

Inter-Pharmacist Collaboration for HIV Patients



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This business model was supposed to focus on collaboration between pharmacists in different settings in treating and monitoring HIV/AIDS patients with cancer. The goal was to identify situations where pharmacists acting as primary care providers, and actively involved as partners in health care teams, would collaborate as do physicians and nurses in similar settings. It was initially assumed that HIV/AIDS patients with various cancers had sufficient complications such that collaboration between ambulatory, inpatient care and infectious disease would be necessary. However, the progress of care for HIV/AIDS has limited the number of patients requiring multi-specialist involvement, and when collaboration did occur it was limited to situations where pharmacists worked within an integrated health care system. Why is this? Is collaboration between pharmacists unnecessary other than for dispensing? What happens as health care moves to Accountable Care Organizations and Medical Homes that inherently require collaboration?

Due to the nature of this limited survey this business model is different from other models in prior journals. This is a survey of various settings referencing various collaborative situations rather than a model for a specific site. As with all business models this is not meant to be exhaustive, but only

suggestive of the practice of some select practitioners.

Two of the authors interviewed multiple pharmacists for this business model. When the interviews were done it was apparent that pharmacists within organized health care groups (OHCG), e.g., Kaiser and the Veterans Administration, did collaborate. However, pharmacists outside of the organized groups did not. This is curious as physicians and nurses collaborate with their peers in various settings in order to obtain information about patients' conditions, history, medications, procedures, support mechanisms, etc. The collaboration of pharmacists within the organized settings reflects similar needs for medication regimens, compliance, allergies, adverse effects, preferences, etc. Yet, outside of the organized settings this information is either not considered important or not part of the dispensing function. As a result, this business model reviews what pharmacists in organized settings achieve with collaboration and why collaboration is important.

To identify the collaborative practice of pharmacists in organized settings we interviewed Dr. Lucy Ung of Kaiser Permanente Coachella Valley, and Drs. Macy Ho and Dr. Mary-Joy Arcellana of the Veterans Administration Long Beach. We also interviewed pharmacists from several community pharmacies in Orange

County, California serving HIV/AIDS patients through the ADAP program, i.e., AIDS Drug Assistance Programs that offer free or reduced cost medications for low income individuals with HIV/AIDS. Of the many calls to Southern California practitioners a few ambulatory pharmacists were able to offer information; namely, Dr. Hong at Procare Pharmacy, Dr. Darshanna Patel at Walgreens, and a pharmacy resident at UCI Family Health Center Pharmacy. These pharmacists offered their personal experience without reference to corporate policies.

Description of the Practice Model

Pharmacists in Organized Health Care Groups

This practice model describes collaboration between primary care pharmacists in ambulatory and inpatient care, as well as with specialty pharmacist in infectious disease. Pharmacists may collaborate based on patients across multiple settings (e.g., inpatient, outpatient, specialty clinic), or on admission, discharge or transfer between facilities. In one OHCG, inpatient primary care pharmacists work with multiple teams including an HIV/AIDS ambulatory team. Patient load varies with an approximate load of 30 patients and about one HIV patient per month. Patients are usually admitted with pneumo-

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cystitis pneumonia and bacterial pneumonia.

The pharmacists in all of the surveyed OHCG work in an interdisciplinary setting - alongside care coordinators, nurses, and internal medicine physicians with specialties in HIV/AIDS. The teams provide primary care and long-term HIV/AIDS care. Since, in most cases, patients with HIV/AIDS also have many comorbid conditions; pharmacists provide comprehensive care for each patient and their disease state. Furthermore, pharmacists have the ability, under protocol, to prescribe the necessary medications, ranging from chronic maintenance meds to HIV antiretroviral drugs.

In a small number of cases patients have both HIV/AIDS and cancer - most commonly Kaposi's sarcoma. When patients are suspected to have cancer they are sent to oncology for diagnosis. Once diagnosed with cancer, the primary care pharmacists work closely with the oncology pharmacist to design the optimal drug regimen that most effectively suppresses the cancer and viral loads, while minimizing drug-induced adverse effects. In addition, the pharmacists work very closely to avoid overlaps in therapy, to renew or discontinue medications, to order labs, and to coordinate therapeutic monitoring. For example, if an HIV/AIDS patient has low T-cell counts, chemotherapy would further compromise the patient's immune system, leaving the body more prone to opportunistic infections. Therefore, the primary care pharmacists and the oncology pharmacist need to weigh the risks of when to start chemotherapy. Ultimately, the coordination of care between pharmacists provides sound treatment options and saves time for the patients.

If patients are first seen (e.g., new member of a team, or on admission to an acute care facility) without information about their medical history and medication profile, physicians and pharmacists conduct thorough histories. To complete medication profiles

pharmacists may also call their ambulatory pharmacy (usually an HIV specialty pharmacy within the OHCG) for past medication history, prior HIV physician or their caregiver. If the history is incomplete despite these efforts, an HIV genotyping is performed on all new patients to determine resistance to certain medications. In many instances pharmacists may also order laboratory tests, e.g., CBC with differentials, STDs, hepatitis screenings, viral loads, etc. They may also order anoscopies, and HIV genotyping. An electronic medical record (EMR) that stores all information (i.e., medications, progress notes, imaging, etc) in a central location is certainly helpful in an OHCG. The EMR can be accessed by every member of the healthcare team so that they are aware of the entire care of the patient. The EMR is obviously not available to pharmacists who are not in OHCG, but that does not mean that collaboration cannot provide information by way of the traditional method.

In one of the OHCG, if a primary care pharmacist has any questions regarding HIV medications (e.g., cut/crush tablets for a stroke patient), they may contact the Infection Diseases (ID) pharmacist. The ID pharmacists usually know the HIV patients' medications very well, since they perform clinical reviews every 2 weeks with the patients. Patients may also be referred to other specialists for non-HIV conditions, e.g., cardiology. The primary care pharmacists may then communicate with the specialists over drug-drug interactions, side effects, or adverse drug reactions due to HIV medications.

Pharmacists in OHCG also participate in the Medication Therapy Management (MTM) services for their Medicare and VA populations. The

primary care pharmacists work closely with the MTM pharmacist to coordinate drug regimens and to make sure all the diseases are managed. For example, if the MTM pharmacist decides to add a lipid-lowering

agent, they contact the primary care pharmacist either via phone or in person to see if the medication is appropriate and not contraindicated with the HIV/AIDS drug regimen. This collaboration reduces duplication of work and provides comprehensive care.

Primary care pharmacists in OHCG also collaborate with the outpatient pharmacy. For example, if a patient is non-adherent on their HIV/AIDS drug regimen, the outpatient pharmacists will notify the primary care pharmacist if refills are not picked up on time. The pharmacists at both ends would educate and promote any necessary lifestyle redesign to promote patient adherence to their medications. The primary care pharmacists also help enroll patients into financial assistance programs including the Medical Financial Assistance Program (MFAP) and AIDS Drug Assistance Program (ADAP). The primary care pharmacists provide the diagnoses and any other patient information needed to qualify the patient for the assistance programs.

In one of the OHCG quarterly meetings by conference call take place amongst all HIV/AIDS pharmacists and other medical professionals in Southern California. Topics of discussion include new therapies, guidelines, and protocols, etc.

Pharmacists in Retail Ambulatory Settings

Compare the OHCG practice above with the ambulatory experience of HIV specialty pharmacies. These pharmacists stated that they do not communicate with outside pharmacists. If they have a problem with insurance, they talk to the insurance companies. If they have a problem with patient information, they talk to the physicians.

One pharmacist mentioned that to talk to other pharmacists about patients' medical records would be against HIPAA – curious and incorrect.

Another ambulatory pharmacist stated that collaboration was mainly with patient physicians on topics including: drug regimen changes, compliance and adherence, and referrals for special support groups for patients. A third pharmacist stated that they do not communicate with outside pharmacists unless they are transferring prescriptions or regarding duplicate therapies. All other collaborations are directly with the patients' physicians.

Resource Requirements

Interdisciplinary teams usually include care coordinators, nurses, physicians, and pharmacists, as well as potentially an MTM pharmacist, and/or an outpatient pharmacist. There is frequently an electronic medical record that collects information from

all sources. Retail, ambulatory care pharmacies, including HIV Specialty Pharmacies, usually do not have access to the EMR. However, they usually do have access to the treating physician and primary care HIV pharmacist.

Description of Successes / Limitations / Restrictions of the Model

The OHCG pharmacists cite multiple clinical successes. They cite viral suppression rates of over 70% to over 90% versus less than 20% nationally in 2011. For example, more than 90% of patients on anti-retroviral therapy have undetectable viral loads. These higher than average viral suppression rates may translate into medication adherence.

While collaboration between pharmacists, physicians and other health care team members in OHCGs is very collegial, there are gaps in access to care. For example, in some OHCG

there is no social work services provided to the patients. Also, some OHCG pharmacists indicate that better access to other specialty clinics (i.e., ophthalmic, dermatology) is necessary as it can take weeks to months to get an appointment.

Restrictions on the model are typically OHCG specific. For example,

Kaiser is in the process of establishing mandatory regulations for TRUVADA usage with regards to Risk Evaluation and Mitigation Strat-

egies (REMS) by the FDA. Until then, TRUVADA is not prescribed at Kaiser.

Future Plans and Direction

OHCG primary care pharmacists would like to see more community engagement and education to raise the awareness of HIV/AIDS so that patients at risk can be tested and prophylactically treated in the community.

Conclusion and Comments

The central issue here is that pharmacists with access to colleagues in organized health care settings collaborate, while those outside of such settings do not. There are several reasons to limit collaboration between pharmacists in multiple settings, including centralized information in EMRs or the patients' primary physicians, the various practice needs of each group, specialty vs. general care, etc. Yet, communication opportunities have increased with phone, pagers, fax, email, webpages, blogs, tweets, or less commonly through the EMR. As the health care system moves patients to retail and commoditizes general care through free-standing and pharmacy-based walk-in clinics, as well as specialty clinics, the need for collaborating becomes even more critical. Accountable Care Organization and Medical Home models are based on collaboration. The need for collaboration and the types of necessary information are well established. Physicians, nurses and other providers collaborate across medical settings. It is time that pharmacists join the party.

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