- Presence and scope of CPAs

## Care Delivery Processes
- Rational methods to identifying patients in need of CMM
- Effective systems for patient scheduling
- Systems for efficient and effective care documentation

## CMM Program Evaluation
- Use of measurement strategies
- Reporting results to improve and expand

## Ensuring Consistent and Quality Care
- Quality Assurance Processes
- Practitioner Training and Coaching

# CMM Practice Management

- A tool to be completed by an *individual practice site*

- Intended to *identify potential areas for practice management improvement*

**Care Delivery Processes**

Directions: Listed below are the essential components of care delivery processes. For each item listed under the essential component, mark the box that best describes your current CMM practice.

Less optimal → Optimal

| Identifying patients for CMM | | | | |
|---|---|---|---|---|
| **Pharmacist identification** | ○ Pharmacists are responsible for identifying **MOST** CMM patients | | ○ Other methods exist (e.g., algorithm, referrals) so that pharmacists are **NOT** responsible for identifying **MOST** CMM patients | |
| **Applying an algorithm** *(Check all that apply)* | □ There are **NO** criteria to prospectively identify patients in highest need of CMM | □ There are criteria to identify patients in highest need of CMM that <u>must be manually applied</u> | □ There is an automated algorithm that is used periodically to prospectively identify patients in highest need of CMM. Manual outreach is needed to schedule these patients for a CMM visit | □ There is an automated algorithm that identifies patients in highest need of CMM and produces an alert in the course of care (e.g., a pop-up alert in the EHR) to encourage provider referral of the patient for a CMM visit. |
| **Non-provider referrals** (e.g. desk staff, community pharmacy, case managers, protocol-based nurse service) | ○ Non-providers do **NOT** identify patients who would be good candidates for CMM | | ○ Non-providers identify patients who would be good candidates for CMM | |
| **Payer referrals** | ○ **NO** CMM patients are identified by payer referrals | | ○ CMM patients are identified by payer referrals | |
| **Generated quality care lists** | ○ **NO** CMM patients are identified by clinic generated lists or registries based on quality measures | | ○ CMM patients are identified by clinic generated lists or registries based on quality measures | |

# Optimizing Medications
## for Better Health



- **Comprehensive Medication Management Implementation and Improvement System**
- **Self assessment tools and reports**
- **MTP documentation tool**
- **Policy updates**
- **A Community of Practice**
- **Resources**

# Objectives

1  Describe the foundational elements of CMM essential to ensuring consistency in implementation of the service in primary care.

2  **Discuss the value proposition of CMM and the importance of ensuring strategic alignment of the CMM service with the goals of the primary care practice.**

3  **Discuss current approaches and future directions to ensuring sustainability of CMM as an integral part of primary care.**

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# CMM Value Proposition

CMM has demonstrated improvement in patient clinical outcomes, such as improved control of hypertension, diabetes, hyperlipidemia, and HIV,[9-17] and has resulted in fewer hospital and emergency department visits.[17-19]

CMM has demonstrated positive impact related to cost avoidance and has demonstrated a positive return-on-investment (ROI) ranging from an average of 3:1 – 5:1 up to 12:1.[13-18,23-24]

**Better Outcomes**

**Improved Clinician Experience**

**Lower Costs**

**Improved Patient Experience**

Primary care physicians view the pharmacist as value-added in providing a unique skill set specific to medication optimization and allowing them to have more time to spend on other tasks. They find the pharmacist to be a collaborative partner in caring for patients.[20-22]

Patients find CMM and the role of the pharmacist to be of value.[17,25] Specifically, CMM can improve their overall health and wellbeing,[26] improve medication adherence,[27] help them reach and maintain their goals of therapy, minimize their medication adverse effects, and improve their understanding of their medications.[14]

*Making It Real…Relationships and business cases more important than ROI (at this point)*

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# CMM Value Proposition…Making It Real

## What are the Goals and Priorities of the Strategic Partner (e.g., The Plan, the Employer, the Primary Care Practice, ACO)
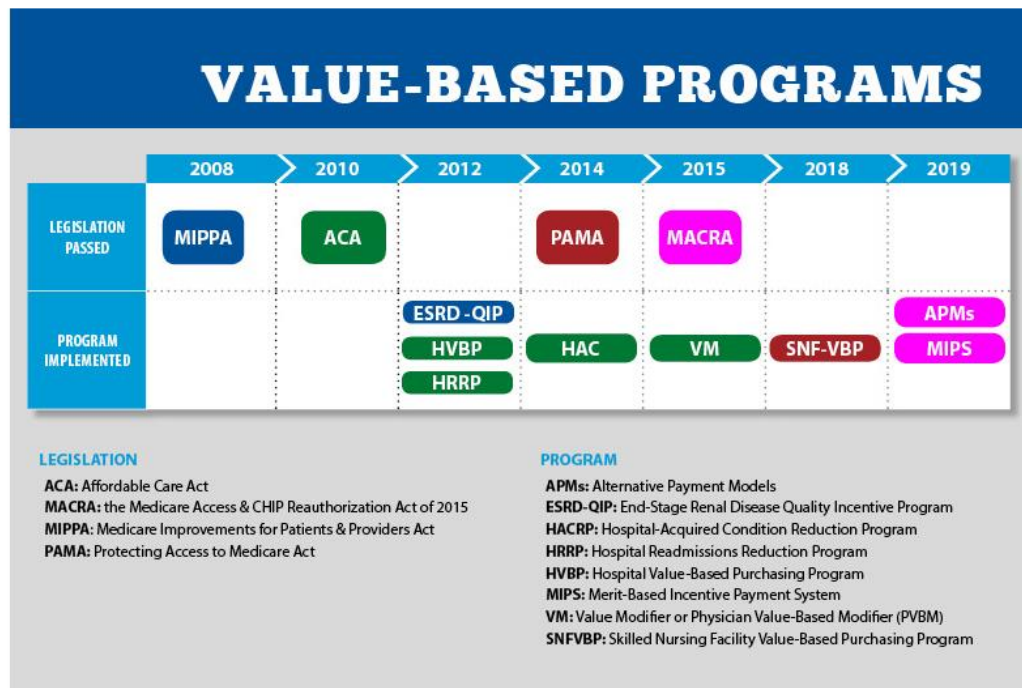
Aligning CMM with the goals and strategic priorities of the stakeholder is key. Highlighting how CMM services bring value to the stakeholder and their patients is a critical step toward establishing CMM and sustaining CMM services.

Key goals and priorities of the strategic partner are the outcomes they are most interested in improving. These outcomes may be clinical, humanistic, or financial. They are the 'metrics that matter' the most to the stakeholder (whether the health plan, the employer group, the primary care practice, or the ACO).
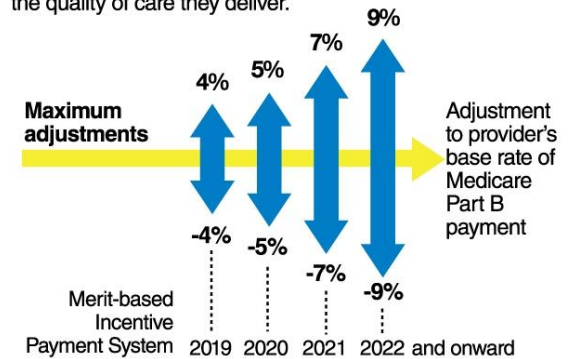
Examples:
- Improving chronic disease quality metrics (e.g., HEDIS measures, Uniform Data System (UDS) measures)
- Improving access
- Reducing readmission rates
- Closing clinical care gaps (e.g., decreasing HbA1c to ≤9% in 70% of patients with HbA1c>9% within 18 months; Meeting system blood pressure goals in 80% of patients by the end of 2020)

# Centers for Medicare and Medicaid Services (CMS) Leading the Way to Value-based Care
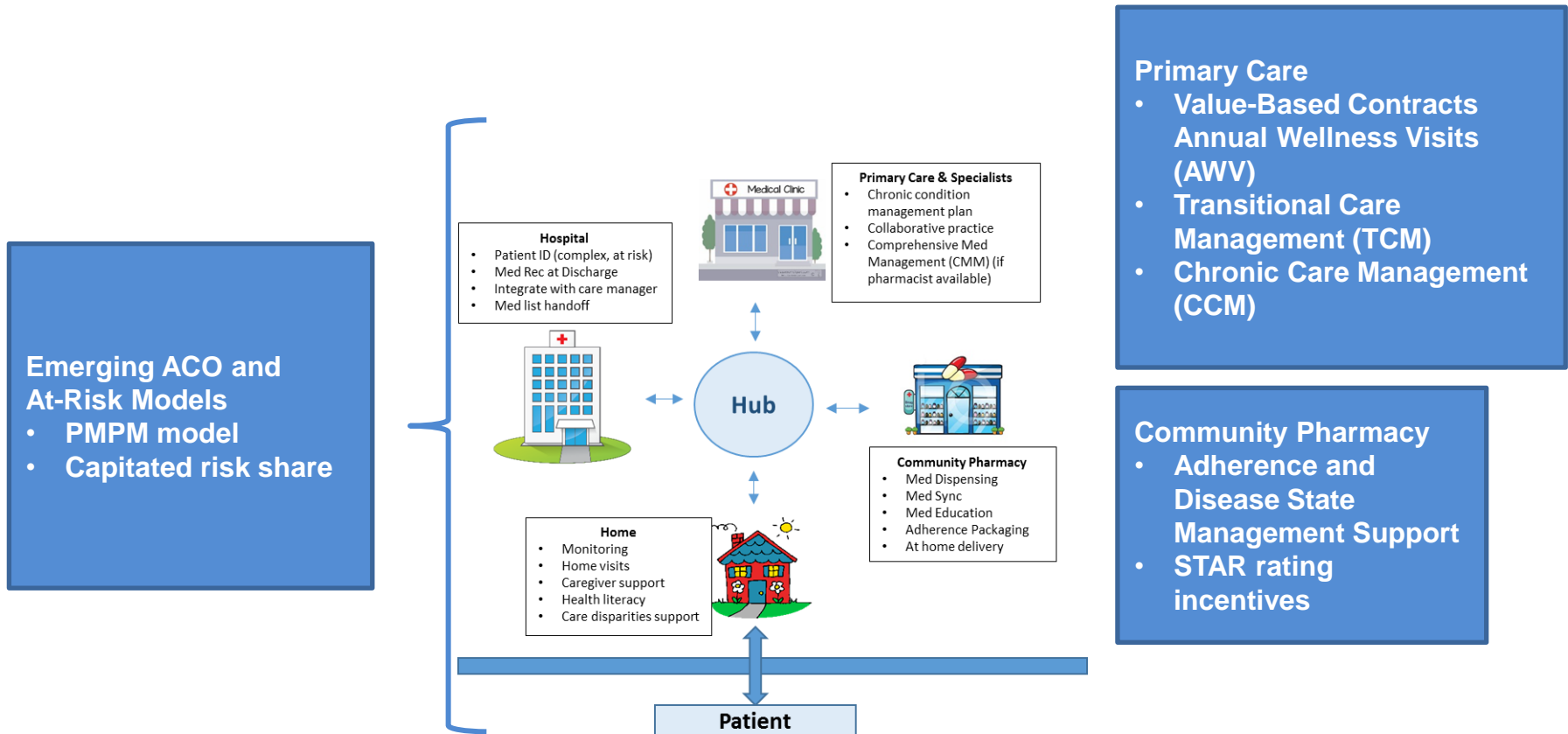
# Aligning Services with Reimbursement Models

**Emerging ACO and At-Risk Models**
- **PMPM model**
- **Capitated risk share**

**Hospital**
- Patient ID (complex, at risk)
- Med Rec at Discharge
- Integrate with care manager
- Med list handoff

**Primary Care & Specialists**
- Chronic condition management plan
- Collaborative practice
- Comprehensive Med Management (CMM) (if pharmacist available)

**Hub**

**Community Pharmacy**
- Med Dispensing
- Med Sync
- Med Education
- Adherence Packaging
- At home delivery

**Home**
- Monitoring
- Home visits
- Caregiver support
- Health literacy
- Care disparities support

**Patient**

**Primary Care**
- **Value-Based Contracts Annual Wellness Visits (AWV)**
- **Transitional Care Management (TCM)**
- **Chronic Care Management (CCM)**

**Community Pharmacy**
- **Adherence and Disease State Management Support**
- **STAR rating incentives**

Source: UNC Eshelman School of Pharmacy Center for Medication Optimization

# A Case Example

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# In Summary

- CMM is a **well-designed**, **evidence-based**, **value-added medication optimization service** prime for replication and scale.

- Relationships and business cases more important than ROI (at this point)

- Think big – Start small – Act local and Act now!