Thinking Outside the Box: Pharmacists’ Role in Ambulatory Care

Tim R. Brown, PharmD, BCACP, FASHP
Director, Clinical Pharmacotherapy in Family Medicine
Cleveland Clinic Akron General Center for Family Medicine

Kristy Butler, PharmD, BCPS, BCACP, FASHP, FOSHP
Manager, Clinical Pharmacy Specialists
Providence Medical Group, Oregon Region
Learning Objectives

- Identify indicators that predict the continued growth of ambulatory care.
- Describe the role of the pharmacist in successful contemporary practice models.
- Describe key metrics being utilized in Ambulatory Care practices and how pharmacists can impact these measures.
- Discuss Provider Status and evolution of the Ambulatory Care practice model
Importance of Ambulatory Care Model Advancement

We Ain’t Getting Any Younger!
Data Points on U.S. Home Healthcare

- 8.6 million to 12 million people receive home healthcare (The Joint Commission, 2011; National Association for Home Care & Hospice, 2010).

- By 2050, 27 million people are expected to receive home healthcare (Home Care & Hospice, 2012).

- More than 1 million home healthcare and hospital workers care for these patients (The Joint Commission, 2011).

- 65.7 million informal and family caregivers (29% of the U.S. adult population) care for the ill, disabled, or aged (Family Caregiver Alliance, 2012).

- 43.5 million adult family caregivers care for someone 50+ (Family Caregiver Alliance, 2012).

- The aging population (65+) will more than double between 2000 and 2030, increasing from 35.1 million to 71.5 million (Family Caregiver Alliance, 2012).

- Estimates of the size of the home healthcare market range from $68 billion (Kayyali et al., 2011) to $74 billion (IBISWorld, 2013) to $85 billion (Leiber, 2012).
Percentage of adults 45-64 and 65 and over with two or more of nine selected chronic conditions

CDC, NCHS Data Brief, Multiple Chronic Conditions Among Adults Aged 45 and Over: Trends Over the Past 10 Years,  http://www.cdc.gov/nchs/data/databriefs/db100.htm, Accessed January 3, 2014
Changes in Source of Hospital Revenues: Outpatient vs. Inpatient

<table>
<thead>
<tr>
<th>Year</th>
<th>Gross Outpatient Revenue</th>
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<td>2011</td>
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Need for Pharmacists

Increasing need for pharmacists in ambulatory care settings:
- Hospital and Health-System Clinics
- Federally Qualified Health Centers
- Patient Centered Medical Homes
- Community Pharmacies
- Physician offices
- Administrators to oversee expansion

Vacancy predicted for Ambulatory Care Pharmacy leadership positions

Increasing focus on smooth transitions in care between settings
ASHP Ambulatory Care Summit and Conference

Circle the Wagons
Key Summit Recommendations

Domain 1: Defining Ambulatory Pharmacy Practice

1.2...Pharmacists who provide ambulatory care services perform patient assessments, have prescribing authority to manage disease through medication use and provide collaborative drug therapy management, order, interpret, monitor medication therapy-related tests, coordinate care and other health services for wellness and prevention of disease, provide education to patients and caregivers... and document care processes in the medical record.
Key Summit Recommendations

Domain 2: Patient Care Delivery and Integration
2.2 Pharmacists who provide ambulatory care services must collaborate with patients, caregivers, and health care professionals to establish consistent and sustainable models for seamless transitions across the continuum of care.

Domain 3: Sustainable Business Models
3.1 Pharmacists must be recognized as health care providers.
Key Summit Recommendations

Domain 4: Outcomes Evaluation

4.2 Through partnering with patients, and as members of the interprofessional health care team, pharmacists who provide ambulatory care services must demonstrate measurable and meaningful impact on individual patient and population outcomes.
Are You Up To Date?

Ambulatory Care Self-Assessment Survey similar to HSA Survey
- One for practitioners
- One for administrators

Pharmacy Forecast 2016
- Ambulatory Care is integral
- Planning for expansion of services
- Engaging pharmacists to increase competencies
- Determining how to increase revenue
- Partnerships that need to be created
Advancing Existing Practice Models

Evolution of Pharmacy Primary Care
Medication Therapy Management
Transition of Care
Annual Wellness Visits
Pharmacy Primary Care Evolution

- Chronic disease state management - earliest model of direct patient care
  - “Coumadin” Clinics
  - Diabetes Management
  - HIV Management
  - Preventative Care
  - One trick pony or care for the entire herd?

- Collaborative Practice Agreements
  - Formalized the relationship with other HC professionals
  - Each state is different in defining scope of practice

- Freestanding vs. Integration
  - Community/Retail practice sites
  - Integrate into physician office space
  - Hospital based clinics/Infusion Centers
  - Academic settings
Primary Care Pharmacy Services

Reimbursement Dilemmas

- Facility billing and/or Incident-To billing
- Employee value programs, Grants, State driven
- Can billing work in community setting?
- Pharmacists direct billing a 3rd party payor for patient care?
- Where does Revenue Stream flow?
- Clinician performance tied to reimbursement – metrics
- Shift from FFS to value-based payment models
  - P4P bonuses/penalties
- Increasing shared risk/savings agreements
Primary Care Pharmacy Services

Expansion of services

- Global Payment Models
- Broadening of care beyond single disease or drug management
- Shift in community pharmacists’ role beyond MTM
- “Reassigning” FTEs within department of pharmacy
- Rural expansion – how to shift the limited workforce
- Population Health and our role
- Shift in pharmacy administration attitude
Medication Therapy Management

- Community Pharmacies immediately saw value in implementing direct patient care
- Formalized medication review and/or reconciliation
- CMS defined pharmacy-driven billing codes
  - Defined type of patient
  - Number of medications to qualify
  - Which chronic disease states matter
- Third party payor systems created
- Altered the expectation of a pharmacist
- Was it revolutionary?
- Did if further our cause?
Transition of Care (TOC) Model

- Huge potential for integration
  - Population Health, CDM, Formulary Management

- Elements for Success
  - Multidisciplinary support and collaboration
  - Data available to justify resources
    - Readmissions
    - Length of stay
    - Emergency Department visits
    - Medication-related problems at med rec (e.g. Duplication of Therapy)
    - Disease-specific metrics
    - Patient satisfaction or Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) – related metrics
  - Electronic patient information and data transfer between inpatient and outpatient partners, including community settings
  - Strong partnership network
TOC Visits

Effective January 1, 2013, new HCPCS codes for Transitional Care Management Services

Codes are used to bill physician and “qualified non-physician providers” care management following discharge from:

- Inpatient setting
- Observation setting
- Skilled nursing facility

Pharmacists are providing these services under supervision of physician or qualified non-physician practitioners in office settings
TOC: CMS Requirements

- Initial Patient Contact in 2 business days
  - 2 attempts counted
  - More than just scheduling a call
- Face-to-Face OV
  - High Complexity: 7 days
  - Mod Complexity: 14 days
- Medication Reconciliation during OV
- Includes all communications with patient
- Documentation within EMR
- Aligns with PCMH concept
TOC: Pharmacists’ Impact

Transitional Care Management Codes

- Face-to-Face visit within 7 days of discharge
  - HCPCS Code 99496
  - High complexity
  - 2012 Medicare reimbursement: $231

- Face-to-Face visit within 14 days of discharge
  - HCPCS Code 99495
  - Moderate complexity
  - 2012 Medicare reimbursement: $164

Claim submitted under recognized CMS provider
Annual Wellness Visits

Yearly "Wellness" visits designed for primary care office settings

- Patient has had Part B for longer than 12 months
- Patient fills out questionnaire, “Health Risk Assessment,” as part of visit.
- Develop a personalized prevention plan including a list of current providers and prescriptions
- Take Ht, Wt, BP, and other routine measurements
- Review patient’s potential risk for depression and level of safety
- Develop a list of risk factors and treatment options for patient
- Visit is covered once every 12 months
- Population Health !!!
AWV: We ARE Eligible Providers

Providers of AWVs

- A physician who is a doctor of medicine or osteopathy
- A physician assistant, nurse practitioner, or clinical nurse specialist
- A medical professional (including a health educator, registered dietitian, or nutrition professional or other licensed practitioner) or a team of such medical professionals, working under the direct supervision
AWV: Revenue Stream Expansion

- CMS based
  - Initial Visit is by PCP: G0438
  - Subsequent Annual Visits: G0439
  - Diagnosis Code: V70.0
  - Medicare Part B benefit

SIGNIFICANT revenue potential!
- Subsequent Visit: $91.23 to $140.09
- Do not forget your diagnosis code
- Modifier -25 if E/M is needed
AWV: Documentation Required

- Medical and family history
- Listing current providers and suppliers
- Vital signs including ht, wt, BMI, waist circumference
- Detection of cognitive impairment
- Review for depression
- Review functional ability and level of safety
- Establish 5-10 yr screening plan
- Development of list of risk factors or conditions
- Furnishing of personalized health advice and referrals aimed at preventive services
Contemporary Practice Models

Education Advancement
Privileging and Credentialing
Patient Centered Medical Homes
Accountable Care Organizations
Education Advancement

Layered learning - concept of a pharmacy team
- Pharmacy attending
- Residents
- Students
- Technicians

Learners play a significant role in model advancement – there is no free ride
Active learning leads to extension of services offered
Appropriate autonomy – not all learners are created equal there must be competency based milestones
Co-exist with new broad based practice models
Education Advancement

- Minimum standards for providers
  - What will 3rd party payors mandate?
  - Are new practitioners prepared/educated to practice immediately after graduation?
  - Residency training for those in direct patient care?
  - Should there be a certification for every practice model/site?

- Expansion of residency slots to meet need or continue to be exclusive

- Continuing education in general has to be overhauled

- Preceptors standardizing students’ clinical experiences

- As model shifts so must educational curricula
Privileging

- Formal process to ensure competency within a health system
- Application process required with proper credentials
- Establishes scope of practice within the boundaries of that system
- Ongoing process with renewal at intervals to ensure competencies are being maintained
- Increases liability for pharmacists while expanding their role in patient care
Credentialed

- Added certification showing achievement of certain competencies
- What is the standard for pharmacy?
- Many different types that range from disease specific to population care and of course areas of practice
- Board Certification remains the most recognized
- How do we “maintain” the credential is the larger question
- Exams, CE, direct/indirect patient care observation, or a combination
Application of Educational Expansion

Bringing Value to the System
Patient-Centered Medical Home

Patient-centered, physician-guided, cost-efficient, longitudinal care that promotes continuous healing through relationships and delivery of care by a “team” of health care providers

Funded by national grants, state Medicaid pilot programs, and the Affordable Healthcare for America Act (Reform bill) via demonstration projects

The Advanced Medical Home. American College of Physicians Policy Monograph, 2006
Exactly what is PCMH?

- 13 definitions with 123 different elements
- Common themes as to what PCMH is:
  - Coordinated – providers responsible for communicating
  - Broad in scope – “whole patient”
  - Has continuity – on going long term
  - Linked to community – coordinates with community resources
  - Meets quality standards
  - Active management – access and follow up
  - Team based care

Vest et al. Medical Care Res Rev 2010
Accountable Care Organizations

- Primary goal of ACOs is to *reduce* the total cost of care for a given population
  
- However, must maintain and improve quality and satisfaction
  
- Key is prevention and wellness – that is the value based care that is needed
  
- An effective ACO should include a pharmacist!

Accountable Care Organizations: *A new model for sustainable innovation*, Deloitte Center for Health Solutions, 2010
ACO: Our Core Functions

As Pharmacists we must focus on:

- Facilitating provider partnerships with patients, families and communities
- Continue to integrate into primary care medicine and advance the medical home concept
- Provide tools and resources to other health care providers
- Focus on population health management
- Quality, efficiency, satisfaction, cost
Pharmacists’ Impact

- Key player between clinician prescribers and pts
  - Medication management
  - Medication reconciliation
  - Monitoring contraindications and overuse
  - Patient safety
- Developing personal medication care plan for each patient
  - Chronic disease state management + MTM
  - Self management goals
- Communicating/Counseling on the care plan with the patient and others in the PCMH
Value Base Pay Already?

- PCMH payment model
- Readmission rates/TOC
- Formulary utilization
- Polypharmacy oversight
- Adult Vaccinations rates
- CMS Star Ratings
- Clinical Quality Measures
  - Adults
  - Pediatrics
Where Do We Go Next?

WE GET PAID!!
What is Provider Status?

- Becoming a federally designated “provider” means Pharmacists can participate in the Medicare program and bill for services that are within their state scope of practice to perform.
- Attaining provider status at the federal level does not expand pharmacists’ scope of practice at the state level.
- Section 1861 of the Social Security Act is the reference point for practitioners and is used as a benchmark for other commercial plans.
- 38 states recognize pharmacists as providers.
Impact on Patient Care

Achieving provider status is about giving patients consistent access to care that improves safety, quality, outcomes, and decreases costs

- 30 million people gained access to medical care in 2014
- 17,000 primary care physicians are currently needed and another 40,000 more by 2025
- Aging population, 58 million retiring baby boomers
- Pharmacists represent the 3rd highest number of licensed health care professionals (approx. 300,000) – The only medication experts
Impact on Patient Care

Acknowledging pharmacists as non-physician providers in the Social Security Act will allow licensed pharmacists to better assist patients by:

- Working collaboratively with physicians and other providers
- Allowing for autonomy to provide care and optimize medication therapy
- Increasing access for patient-centered care in medically underserved areas
Evolution of Profession

- Absence reduces visibility, implies secondary role, impedes care provision

- Extensive documentation of the need and improvement in outcomes, cost, and access when pharmacists provide clinical services

- Pharmacists can provide primary care and manage chronic disease including mental health
  - Improve outcomes of care
  - Enhance medication safety
  - Reduce costs of care
  - Expand access to care

- Lack of Part B eligibility has prevented universal integration – incentives are inappropriately aligned to provide the necessary workforce
Critical For Our Future Pharmacists

Shifting away from fee-for-service?

- Traditional fee-for-service will likely be phased out and replaced with new payment systems that emphasize quality, outcomes, and shared risk/savings/bundled payments

- Focus for pharmacists has been on their roles on interdisciplinary teams

- However, section 1862 of the SSA remains the reference point to identify practitioners who are eligible to participate in new and emerging delivery systems and payment models (e.g. ACOs and Medical Homes)

- Recognition will ensure that pharmacists are eligible for participation on the care team, and participate in new and current delivery and payment systems
Pharmacy and Medically Underserved Areas Enhancement Act

Recognition for Care We are Already Providing
What is H.R. 592/S. 314?

This is the renaming of HR4190 and Intro of Senate Bill

A bipartisan bill that would amend the Social Security Act to recognize pharmacist services to patients under Medicare Part B in medically underserved communities

- Applies to licensed pharmacists working within their state’s scope of practice laws
- Establishes a mechanism of pay for pharmacist provider services under Medicare

- HR 592 has 264 Co-Sponsors

- S 314 has 41 Co-Sponsors
Senate Message

- There was no companion bill to H.R. 4190 in the 113th Congress.
- The PAPCC worked with the Senate offices to introduce S. 314, a companion to H.R. 592 in the 114th Congress.
- Introduced on January 30, 2015.
- Ask for their commitment to increase access for patients living in medically underserved areas.
Keys to Success

- Pharmacy must maintain unified stance
- Grassroots efforts must be robust
  - 270,000 licensed pharmacists in the U.S. can have a huge impact
- Election results do not change our message
- Focusing on the unmet need, new Medicare enrollees, access to care no matter where you live
Individual and State Actions

- Recruit individual health system support of H.R. 592/S. 314 – realize how this affects your practice area
- Solicit other state-level health profession organization support
  - Medical specialties
  - Nurse practitioners
  - Physician assistants
- Visit elected officials/staff
- Educate pharmacists and other providers
- Colleges of Pharmacy, including pharmacy students to assist in providing care to these patients
- Outreach to local media and explain our desire to help
- Public education using social media
Discussion or Questions