COMPLETED GRANT SYNOPSIS

Full circle Clinical Pharmacy Care to help alleviate the primary care shortage. Create link between Independent Pharmacy, Clinical Pharmacist and the Primary care Office

Authors Tracy Mahvan, PharmD
University of Wyoming School of Pharmacy

Objectives

The purpose of this project was to incorporate a community Pharmacist and Clinical pharmacist team into a primary care clinic to enhance patient visits by 10-15% in a day. This project was to test the feasibility of having the team facilitate more patient encounters, explore billing strategies and allow providers to see more patients. A community pharmacist and clinical pharmacist spent an average of two half days per week in an established clinic to develop relationships with patients and providers to introduce the clinical services transition to the community pharmacy. The pharmacist was assigned to a specific practice, so meaningful working relationships were formed with the practice staff and patients. Data was analyzed in a variety of adult ages and a mix of payer groups. The Community-Clinical pharmacy team aimed to improve the existing overall health care experience by creating a new care model that emphasizes personalized, evidence-based medicine and team based coordination of care.

Goal A is to implement a clinical program link between independent pharmacy, clinical pharmacy and a primary care office.

Obj.A1 Create collaborative team (Independent pharmacy, clinical pharmacist and primary care office)
Obj.A2 Equip community pharmacist to provide clinical pharmacy services in the clinic and pharmacy
Obj.A3 Provide clinical services in the clinic
Obj. A4 Integrate the inter-professional team for patient care
Obj. A5 To examine project assessment methodology

Goal B. Design and implement team based logistic plan to increase patient numbers seen by provider by 10-15% in a day

Obj. B1 To identify methods to select patients most likely to benefit from Clinical pharmacy services.
Obj.B2 To implement standard patient Medication reconciliation documents and patient documents
Obj. B3. To provide experiential training for students
Obj.B4 Aim for 10-15% increase in patient clientele per day
Obj.B5 To examine revenue generated by increased patient numbers
Obj. B6 Assess provider satisfaction

Methods

Design	• Patients were eligible if 65 years of age or older with three or more chronic medical conditions and receiving primary care at the site. • Month 1,2: IRB approval, CLIA Waiver application for laboratory values performed in the community pharmacy and Independent Living facilities, met with clinic director, providers, nurses, and billing office, evaluate number of patients per half day (Average NP two; DO six), train on EHR • Month 2-10: Survey insurance demographics (60% Medicare, 20% Medicaid, 10% private insurance, 10% self-pay), train and implement methodology with Pharmacist, outline scope of duties and outcomes to measure, screen patients in EHR, Implement pilot and document outcomes, create standard Excel document for data collection and patient documents, train Ambulatory care rotation students with program, research billing strategies and income, collect provider satisfaction data. • The project piloted incorporating a community Pharmacist/Independent Pharmacy Owner and Clinical pharmacy team into a primary care clinic to enhance patient visits by 10-15% in a day.

	• Initial patient encounters included complete evaluations of each patient, after review of the medical record and included a full work up, the day prior to clinic. Physical assessments were performed. • Medication histories and medication reconciliation was done by the community pharmacist in the clinic and medication related issues were identified and resolved. Chronic disease state management interviews were performed, including smoking cessation, anti-coagulation and diabetes self-management. The Pharmacist obtained patients' history/past illnesses and reviewed preventive screening recommendations, allowing the provider to spend meaningful time with patients enhancing patient satisfaction. • Interventions measured included Drug or Drug-Disease Interaction Identified, Therapeutic recommendations, adverse drug event prevented, and Medication error prevented. • Pharmacy students played an integral role in establishing and maintaining ambulatory care pharmacy services. • Billing code explorations included: "Incident to" billing strategies for a shared visit model including 99212, 99213, 99214 etc, depending on the complexity of the patient and Chronic Care Management (CCM) 99490.
Study endpoints	• To implement a clinical program link between independent pharmacy, clinical pharmacy and a primary care office • Design and implement team based logistic plan to increase patient numbers seen by provider by 10-15% in a day

Results

A local family practice was identified due to preliminary meetings demonstrating a strong interest in the project. The clinic focuses on adult primary care; in a nonacademic/non-University based practice without embedded pharmacists. A local community pharmacy has a strong relationship with the practice and serves as this clinic's sole dispensing pharmacy. Patients were enrolled on a rolling basis by the clinic scheduling department initially, then, by the clinical team. All patients on the clinic schedule were worked up the day prior, including assuring they were eligible for the billable services. Patients billed by the team were evaluated for billing strategies, not all claims had returned due to the time frame of the study (1 yr). The clinical team recruited patients to continue care in the community setting.

Data collection was recorded on a de identified excel spreadsheet and a patient tracking system was used to categorize patient interventions and measures collected.

CLIA waiver was obtained to implement point of care services and appropriate Point-of-care (POC) testing was implemented to perform diagnostic tests, outside of a laboratory, to produce a result rapidly to aid in diagnosis, and/or patient monitoring for diabetes and anti-coagulation and others. Four Independent Living events in the community were implemented that included clinical services and Point of Care testing.

Number Patients reviewed on day of clinic (n=232)

Patient (n = 64)

Mean age 70

Median number medications (range) 10 (0–15)

Median number prescription medications (range) 4 (0–8)

- Interventions included additional drug therapy needed/under treatment 56% (i.e. not on a Statin if indicated; Low dose Metformin with High A1c, uncontrolled HTN), Incorrect dose/duration 14% (dose too high for renal insufficiency, duration (Long term Antibiotics), frequency 5% (high or low) , medication monitoring needed (renal function, serum electrolytes) 45%; inappropriate drug/unnecessary therapy 20%, (Beers list, Drug Disease interactions); adverse drug event (12%) (GI, CNS); and non-adherence 10%, Cost-Efficacy, Lifestyle modification (100%)
- Medication review was performed in all patients, Diabetes education, weight loss management, new medication counseling, uncontrolled hypertension, cost saving regimens are examples of education sessions performed**.**
- Overall AWV and CCM were the top two targets for billing. "Incident to billing" for various indications was explored. Revenue generated from Community Pharmacy Services including the AWV and CMM visits. Additional billing

categories included IBT for Cardiovascular Disease, IBT for Obesity, Smoking Cessation Counseling and Advanced Care planning. The Pharmacy Team's time is not accurately represented as the sum of the time spent in preparation for the visit, especially for AWV visits.

- An increase of 10-15% patients were scheduled on most days.

Billing:
CCM services in the Clinic, Pharmacy and offsite: 45 patients were contacted. 15 patients provided consent to CCM and were billed for the service.
CMM (simple) 15 x40=600 billed
AWV G0439 115.70-127.27; G0438 170.46
GO439 Billed 60x115.70=6,942
G0438 Billed 4x170.46=681.84
Additional billing add on's to AWV included Advanced care planning 99497 86.57 (Minimum 16 minutes),
IBT for Cardiovascular Disease and Obesity 26.33
Barriers to high reimbursement included billing office unfamiliar with these codes.

The AWV included all Medicare required components including required screenings and standardized, evidence-based tools. Preventive screenings, colorectal and breast cancer, hyperlipidemia, and diabetes, were suggested based on the U.S., Preventive Services Task Force (USPSTF) and CDC-recommended vaccines were recommended. All patients underwent a health risk assessment and received personal prevention plans.
Pharmacist performed Physical assessments, hands on screenings for falls, cognitive decline evaluation, home safety evaluations, hearing and depression screenings, Colonoscopy/Dexa scan referrals and triaging for 5-10 year preventative disease states (including mammograms, glaucoma screening).

- abnormal screenings, such as Hearing changes, fall risks, Depressive symptoms or inability to independently perform activities of daily living (ADL), were communicated to patients' PCPs and specialists (Psychology, Hearing loss centers, Senior Center, Neurology) for further assessment and treatment.

- Referrals and blood works were ordered on the day of the visit by the pharmacist
- Poly-pharmacy assessment tools were used to evaluate the risk of an adverse event. The Beers Criteria for Potentially Inappropriate Medication Use in Older Adults, (Beers list), Screening Tools of Older Person's Prescriptions (STOPP) and Screening Tool to Alert doctors to Right Treatment (START). The Medications Appropriateness Index (MAI) as appropriate.
- Pharmacy Students were trained to conduct a Medicare Annual Wellness visit and CCM in a primary care setting.
- Provider satisfaction assessment reported favorable results and the future continuing on this partnership is being discussed. Most notable feedback was the clinic prefers to pay Pharmacy Hourly rate rather than split billing. Patients were all very satisfied with the clinical pharmacy services.
- "Incident to" billing strategies for various higher level CPT codes included 99212 44.20, 99213 77.30, 99214 108.88. Chronic Care Management (CCM) 99490 was performed off site and at the clinic.

Conclusion

This project examined the concept that creating a link between a Community Pharmacist/Clinical pharmacist team with a primary care clinic can enhance billable patient visits. This partnership helped providers see more patients per day, increase billing opportunities for the pharmacy directly from incident-to billing strategies. An increase in the number of patient visits and improved clinical outcomes leads to more patient care opportunities and expansion of billable services offered to community pharmacy patients. Negotiations and sustainably to a full time salary is challenging and requires more time. Positive strides were made by increasing the value of community pharmacy in a clinic and revenue generation.