Expanding Roles in Whole-Person Care for Registered Nurses and Pharmacists

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Steering Toward Success: Achieving Value in Whole Person Care
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The Healthier Washington Practice Transformation Support Hub

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Steering Toward Success:
Achieving Value in Whole Person Care

Expanding Roles in Whole-Person Care for Registered Nurses and Pharmacists

AIMS CENTER | UNIVERSITY of WASHINGTON Psychiatry & Behavioral Sciences

Anne Shields, RN, MHA
Associate Director, AIMS Center

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Introductions

- **Phil Lillich, RN, BSN, MBA**
  - Director Health Services
    - Swedish Medical Group
- **Andrea R. Corona, PharmD, BCACP, CDE**
  - Director, PGY2 Ambulatory Care Pharmacy Residency
  - Faculty Pharmacist, St. Peter Family Medicine Residency Program
    - Providence Medical Group

Learning Objectives

- Describe team roles in integrated care models that utilize registered nurses and pharmacists
- Review case examples
- Define how registered nurses and pharmacists can function in an integrated care setting
- Give examples of best practices from primary care and behavioral health settings

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New Role for Registered Nurses

Behavioral health care managers in primary care settings:

- Active treatment role in depression, anxiety, other BH conditions frequently seen in primary care
- Role may also include managing medical co-morbidities such diabetes and heart conditions
- Based on TEAMcare model, also called multi-condition collaborative care model

New Role for Registered Nurses

Nurse care managers in behavioral health agencies:

- Manage medical co-morbidities in patients with severe mental illnesses or substance use disorders
- Based on Missouri Health Home program model, which achieved significant savings

Emerging Role for Registered Nurses

Nurse care manager in Washington State Opioid Treatment Networks

- Key part of care team supporting patients receiving medication assisted therapy (MAT) and recovery services
- Based on SAMHSA "hub and spoke" model
  - Hub manages MAT induction, stabilization
  - Spokes continue treatment, offer primary care and other services

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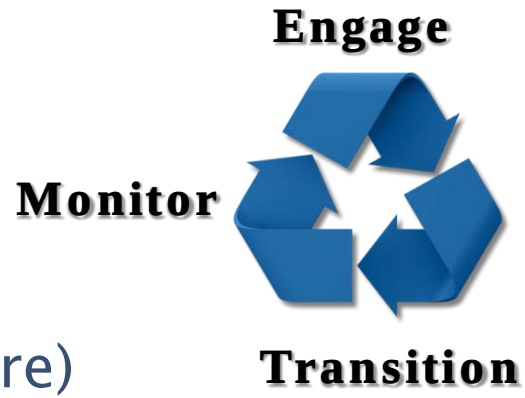
Director Health Services, Swedish Medical Group

Background – Health Services Under Accountable Care



- Care management
  - Enhanced care services
    - Complex care management and collaborative care (Integrated care)
- Medical management
  - Gather data, analyze SMG clinical performance of our Tier 1 at-risk populations
- Patient engagement and outreach
  - Transitions of care calls for patients discharged from acute care and ED admissions
  - Outreach for AWV, gap closures, HCCs
  - Health navigation

Integration Strategies

- Embed RN CCM in primary care based on volume
  - Goal to have each RN embedded in two clinics, a primary and secondary
- Patient engagement staff paired with RNs
  - Goal to provide link to community resources
- Transition of care RNs would also refer potential cases to complex care managers

Integration Strategies

- 31 Primary care clinics
- Covered approximately 300,000 patients
- Collaborative care clinical rounds are every week in a virtual setting, staffed with two teams
- Teams consist of:
  - Complex care manager RN
  - Pharmacist
  - Psychiatrist
  - Diabetic educator
  - PCP representative
  - Health navigator
  - Patient care coordinator
  - Manager of care management

Complex Care Manager RN Role and the Program Approach in Collaborative Care

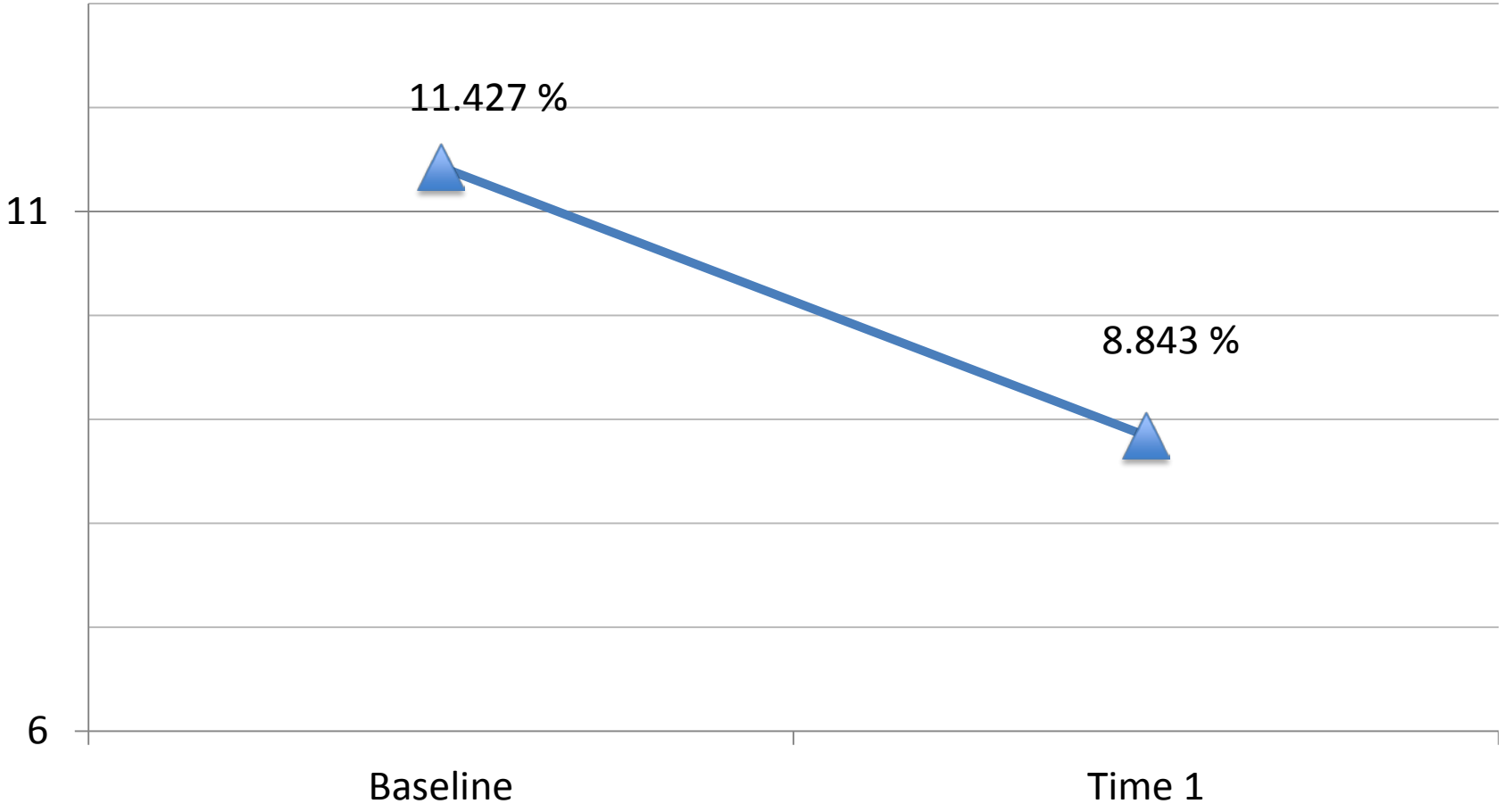
- Strong nursing process
  - Assessment
    - Clinical, social, emotional, financial and readiness to change – activation
  - Diagnosis
    - Patient goals, evidence based goals, finds ways to blend and prioritize the two
  - Planning
    - Tools and strategies – motivational interviewing, decisional balance, adult learning, SMART goals

Complex Care Manager RN Role and the Program Approach in Collaborative Care

- Strong nursing process
  - Implementation – perform interventions
    - Engage, teach, empower/coach – Eric Coleman's Care Transitions – how do you help patients know and understand the red flags?
  - Evaluation
    - Were goals met, did the patient stay engaged and graduate to self-directed health?
    - Did we impact health outcomes?
    - Did we impact total cost of care?

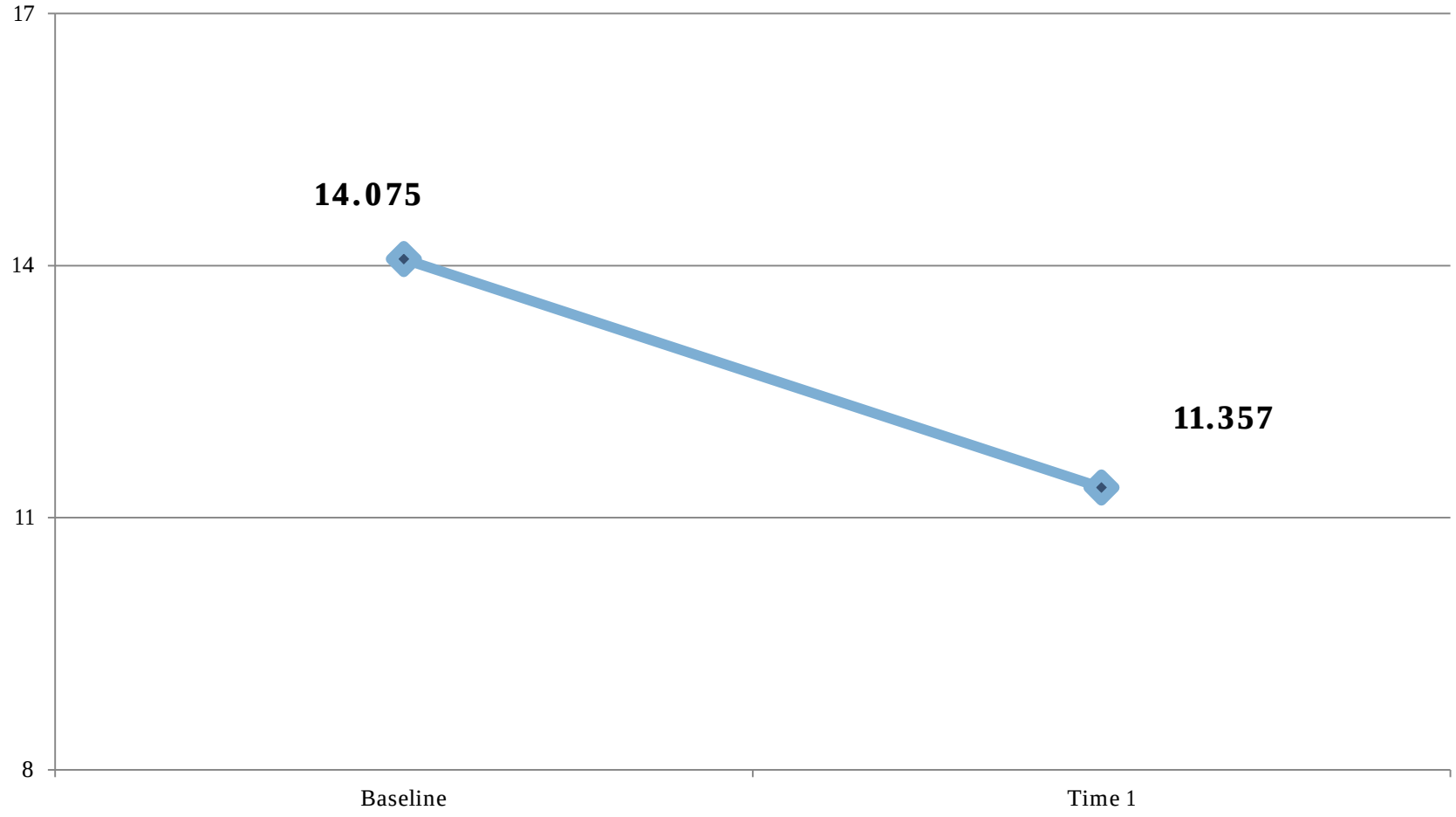
Success Stories – 2016

A1C N = 61 Graduates + Active (mean 14.1 weeks)



Success Stories – 2016

PHQ 9 N = 61Graduates + Active (mean 14.1 weeks)



Collaborative Care—CCM and BH Best Practice

	Inclusion	Exclusion	Enrollment	Case Review	Graduation	Disenrollment
CCM	Diabetic and Depressed (PHQ9≥10) and any of the following: • A1C ≥8 • B/P ≥ 140/90 • No statin with documented ASCVD risk	Cognitive issues that take priority and/or impair ability to set and make progress on patient goals (i.e. Bipolar, Mania, Dementia, etc.)	Referral to Complex Care Management; AMBR0600	Systematic case review, bi-weekly	Pt has met clinical target. Care manager continues to monitor at least 3 months; patient is officially "graduated" and they are unenrolled.	Disenrollment occurs when three attempts to contact patients have been made, including phone and certified letter. Case is closed and PCP is notified.
BH	Diabetic and Depressed (PHQ9≥10)		Referral to Behavioral Health; Warm hand-off	Psychiatry partner meeting, bi-weekly	Graduation occurs when patient has met clinical target.	
Stepped Care	Initially enrolled with BH; Diabetic and Depressed (PHQ9≥10) and one of the following: • A1C ≥8 • B/P ≥ 140/90 • Lack of Statin with documented ASCVD risk		BH refers to Complex Care Management after discussion with PCP; AMBR0600	See CCM	See CCM	

Challenges and Barriers

- Data, data, data
  - Registries, documentation, reporting
- Clear expectations - why are you setting up and developing a collaborative team?
- Role clarification
  - Non-clinical role and providers wanted to pull the RNs into the clinical tasks
- Engagement
  - Patients get tired of weekly PHQ-9s
  - Growing concern around PHQ-9 response bias
- Scalability

Opportunities for Improvement and Lessons Learned

CCM RN role needs to own the relationship with the patient

- Goal is to maintain engagement and graduate the patient
  - Pace, priorities
- Other team members are consultants
- Don't underestimate the impact of social determinants

Future Planning: Next Steps

- Investigate creating regional collaborative care clinical rounds
- Investigate telehealth collaborative care clinical rounds
- Continue to gather clinical outcomes
- Validate the impact of outcomes on readmissions, ED utilization and gap closure rates or health status

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Faculty Pharmacist, St. Peter Family
Medicine Residency Program

Pharmacist's Role in Integrated Care

- Treat to target disease state management
- Population health expertise
- Quality improvement (QI) experience
- Health team and patient education
- Resource for drug information

Scope of a Pharmacist in WA State

- Scope is determined by *state* law
- Brief summary of licensure:
  - Monitoring drug therapy and use
  - Participating in drug utilization reviews
  - Providing information on drugs and devices
  - Interpreting prescription orders
  - Compounding and dispensing of drugs and devices
  - Proper and safe storing of drugs
- Collaborative Drug Therapy Agreement (CDTA)
  - Expands a pharmacist's scope to include prescriptive authority without protocols

Example of Pharmacist Integration

Direct Patient Care

- Independent, joint or telephone appointments
- Treat-to-target disease management via CDTA
- Patient consultations for polypharmacy and comprehensive medication review (CMR)

CDTA

1. Anticoagulation
2. Asthma
3. Cholesterol
4. COPD
4. Depression
5. Diabetes
6. Hypertension
7. Immunizations
8. Renal Adjustment
9. Smoking Cessation
10. Heart Failure

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Example of Pharmacist Integration

Indirect/consultative patient care

- Asynchronous chart review for polypharmacy or CMR
- Participation in transitions of care team meetings for complex patients at high risk of readmission
- Participation in collaborative care for patients with depression and comorbid diabetes
- Answer drug information questions

Population health

- Facilitate interdisciplinary population health meetings
- Lead interdisciplinary QI oversight committee
- Proactive identification of patients not at target

Example of Pharmacist Integration

Education

- Patient education (individual or group)
- Health team education, examples:
  - Guideline updates
  - New drug approvals
- Faculty for medical residencies
- Faculty for pharmacy residencies
- Joint appointments with universities

Goals of Integrated Pharmacy Services

- Support referring provider's relationship with patient
- Streamline management of patients with complex comorbidities and polypharmacy
- Treat to target to improve outcomes
- Increase access to referring provider
- Expand educational opportunities for the clinic team → evidence based practice

Best Practices

- Identify alignment between clinic qualities and pharmacy services
- Identify alignment between pharmacy services needed and pharmacist training/expertise
- Leadership buy-in to integrated services
- Define role and focus of clinic pharmacist

Examples of Role Definition

- All patients with diabetes or only those with A1C >9%?
- Completion of clinic prior authorizations and refills?
- All chronic diseases or only those with metrics related to financial risk?
- All transitions of care or only those patients with > 10 medications?

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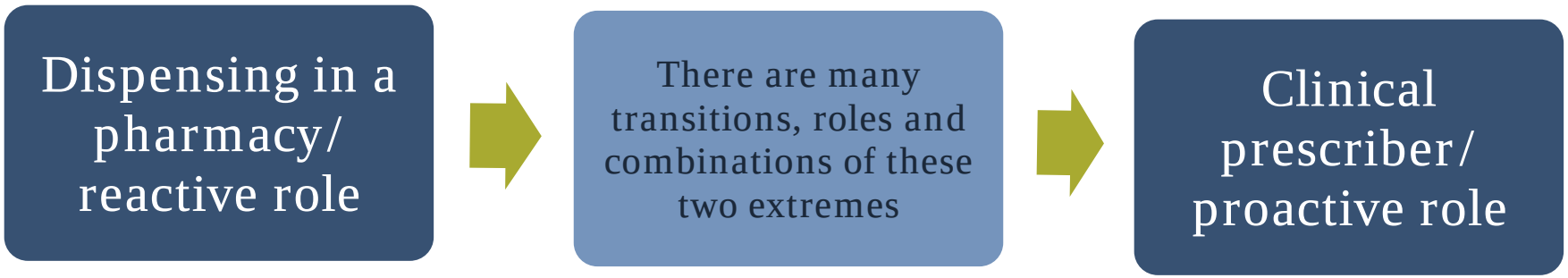
Challenges and Barriers

- Reimbursement for pharmacy services
  - Not recognized as providers by CMS
  - WA state law requires inclusion of pharmacist in reimbursement
- Hiring a pharmacist with the right skill set
- Transforming the stereotype of pharmacists



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Patient Story- “Jo”

Q & A

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