

Advancing Team-Based Care Through the Use of Collaborative Practice Agreements and Using the Pharmacists' Patient Care Process to Manage High Blood Pressure



Advancing Team-Based Care Training Workshop Notes May 24-25, 2017

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Introduction and Outcomes

The National Association of Chronic Disease Directors (NACDD), in coordination with CDC's Division for Heart Disease and Stroke Prevention (DHDSPP), worked with state teams from **Arizona, Georgia, Iowa, Utah, Virginia, West Virginia and Wyoming** to participate in a learning program designed to accelerate team-based care to manage high blood pressure using the pharmacists' patient care process (PPCP) and collaborative practice agreements (CPA). To this end, state teams participated in an in-person workshop on May 24-25, 2017, in Atlanta, GA and subsequently worked in their home state toward the outcomes listed below. An overview of workshop content is presented here.

The desired outcomes of this workshop and follow-up activities included taking actions that lead to:

- Increased engagement between the state health department and state pharmacy and medical professional organizations.
- Increased use of the pharmacist patient care process for managing high blood pressure and other chronic conditions (e.g. smoking cessation, diabetes, dyslipidemia).
- Increased use of collaborative practice agreements between pharmacists and prescribers.
- Increased development of sustainable pharmacy practice models.
- Knowledge transfer from participating states and organizations to non-participating states and organizations.

Key Themes

- Public health is an important partner in helping pharmacists frame themselves as an integral part of supporting patient health to providers, patients, and families.
- Public health can increase awareness of the role of pharmacists through promotion of team-based care, training, and supporting models that broaden pharmacists' ability to be compensated for their time.
- Pharmacy and public health can collaborate to address wider systems change and work with additional partners to develop sustainable models that go beyond a grant or project.
- Pharmacists can look to public health to promote their services and resources, joining forces to institutionalize the PPCP in school of pharmacy curricula and establishing relationships with medical associations and health care centers.

- Challenges identified:
 - Spreading and scaling sustainable collaborative models while also ensuring quality;
 - Addressing the issue of pharmacist time required to implement the PPCP;
 - Communicating to pharmacists about PPCP, trainings, and recognition of their role;
 - Working with communities beyond a single project; data collection;
 - Developing partnerships with large chain pharmacists;
 - Understanding reimbursement; creating universal definitions for the variety of pharmacist tasks and roles.

Presentations and Discussion

Presentations focused on the following areas and were presented by expert faculty from partner organizations.

Methods and resources for engaging pharmacy – Lindsay Kunkle, APhA

There are three levels for aligning public health and pharmacy partnerships, including exploring new partnerships (Level 1), solidifying emerging partnerships (Level 2), and expanding existing partnerships (Level 3). Several methods were detailed to align pharmacy engagement:

- Method 1: Identify pharmacy partners and convene pharmacies, community organizations, and healthcare providers by hosting meetings and developing a strategic plan.
- Method 2: Assess the pharmacy environment through an environmental scan or survey of pharmacy practice; capturing patient perceptions and experiences of pharmacy services that are currently provided; and understanding and disseminating information on the laws, regulations, and policies that govern pharmacy practice.
- Method 3: Promote team-based care by supporting community-clinical linkages; promoting integration of team-based care into curricula, experiential training, and residency programs; educating health care professionals on pharmacists' roles on the team; sharing success stories and evidence; facilitating the use of CPAs; and supporting health care teams as they integrate pharmacists into the patient-centered medical home (PCMH) model.



- Method 4: Provide pharmacy training and education on the public health problems associated with high chronic disease rates; resources to enhance team-based care; and promote existing pharmacist training programs.
- Method 5: Identify opportunities to establish, enhance, and expand services by seeking out gaps in pharmacy services; identifying best practices; promoting adoption of medication adherence interventions; connecting health systems and clinics with pharmacies and pharmacy schools; supporting pharmacists as they collect data, monitor and report performance, build referral systems, and/or expand their understanding of reimbursement.
- Method 6: Enhance data sharing capabilities by encouraging pharmacies to utilize HIT; encouraging the use of pharmacy dispensing data and payer claims data; and promoting the collection of defined quality measures, such as those developed by the Pharmacy Quality Alliance (PQA).
- Method 7: Understand reimbursement opportunities.

Table 1: State Teams’ Levels of Partnership and Description at Project Initiation

State	Current Level	Partnership Development Next Steps
Arizona	Level 3 with current work, Level 2 with rural expansion	Discussing how to sustain the MTM program / partnerships beyond 1305, particularly in terms of getting the services paid for. They are also reaching out to rural community pharmacists and incorporating PPCP and team-based care in schools of pharmacy.
Georgia	Moving to Level 3	Continuing to work on communications and better dissemination of information from their project. They plan to engage public health pharmacists, as there are 40 employed by the state.
Iowa	Moving to Level 3	Working with a new HIE vendor. Also, addressing challenges on behalf of community pharmacists such as time and how to better use pharmacy techs. About to launch the “How do you make every encounter count?” resource. Looking to focus on areas / organizations where the team-based care is not as strong.
Utah	Moving to Level 3	Building on pilot projects within University of Utah Health, and spreading the model across the state. They are developing a Community Pharmacy Enhanced Services Network to support the role of pharmacists as part of the healthcare team and starting to explore HIE collaboration.

Virginia	Level 2	Looking to build on the relationships established in Level 1 to better support true partnership and collaboration. Working with their QIO to better engage physicians.
West Virginia	Between 2 and 3	Establishing an enhanced network of pharmacists, but it's been a slow process. Also, exploring improved data sharing; they have experience in doing this with asthma, so looking to replicate that with hypertension.
Wyoming	Level 2	Expanding the scope of care collaborations to more pharmacists and incorporating CPAs; working on developing a pharmacy network and recruiting more pharmacists to implement the PPCP.

PPCP Resource Guide Overview and Implementing the PPCP Across the Collaborative Practice Model – Marialice Bennett, The Ohio State University

The Pharmacists' Patient Care Process was developed through a collaboration of national pharmacy organizations working to develop a standardized pharmacist patient care process in order to stimulate consistency, predictability, and measurability in pharmacists' service delivery. An overview illustration of the resource is below, and it can be found in its entirety [here](#).

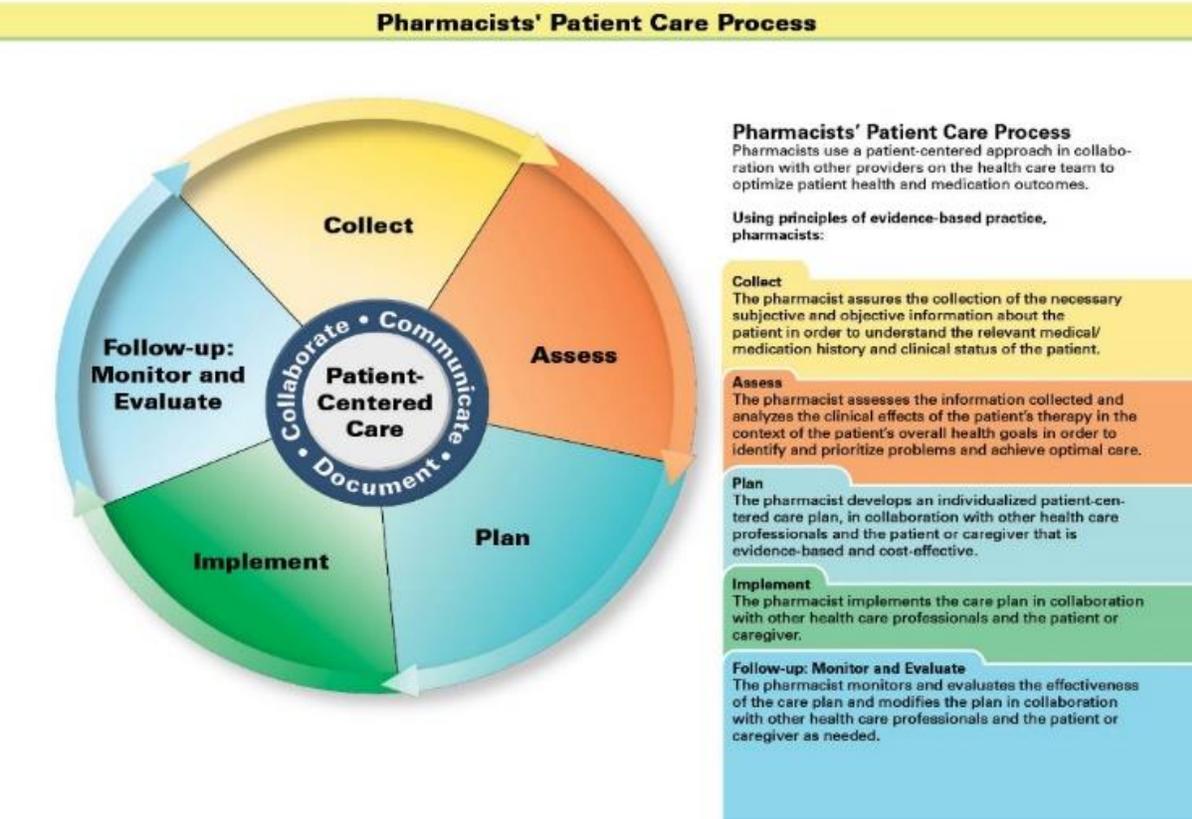


Table 2: Participating partnerships have varying degrees of experience in implementing the PPCP, but for all, the next step is to scale and expand its use.

State	Barriers and Opportunities for PPCP expansion at Project Initiation
Arizona	AZ is doing a lot of telephonic MTM right now, and they are hoping to take this to rural communities, but there is less oversight and access there.
Georgia	GDPH and South University have strong relationship due to 1305, so they are working with students on PPCP, but need to make the work more visible. They are also looking to monitor and track use of PPCP, as some pharmacies have taken off too quickly.
Iowa	IA is continuing to educate pharmacists on the PPCP and is also launching a “making every encounter count” resource for pharmacists to support their expanded role, but it can be hard for pharmacists who feel like they don’t have the time to implement it. They have also been doing a pilot on how to better use pharmacy techs to help address the time issue. They would like to work with big box stores, but corporate collaboration is a challenge, as are mail order pharmacies.
Utah	UT has a pilot program with 16 pharmacists and 15 practice sites where PPCP is embedded with pharmacists, and they are hoping to implement it statewide. PPCP provides a common name to the work already happening, but they need a way to measure outcomes and assess performance.
Virginia	VA has found that the front-line pharmacy enthusiasm for PPCP is great; but they have to implement it more slowly with smaller tests of change (QI process). They are pairing its’ roll out with regulatory changes to protect pharmacists and make it practical for all health care practitioners to work together to help patients. They have good relationships with the four schools of pharmacy in the state, especially VCU in Richmond, but would like to work more with those in rural areas.
West Virginia	WV sees this as similar to immunizations – although they received some pushback initially, it is now an integrated part of their care. They need to work with communities to help them make decisions for themselves and not feel like the state is telling them what to do.
Wyoming	WY is a rural, independent state, and as a result, face-to-face meetings are preferred, but difficult and time-consuming. Changing pharmacy workflows and patterns can be hard, but that is the way to achieving sustainable practices. There are pros and cons to working with independent vs. chain pharmacies first; need to check pharmacy and practice capacity to do this work before beginning.

Developing a Sustainable Collaborative Practice Model – Troy Trygstad, Consultant

Collaborative care goes well beyond the development of CPAs; it takes into account all patient factors and utilizes a variety of resources and means of communication to address them and meet patient needs. Pillars of collaboration are professional, inter-personal, and economic trust; partnerships will only be successful if these components are established from the start. In addition, “mutually agreed to, unambiguous, attainable expectations” must be set as the foundation for sustainable collaborative work. Implementing the PPCP model requires follow up and monitoring well beyond the initial patient encounter, which underscores the importance of collaborative care. Using frontline pharmacists, patients, and caregivers to tout the importance of collaborative care, as well as pharmacists as expanders of care, is much more effective than hearing from policy-makers.

State health departments were asked to consider the following questions as they thought about their partnerships:

- 1) What is the one thing I wish I knew how to do better to plan for sustainability?
- 2) Going in...
 - What are we doing to help patients achieve goals?
 - What are we doing to help providers achieve goals?
- 3) Coming Out....
 - How will it hurt patients if it is turned off?
 - How will it hurt providers if it is turned off?
- 4) Would a random person on the street understand the imperative?

Thinking about answers to these questions generated a good discussion of topics for state teams to explore moving forward, including:

- The economics of pharmacy
- Understanding and working toward patient goals that are life goals, not just health related
- Improving pharmacists’ relationships with patients and getting patients to expect more from their pharmacists
- Promoting the role of pharmacists via personal stories from the community
- Understanding payers; particularly the private payers and how to get them to work with the state on reimbursement
- How to keep partners engaged without funding
- How to make the PPCP and team-based-care a standard of care
- Standardizing and scaling pilot projects and how to make them sustainable

Collaborative Practice Resource Guide Overview and Developing a Collaborative Practice Model – Krystalyn Weaver, NASPA

The establishment of a Collaborative Practice Agreement can be a helpful tool in defining the role of pharmacists in team-based care. However, CPAs should not be the starting point for establishing

relationships; collaborative care work is the beginning. Upon establishing connections, forming solid working relationships, and clearly defining collaborative roles and communications, a formal CPA may be the next logical step. State requirements on the use of CPAs vary significantly, so everything must be translated into your local context. States can help increase knowledge that CPAs are a resource and option, potentially creating a template CPA for your home state. Working with schools of pharmacy to educate students on collaborative care and CPA development, as well as generating partnerships with medical associations and sponsoring events to more widely disseminate information, are additional means of supporting the expanded role of pharmacists.

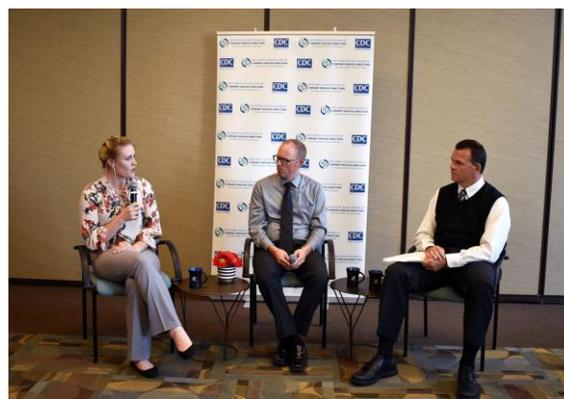
Recommendations for Additional NACDD and CDC Actions

In addition to continued guidance on workplan development and supporting state partnerships in their pursuit of the primary project outcomes, several items were noted as ways NACDD and CDC can help to further advance public health and pharmacy collaboration on the national level:

- Reinforce the importance of consistent performance measures in assessing the PPCP in communications and collaborations with PQA; endorse the recommended performance measures submitted last year.
- Coordinate with larger chain pharmacies.
- Continue collaboration with national organizations such as APhA and NASPA, as well as pharmacy partners not present at the workshop, including, AACP, ASHP, NACDS, and NCPA.
- Develop a self-assessment checklist that states can use with pharmacists to gauge degree of success in PPCP implementation.

Next Steps for State Teams

The primary focus of state teams moving forward from this meeting was to continue and/or establish efforts in support of achieving the five project goals outlined in this document. While the specific actions each state planned as a means to achieve these goals varied, all were expected to foster collaborations in support of these resources, as well as expand upon their dissemination and implementation. As part of refining their workplans post-meeting, state teams detailed their immediate next steps in support of these objectives and participated in resource sharing and monthly webinars, as well as a [fireside chat](#) for additional technical assistance and to share their experiences with a national audience.



Resources

Workshop participants had access to the following resources:

- [Methods & Resources For Engaging Pharmacy Partners](#)
- [Using the Pharmacists' Patient Care Process to Manage High Blood Pressure: A Resource Guide for Pharmacists](#)
- [Advancing Team-Based Care Through Collaborative Practice Agreements](#)
- The American Pharmacists Association (APhA) guidebook, “How to Implement the Pharmacists’ Patient Care Process” - hard copies were available at the meeting; purchasing information available [here](#).

Materials are also available at <http://www.chronicdisease.org/?page=PPCPandCPAProject>

Subject Matter Experts

Workshop sessions were led by the following subject matter experts:

<p>Marialice S. Bennett, RPh, FAPhA Professor Emeritus The Ohio State University College of Pharmacy</p>	<p>Lindsay Kunkle, PharmD Director, Practice & Science Affairs American Pharmacists Association (APhA)</p>
<p>Troy Trygstad, PharmD, MBA, PhD Consultant</p>	<p>Krystalyn K. Weaver, PharmD Vice President, Policy and Operations National Alliance of State Pharmacy Associations (NASPA)</p>

State Teams

The state teams consist of the following state departments of public health and their pharmacy partners:

State	Public Health Partner	Pharmacy Partner
Arizona	David Heath, Program Manager, Heart Disease and Stroke Program, ADHS	Stephanie Forbes, University of Arizona, Medication Management Center
Georgia	Shana Scott, Health Systems Lead, GDPH	Andrea McKeever, South University School of Pharmacy
Iowa	Terry Meek, Health Systems Coordinator, IDPH	Anthony Pudlo, Iowa Pharmacy Association

Utah	Teresa Roark, Health Program Coordinator, UDOH	G. Benjamin Berrett, Manager, Pharmacy Primary Care Services at University of Utah Health
Virginia	Kayla Craddock, VDH	Cynthia Warriner, VA Pharmacists Association
West Virginia	Jessica Wright, WVBPH	Krista Capehart, WV School of Pharmacy
Wyoming	Hannah Herold, Chronic Disease Prevention Program Manager, WDH-PHD	Thanh-Nga Thi Nguyen, UW School of Pharmacy

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