Advanced Pharmacist Practice: The New Mexico Experience

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Outline

• Types of Advanced Pharmacist Practice
  – Requirements
• History of Advanced Pharmacist Practice
• Examples of Pharmacist Clinician Practice
• Barriers to advancement
Advanced Pharmacist Practice: New Mexico

• 1993: Pharmacist prescriptive authority under collaborative drug therapy management protocol
  – The Pharmacist Clinician (PhC)

• 2001: Pharmacist independent prescriptive authority through protocols approved by:
  – NM Medical Board
  – NM Board of Nursing
  – NM Board of Pharmacy
NM Advanced Pharmacist Practice: Requirements

• Pharmacist Prescriptive Authority
  – NM Registered Pharmacist
  – Completion of BOP-approved training course
  – Maintenance: continuing professional education requirements
    • 2 hours of “live” ACPE for each active prescriptive protocol (exception is Tb testing)
  – Currently 5 protocols
    • Immunizations
    • Emergency Contraception
    • Tobacco Cessation
    • Tb testing
    • Naloxone
Pharmacist Prescriptive Authority: Requirements

- Protocol
  - Rx authority has to be in accordance with the written protocol approved by the BOP
  - Any RPh exercising prescriptive authority must maintain a current copy of the protocol for prescriptive authority approved by the BOP
  - Current protocols available at: [http://www.rld.state.nm.us/boards/Pharmacy_Forms_and_Applications.aspx](http://www.rld.state.nm.us/boards/Pharmacy_Forms_and_Applications.aspx)
Pharmacist Prescriptive Authority: Requirements

• Authorized Drugs
  – Limited to those listed in the written protocols

• Records
  – Must generate a written or electronic Rx for any dangerous drug authorized
  – Informed consent must be documented in accordance with the approved protocol and a record of consent maintained in the pharmacy for a period of at least 3 years
Pharmacist Prescriptive Authority: Requirements

• Notification
  – The RPh shall notify the patient's designated physician or primary care provider of the dangerous drug therapy prescribed
  • Vaccines: must also notify the NM DOH immunization program; or can update the DOH immunization program’s electronic database (NMSIIS)
  • TB testing: must also notify the DOH of any positive TB test.
NM Advanced Pharmacist Practice: Requirements

• Pharmacist Clinician
  – NM Registered Pharmacist
  – Completion of BOP-approved 60-hour physical assessment course
  – Completion of direct care preceptorship
    • 150 hours
    • 300 patient contacts
    • Supervised by practitioner with prescriptive authority (physicians, NPs, PAs, or PhCs)
Pharmacist Clinician: Requirements

- **Scope of Practice**
  - A pharmacist clinician shall perform only those services that are delineated in the guidelines of protocol and are within the scope of practice of the supervising practitioner.

- *Care provided is additive not a substitute*
Pharmacist Clinician: Requirements

• Physician Supervision
  - The direction and clinical supervision of PhCs may only be provided by approved supervising MD and/or designated alternate supervising physician(s).
  - May be provided by written guidelines, oral communication in person, communication via the phone, or by other electronic means.
  - Supervising MDs must establish a quality assurance (QA) program for review of medical services provided by the PhC
  - The PhC must have prompt access to the MD by telephone or other electronic means for advice and direction.
Pharmacist Clinician: Requirements

• Protocol
  – Name of PhC and practice location(s) and Primary Supervising MD/DO and all alternate supervisors and their practice locations
  – Purpose or Scope of Practice
  – Policies (should include instances requiring immediate physician notification)
  – Procedures (should outline conditions to be treated, medication classes to be prescribed, diagnostic tests to be ordered, methods of documentation, and emergency/urgent contact)
  – QA Program
  – Signature page
Pharmacist Clinician: Current status

• 139 pharmacists are certified as an PhC
  - 116 have active protocols with the BOP
History of Advanced Pharmacy Practice: Pharmacist Clinician

• The PhC was developed in response to primary care provider shortage in geographically large, rural state

• Legislation was created and pushed by NMPhA with support from NMSHP, the NM BOP, and the UNM COP.

• Prior to introduction support was sought and received from the NM Medical Society and Physician Assistant’s Association as well as the Board’s of Medicine and Nursing.
History of Advanced Pharmacy Practice: NM

• Advocacy:
  – The PhC bill was carried by the Speaker of the House.

• Concessions:
  – Had to include language that the PhC training would be at least equivalent to that of a PA
    • Thus, the 60-hour physical assessment course & preceptorship
  – PhC’s register with both the BOP and the Medical Board
History of Advanced Pharmacy Practice: RPh Prescriptive Authority

• Independent Prescriptive Authority
  – NM ranked near the bottom in immunization rates
  – Again, NMPhA developed a coalition of support beginning with the NM Medical Society, NMSHP, COP, the Boards, and the Department of Health
  – Legislation introduced by Senator who had close relationship with the NM Medical Society

• Once passed regulations were developed in conjunction with the three Boards
History of Advanced Pharmacy Practice: RPh Prescriptive Authority

• Failures
  – Fluoride treatment protocol
  – Hormonal contraception protocol
History of Advanced Pharmacy Practice: NM

• Subsequent activities
  – Changes to statutes to as a result of barriers to pharmacist prescriptive authority
    • 2002: Modified DOH language which recognized only physicians as immunizers. Statute amended from “physician” to “licensed practitioner”
    • 2007: Senate Bill 1097 amended definitions contained within Insurance Code in the HMO Law and the Nonprofit Health Care Plan Law
      – Definition of “basic health services” under HMO law amended to include “services of pharmacist and pharmacist clinicians” under medically necessary services.
    • 2010: Recognition of PhCs as providers in the Medicaid Medical Home Model Trial program
History of Advanced Pharmacy Practice: NM

• Advice
  – Identify areas of need
  – Coalesce key pharmacy group stakeholders
  – Approach other healthcare groups for support
    • Involve them in development of training/protocols
  – Identify effective legislators to introduce legislation
  – Determine other statutory changes that might be needed to enable advanced practice
Student Advocacy Works

Students are well received by legislators!

- This last legislative session, our students met with members of the legislature and helped gain passage for a PBM bill.
- Also advocated for provider status.
- One legislator asked if the students could come back to testify at a committee hearing.
EXAMPLES OF PHARMACIST CLINICIAN PRACTICES
UNM College of Pharmacy Faculty

- James Nawarskas, PharmD, PhC, BCPS & Joe Anderson, PharmD, PhC, BCPS
- Specialty: Cardiovascular Pharmacotherpapy
- Clinics: Heart Failure and Healthy Heart (primary and secondary prevention clinic)
- Protocol allows for wide range of disease states and medications
  - Diagnostics/Lab: laboratory tests, echocardiograms, cardiac stress tests, PFTs, sleep study, holter monitor/event recorder, 24hr BP monitor
• University of New Mexico Health Sciences Center Congestive Heart Failure Clinic
  – Impact of multidisciplinary team (including PhC’s)
  – 1 year pre/post study in 35 “frequent flyer” patients

• Outcomes study results:
  – 91% reduction in CHF hospitalizations
  – Significant improvement in:
    • Patient’s level of functioning
    • Utilization of heart failure medications proven to reduce morbidity and mortality
  – Overall cost savings of **$161,856/year or $4624/patient**

UNM College of Pharmacy Faculty

- Renee Mercier, PharmD, PhC, BCPS & Bernadette Johnson, PharmD, PhC, BCPS
- Specialty: Infectious Disease/HIV
- Clinics: HIV, young adult HIV, HIV-HepC Co-infection, pregnant HIV
- All new HAART patients are referred to PhC’s, all patients discharged from hospital are scheduled with PhC within 72 hours
- Protocol: HAART, antibiotics, order general labs as well as CD4, viral load, tox screens, HLAB5701, GART, phenotype, referrals to psychiatry, dermatology, neurology, social work, PT
- Position Funding: Grants
UNM College of Pharmacy Faculty

- Gretchen Ray, PharmD, PhC, BCPS, BCACP
- Specialty: Diabetes, CV risk reduction, MTM
- Clinics: Family Practice and Adult Internal Medicine
- Protocol: Diabetes, HTN, Dyslipidemia, tobacco cessation
UNM College of Pharmacy Faculty

• Paulina Deming, PharmD, PhC, BCPS
• Specialty: Hepatitis C
• Clinics: UNM HCV Clinic; Truman Clinic HIV-HCV Coinfection Clinic; Project ECHO HCV Clinic; Project ECHO Complex Care Clinic;
• Protocol: Hepatitis C treatment, anemia, HIV
  – CBC, LFTs, iron studies, coag panels, AFP, HIV antibody, viral hepatitis antibodies, imaging- ultrasound, MRI, CT; procedures- EGD, colonoscopy, referrals to other specialty providers
UNM College of Pharmacy Faculty

- Melanie Dodd, PharmD, PhC, BCPS & Rucha Bond, PharmD, PhC
- Specialty: Geriatrics
- Clinics: UNM Senior Health;
- Protocol: Chronic disease and MTM services
  - Disease states: DM, HTN, Dyslipidemia, BPH, depression, HF, dementia, urinary incontinence, hypothroid, fall risk, immunizations
  - Referrals to podiatry, ophthalmology, OT/PT, social work, and psychiatry
  - Assessment: HPI, PMH, ROS, physical exam, and assessment of cognitive, depression, & urologic symptoms
UNM College of Pharmacy Faculty

• Mikiko Yamada, PharmD, PhC, MS
• Specialty: Epilepsy, Pain and headache
• Clinics: UNM Pain Clinic; Pediatric Epilepsy; Project ECHO Pain clinic
• Protocol: Chronic non-cancer pain (CNCP), headache, epilepsy
UNM Hospital PhC practice

- UNM Hospital Department of Pharmacy
  - 4 generalist PhC’s incorporated into the PCMH model between 6 primary care clinics
  - Disease states: DM, HTN, hyperlipidemia, others, and general MTM services. Medication refills with the exception of controlled substances and specialty medications
  - Anticoagulation clinic: 4 PhC’s
  - Pain Clinic: 1 PhC
  - Paid through the Department of Pharmacy
UNM Hospital PhC practice

- Ernest Dole, PharmD, PhC, BCPS, FASHP, CDE
  - Clinic: UNMH Pain Consultation and Treatment Center
  - Disease states: Ambulatory, chronic non-cancer pain (CNCP)
  - Protocol: Design, monitor, adjusts, discontinue medications for CNCP,
    - Monitor NMBOP PMP
    - Order intrathecal pump solution, re-program pumps, fill pumps.
  - Paid through the Department of Pharmacy
  - Note to self, message from Ernie, tell Dr. Fudin “hello”
Community PhC practice

- Presbyterian Medical Group
  - 14 PhC’s staffing 13 primary care clinics and 1 Heart group
  - Disease states: complicated and/or new start anticoagulation, HTN, asthma/COPD, heart failure, hyperlipidemia, diabetes, smoking cessation and general MTM services.
  - PhC’s are budgeted/paid through the individual PMG clinic
Local Data to Support PhC

- PMG PhC CHF Program

- Savings Due to Decreased Admits
  - Cost savings from 1/1/2003 through 6/30/2003: $383,278.77

- Savings Due To Decreased ER Visits
  - Cost Savings from 1/1/2003 through 6/30/2003: $13,770
Community PhC Practice

- Health Centers of Northern New Mexico (HCNNM)
  - Primary care system serving poor and medically indigent residents of Northern NM
  - As part of a HRSA Clinical Pharmacy Demonstration Project, UNM COP partnered with HCNNM to conduct outcomes study
  - Objective: To document the impact of a Ph.C. in the management of patients enrolled in DM disease state management program (DDSM)

Local Data to Support PhC

Increased patients at goal for A1c (22% vs 52%; p=0.002), BP (68% vs 85%; p=0.045), and LDL-C goal (57% vs 77%; p=NS).

Community PhC practice

- Lovelace Medical Group
  - Developing new PhC group (initially 3 PhCs)
  - Integrated into primary clinics and part of PCMH
  - Disease states: HTN, dyslipidemia, and DM
  - PhC’s are budgeted/paid by the LMG
Tips for establishing a clinical service

- Identify key stakeholders
- Perform needs assessment
- Establish relationships with colleagues
  - Admin, physicians and other health professionals, and staff
- Identify the payor mix
- Develop clinic proposal
  - Reimbursement
  - Outcome measures
BARRIERS TO ADVANCED PHARMACY PRACTICE
In your opinion, what is/are the greatest obstacle(s) toward increased utilization of the PhC?

A. physician support
B. pharmacist support/interest
C. public support
D. Lack of recognition as healthcare provider
E. All of the above
Barriers to Advanced Pharmacist Practice

• Survey of PhC’s (NM) and CPP’s (NC) asked to identify barriers to implementation (n = 67)
  – Acceptance: 23.4%
  – Reimbursement: 18.8%
  – Administrative issues: 9.4%
  – Patient acceptance: 4.7%
  – Lack of previous program experience: 3.1%
  – Legislation or regulations: 3.1%

Barriers to Advanced Pharmacist Practice

- Survey of PhC’s (NM) and CPP’s (NC) asked key factors for program success (n = 67)
  - Provider support “buy in”: 40.6%
  - Reporting of health outcomes data: 17.2%
  - Reporting of financial metrics: 14.1%
  - Patient acceptance “buy in”: 14.1%
  - Administrative support: 9.4%

Barriers to Advanced Pharmacist Practice

• Survey of PhC’s (NM) and CPP’s (NC) asked to offer recommendations for setting up a successful program (n = 67)
  – Financial planning: 15.6%
  – Relationship building (MDs, admin): 15.6%
  – Proper planning for implementation: 14.1%
  – Monitoring program outcomes: 7.8%

Barriers to Advanced Pharmacist Practice

• My opinion:
  – LACK OF FEDERAL RECOGNITION AS HEALTHCARE PROVIDERS
  – Without recognition from CMS, it is difficult to obtain recognition from other 3rd party payors
  – Currently, CMS recognizes physicians, nurse practitioners, nurse specialists, physicians assistants, psychologists, and social workers as providers
Barriers to Advanced Pharmacist Practice: Provider Status

• The problem: obtaining provider status takes an act of Congress
  – 2001: Senate Bill S974 and House bill HR2799 introduced to recognize RPh’s as healthcare providers.
    • Never went anywhere.
    • Why? Moran Institute did cost estimate and came up with a final cost estimate of $427 million in 2004 and a 10-year estimate of $13 billion.
    • Never went anywhere.
    • Why?
      – Lack of support from Pharmacy organizations
Barriers to Advanced Pharmacist Practice: Provider Status

• 2008: H.R. 5780
  – Rep. Heather Wilson (R, NM) introduced legislation to recognize the PhC as a healthcare provider under Medicare B.
    • AACP, NACP, ACP endorsed this legislation
    • ASHP could not voice support for this legislation
      – Citing conflicts with current ASHP policy (0318)
    • APhA would not support because it did not recognize all pharmacists
    • ACCP would not support because they did not want to go against the provider coalition
Barriers to Advanced Pharmacist Practice: Provider Status

- 2010: H.R. 5389, the “Medicare Clinical Pharmacist Practitioner Services Coverage Act of 2010”
  - Rep. Martin Heinrich (D, NM) introduced legislation to recognize the PhC as a healthcare provider under Medicare B.
- ASHP was the lone national pharmacy organization to support
Barriers to Advanced Pharmacist Practice: Provider Status

• Some successes
  – MEDICARE D
    • RPh’s recognized as providers of Medication Therapy Management Programs (MTMP)
  – MTM Billing Codes
    • Current and Procedural Terminology (CPT) Codes are published by the American Medical Association to be used for the systematic listing and coding of medical, surgical, and diagnostic procedures and services.
    • RPh-provided MTM codes were made permanent by the AMA CPT editorial panel (effective January 1, 2008)
      – 99605, 99606, 99607
Barriers to Advanced Pharmacist Practice: Provider Status

• Some successes
  – Medicaid
    • NM Medicaid recognizes PhC’s as providers
    • Still must bill under MD
  – 2007: NM Insurance and MCO Statutes modified to include Pharmacists and Pharmacist Clinicians as practitioners and providers
    • Recognized as providers within the PCMH pilot
  – Multiple local health plans have recognized PhC’s as providers
    • Have to meet their respective credentialing and privileging criteria.
  – National Provider Identifier number (NPI)
    • https://nppes.cms.hhs.gov/NPPES/Welcome.do
Pharmacist Clinician: Opportunities

• 2010
  – Patient Protection and Affordable Care Act (PPACA)
    • MTM Grant Programs
    • Integrated care models
    • Transitional care activities
Barriers to Advanced Pharmacist Practice: Provider Status

• New Opportunity
  – HR 4190 “Medicare Coverage of Pharmacist Services”
    • Rep GK Butterfield (D, NC) & Rep Todd Young (R, IN)
  – Recognizes RPh’s as providers under Medicare, Part B based on services authorized by state law
  – Limited to settings located in health professional shortage areas, medically underserved area, or medically underserved population
Barriers to Advanced Pharmacist Practice: Provider Status

• HR 4190 “Medicare Coverage of Pharmacist Services”
  – Supported by Patient Access to Pharmacists’ Care Coalition.

  • ASHP, Albertson's, AACP, APhA, ASCP, Amerisource Bergen, Bi-Lo Pharmacy, Cardinal Health, CVS Caremark, Food Marketing Institute (FMI), Fred's Pharmacy, Fruth Pharmacy, International Academy of Compounding Pharmacists (IACP), National Alliance of State Pharmacy Associations (NASPA), National Association of Chain Drug Stores (NACDS), National Community Pharmacists Association (NCPA), Rite Aid, Safeway Inc., SuperValu Pharmacies, Thrifty White Pharmacy, Walgreens, and Winn-Dixie.
Barriers to Advanced Pharmacist Practice: Provider Status

• HR 4190 “Medicare Coverage of Pharmacist Services”
  – Sign the petitions!!!
    • Steve Soman’s is posted on the White House “We the People” site.
      – Needs 100,000 signatures by April 12th
    • Sandra Leal’s petition is on the Change.org site and targets House members to co-sponsor bill
      – Goal is 1,500 supporters
  – Urge your Rep’s to Co-sponsor!!!
    • Rep. Tonko is on Energy & Commerce Committee!!!
All Bad things must come to an end.