# Community Pharmacist Integration into Team-Based Care Provided by an Accountable Care Organization: A Toolkit for Future Partnerships

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## Objectives

This project set out to do the following:

- Create a model for the integration of a community pharmacist into the Accountable Care Organization care team
- Approach an Accountable Care Organization about a potential partnership
- Obtain access to the electronic health record on and off site
- Educate providers and office staff about pharmacy services
- Deliver comprehensive medication reviews and targeted disease state education sessions to patients by referral
- Explore billable opportunities to sustain partnership
- Create an implementation guide to assist community pharmacist in building future partnership with an Accountable Care Organization Model

## Background

With knowledge in managing disease states and understanding medication regimens, community pharmacists are in a key position to increase medication understanding and adherence, improve disease state control, and reduce readmission rates. A study conducted by Khdour MR, Kidney JC, Smyth BM, et al. focused on pharmacy-led disease and medicine education at an outpatient clinic. One hundred seventy-three patients were included with a confirmed diagnosis of chronic obstructive pulmonary disease (COPD). Eighty-six patients were assigned to receive the intervention, and 87 patients received usual care. The intervention included a combination of education on the disease state, medications, and breathing techniques provided by a community pharmacist. Follow-up was provided at 6 and 12 months during a scheduled visit with the pharmacist. The interventions were done at each outpatient clinic visit, with follow up phone calls to reinforce the education that was provided. The study resulted in statistically significant decreases in emergency department visits and hospitalization rates, decreases in symptoms, and differences in knowledge and adherence compared to the control group.[1]

Community pharmacists were also able to show an impact in chronic heart failure (CHF) patients in a study by Bouvy, Marcel L et al. In the intervention group, 74 patients received a monthly consultation from their community pharmacist during a 6-month period and 78 patients received usual care. Patients in the intervention group had 140 out of 7656 days without use of loop diuretics compared with 337 out of 6196 in the usual care group (relative risk 0.33 [confidence interval (CI) 95% 0.24-0.38]). Patients in the intervention group also had two consecutive days of nondosing on 18 out of 7656 days compared to 46 out of 6196 days in the usual care group (relative risk 0.32[CI 95% 0.19-0.55).[2]

In an initial pilot to achieve a partnership with an Accountable Care Organization (ACO), community pharmacists from Realo Discount Drugs utilized evidence-based patient friendly handouts, current guidelines for possible interventions, and interdisciplinary relationships between the pharmacist and the provider in an attempt to show a positive impact on readmission rates. The pharmacists included in this project were trained in motivational interviewing skills for the purpose of achieving positive patient outcomes. With support from the Community Pharmacy Foundation, Realo Discount Drugs (Realo) set out to show the impact a community pharmacist can have within an ACO by providing services in three ambulatory clinics, building a sustainable financial relationship, and developing a toolkit to assist other community pharmacists establish partnerships with ACOs.

## Toolkit: Integrating a Community Pharmacist into Team-Based Care

This guide will outline the steps Realo took to build a relationship with and become embedded in an ACO to provide pharmacy services. This toolkit will also provide insight into the struggles of embedding a pharmacist within an infrastructure where pharmacy was previously absent; this information is included under the sub-heading of "What We Learned" below some sections. The toolkit includes the following sections:

- Making connections
- Developing a service set
- Obtaining access to the Electronic Healthcare Record (EHR)
- Marketing services
- Providing pharmacy services
- Addressing set backs
- Obtaining feedback
- Presenting results
- Implementing feedback
- Creating a payment model

## Making Connections

### Finding a Local ACO

Realo's flagship store is located in New Bern, North Carolina. New Bern is fortunate enough to have a local ACO. An estimated fifty percent of the patients at Realo in New Bern are under the care of a provider within this ACO. The partner for this project is a multi-specialty group practice consisting of a network of 44 physicians, 11 physician assistants, 8 nurse practitioners and a number of nurses and care managers. Prior to this project there was not a pharmacist on staff.

**Providing Enhanced Services**
Realo is passionate about patient care and improving outcomes. In order to improve patients' overall health and provide them with the support they need, Realo offers many clinical services. Providing enhanced services is also essential to building relationships with healthcare partners.

These services include:

- Transition of care clinical services
- Chronic care management
- Home health consulting
- Specialty pharmacy services state-wide and surrounding states
- Compounding
- Veterinary medicine
- Diabetes Self-Management Education (DSME)
- Kids' vitamins program
- Home visits
- Medication Therapy Management
- Partnered with Carolina Home Medical for Durable Medical Equipment
- Medicare enrollment assistance
- Medication synchronization
- 24-hour on-call emergency pharmacist service
- Adherence packaging
- Local Delivery
- Refill request online, phone/tablet App
- Smoking cessation support
- Naloxone dispensing and education
- Point of care testing and vital signs collection
- Medication reconciliation

Prior to the formal collaboration, Realo worked with many ACO patients and care managers through the adherence packaging programs, and many patients received enhanced services under the care of Realo.

**Building Relationships with ACO Leadership**
Through these enhanced services, Realo was interacting with care managers regularly. To further expand this partnership, Realo initially met with the Director of Care Coordination at the ACO to assess which services would provide the most benefit. Future discussion led to meetings with the Chief Executive Officer (CEO) who was a key driving force in getting the pharmacist embedded in the clinics for the pilot. When discussions expanded the model to include payment, the President and Chief Medical Officer, who also serves as the Quality Assurance/Improvement Chair, was available to bring in the providers' perspectives.

**Learning What Matters Most to the ACO**

Readmissions have a heavy impact on ACOs and decrease reimbursement. The initial pilot set out to improve readmission rates through education. Another area to consider is the quality measure benchmarks by which the ACO is graded and where community pharmacists can have an impact. See https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/sharedsavingsprogram/Downloads/2018-and-2019-quality-benchmarks-guidance.pdf for a list of ACO Quality Measure Benchmarks.

## Developing a Service Set

The initial pilot for this program followed the flow chart in Figure 1. The target population included patients who recently experienced a transition of care and either had COPD and/or CHF. Patients referred to this program would receive three in-person, in-clinic pharmacist consultations and three follow-up phone calls after each in-person consultation.

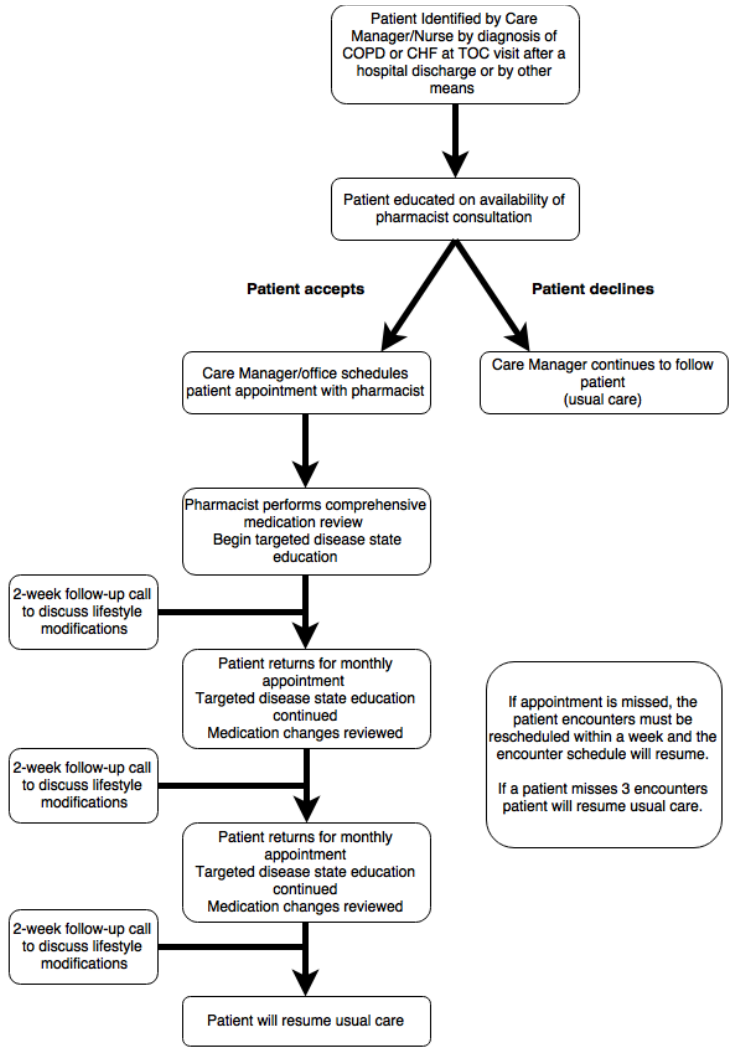


Figure 1.

*What we learned:* Limiting the partnership to two disease states and establishing strict criteria (i.e. recent transition of care) drastically decreased the number of patients eligible for pharmacy services. It is possible that setting these criteria could have led to confusion or inhibited referrals by care managers because they were unsure whether patients met the proper criteria for inclusion.

## Obtaining Access to the Electronic Healthcare Record and Training

To obtain and begin working within the Electronic Healthcare Record (EHR), training was required. This training included training on the EHR system (Allscripts), HIPAA training, and OSHA training. Pharmacist obtained login information to access the EHR as well as access to the virtual private network (VPN) which ensured a secure connection. A pharmacy consult note template was created by the ACO's IT department, and this note was used to provide the service and document findings. Once the pharmacist completed the note, it would force a task to the provider for co-signature. This co-signature would ensure the provider viewed the note and recommendations made by the pharmacist. When training concluded, the pharmacist visited the office location in order to meet pertinent staff (office managers, care managers and providers), receive badges for office access, and secure a laptop to access EHR off-site.

*What we learned:* Under the arrangement the ACO required that they "own" the laptop being used. Limiting access to the EHR on one computer prevented wide-spread use. Access to the EHR allowed for task notes to be sent to a provider for any Realo patient. The ability to task for clarifications simplified the medication reconciliation process; however, only three pharmacists had access to the system, and eight pharmacists work at the pharmacy. Some suggestions would be to obtain remote access to the EHR on dispensing computers at the pharmacy in order to provide easier access. It would also be recommended to obtain user access for all dispensing pharmacists to ensure these additional resources are always available regardless of who is staffing.

## Marketing Services

### Meet and Greet with Providers

Realo pharmacists, accompanied by a Nurse Practitioner who also serves as the Applications Trainer, visited each clinic to meet the providers and detail the services that would be provided. The CEO also marketed the service at each provider meeting.

**Brochure Content:**
Prior to providing the service an electronic brochure was distributed to providers with the following content:

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| **Who Will Be Included:** |
| COPD and CHF patients initially |
| **How It Will Work:** |
| • At the Transition of Care call that is provided within 48 hours of hospitalization, patients will be scheduled with their provider and then the pharmacist.<br>• Patients will come in for an appointment (30-60 minutes) with the pharmacist.<br>• At the conclusion of the appointment the patient will be scheduled for a follow-up session.<br>• Patients will receive three in clinic face-to-face encounters with the pharmacist. Pharmacist will contact the patient two weeks after the encounter to reinforce lifestyle modifications that were reviewed at the previous encounter.<br>• Appointment openings may be used for patients without a recent transition of care visit if still vacant 5 days in advance. |
| **After the Transition of Care of visit with the provider and at the next session the pharmacist will:** |
| • Review the entire medication regimen with the patient.<br>• Provide one-on-one disease state education to include medication regimen, lifestyle modifications, self-care and monitoring.<br>• Address any interactions, cost concerns, adherence barriers. |
| **Why Make This Referral:** |
| • Disease-state education provided by a pharmacist has been proven to decrease hospitalizations, improve adherence and increase disease-state understanding.<br>• A pharmacist's perspective adds to the success of the multi-disciplinary healthcare team.<br>• Enhance patient engagement. |

## Providing Pharmacy Services

Under this pilot, several methods were attempted to increase patient referral rates over an 18-month period.

**Initial Process:**
The pharmacist met with clinic care managers and nurses to detail the service provided. Nurses and care managers identified patients with an active diagnosis in the EHR of CHF or COPD after receiving a transition of care (TOC) office visit. This TOC visit occurred within 7 days of discharge from the hospital. Care managers or nurses made the referral to the pharmacist and scheduled the patient within 30 days of this visit; appointment times were reserved for each clinic location. Patients were also identified through routine office visits and care management interactions; however, priority for appointment times was given to transition of care patients. Patients that opted into the program received a HIPAA Authorization and Adult Consent Form to sign at the initial pharmacist encounter. Patients that opted not to participate received their usual medical care and were not provided the services offered by the pharmacist specific to this study. If patients at the initial encounter did not wish to sign consent forms, they were not enrolled in the study but received a comprehensive medication review. The intervention was initially provided at three clinics, and scheduling was later adjusted to optimize patient interactions and increase recruitment. Patients were scheduled at the conclusion of each session for a follow-up visit with pharmacist the next month. This initial design engaged patients in three clinic consultations over a four-month timeframe and a minimum of three phone follow-up calls. A total timeframe of four months was selected to account for a missed appointment. Under this model only four patients completed the process at the conclusion of year one.

**Attempted Adjustments:**
With poor attendance the model required some adjustments. The initial adjustment was adding an additional clinic into the patient recruitment process. Little progress was made from this change, so adjustments were made to decrease to two clinics. We tried to offer scheduling just one day each week, and then split to two half-days in clinic before decreasing to just one clinic. Ultimately a decision was made to offer a medication review that could occur at the pharmacy, in the clinic or by phone and documenting the encounter in the EHR.

*What we learned:* From our collaboration we learned that having three in-clinic sessions was too intense. Many patients struggled with transportation or keeping their first appointment. We learned that with limited schedule availability, we were not able to capture patients after the transition of care visit. Identifying a patient at the transition of care visit presented a challenge however we were unable to obtain feedback around this issue. Possible solutions were increasing days in clinic or scheduling patients off site at the pharmacy, as most patients come to the pharmacy to pick up new or refilled medications. Scheduling patients to be seen at the pharmacy provides the most flexibility in the event a patient does not show. This allows for the pharmacist to move on to their next available clinical task. While on site at the clinic the pharmacist did not always have access to a phone and could not view the dispensing software or external websites.

**Obtaining Feedback**

Providers were surveyed to gauge their thoughts and perspectives about the involvement of the community pharmacist within the ACO.

**Survey Results**

The survey was distributed to 44 members of the healthcare team, of which 16 responded. Six physicians, one nurse practitioner, three physician's assistants, two nurses, two care managers, one office manager and one practice manager completed the survey.

When asked "What is your vision for the role of the community pharmacist within the health care team?" providers responded with the following:

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| "To be able to educate and assist more patients with medication" |
| "Help avoid medication error and duplication of meds. Education of patients about their meds." |
| "To be readily available for questions about medications and to help review medications for patients with specific issues like polypharmacy" |
| "Recommendations, med interactions, better choices based on up to date pharmacy data" |
| "Education on healthy lifestyles including non-pharmaceutical products. Affordable medical/medication living." |
| "With patients seeing multiple providers these days the community pharmacist is a big asset to help patients with their polypharmacy to avoid interaction and duplication." |
| "Work in conjunction with physicians to coordinate the optimum medication decision making for patients, especially those with multiple medications." |
| "To coordinate care" |
| "To assist in having patients get medications that will be affordable with less interactions with their other meds" |
| "Better patient care" |
| "Share in the coordination for the patients education regarding medication regime and adherence" |
| "Review and cost reduction suggestions" |
| "I think a community pharmacist should be a regular part of the patient care team." |

The barriers identified included:

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|---|
| “Only in one office” |
| “Trying to find time in my schedule to give feedback and communicate with pharmacist” |
| “I see no barriers. My only problem is patients (don’t) show for their scheduled appts” |
| “Lack of funding for such a position” |
| “Patient noncompliance, time, financial coverage, location” |
| “Added cost to the health care burden” |
| “Patients who have limited level of understanding, money, transportation” |
| “Lack of personnel” |
| “Part time” |

When asked if the provider had ever referred a patient for a medication consultation with a pharmacist within their clinic, 7 responded yes and 2 responded “other”, citing they did not have an opportunity yet or that they had only requested that their staff refer to the pharmacist. When asked if the provider had ever referred to a pharmacist’s consult note or task note within the EHR, eight providers responded “yes.” Suggestions given were to increase scheduling availability and to attend the provider’s meeting to share more about services.

*What we learned:* It would have been beneficial to survey providers earlier in the process. The survey was distributed 16 months after first embedding the pharmacist in clinic.

**Presenting Results**

In order to show ACO leadership the impact community pharmacists have had on an ACO patient, we presented a brief handout synopsis which included the survey results. In this handout, Realo included a sample of interventions in clinic and during off-site medication reviews performed by phone or in person, as well as a few examples of clinical impact. Realo also presented a summary of provider responses.

**Clinic Schedule from 10/12/17- present**

| Date | Clinical Highlights |
|---|---|
| 10/12/17 | Suggested discontinuation of corticosteroid beyond recommended duration; identified inappropriate use of Voltaren gel in patient having bleeding episodes |
| 10/24/17 | Med review provided |
| 10/24/17 | Med review provided |
| 11/14/17 | Statin intolerance and therefore non-adherence identified |
| 12/21/17 | Med review provided |
| 1/18/18 | COPD education/incorrect inhaler usage, sleep hygiene/ timing of sertraline admin., helped obtain compression stockings, premarin cream & CV risk |
| 2/8/18 | Blister packs, multiple meds non-adherence, meds missing from ACO med list; able to identify through mail-order pharmacy |
| 3/8/18 | Sleep Hygiene, medication administration corrections |
| 3/13/18 | Med review provided |
| 3/22/18 | Med review provided |
| 3/29/18 | COPD evaluation, uncontrolled, recommended additional therapy |
| 4/5/18 | Fall risk mitigation, dementia assessment and anticholinergic interaction/ discussion with caregiver regarding risk vs. benefit and QOL |

**12-day Impact of Medication Reconciliation performed by Realo Pharmacist**

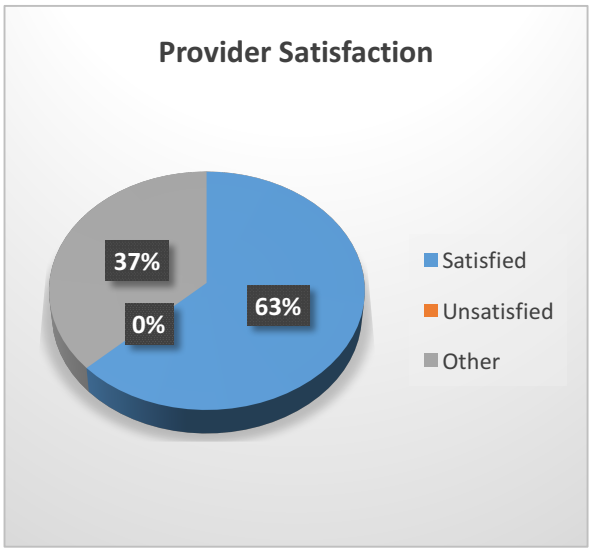
| ***Total ACO Patients Receiving Med Reviews*** | ***27*** | ***% Of Total*** |
|---|---|---|
| ***# of patients taking medications not reported on med list (and some still receiving refills)*** | **10** | **37%** |
| ***# of patients with medications on med list patient was not taking (and was supposed to be)*** | **15** | **56%** |
| ***# of patients with medication dosing/freq changed by physician but not reflected in med list (required new script)*** | **7** | **26%** |
| ***# of patients reporting accurate discontinuation that were still on active med list*** | **12** | **44%** |
| ***Total # of medication discrepancies*** | **44** | ***1.6 med discrepancies per patient*** |

*This snapshot was compiled from the CMRs provided by one of our three clinical pharmacists. Usual combined total CMRs per month average >100.

**Realo Med Review Clinical Impact Snapshots**

| | |
|---|---|
| **1.** | Patient with heart failure unable to diurese fluid despite being on metolazone and furosemide 2T PO QD. He misunderstood treatment instructions and was taking furosemide 40mg BID instead and was not taking metolazone 30 minutes before hand |
| **2.** | Patient was receiving Fosamax treatment dose for osteoporosis and should have been on preventative dose. (Reviewed patient's t-score to determine appropriate dose) |
| **3.** | Patient non-adherent to Symbicort which required clarification to assess if patient should still be taking. Patient was also in need of a rescue inhaler for emergencies |
| **4.** | Patient was non-adherent to Pradaxa. Duplication of therapy with Gabapentin scripts |
| **5.** | 85 year old man still receiving dual anti-platelet therapy 4 years after MI |

## Provider Survey Synopsis




Of the 16 (6 physicians, 1 NP, 1 PA) respondents, no providers were unsatisfied with Realo's participation. Thirty-seven percent (6) selected "other" as an option stating the following:

-They were unaware of the service provided
-Did not believe the service applied to their clinic
-Stated they had not had the opportunity
-Requested more availability
-Requested materials and presence at provider meetings

Ninety-four percent of respondents selected that they'd like to have more involvement from community pharmacists or that they'd like learn more about how the community pharmacist could assist in managing chronic disease states and improve outcomes.

*"Work in conjunction with physicians to coordinate the optimum medication decision making for patients, especially those with multiple medications."*

*"Recommendations on med interactions.*

*Better choices based on up to date pharmacy data."*

*"I think a community pharmacist should be a regular part of the patient care team."*

*"With patients seeing multiple providers these days the community pharmacist is a big asset to help patients with their polypharmacy to avoid interaction and duplication."*

## Implementing Feedback

After meeting with ACO leadership and discussing the survey results, it was decided that the approach for providing this service needed to change. Rather than just making the service available, a Realo pharmacist would partner with one or two providers that was ready to work with pharmacy. Prior efforts made the pharmacist available by having scheduled time in several clinics, but the model did not receive much buy-in from providers. Having a provider voluntarily partner with pharmacy seems to be a more successful approach and is our next step for this project.

## Creating a Payment Model

There are few models by which community pharmacists can be reimbursed for the clinical services they provide outside of the general billing platforms such as Outcomes and Mirixa. Therefore, Realo presented to ACO leadership two models by which they could get reimbursed for providing services under chronic care management codes from Medicare:

1. Pharmacist seeing patients in clinic providing medication reviews
2. Pharmacist seeing patients in the pharmacy or by phone providing medication reviews

Both services include disease state education and adherence support. The ACO partner has care managers regularly billing for and providing chronic care management. Realo pharmacists would simply contribute to the minutes of service.

In June 2018, the ACO agreed to partner with Realo to provide Chronic Care Management services. Under this new protocol, the pharmacist meets with patients in clinic, off site at the pharmacy, and by phone, contributing to the minutes billed to Medicare under the Chronic Care Management code. The ACO has agreed to pay Realo for all the time contributed by its pharmacists reflected in the amount collected from chronic care management services. The referral process is led by the pharmacist at Realo but can also occur by care manager recommendation. The pharmacist is able to task the care manager regarding patients they think would benefit from a medication review or medication education. The care manager will then submit a request to the provider for approval. During the first two weeks under this new process, Realo has seen four patients and has documented notes and minutes that contribute to chronic care management. The pharmacist note created for the initial project was adjusted to allow for the documentation of minutes but maintains the requirement for co-signature by the provider. It will take approximately 60 days to receive reimbursement for the service with the first payment expected in September.

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