Brandon (00:00):

All right. So, again, welcome everyone to session three of the Clinical Pharmacy and Advanced Practice Services series. We're excited to again offer our recognize and acknowledge El Rio Health and Holyoke Health Centers for your great work over the last two sessions. We're excited to wrap this series up with this final session. So, just again, for some housekeeping items... Let me move my slide here. Housekeeping items here, you guys know our mission by now. Again, housekeeping items, again, there's a chat box left to adjust this, but there's the chat box here, certainly within the zoom, you should be able to communicate with everyone. If you want to communicate with someone privately, you can do that as well on this platform.

Brandon (00:44):

And again, as always Noddlepod, our Noddlepod community is there. And if you need access to that or you have a colleague or someone that would like to add there, please be sure to email myself or Tim, and we'll try to get that done for you as quickly as possible. Again, as usual, we don't have any advocacy discussions during this session, funds are solely appropriated for operations related discussions. And the agenda for today is very simple. Again, I left the Program Alert. I mentioned in the last two sessions, we moved it to July, so we just got approved from the Bureau of Primary Health Care on our initial draft.

Brandon (01:23):

So, I am in the process now of finalizing that final PDF document that's going to be published to our health center clearing house, and also, Bureau of Primary Health Care's clearing house as well. So, once that's published and done, there will be a link sent out to all of our pharmacy access office hours attendees. So, you will have that for your reference and use. All right. And again, the focus of the session is that the series three part three of the series with our friends here at El Rio and Holyoke, and then we'll have a wrap it up for Q&A.

Brandon (01:59):

There will not be a 340B updates. I had decided to exclude that because I want to at least give more time for the presentation, and if there's any additional questions at the tail end for our presenters. FYI, our consultant, Tim Mullah, who you all know, he's not going to be on the call today due to some travel. So, if you have any questions specifically for Tim, you have he and I's email, so just feel free to shoot an email to us afterwards so we can try to get a response to you, if it's for Tim, specifically. All right. So, I mentioned the Program Alert, and that's just the TA, a technical assistance documents. And now, I'm just going to hand things over. I'm going to stop sharing my screen so our friends here can share theirs and we'll get the presentation started. All right. Okay. Alyssa.

Alyssa (02:49):

Alexis is going to [inaudible 00:02:50].

Brandon (02:50):

Let's see. There we go.

Alexis Dellogono (02:51):

Can everybody see?

Alyssa (02:58):
[inaudible 00:02:58].

Brandon (02:59):
Yes, we can see it.

Alexis Dellogono (03:00):
Okay. First I guess we'll start off by reintroducing ourselves for those that weren't listening to the other sessions. My name's Alexis Dellogono. I'm one of the clinical pharmacists over at the Holyoke Health Center. Alyssa is another clinical pharmacist at the Holyoke Health Center. Marisa may be joining a little later. She is the associate pharmacy director over at El Rio. So, the last couple of sessions we went over what was possible with what you have at your site and thinking about how to get started, and a little bit about the practice models and different ways that you can do clinical pharmacy services.

Alexis Dellogono (03:45):
At the last visit, it was more about data and how we can look into using data to try and figure out how to start these clinical services and aim them towards your health center goals. And then, different considerations for that. And today, we want to focus on how do we keep this going. Payment and funding, which I know a lot of people have interest in, how is clinical pharmacy or services paid for? How to keep it going and growing, and then some layered learning.

Alexis Dellogono (04:17):
So, some of the direct patient care shared up costs that we have, physical space. So, whether you're in an office in the health center, or if you can repurpose another room or an office, whether it be a patient room or anything that's already in your health center, then you can use obviously that would be cheaper, or if you have to physically design or make room for this clinical pharmacist or pharmacy services. The personnel, obviously you're going to have to pay for that pharmacist. For most of the health centers, at least definitely for ours, we need an interpreter for most of our visits. I personally don't speak Spanish, Alyssa does, so she doesn't need an interpreter, but, it's very helpful to have them, not only just for physically interpreting, but also they are part of the culture.

Alexis Dellogono (05:04):
And they're able to give us a little bit of insight on what's going on in the patient, and what's they're saying, so it's really an invaluable tool. We use CHWs at the health center. Over in El Rio, I know they use MAs, so those can also serve as your interpreters, but again, you're going to have to pay for these people to be a part of these visits. Some of the technology needs, laptop, desktop, computer, printer, scanner, phone, those kinds of things that are going to go in your office, those things cost money. Or you might already have them in the health center and be able to redistribute those. So, you could check with your IT department. Training, so as a pharmacist, you do have to do national conferences to get some CEs or continuing education, that can cost money.

Alexis Dellogono (05:50):
And some sites might pay for their pharmacists to go to these national conferences to get more information and be able to start these clinical services. There's a couple of different pharmacy organizations. Then they have a lot of different things that can help advance pharmacy practice services,

and you can find those out there. It costs money to be licensed. And also, when you're a collaborative drug therapy management pharmacist, you do have to get licenses for that. In Massachusetts specifically, we have to be licensed for controlled substances. So, again, that costs money. It's not a huge cost, but those are little things that might have to take place, for your program to be accredited sometimes.

Alexis Dellogono (06:30):

So, for our residency program, we have to be accredited. We have to be a part of the American Society of Health Pharmacists. We do have to be paid for in that way. And then, obviously, we have some equipment needs like your blood pressure cuffs, if you're doing blood pressure monitoring in-person or refrigerator, if you're doing vaccines. And of course, the vaccine supply also costs money. And then, I talked already about the controlled substance license. It's different between each state, what you need to have, requirements for, so you may have to check with your individual state for different things.

Alyssa (07:05):

[inaudible 00:07:05].

Marisa (07:06):

This is Marisa. Do you mind if I add one thing before we move on to-

Alexis Dellogono (07:08):

Oh, yeah. Go ahead.

Marisa (07:08):

... the next slide? One of the other things related to personnel is that I know... It just came up in the chat as well, is that some health centers may choose to also include in that box pharmacy technicians. And that is absolutely correct. Depending on what kind of model you have, especially if your clinical services are rooted in the pharmacy and are going to grow from that area of practice, then yes, it does make sense that you would include pharmacy technicians at that point. And then, all the subsequent boxes would also have to include things like training and then workspace, so on and so forth, for that provider type. The reason we put MAs versus CHWs is because those were specifically related to our clinic based initiatives at our respective health centers. But thank you for pointing that out.

Alyssa (07:59):

Another thing to remember what the physical space Alexis was talking about, whether you're going to repurpose a space or create a new space, is the laws may vary based on where you're practicing in terms of co-location. So, for example, we're able to run our clinical services, they can be entirely remote of the providers here, but in the state of Massachusetts, if we're going to run collaborative drug therapy visits, those are supposed to be co-located with the providers that we are contracted with. So, it will vary a little bit, but I think traditionally, people will say, or assume that the space needs to be within a pharmacy or directly co-located with the provider, but that may not be true.

Marisa (08:38):

And there was another really great question in the chat related to in the state that the individual who added the comment that pharmacists cannot supervise MAs. And yes, that is absolutely correct. They

have to be in line with the nursing chain of command. And so, again, just based on what Alyssa said is that with that physical co-location with the provider staff there often is an LPN or an RN who technically is the supervisor of that MA. They just happen to be staffing with your pharmacy. So, there are ways to get around you things, but please, the main goal of these presentations has always been to just think creatively and to be willing to step outside the norm when it makes sense and you're not breaking laws obviously. But there are ways to get around those technicalities, especially with things like co-location models.

Alyssa (09:43):

All right. Let's see. I think we're ready for the next slide. Okay. Marisa, I don't know if you want to get us started on this slide since the diabetes collaborative model is more of an El Rio initiative.

Marisa (09:56):

Yeah, absolutely. So, thank you. So, with the diabetes collaborative model, one thing that I'll just say up front is that when you look at these codes, we've been trying to provide useful information for you to look into following this presentation. So, this is not completely... it's not all inclusive. So, these are the ones that we personally have experience with, but when it comes to the diabetes collaborative model, the G0108 is very specific to those programs that are accredited by ADEK or by ADA. And so please, look into that specific nuance, because it does require an extra layer of accreditation and different workflows within your health center.

Marisa (10:45):

But in our case, that does provide a revenue source for our diabetes related services that are provided by our pharmacist. Now, can you have a collaborative model without using the G0108 related to diabetes or any case other things like hypertension, COPT, so on and so forth? Yes. But this specific one for diabetes is only with accreditation. And so, the great thing is that it also helps you to formalize what you're doing internally and can help you better recognize opportunities for managing individuals living with diabetes. And for most of us, I know with the increased number of people who have the diagnosis of diabetes, that this tends to be one of the driving forces. But the better bang for your buck essentially will be what you gain from value-based contracts.

Marisa (11:42):

Things like being inclusive in your collaborative practice model to include vaccine orders. And then, also, other disease states often common diabetes such as dyslipidemia or hypertension. And so, there's a great opportunity for pharmacists to make huge gains in those areas, which ultimately will tie back to your value based contracts. The only reason we have rhinopathy screening included on this site is because at El Rio, we've chosen to purchase in house cameras that can be used. And then we have a tele-health based program that has helped us make huge strides in providing this care, this needed service to individuals living with diabetes.

Marisa (12:26):

And then, our goal was never to capture revenue, but just do what's right for our patients, recognizing that this was a huge gap. But don't be afraid to ask payers because we've been pleasantly surprised that when presented with the opportunity, especially the commercial based plans, often will develop a separate contracts for the service if this makes sense for your health center. The Medicare Annual Wellness visits is another opportunity. Again, within the CHC world, it's a little bit different. So,

pharmacists independently providing this is not an option, but going back to what Alyssa mentioned earlier about the co-located physician extender model or tandem-like visits, this may be another opportunity.

Marisa (13:14):

And the respective codes of G0438 for initial and G0439 for subsequent are some codes that you might want to look into. But again, looking at the cost savings related to polypharmacy, identifying individuals that are eligible for CCM and enrolling them, getting them engaged in that line of service, making sure that you're on top of preventative care measures. If you do any kind of forms for your Medicare advantage plans, huge opportunity there for pharmacists to support. And then, also for risk adjustment, when you're doing the coding to make sure that you're appropriately presenting or painting the picture of the person sitting in front of you so that your health center can gain the appropriate revenue that's due for high-risk complex individuals.

Alyssa (14:05):

The transitions of care model is something that we utilize, and have utilized for a while here in Holyoke. We listed some available billing codes, but I will be upfront in saying, we're not utilizing those in Holyoke at this time. It will depend how you choose to structure the program. So, for many years, our TOC visits ran, like Marisa was mentioning in tandem with the provider visit. So our pharmacists would conduct their medication review immediately prior to the provider's visit. And for that reason, obviously only one of those visits was billable, the provider visit. So, we hadn't pursued any sort of available codes for a long time, that was our model.

Alyssa (14:42):

The pandemic brought us into a telehealth model and has also altered our workflow a little bit in that we're conducting our visits a day or two days to the provider's visit. So, with that, potentially comes the ability to build those visits, but that's still something that we're exploring ourselves with our billing department as well. Regardless, we've still seen ability of cost savings in running these visit types, enrolling these patients in other programs, referring to MTM sometimes for more extensive disease state or medication education. The medication reconciliation piece, really aids our providers and they've found because of the time constraints of their own visit. And the patient may have multiple hospitalizations or a really long rehab stay.

Alyssa (15:27):

They're not able to review the medications as extensively as they would like and still conduct the physical exam and additional requirements of their visit. So, we really take care of that piece and we make sure that the med list is updated accordingly, and we identify medications that they need refills for, et cetera. And then, that way we're also closing the preventative care gap. I can also talk a little bit about outpatient pharmacy. We've talked about this previously as being a big source of revenue, and the clinical services certainly tie it into this. And we've seen here in Holyoke that that increases the prescription volume.

Alyssa (16:03):

One of those main flows would be through our adherence packaging or our Medbox program, partly because those tend to be patients on a number of medications that we're capturing sometimes from outside pharmacies, but also because you're very much guaranteed those fills month after month now,

as the patient adheres to their medications. In some states like in the state of Massachusetts, state Medicaid doesn't allow for auto-filling of prescriptions, where in other states perhaps that is allowed. So, one of the ways that the Medbox program also helps us is we have workflows tied into outreaching of the patients, ensuring that they need the medications that we're going to fill.

Alyssa (16:42):

And in that way, it is contributing to an auto-fill process, but not a traditional auto-fill. We've also seen cost savings through these programs as well, mainly through increased adherence, which improves the patient's health outcomes and Medicare star ratings.

Alexis Dellogono (17:01):

And I'm responding to the chat about the transitions of care Medrec. Doing and done via tele-health prior to the in-person visit. So, yes, we've had to move to a tele-health and with that, we started doing these visits at least one day before. We've started to work on getting a little bit further ahead. So, now we might even do it a couple of days before. And we'll do that over the phone with the patient. We'll put an entire note into the computer and send that over to the provider that's going to see that patient so they can even look that over well in advanced, prior to going to see that patient. And we'll have the med list already and all set for them.

Alexis Dellogono (17:36):

And if the person doesn't respond, we'll even still put that note, and maybe identify discrepancies that the doctor can discuss at that visit, or if the patient still needs further medication reconciliation, they can refer them to the pharmacy. So, for medication therapy management or chronic care management, we've talked a little bit before in the other sessions that our MTM is very similar to El Rio CCM, but there's also different codes for MTM versus CCM. So, you might want to discuss at your health center, which one you want to do.

Alexis Dellogono (18:13):

We at Holyoke Health Center do MTM, and there's a couple of different codes that you can use. But we specifically use the 99211, that's incident to code that we use. And you can always look into the other codes, but our visits that we do we transitioned them to doing telehealth visits. We used to have the patient come into the clinic and have all their meds out in front of them and go through each one, identify any issues, make recommendations to the doctor.

Alexis Dellogono (18:44):

So, we can bill directly through those codes, but we also have a cost savings of going through those medications, making sure the patient knows every single one of their medications and what they're for, increased adherence. That patient education piece is huge. So, then when they go home, they actually know what they're taking and that makes them want to take it more for the most part. And then obviously, it can help improve health outcomes because we can directly make recommendations and send those over to the providers who can then, say we take a blood pressure during an MTM and the blood pressure's high, we can send a note to the doctor saying, "This patient's so-and-so, their blood pressure is high. We would consider increasing the dose of this."

Alexis Dellogono (19:25):

Or if we identify a medication discrepancy, we're able to send that right off to the doctor and make a lot of different impacts through there. And then, collaborative drug therapy management is a little bit more specific to different disease states. So, in Holyoke right now we have blood pressure or hypertension and diabetes. So, specifically, the pharmacist... Again, this is all very state specific, so, you'd have to check in with your pharmacist state specific laws. In Massachusetts, we're able to do specific disease states. We have a collaborative practice agreement with the provider here.

Alexis Dellogono (20:02):

During the visit, the provider has to be within the health center or reachable, and the pharmacist can see the patients independently and then prescribe and order labs, and manage that patient. To make sure that their diabetes gets under control and their blood pressure. Again, we're sending it to the provider so that they're aware of any changes that we're making and we work together to do that. So again, we build the same codes that we use for MTM. For different states, there may be a couple of different codes. Again, this is not an all-inclusive list. But obviously, the cost savings are huge because the pharmacist seeing it, we can maximize the providers time. They can see other patients. We can focus on that disease state, improved health outcomes.

Alexis Dellogono (20:45):

And then, if you didn't do a collaborative practice agreement and you have a pharmacy, you could always refer that patient to the pharmacy or medbox, but you can also sometimes increase prescription volume.

Marisa (20:56):

The other thing... And I know it's come up in the chat a couple of times, I've seen it pop up just now, but asking about how many pharmacists we have, or perhaps speaking to the point of ratios of provider staff to pharmacists. Things like CCM may make a lot of sense if you don't have a large pull from your pharmacy team, because with the chronic care management opportunities, if you're starting from the clinic side to build up that service, pharmacists are individuals that are often left out of that discussion, in my experience. So, I would encourage you to think more inclusively if you're not including the pharmacist team consistently in that effort, many times it's driven by MAs or LPNs, RNs, social work, so on and so forth, which are all super valuable team members and should always be part of that model.

Marisa (21:52):

But just, I'm asking everyone to think more broadly if you have not intentionally included pharmacists in that group, because that may be a great first step for something your health centers already doing that helps you get those monthly minutes. And then, maybe it's that launching point to consider some of these other things that were discussed on this slide.

Alexis Dellogono (22:17):

And one the other things... Go ahead.

Alyssa (22:20):

Sorry, Alexis. I was going to say Sarah had also asked... She was asking about the number of pharmacists. We had broken down the number of staff in the first PowerPoint. So, there's an extensive overview of each of our programs in that slide deck. But in short, in Holyoke, we have about three full-time clinical

pharmacists, and then a number of part-time staff. One that also does informatics, some that also do some community work. One that works in academia that spend some time doing clinical and then, three pharmacy residents, at least in Holyoke.

Marisa (22:51):

And I think when you... If you're able to listen to all three sessions, or if not, if you're just catching up with our series today, is just think, where do we want to start? So, don't be overwhelmed by everything that's presented, but just a what makes sense for us and what can we do with our current staff? And going back to what Alyssa just said, also in that first slide deck from presentation one, we also talk about... These are programs when we speak about our experiences at Holyoke and from here, is that, this is something that we've been working on for quite a while.

Marisa (23:34):

So, these are things to consider in that have all grown from our experiences, but just find something that makes sense to start with, and it just comes along the rest of it. And then it'll help you better determine how you use the time of your pharmacist and the number of pharmacists that makes sense for the initiatives that you have chosen to take on.

Alexis Dellogono (24:00):

There's another stream of revenue that we didn't necessarily include in this slide. But I did talk about it a little bit in the first session. If you're an outpatient pharmacy, you can also use the outcomes platform, which is an online platform that's usually a part of the Medicare part D plan, that allows pharmacists to... if you're working in directly in a pharmacy, it has the patients that are eligible and you're able to do comprehensive medication reviews or CMRs. And also, they have different targeted intervention plans. Both of those can give you a certain amount of money based on those visits. So, we're able to build directly through that platform and get reimbursed after.

Alexis Dellogono (24:49):

So then we wanted to talk a little bit more about... Those were the direct revenue stream, so where you can actually get paid for them. And then also some of the things that help cost savings wise that are more of indirect costs, but we also had a couple other things that pharmacists, if you've had a clinical pharmacist on your team could help with consultative services. So, sometimes we have patients that have drug information questions, or providers that have drug information questions, and the clinical pharmacist usually has a little more time to be able to look into those things. I think this ENM revenue opportunity, I think Mercy, you might know a little bit more about that.

Marisa (25:29):

Yes. The whole idea of... And there's some really great papers that have been published especially very recently, there's a great one that came out from a CHC, where they talked about the ability to increase the level at which you submit your ENM coding if a pharmacist is attached to the beginning of the visit. So, very similar to what Alexis and Alyssa's experience has been at Holyoke with front-loading. But this would not be on a different day this would be same day. But clearly defining what the role of your pharmacist will be specifically speaking to clinical interventions, and then following that up with a very intentional scheduled visit with the provider of record, whether that be an MD, a DO or a PA.

Marisa (26:17):

And many times, you'll see those quotes go from 99212 to perhaps 99214, 99215, depending on what level of services provided by that additional expertise. But that's something to consider as well, especially if your pool from your pharmacy team is not significant. And you're just trying to start somewhere. This may also be an opportunity to consider. We at El Rio, here, the bullet says closed or open system approach. We did not take outside consults. So, any of the clinical services that we provide, whether it's direct patient care or consultative services, is under the operational structure of a closed system approach.

Marisa (27:08):

Although, I have spoken with other health centers who essentially sell their clinical services to other organizations, whether in their community or other CHCs. And I would refer to that, this is my own reference. It's not officially a terminus, but more of an open system approach. So, where you intentionally develop a BAA with another organization that clearly defines what level of service, the frequency, whether it's a days per week or hours per month type of contract, where you can also offer additional services to a community.

Marisa (27:47):

And this could be incredibly helpful in areas where there's limited resources, more of a rural type of community, where you as a health center may be responsible for taking care of an entire county or province. And so, that's a great opportunity for a CHC to engage outside of their CHC walls when partnering with others. And we'll talk about it in another slide. But that may offer great opportunities that I think that all of us should always be thinking about, but I'll hold those comments for the next slide.

Alyssa (28:32):

Okay. So, we talked about some of the codes that you can bill, also some of the cost savings of element. And so, we wanted to talk a little bit more about return on investment as well, and some of the things that we've seen through our initiatives. Overall, we've seen decreased healthcare spend by reducing hospitalizations, also eliminating duplicative services and omission of services. We've also have some data to support this idea of a satisfied customer, helps us to retain staff. We've pulled our providers explicitly about the hospital discharge or transitions of care visits, how they liked the workflow that existed, how they liked the new workflow to take their input and see what they thought about.

Alyssa (29:13):

It also helps with patient retention and improving patient satisfaction. So, we've developed some patient surveys to garner their input on the services we offer in the pharmacy and also with our medical teams. Also, we've seen improvement in quality dollars by improving medication adherence, also improving overall disease state management and maximization of the formulary. Marisa, I don't know if you have any comments from the El Rio standpoint on these things as well.

Marisa (29:40):

No, very similar to Holyoke, especially for the satisfied customers and the improvement in quality dollars. When the program first kicked off 21 years ago, the medical director at the time was just... Because we started really small, 10 patients, 10 of your most difficult to control patients, see what the pharmacist could do with them. And so, what the director at that time did is he used the hetus dashboard and said, "This is you alone, independent practitioner. And this is you when you add other

team members." And so, those other team members 21 years ago versus today are very different. Are much more diverse team today than what we had back then.

Marisa (30:23):

So, it was a lot easier to tease out the clinical pharmacy interventions, but it wasn't to say that the practitioner on their own was deficient, but just how you can utilize the strengths of other team members was really the message to enhance the care of the patient and the shared patient population. And then, how that for the provider who prior to those other team members being added to the team can have a better work-life balance, honestly. How they can utilize that skillset of the care coordinator or the clinical pharmacist or behavioral health primary care to really gain the desired outcomes in a shorter period of time, and then not feel so burdened that they have to take on everything themselves.

Marisa (31:15):

So, really a sense of relief. And then, also we've hired an external consultant firm to regularly pull our patients about their experience. And so it names the provider type that was seen that day, which does include our clinical pharmacist when they're providing independent one-on-one care. And it asks things about the level of service provided the knowledge base of the individual serving them, but then it goes back and ties it into that team approach. How well do you think your team is working together to serve your healthcare needs? So, it's been really nice to measure that and to see from the patient's eyes, what we can do better and the things that we're doing well.

Alexis Dellogono (32:02):

And then we gave an example over at Holyoke, some cost savings data that we look at and have presented at our quality meetings about. So, when we look at our MTM visits, this was a total of 179, 159 patients because we may see patients more than one time. And we looked at the medication-related problems or MRPs, and we wanted to show you just how many that we can find. So, in those patients, there was 1,194 medication related problems found in an average of 6.7 per visit. Below, we have a chart of the five most common ones that we found. So, the medication list being inaccurate, a lot of our provider med lists are inaccurate in different ways. So, if a patient sees a specialist and the specialist doesn't communicate back to the provider about a medication change, that med list might be inaccurate. The patient might have been on something for a while, and it just is still hanging out on that provider med list.

Alexis Dellogono (33:04):

And we can take it off. This may seem like a small thing, but it can really help the providers as at the next visit, we might be able to see if there's any drug interactions, or they might want to put a patient on a medication that the patient is already on, but they have no idea because their med list is not up to date. So, there's a couple of different things that can be helpful by updating that med list as small of a thing, as it sounds. Medication under you. So, obviously, we're able to address the patient, see if they're actually taking those medications. We found that patients have a lot of trust in the pharmacist and may not tell their doctor that they're not taking their medications, but they might be able to tell us, "I don't take my medications in the morning because I'm busy and I'm running around."

Alexis Dellogono (33:47):

But we can have that specific time where we sit down with the patient and try and figure out a way for them to taking their medication easier. Maybe we can switch that one's taking it in the night. They might

not know that they could take it at night or, we provide the med boxes to help them, or as simple as telling them to send an alarm on their phone or a little things like that can help a huge way. Treatment on optimal is usually when we look at their disease state and see if based on the guidelines, if their treatment is up to date. So, maybe they have diabetes and they're not on Metformin. And we try to figure out, is there a reason why they're not, or maybe that patient should be because that's the first line therapy for diabetes.

Alexis Dellogono (34:29):

Those are just some examples. And then, obviously we can identify whether or not there's vaccinations that are needed. So that's a huge help for the providers if they don't have to worry about trying to figure out if the patient's vaccinated, they come to the pharmacist and we're able to do those vaccinations in the pharmacy for pharmacies that do have vaccinations, and we can knock that off their list of things to do. And then inadequate self-management of lifestyle. Basically, that's where we do a lot of that patient education about diet and exercise, or starting to measure their blood pressure at home or their sugars at home.

Alexis Dellogono (35:05):

Those little things that can help improve their health outcomes overall. So then, we looked at those visits and there's about 1300 recommendations and average of seven per visit that the pharmacist's able to make to the provider and able to improve those health outcomes that way.

Marisa (35:23):

One of the things I'd like to add, I love this example by Holyoke. I think it's phenomenal. And it really speaks to the power of clinical interventions by pharmacists. One of the things that we've also done at El Rio is very similar to what you see in front of you. We've had our IT team develop a template within our electronic health record to capture similar data. And then, the other thing that we've done to speak to the cost savings or the improved health outcomes that often is tied to value based contracts is we've taken this data to our pharmacy. We call it pharmacy safety and therapeutics. Many organizations have the P&T, pharmacy and therapeutics committee, but we've included that part of safety because we also want to know all of the information that's on this slide, and then very intentionally study the information coming out of our in-house pharmacy database.

Marisa (36:16):

So an example, similar to what Alexis just mentioned, would be, how do you translate this to a population of 113,000 patients? So an example would be if you, during these one-on-one interventions chart review, pre-visit planning, whatever you choose to set up, identify that there's an unusually high or disproportionately high number of individuals who have asthma that have over utilization of their rescue, but under utilization of their chronic inhalers. That's a great opportunity for your P&T committee to make process changes for the health system that will speak to a healthier population, which is everyone's goal.

Marisa (37:03):

But then also, can help to drive down those unnecessary urgent care, ER, or hospitalizations that occur in individuals living with asthma as an example. If you want to look at things like heart failure and whether what proportion of your patients are using diuretics, or if you're looking at whatever disease state you choose, you can use similar templates. And whether it's an external one, maybe you set up an

Excel database, or you have something built by your team to be part of your EHR, or perhaps your EHR already has something similar that you could tweak.

Marisa (37:43):

Please also think big picture how this information that obviously is super impactful up to close to eight interventions by a pharmacist per visit can now be translated to the large, large, large patient population to change prescribing habits and or lead to things like standing orders, where you can empower different members of your team to overcome barriers that previously existed, so you can create a healthier population.

Alexis Dellogono (38:19):

Somebody asked about how we collected the information. So, on the next slide, I'll show you. These are some of the medication related problems that we are able to identify during these visits. So, I showed you the top five that we identified, but there's clearly very... Oh, there's a lot more, whether they're related to appropriateness of therapy, safety or non-adherence, and then there's some other. So, a couple of the things we didn't really include was the potential adverse drug events or actual adverse drug events. So, that's something that we're able to identify as well.

Alexis Dellogono (38:55):

So, if a pharmacist is able to find a potential adverse drug event, then we are able to maybe possibly save that person in ER visit or a hospitalization, which costs the healthcare system a lot more money. So, that's another way that pharmacists can indirectly save the health center and health care system money. And then, the recommendations we had on the other side. So, we use this information and we created a form. And every time that we identified one of these problems, we would mark that on that form. And then we used an Excel sheet to basically get that data. So, you could probably do it at a number of different ways, but this is not something that we created specifically like the medication related problems is a well-known list of medical problems that you can identify. And you can use this to make the data that we did. Alyssa, you have anything to add or anybody. [inaudible 00:39:53].

Alyssa (39:52):

I just thought this was a good example because on a two slides back, we were talking about how a lot of these services result in cost savings, but it can be hard to justify that. And so, we mentioned that quality data is a good way to look at this and to tie in some dollar amounts. So, this was at least one example we could think about that was really impactful for our medication therapy management visits. Som like Alexis was saying, for the PADEs, if the patient were to be hospitalized, there were studies that suggest hospitalization on average is about a thousand dollars a day. So, depending on the severity of the thing you're presenting, you could tie in some dollar amounts to that. It gets tricky, but this is one way that we're able to do it.

Alexis Dellogono (40:36):

We also use this data to look at our transitions of care, visits as well, and we're able to pull the data for that. And I think there was an average of about four medication related problems. These visits are a lot shorter, so you don't have as long of a time to identify these things. But there was about an average of four medication related problems found. And then we were able to find a couple of... I don't know exactly the number of potential adverse drug events that might help to prevent future hospitalizations.

So, you can also use this list or use that data for different services, not just MTM, it's an overall helpful tool to use for our data.

Alexis Dellogono (41:20):

And then, there's obviously other ways that you can fund things. Marisa, I think you did a lot with the foundation, so I'll let you explain that, but we are able to apply for grants that can also help fund our clinical pharmacy services. There we do have an adult immunization grant with NACHC, and the Million Hearts grant, which we're able to help patients get blood pressure machines, and we can use those different things to help grow your clinical pharmacy services that are not traditional forms of funding, like for not getting direct money revenue through the visit. You can get grants that can help cover these things.

Alexis Dellogono (41:57):

There's also a couple of different grants that you can use through the Pharmacist Association as incentive for creating an innovative service or creating a different clinical pharmacy service. You can grants that way. So, those are just a couple of examples.

Marisa (42:14):

And for as far as the four bullets under the grant section, those were huge opportunities for us and I'll reel at various points in time for us to kickstart multiple clinical pharmacy services. So, going as far back as the learning collaborative through NACHC related to adverse drug events, potential or actual. Like Alexis just mentioned on the previous slide, that was something that we were involved in early. And so, it shouldn't be your driving force for engaging, but many times it gives you that little bit of extra support that all of us know we need so that we can more intentionally explore some of these things that we know are very critical to advancing safety and improving the health outcomes.

Marisa (43:02):

For El Rio... And I don't know how many of the individuals on the call have foundations associated with your community health center, but for us, the foundation at El Rio has been phenomenal. So, the level of support, especially early on, was really one of the driving forces for why after the original HRSA demonstration grant through the office of pharmacy affairs, that El Rio was able to continue that original effort. And so, the foundation talked to everybody and anybody that would listen literally. So, people like Bank of America or the Pascua Yaqui tribe, which was one of our early local partners that approved even to this day be a very critical part of our success.

Marisa (43:53):

And then other family foundations, as an example, unlikely sources like Anheuser-Busch. People who just really, really were impressed by the amount of data we were able to present as far as the interventions made by clinical pharmacists, telling the story about how right now there's limited revenue sources for what we do. Believing in the model and really being invested in the long-term outcomes that can be improved when you add this additional valuable team member.

Marisa (44:33):

And so, I would encourage all of you if you have not already connected with your foundation, if you have one, to about that. And if you don't have a foundation, that's okay. Talk often and talk to anybody who

will listen. So again, the people that you may not think of as potential partners have revenue sources. Comcast, different cable companies, they do these days of caring or these different opportunities to support community initiatives. And so, many times they want to hear about innovation in health centers and might be willing to send some money your way for start-ups services.

Marisa (45:15):

And then more intentionally, those larger partners could be a great opportunity to help fill in the gap while you get all these different things in place so that you can bring on additional staff or carve out time for existing staff to do these different services.

Alexis Dellogono (45:44):

And then, this line is basically going over some of the different things that we have that you can do to start services. So, we here at Holyoke, like Alyssa had said, have a residency program. We started off with just one resident. And then now we expanded from two to now three. Residents are a huge help when we're having these clinical pharmacy services, because they start off more of like on a student level, but then they grow to become independent. They are pharmacists that are already... they become licensed during their residency year.

Alexis Dellogono (46:23):

So they're not able to do a lot of the things in the beginning on their own, but by the end, they're able to be another helpful clinical pharmacy staff. And as a resident, you are paid a significantly less amount from a regular pharmacist that might be hired. So, that could be a source of a cost savings if you have from a resident able to do those services. We don't want to make that the end goal for you to save money using a resident, but they do provide services at a lower cost, which is nice but also very helpful. As a clinical pharmacist, we love having residents here because they're also helpful, providing our services, but also keeping us up to date on the new things that they learned in school and same thing with the students.

Alexis Dellogono (47:08):

We have advanced practice students that come from different clinical schools of pharmacy, that can also help grow our program and show them how clinical pharmacy services can be started. And they can go into ambulatory care that way. And then academia, we have at Holyoke one pharmacist that is actually associated with one of the schools of pharmacy. So, she helps run some of our clinical pharmacy services and sees patients with us. But it's actually paid for fully by the school of pharmacy. So, some places might start off that way, where if they don't have money to pay a clinical pharmacist, they can use the school pharmacy, if they have anybody close to them, that might be able to start those clinical pharmacy services using that academic professor.

Alyssa (48:04):

Marisa, I know your model runs a little bit differently at El Rio, especially in terms of academia. So, I don't know if you want to mention that at all.

Marisa (48:12):

Yeah. So, our model for El Rio is we do have an agreement. There's an affiliation between El Rio and the University of Arizona. And so, we contract time from a faculty member who is very skilled, and has done

a two-year residency up for ambulatory services, and serves as full-time professor at the university, but is a part-time clinician for us. And so, we buy her time from the university. And so, with her skillset, which happens to be in pain, it's a whole new opportunity to expand services into new area that's needed for our health center patients, but also, she helps to be part of our core clinician team and brings along with her the students that are on rotation, who oftentimes are answering drug information related questions, or are working on some of the larger pharmacy and therapeutic committee related projects.

Marisa (49:14):

And also, posters because many times the students are required to do some research as part of their curriculum. And so, that has greatly benefited the organization again, because we don't always have the time that we wish we had to do all these extra projects, but we know the value they bring. So, that's how we have benefited greatly from having learners on site, but completely opposite to Holyoke where they employ the pharmacist who teaches at the college. We buy time from the college for the clinician that practices in our organization.

Alyssa (49:54):

I think just another good reminder that there's no one way to do all of these things. We've all come to the same determination in Arizona and out here in Mass, but we're doing them in totally different ways sometimes.

Alexis Dellogono (50:10):

And then I think somebody asked a little bit more about the incident to billing. So we wanted to give you some resources for some of those codes that we use. Well, there's a little more information in each of these. You can click on the links on here and it'll bring you to the site that explains exactly what the requirements are for the billing code. So like we said, we don't actually use the transitions of care billing code. There's a lot of different things that go into it. So, we're still, like I said, or like Alyssa said, trying to figure out what their finance department, if it's possible.

Alexis Dellogono (50:39):

So, feel free to click these links and look in to see if that's something that your health center can do. It has a lot of great information about the different requirements. And there's also an update on the incident to billing. So that star right there explains a little bit more because there was a couple of different codes that you could use, but Medicare has looked back at that and changed things in 2021. So, these things might change frequently, but these are some good places to look for if you're starting to think about how to bill.

Alexis Dellogono (51:10):

And then, I know we tried to answer some of the questions in the chat, but I guess at this time it can open up for any other questions that anybody might have.

Brandon (51:24):

Or you can just post those questions in the chat to everyone. And yes, Logan, I will... Actually that survey link, the evaluation only will go out after the session. All right. Any additional questions for our speakers? Thanks again to El Rio and Holyoke for a great series of topics on this clinical pharmacy and

the care model. I think this has been very relevant, awesome topic for us to focus on and certainly some health centers as we look at how we redefine or redevelop our pharmacy programs. I'm really pleased with this series of presentations and we hope that was helpful to all of you.

Alexis Dellogono (52:17):

Thank you for having us.

Brandon (52:20):

Of course.

Alyssa (52:20):

Thank you.

Brandon (52:21):

Of course.

Marisa (52:23):

Thank you very much.

Brandon (52:24):

You bet. Thanks, Marisa. We still have a few more minutes. So, if you guys have any pressing questions, please feel free to unmute and ask, or you can throw it in the chat.

Marisa (52:35):

Brandon, I noticed something in the chat just now, and I completely agree with the individual who posted it, about, don't forget your pharmacist in the pharmacy. We definitely, that was one of our points from one of the prior sessions, is that everybody has a role. And so, talking very intentionally to your team, and that is inclusive of the pharmacist working in the in house pharmacies, as well as those that feel like they want to expand their services into the clinic, but there are tons of opportunities to provide very critical clinical interventions from the pharmacy. And we do not at all overlook those team members. They are a critical part of this process.

Marisa (53:19):

The other thing is that, like you said, we are very similar and we talked about this as a team when we kick this off, is that none of us really like the term clinical pharmacists, because it creates this hierarchy. And so, that's why our title is... because most people know that who are not pharmacists, they refer to us as clinical pharmacists, but within our profession, all of us on this call and this team very firmly believe that it's the advanced practice services offered by all pharmacists. And so, we wanted to be very intentional about that, that what we spoke about through the three different presentations could be modified to meet the needs of anybody who's part of your team.

Marisa (54:07):

Also, recognizing that their level of exposure to these different services that now exist, maybe wasn't even part of the curriculum, but there's no reason to say they couldn't be taught or brought up to speed

on some of those. And then just ask, what do you want to do? What do you feel comfortable doing? What do you see your role being? And I prefer the last statement. What do you see your role being? Because it doesn't give you an opt out option. It's tell us what you do want to do. Because we know there's great strength in them being part of our health center movement.

Brandon (54:45):

Awesome. Thank you, Marisa. And again, thank you to the speakers, Alexis and Alyssa. I really appreciate it. And just look last couple items. Housekeeping items before we close. The finals slide deck will be sent out to everyone. You'll probably get it from us via email from Olivia and we'll make sure that's published on Noddlepod and with a link to download on our online library. Again, the evaluation link will be sent out after the session. It will probably come from Olivia more than more likely. And then lastly, more importantly, our year two, we actually a year two planning for our NACHC training season, actually started on July 1st.

Brandon (55:21):

So, we're really excited to offer a new or even extended series of learning collaboratives that we've been doing. And even on the pharmacy piece. So, when you complete your evaluation link, be sure to include any topics that you'd love for us to present on. Obviously, we'll assess them for relevance with the climate, but if there's any topics which you want us to present on, I know we have a few in our inbox now, Tim and I, but anything else you'd like for us to identify some presenters, please let me know.

Brandon (55:54):

You have my email and Tim's email. And you can also post that Noddlepod. We're constantly assessing and reviewing messages on Noddlepod. So again, thank you everyone. Thanks to our presenters. We hope you enjoy the rest of your afternoon. Again, if you have additional questions, you have our presenters emails and you certainly have mine and Tim. All right, take care, everyone.