FOCUS:
COLLABORATIVE PRACTICE AGREEMENTS

Working collaboratively

Pharmacists are a perfect fit for collaborative practice settings

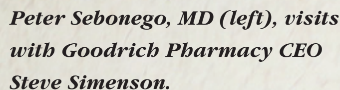
by Chris Linville

When you've been in business in the same place for 135 years, you've clearly become a community institution. That's certainly the case with Minnesota-based Goodrich Pharmacy, established in 1884. Goodrich, located in the Minneapolis-St. Paul suburb of Anoka, provides all the products, services and other bells and whistles that a modern pharmacy is expected to have in this day and age.

And in keeping with the times, another revenue source that looks increasingly promising is collaborative practice agreements, or CPAs, with other health care practitioners, a trend that has become more commonplace in recent years. With the talent on his staff and the services the pharmacy can provide, Goodrich CEO Steve Simenson says it's a natural.

"I think this is something that's going have to be a part of everybody's practice, or somebody else is going to do it for their patients and soon, pharmacists won't have the opportunity," he says.

Along with the headquarters in Anoka, Simenson says Goodrich has leased space and embedded pharmacists in four primary care clinics. It also has space in a grocery store, which is the local health care hub as there is no clinic within 15 miles in any direction. The clinics are operated by several major health systems in the Twin Cities. Goodrich has six pharmacists in Anoka and usually two each in the clinics, all rotating between standard pharmacy duties and working with other



Peter Sebonego, MD (left), visits with Goodrich Pharmacy CEO Steve Simenson.

Working with prescribers to treat opioid addiction

There's no question that opioid addiction is a particularly virulent opponent. So much so that Goodrich Pharmacy CEO Steve Simenson says that when it comes to opioids, "the doctors don't really want to have anything to do with them anymore — it's like touching a hot stove."

But Simenson says his pharmacy is committed to treating addicted patients and trying to enlist physicians to help. With many disease states, pharmacists can work with prescribers through a collaborative practice agreement. But pharmacists can't prescribe controlled substances to treat addiction, even under a CPA.

Simenson says that physicians have been receptive to his staff's efforts because of the work they have done with many other disease states' CPA programs.

"We can put a plan in front of them and say, 'You need to write these prescriptions and we'll keep telling you what we're doing, and how we are doing it,'" he says. "Then they write the prescriptions and we manage those patients though phone calls and visits, and eventually taper them off. It's hard to get the patient to [taper off] because most patients don't want to, but when you get them committed to do it, it's very effective working with a physician."

Editor's Note: *If you have questions about collaborative practice agreements and would like more information, contact Steve Simenson at ssimenson@goodrichpharmacy.com, or Goodrich Pharmacy Clinical Director Amanda Schroepfer at amanda.m.schroepfer@gmail.com.*

health care practitioners in collaborative practice. Having that proximity is important.

"If you really want to build relationships with physicians and other providers, being in their building makes a huge difference," he says.

WHAT'S A COLLABORATIVE PRACTICE AGREEMENT?

Generally speaking, collaborative practice agreements are used to create formal relationships between pharmacists and prescribers. In a CPA, pharmacists are authorized by prescribers to perform certain patient care functions, such as initiating or modifying medication therapy, ordering lab tests, and authorizing refills. CPAs may differ in scope and are governed by laws and regulations that vary considerably from state to state. The National Alliance of State Pharmacy Associations says 48 states and Washington, D.C., have some level of CPA authority.

Simenson, who has been with Goodrich since 1977 and also serves as its managing partner and treasurer, says the pharmacy has been involved in CPAs for about a decade. When CPAs were beginning in Minnesota the law stated that a single pharmacist had to work individually with a single prescriber, which became cumbersome when trying to work with 30-40 prescribers. Fortunately, he says, the state changed the rules, allowing a single person — such as a clinic medical director — to sign for a group of prescribers to initiate the CPA, allowing multiple providers and multiple pharmacists to work under that agreement.

"The majority of our agreements are with one clinic system," Simenson says. "Every year we renew them and review them, and update with what's the latest state-of-the-art best practices."

Simenson says that Goodrich initially did hypertension under a CPA. Then it added asthma and diabetes. Now it has nine disease state CPAs and six therapeutic substitution CPAs. Simenson says each health condition needs a separate agreement.

“They have to be somewhat disease-dependent to help manage effectively,” he says. “It’s not like you can just say you are going to manage all drugs and all labs. Also if you have different collaborative practices for different situations, it’s much easier to change one when you get new therapy or new best practices for treating specific patients. It’s easier to change one and not have to change them all at the same time.”

Simenson said when his pharmacists initially began working in the clinic, they thought it would mostly be medication therapy management. “But then we were finding all kinds of gaps in care when examining patient drug therapy, and we would have to contact [prescribers] and discuss with them what our solutions were. They said, ‘We don’t just want you to find problems, we want you to fix them.’”

Simenson does a consultation with a patent.

Collaborative practice agreement resources

The National Alliance of State Pharmacy Association has a complete overview of collaborative practice agreements, with recorded webinars, a toolkit it made with the Centers for Disease Control and Prevention, and plenty of other useful links. Visit www.naspa.us/resource/cpa/.

GETTING IN THE DOOR

Simenson says that when trying to get your foot in the door for a CPA, there are a number of things that prescribers want to know: how can you help them with workflow, solve problems, make their job easier, improve efficiency, and make them look better in community measures.

“Be a resource, solve a problem, and meet a need,” he says. “They appreciate that, because it’s not about what’s in it for us as pharmacists, it’s what’s perceived as a need. A lot of things we have started doing have come from them saying, ‘Could you do this?’ ‘Could you okay refills?’ Well sure we can if you give us permission to do that. Those are the kind of things that you suggest and discuss with the physician to get your foot in the door. If you can find ways to make them look good and provide better patient outcomes, they certainly at least give you an opportunity to try it.”

Simenson says the typical timeline from a pharmacy’s first contact with a provider to finalizing a CPA is at least 90 days. He says that prescribers tend to be more comfortable if it’s a pre-approved CPA that’s been in the system or with somebody else.

“There’s no right or wrong way to do it,” he says. “We like to keep it as simple as possible and as short as possible and accomplish what we need to accomplish with a CPA. You want pharmacists to be able to use their clinical judgment and experience, which in most cases are really good. You want to give them some room to operate.”

SPEAKING THE SAME LANGUAGE

Simenson says pharmacists have to demonstrate competency and credibility to gain acceptance from other health care providers. He says that Goodrich Pharmacy does its own credentialing, ensuring that its pharmacists are current on continuing education and proficient with immunizations, medication therapy management, and other services. To work in a clinic under a CPA, pharmacists need to be privileged, which is a step up from credentialing.

Simenson says that things have changed since 1977, when he graduated from pharmacy school. He’s brought on plenty of younger pharmacists, who tend to have more of a clinical background and are comfortable in a CPA setting.

“Doctors, nurse practitioners, and physician assistants are all credentialed in a facility and privileged if they practice in the hospital,” Simenson says. “If you talk the language and you understand the system and

Key components to a typical collaborative practice agreement

- The pharmacist agrees to work with the provider under a written and signed agreement to perform certain patient care functions under specified conditions.
- The pharmacist has the knowledge, skills, and ability to perform authorized functions.
- There is the ability to document activities in a medical record.
- There is accountability for the same quality measures for all health professionals involved in the collaborative agreement.

what collaborative practice is, you get confidence from the prescribers in what you do."

COMMUNICATION AND DOCUMENTATION

It seems like common sense, but Simenson says it's important to stay interconnected. Yet in health care there still is a tendency for different practitioners to stay in silos, where the one hand doesn't know what the other is doing. Simenson says having access to the provider's electronic medical records documentation system is the most effective way to help break down those barriers.

Simenson uses immunizations as an example, as they have become fairly routine in pharmacies across the country. Being up to date on immunizations can improve outcomes, and in turn can help health plans boost results-oriented metrics that lead to better Medicare Star Ratings.

"With immunizations, when we code them we try to get access to the prescriber's EMR so we can show that the patient has received the appropriate immunization," he says. So, even if the immunizations were not done by the physician or someone on his or her staff, that physician will still get credit for having all patients up to date on vaccines because it is documented in the patient's EMR.

"There hasn't been a case yet where we haven't been able to help that provider with some pharmacist intervention and collaboration and move them up significantly in those care measures and outcomes," Simenson says.

GETTING PAID

Of course, everyone wants to be compensated for their efforts. So what about payment? For services such as MTM, Simenson says they typically bill insurance for that time. Treatment for conditions such as strep and flu are fee-based cash business. Goodrich does pharmacogenomics testing under a CPA on an all-cash basis. The pharmacist will do a pre-consultation and the patient will pay for the test. After the test results are returned, the pharmacist will do a post-consultation and charge for that time.

"Patients are more than willing to pay for it, at least at this time," Simenson says. "I see pharmacists getting paid by insurance and Medicare in the future."

In an attempt to simplify processes, Simenson says the pharmacy has contracted with the clinic for the hours they are there, setting up four-hour blocks of staff time.

"You can do four hours in the clinic, or eight, or four in the pharmacy to complete a shift," he says. "For those contracted hours we figured out what their benefits and their salary are and I added in a reasonable return on investment for what they were doing. For the hours they are in the clinic, we don't tell them what they have to do. The clinic feeds them all the workload but we bill the clinic directly for their time, not for the service. And the clinic can in turn, if it's a billable event, go and bill it to the different insurance companies."

Simenson says that Goodrich measures and breaks out its clinical services separately. "One of our goals every year is to have that grow," he says. "It has to be self-sustaining, and it's more than self-sustaining — we've experienced increasing clinical net revenue and clinic demand every year."

He does say that he would like to see other payment options eventually. "I do think in the future we have to work out a system where we get paid like an auxiliary health care provider or mid-range health care provider when we are doing these things."

DOWN THE ROAD

Looking ahead, Simenson say that with pharmacists increasingly enhancing their clinical skills, they are being more easily accepted and integrated into health care teams, and he's hoping to enter into more agreements.

"Pharmacists in general have good relationships with other health care providers," he says. "They should develop those relationships into income streams while helping those providers do a better job of what they are supposed to do. They all are so busy that any help is usually warranted and appreciated. It's a win-win for everybody." ■

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