Brandon Jones (00:01):

All right. So I think we have about just under 140 people on. So I'm sure well have some stragglers joining a little later. So let's go ahead and get started, so we can get to our presentation as quickly as possible. Welcome everyone to part II in our pharmacy access office hours, on the topic of clinical pharmacy or advanced practice services in a community health center. Next slide, please.

Brandon Jones (00:30):

Now I'm not going to spend time on our mission. Webinar logistics again, we'll have the slides available for you and Noddlepod again same for recordings and the slides, they'll all be available on the NACHC's 340B webpage. We'll normally send you an email so you'll know that they've been published and we'll keep you posted on that. Again, we've just chatted in our, we've just done the test for the chat, so it looks like that's working for us. All right, we're going to move on to the next slide, please. As a general reminder, office hours are supported with federal dollars.

Brandon Jones (01:03):

So we're prohibited from discussing anything related to advocacy in this forum. Next slide. All right, so today's agenda is as we always like to provide you with any 340B developments or updates from our 340B policy team. Then I left it on here, this session is a repeat from last session. Tim and I, along with some TTA folks here NACHC worked on a TA document entitled, "Pharmacy Operations Troubleshooting Guide" and the topics on Mitigating Manufacturer Actions Impacting 340B Financial Savings to Health Centers." Just that document is in review at BPHC, it's a publication from NACHC, so that's in review from BPHC, the Bureau of Primary Health Care. Once we hear back from them, their feedback, I'll be finalizing that final document and you all should get a notification of that publication link, when it's available. All right?

Brandon Jones (02:01):

Then of course, we'll have our presentation from our speakers from El Rio and Holyoke, around part II of this topic and then we'll do some Q & A. I did want to add, shortly before we get to the Q & A, we've had a poll added into this presentation that we'll get to sometime in the middle of our topic presentation. To gauge your appetite for an additional presentation of this, part III of this topic, or if you'd like for us just to provide you with a TA document, like a technical assistance document with those additional resources. So just be on the lookout for that poll when we get to that point. All right? Let's move to our next slide, please. All right, did we miss our Matt's update, Olivia? I think I had those in there.

Olivia (02:54):

Yep, apologies. I just have the wrong order. Just give me one second.

Brandon Jones (03:00):

Thank you, Olivia.

Brandon Jones (03:00):

(silence)

Brandon Jones (03:10):

Just going to have Olivia switch the slides around, so we can get to Matt's 340B developments. All right. So I'm going to hand things over to Matt, to give those 340B operational developments. Matt?

Matt (03:21):

Thanks, Brandon. If we could go to the next slide, please. Okay, so I have a couple of updates for you and I guess one request that we are asking for at NACHC. The first of which I'll deal with is, just dealing with kind of the collective whole of the manufacturer litigation cases. As you know, NACHC and Ryan White Center and covered entities filed cases against HHS, to kind of force or push along the 340B program, to push, to force HHS to finalize their ADR rule and to implement their ADR program. There was some developments that happened, where HHS released an advisory opinion, which essentially asserted that contract pharmacies are to be viewed as covered entities. Well at the beginning of this year, as you all probably know, the manufacturers took issue with that and they sued over these issues.

Matt (04:24):

So one of the developments that happened, is that in May, the HRSA, HRSA's Office of General Counsel sent a letter to these manufacturers and stated to them that they were to resume shipping to health centers by June 1st. They tried to do some protests, or litigation moves in court, to try to get around that, but none of the judges actually took them up on it. They were unsuccessful at that. So currently, where those cases sit, is that these entities, or these manufacturers, are supposed to be shipping again, to health centers. So what NACHC is asking is that, "If you know that manufacturers have resumed shipping to your health center, please do let us know." I guess I would also say conversely, "If they haven't done that, then let us know that, as well. That at least just helps us to keep a pulse on where things are."

Matt (05:25):

The other litigation update that I wanted to bring to your attention, is something that just occurred yesterday and it's dealing with the AstraZeneca versus HHS case. It's similar to many of the other ones, but the ruling that occurred yesterday, was the judge in the case denying HHS' motion, to try to dismiss the matter. Really though the heart of the reason why, was because the judge came to the conclusion that the 340B statute is silent as to the role of contract pharmacies. Given that the judge felt that it was silent, his conclusion is that there may be more than one interpretation in the statute. Ultimately, what that means is that the judge's position is that, Congress needs to make a decision as to what is a contract pharmacy's role and yes or no as to whether or not it is a covered entity.

Matt (06:29):

The underlying issue though of the case, which is whether or not HHS' advisory opinion about contract pharmacies in enforceable, that is still an issue. That was not decided yesterday. So the case still has to do some level of moving forward, to resolve that. I know that there is supposed to be a status update, I believe either today or tomorrow. So the policy team at NACHC, will continue to stay on top of that and keep apprised of it and certainly, as more updates come, we will be sure to get those out there to the field and let you all know what's going on with these cases. Just keep in mind that there's a lot of different cases in a lot of different districts. So the central issue that it's trying to get some form of resolution is, whether or not contract pharmacies are valid as covered entities. Next slide, please.

Matt (07:30):

So the other development that I wanted to bring to your attention, was that yesterday, HRSA announced that it was going to rescind the EpiPen and insulin file. So they issued a notice of proposed rule-making. In that notice they acknowledged that the previous rule was creating a new requirement and that requirement was that health centers were to provide insurances the date of established practices, to provide insulin and EpiPens at or below discounted prices, to patients with low incomes. So in their notice of proposed rule-making, they gave some level of explanation as to why they thought it would be best to rescind it.

Matt (08:22):

So one of the things that they point out is that, they realize that this rule was going to create a significant administrative burden, because it would have required health centers to implement new protocols, new practices, new procedures. Specifically, one of the problems was that they noted that trying to meet the burden of complying with all of these new requirements, would have hampered the ability of health centers to provide ongoing primary care services and in the middle of this pandemic, which is still ongoing, they recognized that that would have been, frankly, a very harmful development for health centers across the board.

Matt (09:05):

Specifically another issue that they recognized is that, changing the eligibility for sliding fees to 350% of the federal poverty guideline, would have required the health centers to hire additional staff just to comply with those requirements. It would have required us to have essentially, multiple eligibility systems and then having to build out the abilities to be able to monitor those things. So given the situation, understanding what the impact of that new proposal was, HRSA has decided that they would like to rescind it.

Matt (09:46):

So what that means is that there is now a 30-day comment period that's open. Comments will be due by July 16th. NACHC will be providing some template comments. We are already in progress with working on that, essentially HHS wants to get feedback on how this would result in loss for health centers. I know that when they went with the first round of things and NACHC issued its comments and other health centers issued their comments, we certainly spoke up and voiced a lot of the concerns, which they recognized in this notice of proposed rule-making. So we're seeking to do that again.

Matt (10:27):

One of the other things I want to emphasize though, is that even if this rule gets rescinded, there is an underlying executive order, which is still a threat and the notice of proposed rule-making, actually mentions that. So as we're working on developing this comment letter to address this rule being rescinded, we're also assessing strategies or angles to take, on how to try to get that executive order taken care of. So certainly, if you have any questions, I would say reach out to the regulatory team at NACHC. Our email address is regulatoryaffairs@nachc.org. Or you can email me. My email address is mhunter@nachc.org. If you have any further questions, just say something in the chat, or say something in the QA session. I'm happy to assist. Thank you.

Brandon Jones (11:22):

All right. Thank you, Matt, for those updates. I'm not going to go over this again. I mentioned the program a little earlier in our overview. So we'll move on to the next slide. All right. So I'm going to quickly give things over to Alyssa with Holyoke and we're going to get our topic started. Alyssa?

Alyssa (11:41):

Hi, everyone. Thank you, Brandon.

Brandon Jones (11:43):

You bet.

Alyssa (11:44):

Okay. So it's just me joining from Holyoke today. Alexis is on vacation and then Marisa from El Rio. All right, so as Brandon mentioned, this slide has the poll on it. But we wanted to start with a little bit of a session overview. For those of us who joined us last time, we discussed some staffing considerations, as well as practice models, for clinical pharmacy, or advanced practice models in pharmacy. Today, we're going to talk primarily about the role of data and some clinical and advanced practice services, how the data can support that, as well as some additional service considerations. But for the third session, the poll's going to ask, kind of how you want that information delivered. I'll give everybody a minute to respond.

Alyssa (12:26):

(silence)

Olivia (12:50):

Alyssa, I had to take presenting privileges away from you for just a second to open this poll. So you can just let me know when you want to go to the next slide and then I'll hand it back to you, once the poll is closed. Thanks.

Alyssa (13:05):

Olivia, can we move to the next one and still give them the opportunity to respond, or? Okay.

Olivia (13:16):

Yep, feel free to go ahead.

Alyssa (13:17):

Okay. So this was a repeat slide from the last deck, for those of you who are just joining us this time. When I was looking at the chat briefly when everybody logged in, we definitely have people from health centers near and far. So I'm located in Massachusetts at the Holyoke Health Center. Marisa from El Rio is out in Arizona. So we represent two kind of distinct health centers, different sizes, different models. But are still running some of the same clinical services, as well as some unique services, so.

Alyssa (13:48):

This again is just a review for everybody about what are clinical or advanced practice services? They can accompany a variety of different roles. Mostly, they involve direct patient care, medication management for ambulatory patients, coordination of care, triage referral and education and self-management.

Alyssa (14:12):

Okay. These were some of the practice models that we discussed last time. So here in Holyoke, we do have outpatient pharmacy. We also have pharmacists that serve in kind of a hybrid role, bridging between outpatient and then the direct patient services. I work mostly in direct patient care clinical practice and then we also have a staff member who works in academia. Marisa in El Rio also has all four of these areas covered. So we can speak to all four, but I know for someone who's trying to start these services from the ground, it can be a little bit daunting to decide where to start, or what services to start with. So that's kind of where we come in to help. I'm going to give this slide over to Marisa.

Marisa (14:57):

Thank you, Alyssa. So very briefly, I am very appreciative of that connection, because we wanted to make sure to bridge you into what we're going to talk about today. That really is, how do you just do it? How do you get to the point where you as an organization have made the decision, "This makes sense and what next?" So the what next is really, really important, because I'm sure all of us want to be on the road to success, correct? We don't want to be falling off a cliff into Never, Neverland.

Marisa (15:24):

So part of that involves intentional analytics upfront and we'll also talk about analytics on the backside. But when you're planning and strategizing how best to use your pharmacy talent within your organization, I cannot under emphasize the importance of preparation. So really, what is your organizational need and how does that match up with your departmental talent? That's what I love about working with Alyssa and Alexis from Holyoke and their incredibly effective model, is that we have come at it at two completely different ways.

Marisa (15:57):

So unlike Holyoke, where they really built up very strong and effective clinical services from their in-house pharmacies, we really are coming at it from the clinic side, with the advanced practice services, that was all afforded to us through an opportunity through HRSA and the Office of Pharmacy Affairs, to implement pharmacy practices in primary care settings and now are carrying over those practice models into our in-house pharmacies. So it's really what do you have at the time you initiate and what makes sense for you?

Marisa (16:28):

The other thing is, does direct patient care, will it have the greatest impact? So do you need to see people face-to-face, or can you use technology to connect to individuals? So things like telehealth and/or consult-based services. A lot of the new reimbursement model is related to the different [inaudible 00:16:49] codes these days, talk about the consultation between the clinician and the provider and really are not speaking to the interaction of the pharmacist with the patient.

Marisa (16:59):

So just be very smart and strategic about that early set up and also weighing supply and demand. That's where my strongest message today will be is, don't bite off more than you can chew in the beginning. So starting small and growing from lessons learned and developing those best practice models will get you far. So we use smart goals as a concept commonly with patients when we're helping them to advance their self-engagement in their disease state management. But I think all of us can benefit from smart goals, right? So being really intentional about that upfront.

Marisa (17:39):

The next slide, we start to talk about how that alignment makes sense and the departmental alignment. So when you're looking at things, whether you're part of a formal operation or arrangement, such an ACO as an example, or if you as an organization have just determined, this is what makes sense for you. Will the focus for your talent in your pharmacy department be related to closing gaps in care and helping to achieve quality metrics. Especially things like decreasing the percentage of patients living with an A1C greater than 9%, or perhaps those with uncontrolled hypertension. Or you're looking more at a morbidity, mortality disease impact, truly medication-wise. So using data to say, "Here's our patient population that are increased risk for cardiovascular disease. Who doesn't have a statin? Who is a candidate for [inaudible 00:18:34] therapy, but doesn't have that?"

Marisa (18:36):

So you could also take that kind of an approach, based on what your supply is within your organization, specifically your pharmacy team. Also, the risk assessment and this is something, I know that Alyssa and I talked about via email before our presentation today, but specifically, what risk in my mind and why I included it as a bullet as part of our shared conversation today, is what are the unintended consequences of shifting your limited resources to a new service line?

Marisa (19:07):

So let's just use an example and I'll ask Alyssa to speak about their experience from the in-house pharmacies, but with us, if we were as an El Rio team to say, "We're going to go full force. We're only going to offer Medicare annual wellness visits", as an example. "And we're going to do that in a tandem mode with the provider staff." Yes, there's huge benefits to that, but are we going to follow the guidelines of just checking the boxes of what CMS deems necessary for CMS? Or are we going to take more of this holistic preventative care type of concept to the next level, where we're also perhaps doing disease state management? Does it make sense to have a start up CHF clinic, that's completely staffed by our APP, advanced practice pharmacy staff. Or does our population of 11,000 patients living with diabetes make more sense?

Marisa (20:07):

So really, just seeing when you shift that talent to these different areas, what are the gains that could be made, but also what are the possible consequences of redirecting focus that may not be what makes the most sense for your team. Then the timing and sustainability. We're in this post-COVID recovery phase. So I'm so excited that we have 173 people on the call today. That's amazing. I couldn't have asked for a better audience. But does right now make sense? Or is this where you should really be spending your time and effort on that early implementation and evaluation of services that do make sense? Alyssa, would you like to share about your experience around this, before we move on?

Alyssa (20:52):

Yeah, I would say we've had a lot of the same conversations here. I think one of the things we experience in our health center is, once people get a taste of what pharmacy can do, everybody has an idea, or everybody is coming to the table with a project that a pharmacist can chime in on. So recently, one of the pediatricians brought a project to the table and we don't usually work very closely with the pediatrics department. We're much more focused with our elderly patient population. She wanted to run some services related to pediatric asthma and hospitalizations related to asthma and had some great ideas, but we knew that that wasn't going to be a billable service and we had to think about, "Okay, like how can we implement this, while not also detracting from the other services that we're offering? The COVID shots that we're giving?" Because, our team isn't growing at this time. So it's definitely always something to consider.

Marisa (21:46):

One of the things that I think will help us carry into this next section about departmental alignment, that both of us were able to speak to right now, is also how you approach services a little differently, right? So we talked last session about honoring long-timers, people who perhaps didn't have the same educational training in their pharmacy curriculum. Either chose not to or didn't have the opportunity to engage in residency training and/or fellowship. They still have a really important role in this whole process of advanced practice services. But this is where you can get really creative.

Marisa (22:21):

So as an example, I love Alyssa's point just now, about the other people wanting us, right? Everybody wants us to help and that's a great position to be in, but when you're balancing the direct services to how we also support these other projects that are really important, but we just don't have man-power to truly staff, think creatively about things like drug information services. So at El Rio, we developed, it's called, askapharmacist@elrio.org. So it's kind of our drug information hotline. It also can be used for consults.

Marisa (22:59):

So it is not uncommon, through this email system, to get questions about, "Have you heard, or what is the primary literature that supports use of testosterone for the treatment of migraine headache" as an example. Or, "My patient just moved here from Vietnam and they have all these medications. Can you please convert them to formulary equivalents?" Another one, "My patient has thrombocytopenia and a transient increase in liver function tests. Could this possibly be drug-related?"

Marisa (23:30):

So it doesn't always have to be face-to-face, although that's nice and it's great. But you can also use simple things like email, to also meet the greater need of the organization, where maybe it doesn't make sense to staff, an individual person or a team of pharmacists at that location, but you're honoring the request. You're just approaching it a little differently. Then that also has been incredibly useful for making that bridge, right? So again, we don't want anybody to not have a role and can you risk non-engagement from your entire team? But maybe the question should be, "How do I modify service lines to be more inclusive of the team?"

Marisa (24:21):

Next slide, please. The other thing and I see this happen a lot and knowing Holyoke on two different platforms, this experience as well as our vaccine hesitancy experience with NACHC a little bit earlier this

year and last year. This is something that I know we both share a lot of these same philosophies. So people get excited, they want you. They want you to be there certain hours. But then it's a reality of people fighting for physical space. "Well, we don't have any space to put you." This crunch of new work stations, making everybody feel valued.

Marisa (25:06):

So again, that's where things were, you can do things remotely, or consultatively may make sense for you in the beginning. The in-person versus virtual. There's opportunities to be really effective in setting up the clinicians for having a successful encounter with their patients and having your pharmacy team use their skill and talent in their training, to maximize the experience for the patient. So advanced disease state management, to de-prescribe, to address poly-pharmacy that's going on, to make sure that care gaps are closed, so that the clinician who sees them after, can really focus on what the acute care issues, or things that are outside of scope for the pharmacy team members.

Marisa (25:53):

The other thing that's been really important as well, is when planning or templating, when it does make sense to have on-site advanced practice services, is to try to marry the time that you have your limited resources with that target population and I'm going to use the example of Medicare annual wellness visits. So one of the [inaudible 00:26:16] services for us here, is to do tandem visits for annual wellness visits. So Medicare and Medicare Advantage population. So again, when we were in that planning stage of analytics and what makes sense, we first pulled anybody who had a payer type of Medicare or Medicare Advantage and said, "Number one, when are they requesting appointments and number two, when are those patients most likely to actually show or keep their appointment?"

Marisa (26:42):

So for us, our window of opportunity is nine a.m. until two p.m. Monday through Friday and a little spattering on Saturdays. But the good news is that when we had to get down to the nitty gritty and building templates for this visit type, we really were intentional about focusing on that time period of nine a.m. to two p.m., so that we were mostly likely to be able to meet the needs and the requests of the patients that we were hoping to engage with. So that's just one example, again, of how using that upfront planning can influence things like physical space. Is it in-person, or is it virtual? Then also creating templates where other team members can help to schedule a patient into your service line.

Speaker 1 (27:26):

[crosstalk 00:27:26].

Alyssa (27:26):

So we were able to discuss a little bit some of those direct patient care considerations, things that we've thought about both in El Rio and Holyoke, as we're starting new services. That's kind of the checklist. Do I have the space for it? What space is required? Am I going to now in this kind of COVID time, run the service virtually or in-person? So we've really used data at both of our health centers, to answer a lot of these questions and to drive the services that we build and then to assess the productivity of those services. So I have some examples of some data dashboards that we use in Holyoke, one of which is our assessing our hospital discharge follow up encounters, the percentage of those visits that are attended by a pharmacist.

Alyssa (28:14):

The other one below, is a dashboard we use actually related to some of the grant work that we do with NACHC, looking at vaccination rates, specifically the [inaudible 00:28:22] vaccine. So I would encourage you guys to develop some data dashboards, or use the data services that you have, to assess your need and then once you've built these services, to also assess your productivity. So like the top one mentions, what percentage of our visits are being attended by pharmacists? Then we can take a look at the small proportion of visits that are not and assess why that is.

Alyssa (28:44):

Oftentimes, it might be work flow related. They were booked into the wrong schedule. It wasn't coded, so it didn't pull up when the pharmacist was doing the prework. It was added last minute. It wasn't communicated. So we're able to change some protocols with the scheduling department, with the nurse teams, so that we're kind of striving for the 100% attendance rate for pharmacists in our hospital discharge visits. Also, looking at quality. So gaps in care, adherence rates, that has helped us to determine where we're going to start some services, looking at quality metrics and metrics that are under performing. That's often a way that new services are brought to our attention, are kind of built.

Alyssa (29:24):

Lastly, we do look at satisfaction scores. So both our patients and our staff. So do the services that we're providing that are patient-based, like medication therapy management, do those visits that the patients need, do they feel they had enough time and that their questions were answered? But also, our staff.

Alyssa (29:44):

So the hospital discharge visits, that's a big visit that we look at, in terms of our staff satisfaction. When the pandemic hit, we transitioned from doing those visits in-person, immediately prior to the provider's visit with the patient, to a day, to two days prior to the provider's visit, over the phone. We were kind of forced to change our model because of the pandemic, but we found coincidentally, that that new virtual model works a lot better. When we sent out some satisfaction surveys to our providers, they said, "I like this model. I have the pharmacist notes at least 24 hours in advance of my visit and it gives me more time to read their findings and consider their recommendations, et cetera." So I think data can be a big driver of the service that you want to implement, but then also assessing that service. Next slide, please. Marisa, I don't know if you want to talk about smart goals?

Marisa (30:42):

Sure, so this was mentioned a little bit earlier. But really an example of using smart as the guideline. Specific, measurable, attainable, relevant and time-based. Another example here that I'll use is, unlike Holyoke, we're a little bit different with our vaccine administration. So both super effective models, great adherence rate with age-based recommendations. But in our model as an example, because of the in-house pharmacies and because of the two service lines within the organization from our department, it really makes more sense for us to have the medical assistance, to administer the vaccines, as an example.

Marisa (31:25):

So what we do here is, we really want to try to maximize and have everybody working to the top of their license, within scope and then again, redirect services that are more appropriate for various team

members and allow them adequate time to complete those services. So here, what we might do in our model, unlike a traditional pharmacy model, where the pharmacist is administering vaccines and I know with COVID, rules have changed with interns and techs, which is great. I hope many of those things are forever. But here, the conversation may begin, because our experience and again, I don't want to only focus on COVID, but similar to what Alyssa said, lessons learned, right? There's so many things that we will take forward, that we hadn't had an opportunity, or that we hadn't fully explored prior to COVID and now we have so much experience, we don't know what to do with it.

Marisa (32:22):

But this is one where we weren't seeing people coming into the medical clinic, but we were having quite a few encounters through the pharmacy, of people picking up their medications and so we really intentionally strived to have the conversation about re-engagement. Care can't wait. I mean there's various logos, slogans excuse me, that you can use. But the whole concept of, care can't wait and talking to our patients at the point of contact at the pharmacy window, about different services, preventative care-wise, that might be beneficial. Then we coordinated with our medical assistant team who have standing orders to administer those vaccines.

Marisa (33:01):

But what that allowed us to do as a department, as a team of pharmacists, is to use our talent to then say, "We had the conversation about the vaccines as an example, or the mammogram, or the standing order for other services." Those are taken care of. No labs, no [inaudible 00:33:20] uncontrolled blood pressure. Pharmacist team go. So then our clinic based team was able to interact both depending on the patient's preference, whether it was telehealth or in-person, to help address chronic disease state management. In this example, in the context of the pandemic and offer care that was appropriate and comfortable for the patient, so that we have hopefully less ground to make up in this recovery stage. Then the other thing I had mentioned about, and Alyssa did a great job around the accountability, is being really transparent with your dashboards.

Marisa (33:56):

So develop those upfront, in the pre-planning stages. Stick to them. Determine who's going to run them? How often and make sure that there's no secrets. Everybody should see what everybody's doing. There should not be any shame, there should not be any lack of transparency that exists, because it's just going to make your department stronger and your services more effective. Speaking to the over-committing, just really look also to say, "Does it make sense for us to own this, or should we be looking at community partners who provide various service lines, that maybe we don't have the current staff, or overhead, or space to do and how would we make that happen?" Next slide, please.

Alyssa (34:39):

All right, this slide is mine. So we wanted to take some of the lessons that we included in the other slides and kind of break it down, how we applied that information to getting a service up and running here in Holyoke. So I thought asthma would be a good example. A little bit different from what I mentioned before about pediatric asthma. This service came about as a result of an organizational need. We were looking at quality metrics, our quality team was and identified that one of the metrics we were under performing in, is patients who over fill their rescue medications, like an albuterol inhaler. As compared to filled on their maintenance inhalers. Medications they should be using every month.

Alyssa (35:19):

So in these patients, the data point will tell you that something is out of whack. Their asthma is poorly controlled, but they're not filling the maintenance medication and thus arose this idea that pharmacy could kind of jump in and work on this metric. So we took a look at our departmental talent. What did we have and what people could we put toward this service?

Alyssa (35:39):

So we have a team already of clinical or advanced practice pharmacists. We also have several pharmacy residents, that are already providing MTM, or medication therapy management visits, that are very comprehensive, focusing on a variety of disease states, addressing medication adherence, et cetera. We also have our team outpatient pharmacists that are providing DUR, or drug utilization review and patient counseling at prescription pick up, as this is also another source of referral to MTM.

Alyssa (36:06):

So we decided, okay, the clinical team would run these visits to address asthma, specifically to talk to these patients and educate them about their maintenance inhalers, asthma triggers, et cetera, but our outpatient pharmacists could also easily identify patients that fall into this bucket, when they're filling their rescue medications and you see just lines and lines and lines of fills on that medication and no fills on the maintenance inhalers. So they're also working to provide point of care counseling at prescription pickup and also, referral back to MTM if it seems that the patient needs a more extensive education session than can be offered just at the register.

Alyssa (36:44):

So we looked at direct patient care considerations, like a couple slides back. Things like staff time. How would we run these visits, if we're relying on the same group of people and now adding an additional service line? What kind of space would we need for the visits and also, scheduling and referrals? So we decided to utilize the same group of staff, utilizing the same spaces that we've been using, although we're about to expand and get some more visit space. But since all our visits are virtual right now, the traditional visit space is not the only ones that we can use. We can use some other offices out of the patient areas, that can still be used for telehealth.

Alyssa (37:20):

So we're able to do that and then when it came to scheduling and referrals, we determined that some of the same MTM time, would just be dedicated to these asthma MTMs and we set up a new referral process, so we could kind of sort them out, because we realized early on if we were using the same referral process as our regular MTMs, we would have a hard time telling who needed this targeted asthma outreach, versus our other MTM patients addressing a variety of disease states. So then we looked to our analytics, to kind of determine what our next steps would be. We developed data dashboards and when our data analysts came to us with this list of patients, right, they're over-utilizing their rescue inhalers, it totaled at least about a month ago, 1,200 patients from our patient population.

Alyssa (38:04):

So that was a little staggering, right, because we decided we're going to run this with the same people and the same space and the same time. How are we going to make a dent on this metric when we have 1,200 patients to outreach? So we asked our data analysts to kind of layer in some other metrics or

some other factors that we would consider, that would make a patient a really great candidate for an MTM. So things like poly-pharmacy, or filling 10 plus medications. Patients that have an A1C greater than nine. We layered those on top of each other, so when you get down to the bottom of our dashboard, they have asthma, this asthma diagnosis, where they are filling the rescue inhaler too frequently and they have uncontrolled diabetes.

Alyssa (38:42):

Well there's only 16 patients that fall in both of those patient pools. By breaking the data down a little bit more, it makes it more manageable. We can start with those 16, maybe they are some of the most acute patients to outreach in this service and we can go from there. So that's an example of how a new service kind of came to be in Holyoke, the considerations that we had and how we made that manageable for our team. Next slide, please.

Marisa (39:10):

So I'm going to choose to speak about diabetes and very similar to Alyssa's example with Holyoke, we had to have a similar conversation within our organization. So at the time we implemented diabetes services and worked to develop our collaborative practice agreement, that included hypertension, dyslipidemia, smoking cessation, all the other things that you would want to make sure to focus on. We did very intentionally build in medication management. So allowing the pharmacist to also use their strength and their skillset, that although the driver for the consultation may have been diabetes, that within that consultation, you may also encounter medication-related complications, or other chronic disease state management issues, that would require more urgent attention.

Marisa (39:59):

So we very clearly defined what was in scope and out of scope for a prescriptive authority and then what process would be followed within that process, so that we would alert the provider, engage them early, versus more of an independent practitioner type of a role. So looking at our patient population, recognizing that there's a very large number of individuals living with diabetes within our organization, we also had to have that shared responsibility. So Relevant is a tool that we use now. I2I is something we've also used in the past. But right now, those are two really our drivers for how we use data, to continue to activate our team. So first recognize the problem, which in this case, 10,000 plus patients with a diagnosis of diabetes of which approximately 36% have an A1C greater than 9%. Then you further drill down very similar to Holyoke, which ones make most sense for which team member?

Marisa (40:59):

So we can't just ignore the people who don't have an A1C greater than nine, because perhaps they're still not at goal. So they're in that in between range of maybe 7-9%. But for our model, it really made sense to connect those patients to our registered dieticians and what we call health builders. So that's more of the group programming class, really focused on the education and also, the engagement in a group like setting, which lends itself well to a peer support group and then we also had those greater than nine, that we were focusing our team effort, our advanced practice pharmacy team's effort, on those with poly-pharmacy and/or frequent hospitalizations and/or the extremes, right? So your feet are in the oven, or your head is in the freezer. There's not much in between. So you're a 30 or you're a 300, but nothing really makes sense in the middle. Those were perfect for our team.

Marisa (41:56):

So we very intentionally targeted those individuals. So that's that little tiny graph on the left. How we used the data, what made sense, what was the problem and how do we direct people? Again, very similar to Holyoke, we said, "Where do we have to have physical presence?" So that second graph is really not to show you the detail of it, but just to recognize that we have various primary care sites within our health system model and what staff ratio made sense at each of those locations, being driven by their total population, which is represented in the orange graph. So if people living with diabetes and then the red bars, are those with the A1C greater than nine. So that helped us to play FTE presence and then we more intentionally drilled down into space, hours of the day, so on and so forth.

Marisa (42:45):

The third graph over, is speaking to productivity. So green would be in-person visits. Yellow is when telehealth entered our lives and then the orange colored bar that's going up and down, is tracking our productivity. So we do have thresholds that we discussed very intentionally upfront with the planning team, which does include finance and should include finance, to help guide, what makes sense, as a minimum productivity? So we are not a productivity driven team. We are more aligned with the specialist or consult type of service. So we do need a little bit more time.

Marisa (43:23):

Because, there's a lot of things that we're impacting. But on the last graph is just one example of how we measure impact. So yes, we can look at A1C reduction, but we also intentionally are capturing and this specific one that I chose to display here, knowledge. So the impact of education. So we could have very easily designed a service that was just medication titration. There's nothing wrong with that, at all. But in our case, having a formal diabetes self-management education support program, that's accredited, made a lot of sense, because the medication titration alone wasn't working. It didn't make sense for us.

Marisa (44:02):

So we wanted to intentionally pair that with education, within the [DS/MES 00:44:07] curriculum. In addition to that, we also have very intentionally measured things, like when we've added this service and we've taken the time to train these advanced practice pharmacists who recognize the organizational need for closing gaps related to colon cancer screening, mammogram completion, vaccines is an example. Making sure that advanced directives are completed. What has been the gain there? So it is very clearly noted that when you activate your entire team and you remove unnecessary barriers, your patients will benefit. Next slide, please.

Alyssa (44:53):

Okay. So that concludes the slides that we had prepared. We have about 10 minutes or so to take questions, if people want to put them in the chat.

Brandon Jones (45:08):

I believe people are able to, thank you both for a really great presentation. I believe you are also able to unmute, right Olivia? If they're able to unmute, you can put them in the chat, or if you're comfortable unmuting, feel free to ask those questions verbally.

Brandon Jones (45:25):

(silence)

William (45:43):

Well I believe, this is William a community health member down in Texas. I believe you mentioned on one of your slides, regards to having a pharmacist in a clinical practice. I believe would be Medicare Advantage plan patients. Is there anything in the pipe line for that possibly expanding to non-private insurance patients, basically Medicaid as well?

Marisa (46:15):

So at El Rio, our advanced practice pharmacy services are for all patients, regardless of payer. So within that, of course there's going to be the benefit of decreasing morbidity and mortality for those diseases that you're enabling your team to help manage, co-manage or independently manage through collaborative practice agreements. So overall, it may be self-pay patients that you're more effectively managing, because they're on a more appropriate regimens. You're seeing decreased morbidity and mortality associated with their various conditions. But then also, there's the reimbursement lines that do make themselves available through Medicare and Medicare Advantage. So that could include things like tandem visits for annual wellness visits, MTM, chronic care management, or CCM. Those are transitions of care encounters. Those definitely come with dollars, but the model and the concept for us, we don't limit it to a payer type. It's any patient of the health center will receive the same level of care, from all team members.

William (47:26):

Right, that makes sense. All right, thanks a lot.

Brandon Jones (47:32):

Presenters, there's a question in here from Joanna. She asks, "Other than Azara, what platforms do you use to create these dashboards and pull data?"

Alyssa (47:42):

I had mentioned that at Holyoke, we use a data service called Tableau. So the screenshots that were included on that slide are from that software. I will say though that I cannot make my own data dashboards in Tableau. It takes somebody who knows how to code and we do have a data analyst team here at Holyoke. So we'll meet with them. They plug in the data that we're looking for and then what you see is the result.

Brandon Jones (48:06):

Great. Alyssa, one targeted at you. Did you say poly-pharmacy was 10 plus medications? It was supposed to be [crosstalk 00:48:13].

Alyssa (48:13):

Yes, I was typing to [inaudible 00:48:14]. The formal definitions will be four to five plus meds, but as I was kind of typing out, at Holyoke our patients are very medically complex. So if we left the definition as four to five plus, almost every one of our 50 to 60 plus year old patients, would qualify under that definition. So we expanded it to 10 plus, to kind of hone our efforts, again, to try and find those patients that would benefit most from our interventions.

Brandon Jones (48:42):

Thank you, Alyssa. You all see Hannah's question in there. "Is there a good resource for researching the pharmacist practice guidelines specific to your state?"

Marisa (48:57):

So I would start with the State Board of Pharmacy and it'll be located in your state's statutes. So depending on where you are in the United States, you may be able to engage in collaborative practice agreements and whether or not that includes prescriptive authority, again, is very state-specific. But within that, it's interesting. You can have states that say it's medication-driven.

Marisa (49:18):

So for example, you can set up an anti-coagulation clinic and treat whatever possible medication condition that would result in the need for anti-coagulation, versus other states may take the approach of, chronic disease state management and then you define what medications make sense for your organization. The other thing I don't want people to leave this session, whether you attended the first one today, or you do the whole thing, is that start somewhere. So collaborative practice agreements are not the only way to implement advanced practice services. You can very effectively use your talent within your pharmacy department in your team, to tackle non-traditional services.

Marisa (50:03):

So an example is if it's important for you to do quality improvement projects through your pharmacy and therapeutics committee, as an example, overload that committee with data. Help them to see where you can help and I think Alyssa's example of the asthma mismatch, is perfect for this, right? So you as the pharmacy team have endless amounts of data related to adherence and then fills, excuse me, claims data. So when there's mismatches for various medical conditions, make that apparent and marry that with primary literature and then ask, "What will be our team's role in addressing this moving forward?"

Marisa (50:47):

So maybe it's consultative. Maybe it's continuing to run dashboards that say when we engage, for example, the nurse care team. The care coordination team, or the asthma treatment program, that this is the benefit we gain by partnering and all using our talents in various ways. If you don't have a vaccine administration program, maybe that's a great place to start. So it changes the mentality of your patient population and they start to see pharmacists in a different light and now you can start to creep into clinic based services. Have your providers understand the power that exists in your team members and everything that your pharmacists bring to the table.

Marisa (51:31):

So if that starts out with, maybe the pharmacist comes into the room and is there as the appointment is occurring and then the provider is very intentionally asking the pharmacy team member to comment on what they might do, that shift in mentality for your customer, your end user, cannot be underestimated. So start somewhere. Whatever makes sense for you, but please don't leave these sessions thinking, "We don't have collaborative practice agreements in our state. It does or doesn't have prescriptive authority. This is just too much." Pick something and just do it.

Alyssa (52:10):

Yeah, I agree with Marisa. We've been doing clinical services for like 10 plus years throughout Holyoke and only recently started with the collaborative drug therapy management, just because that's so complex and takes such a deep trust between the provider and the pharmacist. So we won them over with a lot of our other interventions and services and then they wanted to do CDTM. So we started with one disease state and expanded from there.

Brandon Jones (52:34):

Thank you both. Hey Marisa our Alyssa, there is a question here from, it just says pharmacy. So I'm not sure who it is. "Did you come up with any outside of the box ideas for lack of space to meet with patients other than telehealth?"

Alyssa (52:49):

I think we, at least in Holyoke-

Brandon Jones (52:52):

[inaudible 00:52:52].

Alyssa (52:51):

We've always been creative about what space that we're going to use. So if it's a designated pharmacy visit, traditionally we were running those visits out of some consultation rooms in the pharmacy. But we've expanded to using some exam rooms up on the floors. When we do CDTM, Massachusetts will say that we should be co-located with the providers when we're doing those visits. So that was the first kind of venture out of the pharmacy, to use some exam rooms up with the medical providers. But we've started to do that more and more. Like Marisa mentioned, some of our visit types aren't necessarily a pharmacist visit. We're going in to do med req and kind of work alongside the provider. So that doesn't need any additional space dedicated to us, because we're kind of just jumping in in tandem on the provider's visit.

Brandon Jones (53:38):

Great. Just a quick little note. I see Linda put in there, "Check in with your state's pharmacist association, just for a different reference." I think she was referencing Hannah's question. So just FYI. Thank you, Linda, for putting that in there. All right. So just as a reminder, I don't see any additional questions. This is a reminder, this session is recorded, as all our sessions are. Once the recording's published to our NACHC 340B archives page, we'll make sure that link gets out to everyone who's participated in this call.

Brandon Jones (54:08):

So you have access to the recording for future reference. All right and here you see on the slide there, our health center clearinghouse. I always reference the clearinghouse, if you're just looking for additional resources, so you're not reinventing the wheel, many health centers have done some really nice promising practices. So take a look at that. You can always search using some keywords, to find any projects that you're looking to do. Then lastly, on our last slide here, again we're wrapping up year one, here at NACHC and we will continue. Thank you for submitting your poll responses. We are going to do an additional third presentation, based on those responses. But in addition to any comments you have

in the chat, if you'd like to submit any additional questions, feel free to submit those to Tim and/or I, in particular, focused topic ideas.

Brandon Jones (55:00):

So if there's anything, relevant topics that you'd like for us to highlight during our office hours, please let Tim and I know. You have our emails there. All right and then Olivia will be sending out evaluations for this session, as we all get done, following this session shortly. All right? Not seeing any additional questions, we are right at time. Thanks again to the Holyoke team and the El Rio team, Marisa and Alyssa for your wonderful presentation and we're looking forward to seeing everyone next month, for our third part of this series. All right, thanks everyone.