CHC Expert Session #1
Bringing Pharmacy Into the Fold: Aligning Your Health Center’s Pharmacy Program for Operational Excellence and Optimal 340B Compliance

Moderator: Sue Veer, MBA
President and CEO
Carolina Health Centers, Inc.
Statement of Conflicts of Interest

• Sue Veer has no actual or potential conflict of interest in relation to this presentation
Today’s Agenda

During today’s session we will:
• Consider a paradigm shift in how we think about health center pharmacy programs;
• Discuss the potential impact of that shift on our health center and the patients and communities we serve;
• Explore the organizational philosophy and framework necessary to support such a shift in thinking;
• Hear from two pioneers who have been instrumental in the growth and development of robust pharmacy programs; and
• Consider external and internal factors that must be addressed to support this expanded paradigm.
CE Question

Which of the following is within the scope of practice for a clinical pharmacist?

A. Immunizations
B. Patient assessments
C. Patient education
D. All of the Above
E. None of the above
This is a paradigm many of you have become accustomed to seeing:

The heart of the value proposition for the 340B Drug Pricing Program lies at the intersection of:
- Access
- Quality
- Financial Capacity
Consider the impact on that paradigm if we expand our frame of reference...
Why is this paradigm shift important?

Nothing good can come out of failing to take a medication as prescribed. "Drugs don’t work in patients who don't take them."

Surgeon General C. Everett Koop

125,000 people with treatable ailments die annually in the United States because they do not take their medication properly.

Poor adherence in CardioVascular Disease = $100 billion annually.

33-69% of hospital readmissions are the result of poor medication adherence.

2019 Literature Review

“To diagnose but not be able to treat is always an exercise in futility, but sometimes it’s a death sentence.”

Community Health Center physician
Essential pillars of a primary care medical home according to the American Academy of Family Practice
According to the American Society of Health System Pharmacists it is within the scope of practice for pharmacists to:

- Perform patient assessments;
- Develop collaborative practice agreements with physicians;
- Order, interpret, and monitor medication therapy-related tests;
- Coordinate care for wellness and prevention of disease;
- Deliver immunizations;
- Provide education for patients and caregivers;
- Document care processes in the medical record; and
- Bill for cognitive services.

Is this an untapped source of value for our health center and the patients we serve?
Organizational Framework for Optimal Value & Compliance

• Alignment of clinical pharmacy as a core component of a primary care medical home
• Clear and specific understanding of the benefits of an effective pharmacy program
• Over-arching board approved corporate policy
• Service delivery model that is best practice for your health center
• Multidisciplinary Pharmacy Oversight Committee
• Consideration in strategic and operational decision making
• Included in outreach and marketing material
• Corporate-wide staff education and communication
• Optimal utilization of 340B inventory
• Data driven performance management
• Comprehensive “Integrity Plan”
• Demonstrating value
CE Question

Which of the following is within the scope of practice for a clinical pharmacist?

A. Immunizations
B. Patient assessments
C. Patient education
D. All of the Above
E. None of the above
Let me introduce our expert panelists:

Nicole Thibeau
Director of Pharmacy Services, Los Angeles LGBT Center
nthibeau@lalgbtcenter.org

Aida A. Garza, PharmD, CDE, BCACP
Associate Pharmacy Director/Clinical Pharmacist
CommUnityCare
Aida.Carza@communitycaretx.org

Michael B. Glomb, Partner
Feldesman Tucker Leifer Fidell LLC
mglomb@feldesmantucker.com
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Developing a Team Approach to 340B

Nicole Thibeauf, PharmD, AAHIVP, Director of Pharmacy Services
Los Angeles LGBT Center
Statement of Conflicts of Interest

• Nicole Thibeau has no actual or potential conflict of interest in relation to this presentation
Today’s Agenda

• About the Los Angeles LGBT Center
• How 340B was handled in the past
• Development and make-up of current 340B team
• 340B team decision process
CE Question

Only pharmacists should be part of a 340B team.

• True
• False
Los Angeles LGBT Center

• Largest LGBT organization in the world
• Founded in 1969 as social services organization
• Nine locations
• Youth/senior programs including housing, legal services, education and job placement, community outreach, advocacy
Health Services

- Federally Qualified Health Center (FQHC) and Ryan White grantee
- Clinic: HIV care and prevention, sexual health program, LBQ+ women’s health program, transgender medicine, and LGBTQ+ primary care
- Mental Health: Psychiatry, counseling, group therapy, addiction recovery services (including MAT)
- Pharmacy
- Research
- Quality/Credentialing, Health Information Team, Health Programs Finance Team
Pharmacy

• One in-house, open-door retail pharmacy
• Two dispensary locations (one at each intermittent clinic)
• HIV focused
• 60+ staff members
  • 9 full time staff pharmacists (+ part time and on call)
  • 2 full time clinical pharmacists (+1 part time)
  • 25 full time technicians (+ part time and on call)
  • 6 supervisors
• 200,000+ scripts this fiscal year
• Average scripts per client = 4-5
Who worked on 340B in the past?

• Primary = Regularly
  • Deputy Director of Health Services
  • Director of Pharmacy

• Secondary = Occasionally
  • Compliance Officer
  • Senior Finance Manager – Healthcare Programs

• C-Suite = Rarely
  • Chief-of-Staff
Developing 340B Team (1\textsuperscript{st} Attempt)

- What prompted?
  - 340B Winter Conference 2017!!

- Technique
  - Create shared responsibility
  - Once monthly meeting with all 340B stakeholders (~30 people)

- Outcome
  - Ineffective: too broad and included too many people
  - Cancelled after 3 months (only pharmacy staff were attending)
    - However, continued to train key members of pharmacy staff
Developing 340B Team (2nd Attempt)

• What prompted?
  • Deputy Director of Health Services left organization

• Technique
  • Create layers of 340B communication by grouping tasks/categories
  • Director of Pharmacy as the point person for all groups

• Outcome
  • Effective: individuals included only in context of their role
  • Many more people involved across various areas of health services
Current 340B Team (Primary)

• Primary
  • Pharmacy
    • Director of Pharmacy Services
    • Pharmacy Operations Team
    • Pharmacy Finance/Inventory Team
    • Assistant Pharmacy Manager (Compliance)
    • Working knowledge for all staff

• Finance
  • Senior Finance Manager – Healthcare Program
  • Billing Manager
  • Benefits Specialist Supervisor (financial screening)
Current 340B Team (Secondary)

• Clinic
  • Director of Nursing
  • Nursing Manager

• Health Information Systems (HIS)
  • HIS Director
  • HIS Operations Manager
  • HIS Business Intelligence Manager

• Quality
  • Compliance Officer

• Policy
  • Director of Government Relations
  • Director of Policy and Community Building
Current 340B Team (C-Suite)

- C-Suite
  - Chief of Staff
  - Chief Financial Officer
  - Chief Medical Officer
  - Co-Directors of Health Services
340B Pathway Examples

• Finance
  • Pharmacy Finance/Inventory Team ➔ Director of Pharmacy ➔ Senior Finance Manager ➔ CFO

• Policy
  • Director of Government Policy ➔ Director of Pharmacy ➔ Co-Directors of Health Services ➔ Chief of Staff

• Operational
  • Director of Pharmacy ➔ Nursing Manager ➔ Director of Nursing ➔ CMO
Successes and Challenges

• Successes
  • Engaged larger group of stakeholders
  • Increased institutional knowledge of 340B
  • Shared responsibility

• Challenges
  • Decision-making
  • Director of Pharmacy still has highest risk
  • Sometimes “too many cooks in the kitchen”
CE Question

Only pharmacists should be part of a 340B team.

• True
• False
Additional Questions?

Nicole Thibeau, PharmD, AAHIVP
Director of Pharmacy Services
Los Angeles LGBT Center
1625 Schrader Blvd.
Los Angeles, CA 90028
(323) 993-7445
nthibeau@LALGBTcenter.org
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Successes and Challenges at CommUnityCare

Aida Garza, PharmD, Associate Pharmacy Director
CommUnityCare Health Centers
Statement of Conflicts of Interest

• Aida Garza has no actual or potential conflict of interest in relation to this presentation
Today’s Agenda

- Review pharmacy integration at CommUnityCare Health Centers
- Discuss the role of a clinical pharmacist in an integrated team
- Discuss the importance of integrating pharmacy into the primary health care team
- Review how pharmacy can improve quality of care and outcomes
CE Question

Pharmacy integration into team-based care can provide what benefits to a health center?

• Positive clinical outcomes
• Reduction in health care costs
• Patient satisfaction
• All of the Above
CommUnityCare Health Centers

- Federally Qualified Health Center in Travis County, Texas
  - 28 locations
  - Over 100,000 unique patients
  - Offers adult primary care, women’s services, pediatric care, behavioral health services, healthcare for the homeless, specialty care, HIV care, dental care, pharmacy services
Pharmacy Department

• CommUnityCare’s Pharmacy Department provides a range of medication services
  • Pharmacy Benefits program manages the delivery of pharmacy benefits to our safety net population
  • Two in-house Class A community pharmacies
  • Clinic administered medications and Class D clinic pharmacies
  • 340B compliance/administration
  • Patient Assistance Program assists to obtain medications for patients through individual patient applications from pharmaceutical manufacturers
  • Clinical Pharmacy provides chronic disease medication management

• 50+ staff members
Clinical Pharmacy

- Consists of 12 pharmacists and one post graduate year two (PGY-2) Ambulatory Care Resident
- Doctor of Pharmacy
- Post graduate residency: 1-2+ years
- Board Certifications: Pharmacotherapy (Board Certified Pharmacotherapy Specialist) or Ambulatory Care (Board Certified Ambulatory Care Pharmacist)
- Available by referral via delegation through a collaborative practice agreement
- Services include: chronic disease medication management, drug-consults, assistance with medication refill requests, team based care co-visits, formulary management, medication safety
Integration Of Pharmacy Into Team Based Care

Old Care Model

• Provider focused
• Provider reviews all patient data, makes decisions, refers to specialists as needed
• Many tasks for provider to complete
• Silo practice

New Care Model

• Patient focused
• Team approach to patient care and tasks
• Pharmacy added as collaborative team member
• Improved quality
Benefits of Clinical Pharmacy

- Improve chronic disease state via medication management
- Available for more frequent medication titrations
- Medication education
- Encourage patients to make lifestyle changes
- Quality improvement projects and committee work

- Improve quality of life for patients
- Improve clinical outcomes
- Reduce long-term healthcare costs & complications
- Patient satisfaction
Impact of Physician–Pharmacist Covisits at a Primary Care Clinic in Patients With Uncontrolled Diabetes

Jasmine Peterson, PharmD¹, April Hinds, PharmD, BCACP¹,², Aida Garza, PharmD, BCACP, CDE¹, Jamie Barner, PhD, FAACP, FAPhA², Lucas Hill, PharmD, BCPS, BCACP¹,², Michelle Nguyen, PharmD, BCACP¹, Phillip Lai, PharmD, BCPP¹, and Tyler Gums, PharmD, MS, ASH-CHC²

Abstract

**Purpose:** A popular method for enhancing medication management within a patient-centered medical home (PCMH) is the physician–pharmacist collaborative management (PPCM) model. To improve efficiency of health-care delivery within 4 federally qualified health centers (FQHCs), the PPCM model was implemented through coordinated physician–pharmacist covisits.

**Objective:** To evaluate the impact of physician–pharmacist covisits on clinical outcomes among patients with uncontrolled diabetes.

**Methodology:** This was a retrospective multicenter cohort study including adults (≥18 years old) with uncontrolled type 1 or type 2 diabetes (hemoglobin A₁c [HbA₁c] ≥ 8%) who had at least one covisit between January 1, 2013, and October 1, 2016. The primary clinical metric was mean change in HbA₁c from baseline to follow-up. Secondary outcomes included adherence to select American Diabetes Association (ADA) Standards of Medical Care. **Results:** A total of 106 patients were included in this analysis. Patients who were managed in the PPCM model experienced a significant decrease in mean change in HbA₁c from baseline to follow-up (−1.75 [2.63], P < .001). There was no significant difference in the proportion of patients receiving recommended vaccinations or cardiovascular (CV) risk reduction medications. **Conclusion:** The results suggest that physician–pharmacist covisits may improve glucose control in patients with uncontrolled diabetes.
Adherence to the 2013 Blood Cholesterol Guidelines in Patients With Diabetes at a PCMH

Comparison of Physician Only and Combination Physician/Pharmacist Visits

April Hinds, PharmD, BCACP
Debra Lopez, PharmD, BCACP, BCPS, CDE
Karen Rascatt, Phd
Jason Joksrif, PharmD, BCPS
Meera Sriyans, PharmD, CDE, BCACP

From the University of Texas College of Pharmacy & CommUnityCare, Austin, Texas (Dr Hinds); University of Texas at Austin, College of Pharmacy, Clinical Pharmacist at Sanofi, Austin, Texas (Dr Lopez); University of Texas at Austin College of Pharmacy, Austin, Texas (Dr Rascatt); Clinical Pharmacist at CommUnityCare, Austin, Texas (Dr Joksrif, Dr Sriyans).

Correspondence to April Hinds, PharmD, University of Texas College of Pharmacy & CommUnityCare, 2901 Montopolis Drive, Austin, TX, USA. April.Hinds@utexas.edu.

Purpose

The purpose of this study is to assess adherence to the 2013 blood cholesterol guideline in a population with diabetes based on the atherosclerotic cardiovascular (ASCVD) risk.

Methods

Patients with diabetes were assessed to see whether they received the appropriate intensity statin therapy via chart review. Patients seen by a physician or pharmacist at CommUnityCare, a PCMH, from December 2013 to October 2014 were included in this retrospective study. The ASCVD risks were calculated to determine if the patients received appropriate intensity statin.

Diabetics meeting a pharmacist 24% more likely to be placed on a statin (P=0.003)
Impact of a Clinical Pharmacy Program on Changes in Hemoglobin A1c, Diabetes-Related Hospitalizations, and Diabetes-Related Emergency Department Visits for Patients with Diabetes in an Underserved Population

Nancy Chung, PharmD, BCACP; Karen Rascati, PhD; Debra Lopez, PharmD, CDE, BCPS, BCACP; Jason Joket, PharmD, BCPS; and Aida Garza, PharmD, CDE, BCACP

ABSTRACT

BACKGROUND: Diabetes mellitus is associated with substantial morbidity and mortality. With the rise in prevalence of diabetes, there has been an increased need for clinical pharmacy services focused on diabetes management in ambulatory clinics. However, more data is needed to determine the overall impact that clinical pharmacists have on preventing diabetes-related inpatient admissions and emergency department (ED) visits for patients with diabetes, especially in an underserved population.

OBJECTIVES: To assess the impact of clinical pharmacy services on the change in hemoglobin A1c measurements, the number of diabetes-related hospitalizations, and the number of diabetes-related ED visits for patients with uncontrolled diabetes.

METHODS: This was a retrospective study that evaluated outcomes for patients referred to a clinical pharmacist for management of diabetes, compared with patients who were not seen by a clinical pharmacist. Adult patients aged between 18 and 89 years with a diagnosis of type 1 or type 2 diabetes mellitus were identified, using the electronic medical records from the institution.

RESULTS: The intervention group had an increase of 4 ED visits (4 visits per 220 patients, mean = 0.018, SD = 0.641). Both the t-test (P = 0.18) and GLM model (P = 0.26) indicated that the difference was not statistically significant. A1c levels were reduced in the post-index period for both groups. For the control group, A1c reduction was 1.69 (from 11.17 to 9.47, SD = 2.49). For the intervention group, A1c reduction was 1.90 (from 11.09 to 9.19, SD = 2.44). Both the t-test (P = 0.04) and GLM model (P = 0.05) indicated that the A1c difference was statistically significant.

CONCLUSIONS: Underserved patients with baseline uncontrolled diabetes who were managed by a clinical pharmacist in the outpatient setting had a higher decrease in A1c compared with usual care. The changes in diabetes-related hospitalizations and diabetes-related ED visits were in the hypothesized direction, but the comparison for ED visits was not statistically significant.

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- 110% reduction in diabetes-related hospital admissions when poorly controlled diabetics met with the pharmacist at least 3 times in a year compared to usual care
- ROI: 2.7:1
Spanish-speaking patients’ satisfaction with clinical pharmacists’ communication skills and demonstration of cultural sensitivity

Dawn N. Kim-Romo, Jamie C. Barner, Carolyn M. Brown, José O. Rivera, Alda A. Garza, Kristina Klein-Bradham, Jason R. Jokerst, Xan Janiga, and Bob Brown

Abstract

Objective: To assess Spanish-speaking patients’ satisfaction with their clinical pharmacists’ communication skills and demonstration of cultural sensitivity, while controlling for patients’ sociodemographic, clinical, and communication factors, as well as pharmacist factors, and to identify clinical pharmacists’ cultural factors that are important to Spanish-speaking patients.

Design: Cross-sectional study.

Setting: Central Texas during August 2011 to May 2012.

Participants: Spanish-speaking patients of federally qualified health centers (FQHCs).

Main outcome measures: Spanish-speaking patients and Spanish-speaking patients’ satisfaction with their clinical pharmacists’ communication skills and cultural sensitivity.
Postdischarge interventions by pharmacists and impact on hospital readmission rates

Jessica M. Bellone, Jamie C. Barner, and Debra A. Lopez

Abstract

Objectives: To determine whether a difference exists in hospital readmission rates at 60 days postdischarge between patients who saw (intervention group) or did not see (control group) a pharmacist within 60 days of discharge and to describe the number and type of pharmacist interventions.

Design: Retrospective electronic record review.

Setting: Austin, TX, from January 2006 to January 2010.

Patients: 131 adult patients aged 18 to 65 years who were on at least three prescription medications.

Intervention: Pharmacist visit within 60 days post-hospital discharge.

Main outcome measure: Hospital readmission rates at 60 days postdischarge.

Results: The intervention and control groups did not differ regarding age or gender, but the control group had a higher percentage of whites, fewer medications, and fewer diseases. Chi-square analyses revealed that of 65 patients in the control group, 28 (43.16%) were readmitted to the hospital within 60 days of discharge compared with 12 of 66 (18.18%) intervention group patients (P = 0.0020). Pharmacists provided approximately two interventions per patient. The most frequently provided pharmacist interventions were medication counseling (68.16%) and drug dosage adjustment (52.2%).

Conclusion: Patients on multiple prescription medications and with chronic diseases may benefit from a pharmacist visit within 60 days of hospital discharge. However, future studies are needed to further determine the effectiveness of pharmacists’ interventions post-hospital discharge.

Keywords: Continuity of care, interventions, hospital readmissions.

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Jessica M. Bellone, PharmD, BCACP, was PGY-2 Ambulatory Care Pharmacy Resident/ Clinical Instructor, College of Pharmacy/ Blackstock Family Practice, University of Texas at Austin, at the time this study was conducted; she is currently Assistant Clinical Professor, Harrison School of Pharmacy, Auburn University, Mobile, AL. Jamie C. Barner, PhD, BPharm, is Professor, College of Pharmacy, University of Texas at Austin. Debra A. Lopez, PharmD, CDE, BCACP, is Clinical Pharmacist/Clinical Associate Professor, College of Pharmacy/Blackstock Family Practice, University of Texas at Austin.

Correspondence: Jessica M. Bellone, PharmD, BCACP, Harrison School of Pharmacy, Auburn University, 650 Clinic Dr., Room 2100, Mobile, AL 36688. Fax: 251-445-5341. E-mail: jmb0064@auburn.edu

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Previous presentations: Alcalde Pharmacy Residency and Leadership Conference, Galveston, TX, April 8–9, 2010.

- 60% reduction in hospital readmission rates when patients met with clinical pharmacists after discharge compared to usual care
- ROI: 28:1
Successes and Challenges

• Successes
  • Quality data highlighting support of pharmacy
  • Partnerships
  • Sharing the care
  • Growth of clinical program
  • Creating innovative services

• Challenges
  • Continual need for developing quality data and finding ways to support growth
  • Balancing workloads/bandwidth with increasing growth
  • Culture shifts
  • Payment reform
CE Question

Pharmacy integration into team-based care can provide what benefits to a health center?

• Positive clinical outcomes
• Reduction in health care costs
• Patient satisfaction
• All of the Above
Additional Questions?

Aida Garza, PharmD
Associate Pharmacy Director
CommUnityCare Health Centers
1210 W. Braker Lane
Austin, TX, 78768
512-978-9386
Aida.Garza@communitycaretx.org
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Legal and Operational Barriers

Michael B. Glomb, Partner
Feldesman Tucker Leifer Fidell LLP
Statement of Conflicts of Interest

• Michael B. Glomb has no actual or potential conflict of interest in relation to this presentation
Today’s Agenda

• Patient definition – who has the “responsibility of care”
• Reimbursement issues – who pays?
• Integrating pharmacy in a contract pharmacy model
CE Question

True or False:
Consultation with a pharmacist alone qualifies a patient for 340B drugs.
Two questions to consider:

**Question # 1:**
What considerations and barriers must be addressed to enable health centers to “move the needle”, “raise the bar”, “expand the nexus” of pharmacy services as a core component of a value-based primary care medical home?

- Licensure, credentialing, scope of practice
- Reimbursement
- Responsibility for care
- System perspective
Two questions to consider:

**Question # 2:**
What changes are required with regard to philosophy and operating structure in order to enable the Health Center to imbed pharmacy in the core of its organizational framework?

- Knowledge and awareness
- C-Suite commitment and SME
- Analytics
- Priorities
- ???
CE Question

True or False:

Consultation with a pharmacist alone qualifies a patient for 340B drugs.
CE Question

False:

Consultation with a pharmacist alone qualifies a patient for 340B drugs.
Additional Questions?

Michael B. Glomb
Partner
Feldesman Tucker Leifer Fidell LLP
1129 20th Street, NW, Fourth Floor
Washington, D.C. 20036
(202) 466-8960
mglomb@ftlf.com