Hypertension and Hyperlipidemia Management in an FQHC: Clinical Pharmacy Interventions

Michelle Hughes, PharmD, BCPS, BCACP
Clinical Pharmacist
Neighborhood Healthcare

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Learning Objectives

• Describe the clinical pharmacist’s role in managing hypertension and hyperlipidemia through collaborative practice and team-based visits
• Describe a model for generating billable visits to sustain a clinic-based MTM program
• Review common activities performed by a clinical pharmacist in a clinic-based MTM program and prescription renewal program
NHCare By the Numbers

- Neighborhood Healthcare is a Federally Qualified Health Center (FQHC) with Level 3 Patient-Centered Medical Home (PCMH) recognition

- 17 sites across San Diego and Riverside Counties
- 720 staff
- 76 medical or dental providers
- 1,197 patients seen daily
- 66,269 patients seen annually
- 70% of patients at or below 200% of the federal poverty level (FPL)
- 10,074 patients w/HTN
- 9,490 patients w/HLD
- 6,794 patients w/DM

INSURANCE STATUS

- Medi-Cal: 73%
- Uninsured: 18%
- Medicare: 2%
- Private: 2%

RACE/ETHNICITY

- Hispanic/Latino: 61%
- White: 30%
- Black: 2%
- Other: 7%
Pharmacy Services

Retail Pharmacy
- 1 Pharmacist FTE
- 2 Pharm Tech/Clerk FTE for all sites

Clinical Pharmacy
- Medication Therapy Management (MTM)
  - 0.4 Pharmacist FTE*
  - 0.4 Health Coach FTE for 3 sites
- Refill Center
  - 1.6 Pharmacist FTE
  - 4 Pharm Tech FTE for 9 sites

*0.2 Pharmacist FTE provided through Palomar Health Partnership
Leverage partnerships to demonstrate proof of concept

Achieving controlled hypertension is a team-based effort enabled through population health analytics

Approximately 50% of patients aren’t taking their medications as prescribed
  - Patients have a difficult time managing complex medication regimens
  - Patients have a poor understanding of their medications and the prescription process
  - Patients can’t afford their medications
Where are we today?
The Role of NHCare’s MTM Program

- Under a collaborative practice agreement (CPA), a clinical pharmacist may:
  - modify, add and/or discontinue drug therapy for hypertension, hyperlipidemia, and diabetes in accordance with the latest clinical practice guidelines
  - order drug-related laboratory tests to monitor efficacy and/or side effects
  - provide routine counseling on medications, disease states, and/or therapeutic lifestyle changes
MTM Referral Criteria

- Transition from HTN registry-based enrollment to referral-based enrollment

Referral Criteria

- Uncontrolled HTN or DM with at least 1 of the following:
  - Major polypharmacy (≥10 medications)
  - Polypharmacy in older adults with multiple co-morbidities (Age≥65 with ≥3 chronic disease states and ≥6 medications)
  - Need for medication reconciliation (non-adherence, medication confusion, transitions of care)
- Self-pay/Unfunded patients who need medication adjustment for HTN or DM
Sustaining MTM with Enhanced Medical Visits (EMVs)

- **Health Coach**
- **Pharmacist**
- **Insured Patient**
- **Non-billable or cash pay visit**
- **Uninsured/Unfunded Patient**
- **5-15 min + Provider**
- **EMV (billable visit)**

- **15-45 min**
First Encounter: Comprehensive Medication Review (30-45 min)

- **Health Coach**
  - Vitals
  - Disease and lifestyle education
  - +/- Home BP monitoring and log

- **Pharmacist**
  - Medication reconciliation (including pharmacy and specialists)
  - Identify and address barriers to adherence
    - Poor understanding/negative perceptions ➔ education, motivational interviewing
    - Cost ➔ 340b, discount cards/coupons, unfunded program, therapeutic substitution
    - Complexity ➔ deprescribing, combination pills, once daily administration, simplified medication schedule
    - Language/literacy ➔ spanish or arabic labels, sun/moon stickers numbering system
    - Transportation ➔ delivery, mail order

“Metoprolol Monday…”
Additional Medication Adherence Interventions

For complex medication regimens/polypharmacy:

For the visually impaired:
Take 2 pills twice a day...
Follow-Up Encounters: Targeted Medication Review (15-30 min)

- **Health Coach**
  - Vitals
  - Lifestyle check-in/reinforcement
  - Address outstanding care needs

- **Pharmacist**
  - Review home BP log
  - Medication adherence check
  - Adjust, add or discontinue drug therapy as needed to address HTN and HLD:
    - under CPA for self pay/unfunded
    - under direct supervision for EMVs
  - Lab monitoring when indicated
  - “Treat and release”
Refill Center

- Pharmacists and pharmacy technicians provide protocol-based prescription renewal services for chronic medications, including blood pressure and cholesterol medications
  - Ensures timely and adequate refills of medications
  - Prompts care team follow-up for overdue appointments and labs
  - Provides opportunity for profile review to optimize therapy

### Antihypertensive Medications

*JNC 8 Guidelines for High Blood Pressure Goals
Age < 60 or DM or CRD *<140/90
Age > 60 <150/90*

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<thead>
<tr>
<th>Angiotensin Converting Enzyme Inhibitors (ACEI)</th>
<th>Potassium Level, BMP, BMP or Tidal Panel annually</th>
<th>Annually</th>
<th>12 months</th>
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<tbody>
<tr>
<td>PRINivil 20/100 mg</td>
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<td>VANDADEC 20/100 mg</td>
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<td>LEOCOL 10 mg</td>
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<tr>
<td>SYMRA 5 mg</td>
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*Ensure patient is not on another angiotensin and a statin by reviewing the alerts app*
What’s Next?

- “Re-brand” MTM to CMM
- Expand to more sites
- Explore role in complex care coordination (i.e. Health Homes Program)
- Pilot high priority clinical initiatives (e.g. T2DM prevention w/metformin for high risk pre-DM patients)