A Resource Guide for the Collaborative Roles with Medication Management in a Patient-Centered Medical Home

PCMH
The purpose of the *Resource Guide of the Collaborative Roles With Medication Management in a PCMH* is to provide examples of services and methodologies that are in current use or development with medical homes to improve medication treatment and adherence outcomes. *The Resource Guide* does not specifically endorse any of the enclosed recommendations.

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Overview

A critical focus of a successful Patient-Centered Medical Home is the collaboration among team members. Key questions are: (1) Who makes up the team? (2) What are the roles and routines? (3) How do the roles and routines align with one another? This is particularly important when integrating comprehensive medication management services into the medical home.

The work of the pharmacists and medication therapy practitioners needs to be coordinated with other team members in the PCMH. One of the principles of the PCMH is the team approach, and the composition of the PCMH team will vary based on a range of factors, including the specific needs of patients and the scope of services to be offered and/or coordinated. For patients on multiple and/or chronic medications, pharmacists, who are trained to provide comprehensive medication management services, have the necessary expertise to help them and their health care team in the patient-centered medical home to maximize the benefits from the very effective medications that are available in this country.
Collaborative Practice Agreements

Collaborative practice agreements are gradually becoming a routine part of the pharmacist’s practice. A collaborative practice agreement is a voluntary agreement between one or more prescribers and pharmacists establishing cooperative practice procedures under defined conditions and/or limitations, wherein qualified pharmacists working within the context of a defined protocol are permitted to assume professional responsibility for performing patient assessments; ordering drug therapy related laboratory tests; administering drugs; and selecting, initiating, monitoring, continuing, and adjusting drug regimens.

Scope of Collaborative Practice Agreement Use

Each state has its own regulations regarding collaborative practice agreements. As of May, 2004, 41 states and the territory of Guam allow for some form of Collaborative Practice Agreement between pharmacists and prescribers. Thirty-six states allow for statutory authority and five states use regulations to authorize Collaborative Practice Agreements. These numbers are changing. To stay up-to-date on your state’s collaborative practice regulations and to obtain comprehensive information specific to your state, search the web for “<your state> collaborative practice agreement regulations.”

The features listed below can also be used as a guide when building a collaborative practice agreement.

- Names of participating parties
- Description of the activities to be performed by the pharmacist
- What is this collaborative practice agreement for (drug, disease, etc.)
- Which patients, referral only
- Details on care process, patient-specific decision making, and what you will and will not be doing
- Qualifications of participating pharmacist (determination and demonstration of competency)
- Specifics of the protocol to be used
- Documentation requirements
- How your work will be communicated to the physician
- Accountability for quality measures
- Compensation stipulations
- Expiration statement
- Signature
Patient Communication Techniques

Greater demands are being placed on patients as consumers of health care. The health care system is increasingly complex and demanding of patients – from direct-to-consumer advertising to shorter hospitalizations with greater self-care requirements after discharge. At times, providers may actually place greater burdens on patients to make informed decisions that can affect health outcomes. Patients will benefit from the following recommended strategies for patient-centered visits.

1. Explain things clearly in plain language
   - Slow down the pace of your speech
   - Use plain, non-medical language
     - “Blood pressure pill” instead of “antihypertensive”
     - Pay attention to patient’s own terms and use them back
   - Avoid vague terms
     - “Take 1 hour before you eat breakfast” instead of “Take on an empty stomach”

2. Focus on key messages and repeat
   - Limit information
     - Focus on 1-3 key points
   - Develop short explanations for common medical conditions and side effects
   - Focus on behaviors – what do you want the patient to do?
   - Review each point at the end – summarize and reinforce

3. Use a “teach back” or “show me” technique to check understanding
   - Ask patients to repeat in their own words to gauge comprehension versus asking, “Do you understand?”

4. Effectively solicit questions
   - Rather than say “Do you have any questions?”, open the door by effectively soliciting patient questions and ask, “What questions do you have?”

5. Use patient-friendly educational materials to enhance interaction
   - Guidelines for written materials:
     - Few messages, with no assumptions that patients know about how the body works, diseases, or medications
     - Short, simple, and familiar words
     - Easy-to-understand phrasing of numeric information
     - Large, sans serif fonts
     - Short, simple, and familiar words
     - Short lines and lots of white space
     - Simple illustrations that are directly applicable to the text

Source: AHRQ Publication No. 07(08)-0051-1-EF October 2007
Measurement of Effectiveness for PCMH Collaboration

The PPC®-PCMH™ program reflects the input of the American College of Physicians (ACP), the American Academy of Family Physicians (AAFP), the American Academy of Pediatrics (AAP), and the American Osteopathic Association (AOA), as well as others to assess whether physician practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC®-PCMH™ standards emphasize the use of systematic, patient-centered, coordinated care management processes.

There is a standard on Care Management that includes elements on a team approach to managing patient care and the coordination of care and follow-up with external organizations and other physicians. The information that follows contains details and examples of these two important collaborative elements of a PCMH.

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The practice maintains a team approach to managing patient care.

A team approach includes use of nonphysician staff. Shared responsibilities are designed to maximize each team member’s level of training and expertise. In small practices, roles may be designated for the physician, the nurse and existing administrative staff. Supporting documentation for this element includes protocols, job descriptions, standing orders that show how the practice involves nonphysician staff in various aspects of patient care management.

EXAMPLE* Documentation

<table>
<thead>
<tr>
<th>Class of med</th>
<th>Cholesterol Reducing</th>
<th>HCT/Z</th>
<th>Discrete For HTN</th>
<th>Cardiac Drugs (Digoxin and others)</th>
<th>Metabolic Disease</th>
<th>Allergy</th>
<th>Glucose</th>
<th>Diabetes</th>
<th>GI (Cirrhosis, Peptic ulcers)</th>
<th>Anti Depressant (Post, Pneum, etc)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Type of lab</td>
<td>Lipid met CMS</td>
<td>SMB or CMS</td>
<td>SMB Q4 mo</td>
<td>Digestive level, potassium</td>
<td>HbA1c Q4 mo</td>
<td>Lipid Q4 mo</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Visit Frequency</td>
<td>6 mo.</td>
<td>6 mo. if pt comes in regularly, otherwise 1 month and re-visit</td>
<td>6 mo.</td>
<td>Check chart note for HbA1C-Q, then Q6 mo</td>
<td>See chart note, minimum Q6 mo</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*This is an example and is not an endorsement of a specific software or format.
The practice coordinates care with external organizations and other physicians.

The practice identifies patients treated in inpatient and outpatient settings and contacts them after discharge to provide or coordinate follow up care. It maintains processes for coordinating care for patients who receive care management or disease management services and provides coordination for patients who receive care from other physicians.

**EXAMPLE* Documentation**

<table>
<thead>
<tr>
<th>Date of ER Visit</th>
<th>Diagnosis</th>
<th>Follow up call</th>
<th>Follow up appointment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>SOB</td>
<td>We admitted pt</td>
<td>Pt has problems with providing care for his wife.</td>
</tr>
<tr>
<td></td>
<td>Cath drop</td>
<td>Yes</td>
<td>no fu necessary</td>
</tr>
<tr>
<td></td>
<td>Fever dialysis pt</td>
<td>F/u to specialist</td>
<td>no fu with us</td>
</tr>
<tr>
<td></td>
<td>Injured L. Hand</td>
<td>no fu necessary</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Diarrhea, fever, vomiting</td>
<td>Told to go to ER</td>
<td>Pt told to go to Er by us</td>
</tr>
<tr>
<td></td>
<td>Flu</td>
<td>F/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Leg Bleed</td>
<td>F/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dialysis Pt C/f</td>
<td>F/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Blood Test</td>
<td>F/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Sodium Level</td>
<td>F/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dropped Ams</td>
<td>F/u scheduled</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Chest Pain</td>
<td>Pt has been called</td>
<td>Not been in clinic</td>
</tr>
</tbody>
</table>

*This is an example and is not an endorsement of a specific software or format.
Recommended Resources

Resource Articles


Resource Links

The Patient-Centered Primary Care Collaborative
http://www.pcpcc.net

The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes – A Resource Guide
http://www.pcpcc.net/files/medmanagement.pdf

American Academy of Family Physicians – Step by Step Plans and Tools
Resource Materials and Templates

Examples of Triggers for Referral

Diabetes:
- A1C >7.0%
- Newly diagnosed
- Intolerance to medications

Hyperlipidemia:
- LDL >100 in patients with heart disease and/or diabetes
- HDL <40 in patients with heart disease and/or diabetes
- LDL >160 in patients with no heart disease or diabetes
- Intolerance to medications

Hypertension:
- Intolerance to medications
- Patients on 3 or more medications and poor control of BP
- Patients with poorly controlled BPs

Asthma/COPD:
- Any patient with poor control of symptoms of COPD
- Any asthma patient with poor control
- Newly Diagnosed

Polypharmacy:
- Any patient on >7 medications
- Any patient with Hx of poor compliance
- Any patient with adverse reactions
Sample Clinical Pharmacist Referral Form

<<eMR auto populates all patient information and assigned PCP>>

CLINICAL PHARMACIST
REFERRAL FORM

Referring Name: ____________________________________________________________

Patient's PCP: ____________________________________________________________

Select service(s) requested for your patient on 5 or more chronic use medications:

☐ Evaluation of non-adherence issue (not cost-related)
☐ Potential drug-related problem leading to medical concerns
☐ Medication administration issues (ie, timing of administration, pill burden)
☐ Drug-Lab monitoring of safety/efficacy for patients with serum creatinine >2mg/dl, potassium levels >5.5 mmol/L, AST/ALT elevations >2x normal

Additional comments or other pertinent information (please provide specifics, any are appreciated):
_____________________________________________________________________
_____________________________________________________________________

PLEASE list contact phone number and best time for pharmacist to call patient:
_____________________________________________________________________

I consider this referral a necessary part of this patient’s medical care.

Referring Name/Signature: ________________________________________________

Date: ___________________________
## Sample Medication Management Plan

### Medication Management Plan

<table>
<thead>
<tr>
<th>Identified Drug-Related Issues</th>
<th>Goal(s) of Therapy</th>
<th>Initial Changes (most commonly by RPh)</th>
<th>Follow-up (most commonly by CM)</th>
<th>When to Contact RPh</th>
</tr>
</thead>
<tbody>
<tr>
<td>LDL not at goal</td>
<td>LDL &lt;100</td>
<td>Double dose of simvastatin</td>
<td>LIPOP / ALT in 8–12 weeks</td>
<td>If LDL above 100 on repeat draw</td>
</tr>
<tr>
<td>Allopurinol dose adjustment based on GFR</td>
<td>Prevent gouty attacks</td>
<td>Reduce dose by 50%</td>
<td>Symptoms of gout attack</td>
<td>none</td>
</tr>
</tbody>
</table>