Collaborative Practice in Kansas

Kansas Pharmacists Association
Meeting
September 25, 2016
Jim Garrelts
Disclosures

• Jim Garrelts has nothing relevant to disclose
Learning Objectives

• Gain familiarity with the statute and related regulations for collaborative practice in Kansas
• Discuss general requirements for establishing and maintaining a collaborative practice relationship with one or more physicians
• Understand resources available to pharmacists and physicians who are interested in a collaborative practice relationship
Pre-Test Question

• Kansas pharmacists may sign a collaborative practice agreement with only one physician at a time?

• True or False
Pre-Test Question

• A signed collaborative practice agreement is necessary for Kansas pharmacists to provide:
  a) Medication therapy management (MTM)
  b) Collaborative drug therapy management (CDTM)
  c) Both of the above
  d) Neither of the above
Questions to Consider

• Why should pharmacists provide collaborative drug therapy management (CDTM)?
• How does CDTM differ from medication therapy management (MTM)?
• Which pharmacists are qualified to provide CDTM?
• How do you establish a collaborative practice agreement with a physician?
Why should pharmacists be interested in pursuing collaborative drug therapy management (CDTM)?
CH – a 52 y/o Caucasian female
PMH: HTN, hyperlipidemia, depression, tobacco use
Problem: newly diagnosed DM (A1c 13.8%)
- Collaboration: APRN, RPh, Care Coord, pharmacy MAP
- Barriers identified:
  - finances
  - uninsured
  - no knowledge of diabetes self-management
Patient Story

• RPh provided diabetes/medication education and therapy options
• Pharmacy MAP helped obtain PAP meds
• Patient outcome improvements:
  - A1c decreased from 13.8% to 7.6% in 3 months (maintained currently 1.5 years later)
  - 27 lb. weight loss in 4 months
  - working toward smoking cessation
  - improved understanding of self-care
  - improved mood and overall well-being

Acknowledgement: Lyndsey Hogg, PharmD
Justification: Asheville Project

- **Diabetes**: improvement in A1c, BP, BMI, vaccination rates, foot & eye exams, etc.\(^1\)
- **Cardiovascular**: improvements in surrogate markers, CV event rate reduced by half, CV-related medical costs reduced 46%\(^2\)
- **Asthma**: objective / subjective measures improved, ED visits and hospitalization reduced, significant healthcare cost savings\(^3\)

1. JAPhA 2008; 48: 181-90
2. JAPhA 2008; 48: 23-31
3. JAPhA 2006; 46: 133-47
Justification

• Hickory Project\textsuperscript{4}

\textbf{Diabetes}: 3 year study, surrogate disease markers improved, healthcare costs reduced $2,704/participant/year; ROI 4.89 : 1

• Diabetes Ten City Challenge\textsuperscript{5}

\textbf{Diabetes}: surrogate disease markers improved

5. JAPhA 2008; 48: 181-90
Justification

Minnesota Experience⁶
12 Medical Conditions: DTP’s resolved, HEDIS measures improved, overall health expenses reduced ($11,965 to $8,197 per person),
ROI > 12 : 1

Fairview Health Services⁷
Medical Conditions: onsite & virtual, DTP’s resolved, reduced healthcare costs, improved clinical outcomes, ACO quality measures, reimbursement by insurers and employers

6. JAPhA 2008; 48: 203-11
Justification: Triple Aim

- Improve patient experience of care
- Improve population health
- Reduce cost of healthcare
Pharmacist Impact on Triple Aim

- **Improve patient experience of care**
  - increase time with patients for education/support
  - solve medication-related problems
- **Improve population health**
  - manage patients with chronic conditions to help achieve goals
  - preventative care measures
- **Reduce cost of healthcare**
  - prevent hospitalizations, readmissions, ED visits
  - streamline / optimize medication regimens
Statutes vs Regulations

• **Statute**: general guidance from the Legislature, specifying what authority the profession has and does not have

• **Regulations**: specific requirements promulgated by the Kansas Board of Pharmacy
Senate Substitute for House Bill 2146

• “Practice of pharmacy means...

- performance of collaborative drug therapy management with one or more physicians who have an established physician-patient relationship”
• “CDTM means a practice of pharmacy where a pharmacist performs certain pharmaceutical-related patient care functions for a specific patient which have been delegated to the pharmacist by a physician through a collaborative practice agreement”
Senate Substitute for House Bill 2146

• “A physician who enters into a collaborative practice agreement is responsible for the care of the patient following initial diagnosis and assessment and for the direction and supervision of the pharmacist throughout the collaborative drug therapy management process.”
Senate Substitute for House Bill 2146

• “Nothing in this subsection shall be construed to permit a pharmacist to alter a physician's orders or directions, diagnose or treat any disease, independently prescribe drug or independently practice medicine and surgery.”

Language inserted at request of Kansas Medical Society
Senate Substitute for House Bill 2146

• “Collaborative practice agreement means a written agreement or protocol between one or more pharmacists and one or more physicians that provides for collaborative drug therapy management.”
Senate Substitute for House Bill 2146

• “A collaborative practice agreement shall be:
  (A) consistent with the normal and customary specialty, competence and lawful practice of the physician; and
  (B) appropriate to the pharmacists training and experience.”
How did we get to this point?
Pharmacist-Physician CPA Timeline

2013
BOP meetings
to prepare for
CP legislation

2014
Nov
First CP
Advisory
Committee
meeting

2015
Fall
Final proposed
regulatory
language
approved by DA
& AG

2011
Oct
Initial
discussions on
CP in Kansas
began

2014
July
CP legislation
enacted

2015
June
Regulatory
language
drafted by
Advisory
Committee

2016
April
Regulatory
language
approved by
Board
(effective 5-27-2016)
Collaborative Practice Committee

11-7-2014: review statute, review other states regulations, general discussions begin

12-19-2014: definitions, practice settings, training, emergency protocols, documents

6-26-2015: regulatory process review & discussion, physician-pharmacist agreement, protocol location, communication, backup, competency

3-28-2016: regulation review & discussion, CPA samples, submitting/tracking CPA’s, resources to make available, scope of services available
Committee Discussions

- Desire to have a team approach
  - protocols/guidelines allow RPh to initiate, modify, continue, discontinue therapy
- Must differentiate CDTM from MTM
- Must differentiate CDTM and hospital protocols
- Desire to keep regulations short and general
  - guidance documents for more specifics
Committee Discussions

• How will MD’s understand competency of RPh’s, or even what they can provide?
• Regulations can’t extend authority beyond the statute
• What does statutory language “Nothing in this subsection shall be construed to permit the pharmacist to alter a physician’s orders...independently prescribe...” mean?
Committee Discussions

• Does an employment change dissolve the CPA?
  - not if the MD-patient and MD-RPh relationships continue

• How should RPh handle specialist MD prescriptions if CPA is with PCP?

• How often should CPA be updated / renewed?
Committee Discussions

• Can RPh list only their name on Rx’s they generate, or must MD name be on it?
• Communication issues
  - documentation of issues by both RPh and MD must be maintained
  - communication by RPh must be timely if potential patient adverse outcome
Committee Discussions

• Understanding professional backup in an emergency, or when not available (e.g. vacation)

• Should RPh have to be licensed in Kansas?
Regulation Timeline

K.A.R. 68-7-22 Collaborative Practice

• First committee meeting (11-7-2014)
• Review / approval D of A (9-4-2015)
• Review / approval AG (12-8-2015)
• Approved by Ks BOP (4-21-2016)
• Published in Ks register (5-12-2016)
• Effective in Kansas (5-27-2016)
“Any pharmacist may practice collaborative drug therapy management only pursuant to a collaborative agreement or update established and maintained in accordance with this regulation.”
“...each pharmacist who engages in collaborative drug therapy management shall be responsible for all aspects of the CDTM performed...”.
“A pharmacist shall not become a party to a CPA or update that authorizes the pharmacist to engage in any CDTM function that is not appropriate to the training and experience of the pharmacist or physician, or both.”
“A pharmacist shall not provide CDTM to a patient if the pharmacist knows that the patient is not being treated by a physician who has signed the pharmacists current CPA.”
“Each CPA and update shall include the following:

A statement of the general methods...

a statement of the procedures...to document...”
K.A.R. 68-7-22

“Each CPA and update shall include...a statement of the procedures to communicate...

Each change in a patient’s condition...

Each CDTM decision made...”
K.A.R. 68-7-22

“Each CPA and update shall include the following:

“a statement identifying the situations in which the pharmacist is required to initiate contact with the physician

“a statement...to be followed by the pharmacist if an urgent situation involving a patient's health occurs...”
K.A.R. 68-7-22

“Each CPA and update shall be reviewed and updated at least every 2 years.”

“...pharmacist shall deliver a digital or paper copy of each CPA and update to the board, within five business days...”
“Within 48 hours of making any drug or drug therapy change to a patient’s treatment, the pharmacist shall initiate contact with a physician, identifying the change.”
“This regulation **shall not be interpreted to impede**…
- current hospital or medical care facility procedures…
- the provision of medication therapy management…”
"As part of each pharmacist’s application to renew...shall advise the board if they pharmacist has entered into a CPA."
Pharmacists Role in Providing CDTM
Medication Related Challenges

– Poly-pharmacy: 46% of patients take > 10 medications

– >70% can’t list their medications

– Drug interactions are common and often unrecognized
  • Fragmented care models
Pharmacists Role

– **Integral member of care team**
  - Drug therapy specialist
  - Medication & chronic condition education
  - Adjust & optimize therapy
  - Patient safety

– **Patients who can benefit**
  - Uncontrolled chronic diseases
  - Polypharmacy (multiple medications)
  - Barriers to proper medication use
• Patient Story
RH- 59 y/o Caucasian Male

- **PMH:** T2DM, HTN, hx DVT, depression
- **Problem:** Uncontrolled T2DM and labile INR

  - **Collaboration:** PCP, PharmD, RN, care coordinator
  
  - Patient barriers identified
    - Low health literacy
    - Finances
    - Lack of family support

  - Regular appointments with PharmD scheduled
    - INR obtained same day
    - Written instructions
## Patient Case - Outcomes

### Improvement in A1C

<table>
<thead>
<tr>
<th>Date</th>
<th>A1C</th>
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<tbody>
<tr>
<td>1/31/14</td>
<td>11%</td>
</tr>
<tr>
<td>4/25/14</td>
<td>9.6%</td>
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<tr>
<td>7/30/14</td>
<td>8.1%</td>
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### Before CP - Fluctuating INR

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<tr>
<td>7/29</td>
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</tr>
<tr>
<td>10/30</td>
<td>1.3</td>
</tr>
<tr>
<td>1/21</td>
<td>1.2</td>
</tr>
<tr>
<td>1/31</td>
<td>9.8</td>
</tr>
<tr>
<td>2/7</td>
<td>2.7</td>
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</table>

### During CP - INR Stabilization

<table>
<thead>
<tr>
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<tr>
<td>3/6</td>
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</tr>
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<td>3/13</td>
<td>2.9</td>
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<tr>
<td>5/8</td>
<td>2.6</td>
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<td>5/30</td>
<td>2.1</td>
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Acknowledgement: Lyndsey Hogg, PharmD
Programmatic Impacts
### Overview of Patients

- **Evaluation of patients over 9 month period**

<table>
<thead>
<tr>
<th></th>
<th>Total</th>
<th>Average</th>
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<tbody>
<tr>
<td>Unique Patients</td>
<td>128</td>
<td>60.7 years old</td>
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<tr>
<td>Total patient visits</td>
<td>295</td>
<td>---</td>
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<tr>
<td>New Patients</td>
<td>107</td>
<td>---</td>
</tr>
<tr>
<td>Drugs Evaluated</td>
<td>1,742</td>
<td>13.6 per patient</td>
</tr>
<tr>
<td>Conditions Evaluated</td>
<td>1,073</td>
<td>8.4 per patient</td>
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</table>

- 46% had >10 medications
- 70% had ≥ 5 conditions
Drug Therapy Problems Identified/Resolved

Unnecessary Therapy: 8%
Additional Therapy Needed: 11%
Effectiveness: 36%
Safety: 24%
Compliance: 20%

Total DTPs in 2014 = 477
## Estimated Health Care Savings

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<thead>
<tr>
<th>Event</th>
<th>Number of Events</th>
<th>Estimated Savings</th>
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<tbody>
<tr>
<td>Clinic visit avoided</td>
<td>269</td>
<td>$71,285</td>
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<tr>
<td>Specialty office visit avoided</td>
<td>4</td>
<td>$1,216</td>
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<tr>
<td>Urgent care visit avoided</td>
<td>2</td>
<td>$164</td>
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<tr>
<td>Emergency department visit avoided</td>
<td>14</td>
<td>$7,518</td>
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<tr>
<td>Hospital admission avoided</td>
<td>2</td>
<td>$21,732</td>
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<tr>
<td><strong>TOTAL</strong></td>
<td></td>
<td><strong>$101,915</strong></td>
</tr>
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</table>

Acknowledgement: Lyndsey Hogg, PharmD
Overview of Diabetes Patients

• Diabetes management
  – Total patients = 68
  – Average HbA1c

<table>
<thead>
<tr>
<th></th>
<th>Initial</th>
<th>3 mo.</th>
<th>6 mo.</th>
<th>9 mo.</th>
<th>12 mo.</th>
<th>15 mo.</th>
<th>18 mo.</th>
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<tbody>
<tr>
<td>Patients</td>
<td>68</td>
<td>49</td>
<td>37</td>
<td>27</td>
<td>17</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>avg A1c</td>
<td>10%</td>
<td>8.2%</td>
<td>7.9%</td>
<td>7.8%</td>
<td>7.4%</td>
<td>7%</td>
<td>7.4%</td>
</tr>
</tbody>
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Questions?