Collaborative Practice Agreements and Pharmacists' Patient Care Services

A RESOURCE FOR GOVERNMENT AND PRIVATE PAYERS

CDC

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

Pharmacists can improve patients' health and the health care delivery system if they are part of the patient's health care team. One way to meet this goal is with a collaborative practice agreement (CPA) between pharmacists and other health care providers.[1] Patient care services provided by pharmacists can reduce fragmentation of care, lower health care costs, and improve health outcomes.[1] A 2010 study found that patient health improves significantly when pharmacists work with doctors and other providers to manage patient care.[2] The Community Preventive Services Task Force also found strong evidence that team-based care can improve blood pressure control when a pharmacist is included on the team.[3]

States regulate pharmacists' patient care services through "scope of practice" laws and related rules, including boards of pharmacy and medicine regulations. Depending on each state's laws, pharmacists can work with other health care providers through CPAs to perform an array of patient care services (Figure 1).

In January 2012, the American Pharmacists Association (APhA) Foundation brought together a group of 22 national subject
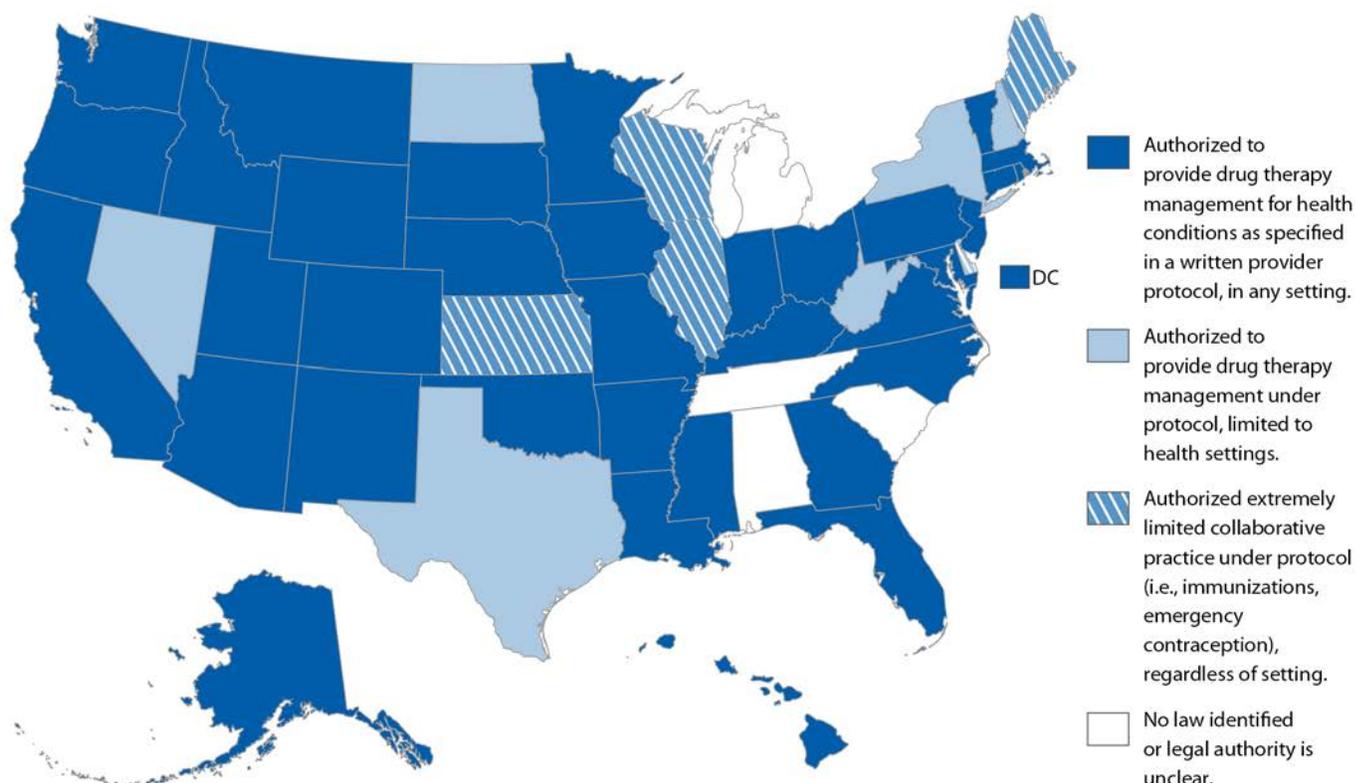
Pharmacist Collaborative Practice Agreement (CPA)

A formal agreement in which a licensed provider makes a diagnosis, supervises patient care, and refers patients to a pharmacist under a protocol that allows the pharmacist to perform specific patient care functions.

matter experts to identify evidence for effective policies, practices, and key supports and barriers to expanding the role of pharmacists in delivering patient care services and entering into CPAs.[4]

Consistent with the findings of the Office of the Chief Pharmacist 2011 Report to the U.S. Surgeon General,[1] the group found that broad access to patient care services delivered by pharmacists is limited by policy and compensation barriers. The group proposed several strategies for expanding pharmacists' patient care services through team-based care and CPAs.[4] Payers can use these strategies to build and

Figure 1. Map of States with Laws Explicitly Authorizing Pharmacist Collaborative Practice Agreements, 2012

Authorized to provide drug therapy management for health conditions as specified in a written provider protocol, in any setting.

Authorized to provide drug therapy management under protocol, limited to health settings.

Authorized extremely limited collaborative practice under protocol (i.e., immunizations, emergency contraception), regardless of setting.

No law identified or legal authority is unclear.

Note: Physician delegation is considered permissive in MI and WI, allowing physicians and pharmacists to enter into CPAs.

strengthen partnerships between pharmacists and other health care providers to improve patient care.

Strategies for Advancing Pharmacists' Patient Care Services

Create and expand an infrastructure that embeds pharmacists' patient care services and collaborative practice agreements into care, while creating ease of access for patients.
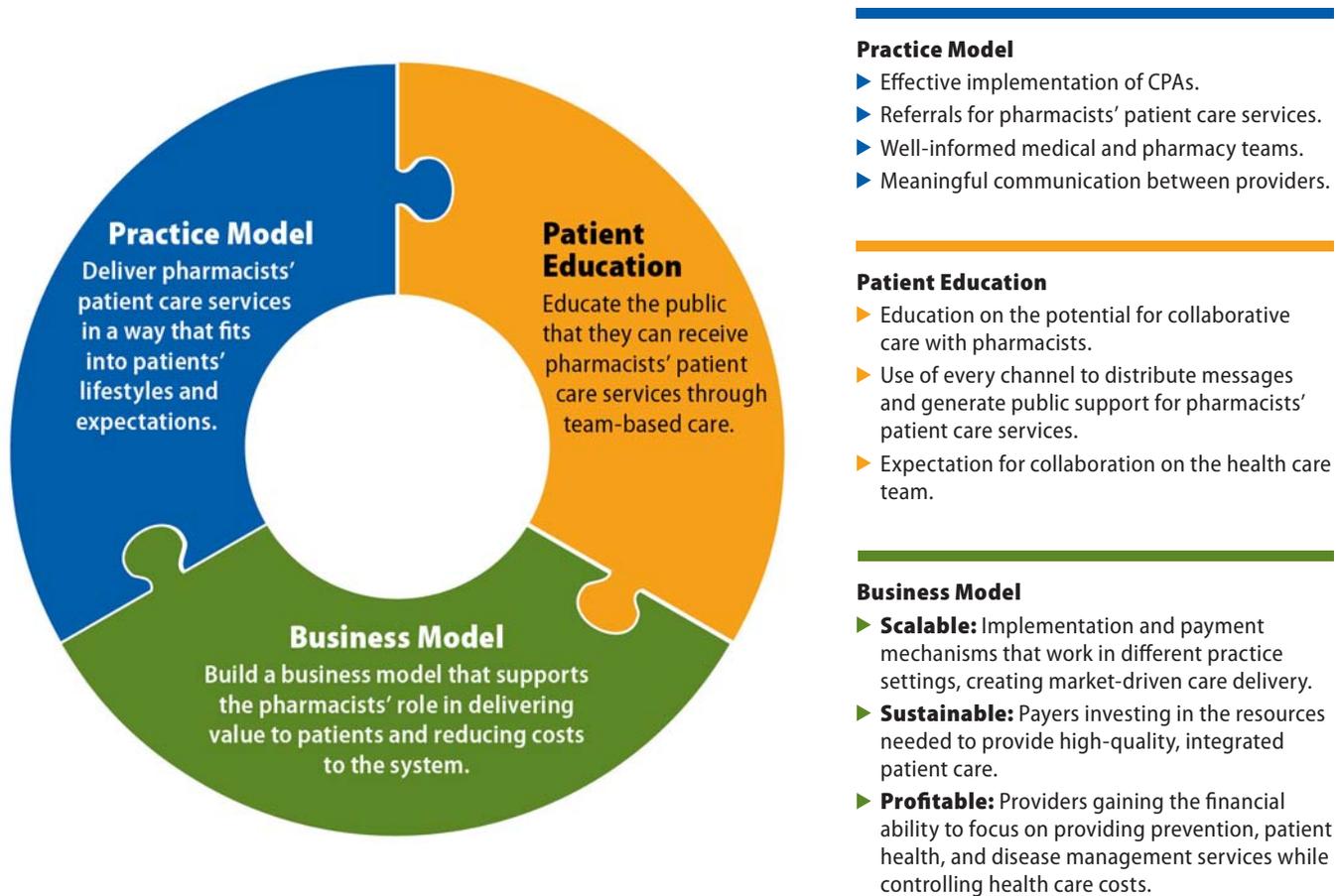
Pharmacists' patient care services, including those provided through CPAs, can reduce fragmentation of care and improve health outcomes if they are set up properly.[1] Infrastructure that embeds pharmacists' patient care services into current care processes and public education initiatives could help patients understand the services available to them. Processes may need to be changed within different practice settings to integrate pharmacists. Components of this infrastructure and associated process changes include the practice model, the business model, and patient education (Figure 2).

Terms Used to Describe Pharmacists' Patient Care Services

Medication Therapy Management (MTM): A distinct service or group of services that optimizes therapeutic outcomes for individual patients. MTM includes five core elements: medication therapy review, personal medication record, medication-related action plan, intervention and/or referral, and documentation and follow-up.[8]

Collaborative Drug Therapy Management (CDTM): A collaborative practice agreement between one or more providers and pharmacists in which qualified pharmacists working within the context of a defined protocol are permitted to assume professional responsibility for performing patient assessments, counseling, and referrals; ordering laboratory tests; administering drugs; and selecting, initiating, monitoring, continuing, and adjusting drug regimens.[9]

Figure 2. Infrastructure and Process Changes to Integrate Pharmacists' Patient Care Services

Practice Model
Deliver pharmacists' patient care services in a way that fits into patients' lifestyles and expectations.

Patient Education
Educate the public that they can receive pharmacists' patient care services through team-based care.

Business Model
Build a business model that supports the pharmacists' role in delivering value to patients and reducing costs to the system.

Practice Model
▶ Effective implementation of CPAs.
▶ Referrals for pharmacists' patient care services.
▶ Well-informed medical and pharmacy teams.
▶ Meaningful communication between providers.

Patient Education
▶ Education on the potential for collaborative care with pharmacists.
▶ Use of every channel to distribute messages and generate public support for pharmacists' patient care services.
▶ Expectation for collaboration on the health care team.

Business Model
▶ **Scalable:** Implementation and payment mechanisms that work in different practice settings, creating market-driven care delivery.
▶ **Sustainable:** Payers investing in the resources needed to provide high-quality, integrated patient care.
▶ **Profitable:** Providers gaining the financial ability to focus on providing prevention, patient health, and disease management services while controlling health care costs.

Case Example: Iowa

Osterhaus Pharmacy in eastern Iowa provides immunizations to patients through CPAs with Maquoketa Family Clinic, a local medical group of family practice doctors and nurse practitioners. The pharmacy also provides MTM services to eligible Medicaid and Medicare Part D beneficiaries with chronic diseases. MTM services are provided through informal agreements with Maquoketa Family Clinic and another local medical clinic, Medical Associates of Maquoketa. To develop an effective process, the pharmacy created practice and business models that highlight the benefits of formal collaboration for those involved and build on existing informal relationships. For example, as part of the immunization protocol, pharmacists educate patients about their eligibility for these services by telephone, in person, or by fax, depending on which method is most convenient for the patient. The pharmacist administers the immunizations according to the terms of the CPA, documents these services in the pharmacy system, and communicates this information to the doctor as agreed. Osterhaus Pharmacy's staff believe this business model is sustainable because immunizations and MTM services are reimbursed by many private and public insurers.[5]

Use simple, understandable, and empowering language when referring to pharmacists' patient care services.

Different terms can be used to describe similar patient care services provided by pharmacists. Simple terms can promote understanding and help create meaningful CPAs that include pharmacists' services in routine patient care.

Pharmacists' clinical capabilities include the following:

▶ Communicating and collaborating with doctors and other prescribers to provide patient care.
▶ Improving quality of medication management and health outcomes.[2]
▶ Improving public health outcomes.[3]

Case Example: Arizona

Since 2000, Arizona law has authorized CPAs between pharmacists and doctors in specified health facilities (ARS §32-1970 [A–D]). The law was amended in 2011 by Senate Bill (SB) 1298 (Ariz Sess Laws Ch 103 [2011]) to allow pharmacists in any setting to enter into CPAs with doctors and nurse practitioners.
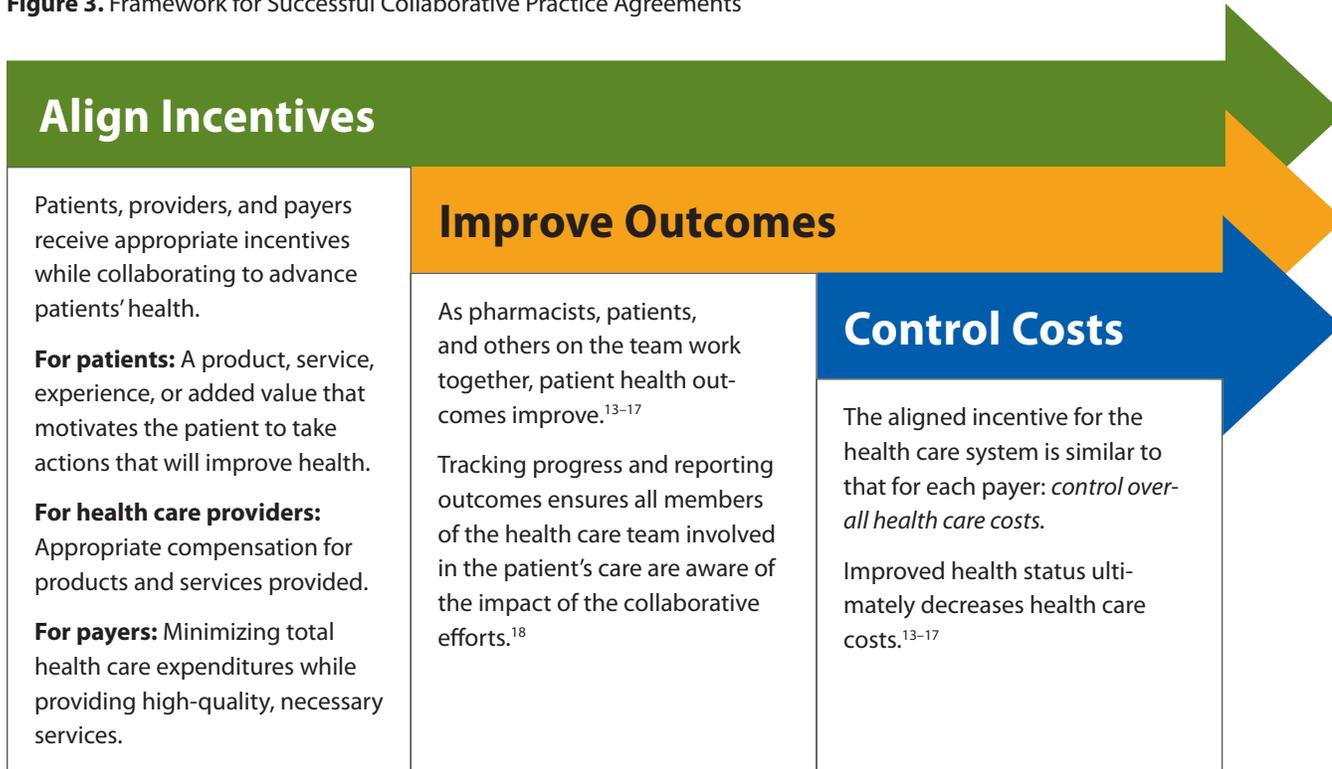
Pharmacists at El Rio Community Health Center[10] have worked with local doctors since 2000. El Rio is the largest local provider of medical services to uninsured and Medicaid patients in Pima County. Each pharmacist and provider negotiates the terms of the CPA to allow the pharmacist to care for patients with diabetes, high blood pressure, and high cholesterol. Compared with other health centers, El Rio reports lower costs, more screenings, and fewer emergency room visits among its patients.[11]

SB 1298 allowed health care providers at El Rio to set up CPAs without changing their diabetes care protocol. It removed requirements to renew CPAs annually or obtain Board of Pharmacy approval for each protocol. El Rio staff found this change reduced the administrative burden and cost for pharmacists and providers. The new law also removed a requirement for a separate CPA for each health condition for each individual patient. This change allows pharmacists to work more efficiently with other providers to provide care to patients with multiple chronic conditions.[12]

Properly align incentives based on meaningful process and outcome measures for patients, payers, providers, and the health care system.

Successful CPAs include two core components: (1) appropriate incentives, which in turn are based on (2) meaningful process and outcome measures for all providers involved in patient care.[8] A simple framework describes how this could be accomplished (Figure 3): *Align the incentives. Improve the outcomes. Control the costs.*

Figure 3. Framework for Successful Collaborative Practice Agreements

Align Incentives

Patients, providers, and payers receive appropriate incentives while collaborating to advance patients' health.

For patients: A product, service, experience, or added value that motivates the patient to take actions that will improve health.

For health care providers: Appropriate compensation for products and services provided.

For payers: Minimizing total health care expenditures while providing high-quality, necessary services.

Improve Outcomes

As pharmacists, patients, and others on the team work together, patient health outcomes improve.[13–17]

Tracking progress and reporting outcomes ensures all members of the health care team involved in the patient's care are aware of the impact of the collaborative efforts.[18]

Control Costs

The aligned incentive for the health care system is similar to that for each payer: *control overall health care costs.*

Improved health status ultimately decreases health care costs.[13–17]

Case Examples: Pharmacist-Provided Care for Controlling Diabetes, High Blood Pressure, and High Cholesterol

The Asheville Project, the Patient Self-Management Program for Diabetes (PSMP), and the Diabetes Ten City Challenge (DTCC) were efforts by self-insured employers to provide education and mentoring for employees with chronic health problems such as diabetes, high blood pressure, and high cholesterol. Patients were enrolled in collaborative care programs that included a community pharmacist on their health care team.[13–17] When the programs were assessed, researchers found the following benefits:

Savings on Overall Health Spending

▶ **Asheville:** Average net savings of $1,622–$3,356 per person per year.[13,14]
▶ **PSMP:** Average net savings of $918 per person per year.[15]
▶ **DTCC:** Average net savings of $1,079 per person per year.[16,17]

Improved Patient Health

▶ **Asheville:** 50% average reduction in number of sick days.[13,14]
▶ **PSMP:** 100% of study participants had their glycosylated hemoglobin (A1C) level tested; 94% of patients met the Health Plan Employer Data Information Set (HEDIS) goal of 7% or less for A1C level.[15]
▶ **DTCC:** A1C and screening rates improved to 97%; 91% of patients achieved an A1C level that met the HEDIS goal.[16,17]

Increased Preventive Care

▶ **PSMP:** 78% of patients received flu shots and 82% received foot exams.[15]
▶ **DTCC:** 65% of patients received flu shots and 81% received foot exams.[16,17]

Provide incentives and support for the adoption of electronic health records and the use of technology in pharmacists' patient care services.

CPAs that bring together pharmacists and other providers depend on information being shared between all members of a health care team. Electronic health records (EHRs) and other health information technology (HIT) can support the expansion of this care model. Computer systems that can interact with each other and are integrated into current pharmacy and medical systems allow pharmacists to send and receive care notes, intervention records, lab and assessment values, and patient information.

A 2011 survey of Nebraska pharmacists found that only 8% of respondents could access the EHRs used by their patients' health providers. In contrast, 80% thought they should be able to access these records.[19] Integrated systems allow for better medication reconciliation, hospital discharge, transitions of care, coordinated billing for services, patient referrals, and understanding of patient health status.[20]

Health Information Technology Legislation and Incentives

▶ Under the Health Information Technology for Economic and Clinical Health (HITECH) Act (PL 111-5), incentive payments are specifically tied to achieving advancements in health care processes and outcomes, also called "meaningful use" criteria.

▶ Pharmacists and pharmacies are not listed as eligible providers for aid through these incentive programs, which may impact their use of EHRs and HIT. Providing incentives to pharmacists could increase their use of EHRs, making it easier to participate in CPAs.

Case Example: Minnesota

In the early 1980s, Goodrich Pharmacy, a locally owned community pharmacy in Minnesota, began entering into medication substitution agreements with local doctors. With the adoption and evolution of MTM services in the 1990s, Goodrich expanded to five sites around the Twin Cities by 2010. The pharmacy now provides extensive MTM and patient care services through CPAs for chronic disease care and patient education with the Anoka River Way Clinic.

Steve Simenson, president of Goodrich Pharmacy, stated that "patient-focused collaborative care has improved as a result of closer relationships that we established with other health care providers." Two to three patients are referred for MTM services each day. The majority of patients participate in the University of Minnesota's employee health plan, UPlan, which provides MTM services at no cost to eligible patients. According to Simenson, university officials support efforts to improve employee health, and they recognize pharmacists' contributions to better MTM services.[6,7]

Case Example: El Rio Community Health Center

At Arizona's El Rio Community Health Center, switching to an EHR system helped providers set up CPAs with local pharmacists for the center's 800 patients who are receiving diabetes management services. Doctors and nurse practitioners refer patients to the pharmacist through the EHR. The pharmacist care plan is then documented in the EHR, along with a copy of the CPA. Changes to patients' medications—such as the introduction of a new medication or a change to a current prescription—are tracked in the system, and this information is accessible to the provider and pharmacist. The new system has created demand for more resources to be devoted to HIT services and data collection and storage.[12]

Action Steps

State scope of practice laws can allow for broad, unrestricted CPAs between pharmacists and other providers. To build and strengthen collaborative practices, payers can implement the following strategies, which were proposed by the APhA Foundation's expert group:

▶ Use simple, understandable terms to describe the patient care services that pharmacists can provide.
▶ Use viable business models to support pharmacists' patient care services.
▶ Set up programs that educate patients about the pharmacist's role on the health care team.
▶ Create meaningful ways to share health information electronically between health care providers.
▶ Show relevant stakeholders the value of aligning incentives and reimbursement for all health care team members involved in patient care to improve health and decrease costs.

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References

1. Giberson S, Yoder S, Lee MP. *Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General.* Rockville, MD: Office of the Chief Pharmacist, US Public Health Service; 2011.

2. Chisholm-Burns MA, Kim Lee J, Spivey CA, Slack M, Herrier RN, Hall-Lipsy E, et al. US pharmacists' effect as team members on patient care: systematic review and meta-analyses. Med Care. 2010;48:923–33.

3. Guide to Community Preventive Services. Cardiovascular Disease Prevention and Control: Team-Based Care to Improve Blood Pressure Control. Guide to Community Preventive Services Web site. www.thecommunityguide.org/cvd/teambasedcare.htm. Accessed June 27, 2013.

4. American Pharmacists Association Foundation, American Pharmacists Association. Consortium recommendations for advancing pharmacists' patient care services and collaborative practice agreements. J Am Pharm Assoc. 2013;53:e132–41.

5. ICF International. *Osterhaus Pharmacy CDTM Policy Implementation Case Study Report.* Atlanta, GA: ICF International; 2012.

6. Egervary A. MTM, Minnesota style: Steve Simenson, BPharm, promotes MTM in the Twin Cities. Pharm Today. 2010;16(3):34–6.

7. Simenson S, Nau DP, Reed B. Health care reform and the role of the pharmacist. J Am Pharm Assoc. 2009;49:356–62.

8. American Pharmacists Association, National Association of Chain Drug Stores Foundation. Medication therapy management in pharmacy practice: core elements of an MTM service model (version 2.0). J Am Pharm Assoc. 2008;48:341–53.

9. Hammond RW, Schwartz AH, Campbell M J, Remington TL, Chuck S, Blair MM, et al. Collaborative drug therapy management by pharmacists—2003. Pharmacotherapy. 2003;23:1210–25.

10. Pharmacy Services. El Rio Community Health Center Web site. www.elrio.org/pharmacy.html. Accessed June 27, 2013.

11. Felt-Lisk S, Harris L, Lee M, Nyman R. *Evaluation of HRSA's Clinical Pharmacy Demonstration Projects. Final Report, Vol II: Case Studies.* Bethesda, MD: Health Resources and Services Administration, US Dept of Health and Human Services; 2004. ftp://ftp.hrsa.gov/bphc/pdf/opa/CPDPvolume2finalreport.pdf. Accessed June 27, 2013.

12. ICF International. *Arizona and El Rio Community Health Center CDTM Policy Enactment and Implementation Case Study Report.* Atlanta, GA; ICF International; 2012.

13. Cranor CW, Bunting BA, Christensen DB. The Asheville Project: long-term clinical and economic outcomes of community pharmacy diabetes care program. J Am Pharm Assoc. 2003;43:173–84.

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14. Bunting BA, Smith BH, Sutherland SE. The Asheville Project: clinical and economic outcomes of a community-based long-term medication therapy management program for hypertension and dyslipidemia. J Am Pharm Assoc. 2008;48:23–31.

15. Garrett DG, Bluml BM. Patient self-management program for diabetes: first-year clinical, humanistic, and economic outcomes. J Am Pharm Assoc. 2005;45:130–7.

16. Fera T, Bluml BM, Ellis WM, Schaller CW, Garrett DG. The Diabetes Ten City Challenge: interim clinical and humanistic outcomes of a multisite community pharmacy diabetes care program. J Am Pharm Assoc. 2008;48:181–90.

17. Fera T, Bluml BM, Ellis WM. The Diabetes Ten City Challenge: final economic and clinical results. J Am Pharm Assoc. 2009;49:383–91.

18. Wright JS, Wall HK, Briss PA, Schooley M. Million Hearts—where population health and clinical practice intersect. Circ Cardiovasc Qual Outcomes. 2012;5:589–91.

19. Fuji KT, Gait KA, Siracuse MV, Christoffersen JS. Electronic health record adoption and use by Nebraska pharmacists. Perspect Health Inf Manag. 2011;8:1d.

20. Pharmacy e-Health Information Technology Collaborative. *The Roadmap for Pharmacy Health Information Technology Integration in U.S. Health Care.* Alexandria, VA: Pharmacy e-Health Information Technology Collaborative; 2011. www.pharmacyhit.org/pdfs/11-392_RoadMapFinal_singlepages.pdf. Accessed June 27, 2013.