Caring for the Underserved - Innovative Pharmacy Practice Integration

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Learning Objectives

• Identify unique opportunities for clinical pharmacy in integrated behavioral health care in a Federally Qualified Health Center (FQHC) setting.
• Describe the role of the clinical pharmacist in providing behavioral health care to the underserved and indigent patient population.
• Discuss clinical outcomes attained through inter-professional practice and education in the provision of comprehensive medication management in the FQHC setting.
Disclosure Statement of Financial Interest

I DO NOT have a financial interest/arrangement or affiliation with one or more organizations that could be perceived as a real or apparent conflict of interest in the context of the subject of this presentation.

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ETSU Community-Based Clinics

Johnson City Community Health Center (JCCHC)

Mountain City Extended Hours Health Center

Johnson City Day Center

Johnson City Partners for Health
JCCHC

- 23,000 square foot facility completed and opened for patients in October 2012
- A state-of-the-art, interdisciplinary facility for the delivery of primary health care services and the education of students
Background

• The Gatton College of Pharmacy (GCOP) and JCCHC are located in the northeastern part of Tennessee
• Northeastern Tennessee is located in Southern Appalachia and has significant health disparities compared with the rest of the state
• Mental health diagnoses for serious psychiatric and addiction disorders are proportionately higher in Appalachia than the rest of the nation
• The JCCHC is one of only a few nurse-managed health centers in the nation to be designated as a Federally Qualified Health Center (FQHC) and is a unique CHC in the nation operating in conjunction with a College of Nursing

Background

• Barriers to treatment for mental illness in the Appalachian region
  – Limited access and high demand
  – Transportation
  – Cultural and family barriers
  – Stigma and privacy concerns
  – Limited payment options

• Opportunities exist for psychiatric pharmacists to collaborate with primary care nurse practitioners and therapists to provide a bridge for psychiatric care
Background

- JCCHC provides care to the uninsured, underinsured, TennCare enrollees, a growing Hispanic population, and medically indigent individuals. No one is turned away because of their inability to pay.

- Behavioral health services at the CHC traditionally included a psychiatric nurse practitioner and counseling services; however, the nurse practitioner has not been able to see new patients in over a year because of demand.

- The wait to see a psychiatrist in the community for medication management is often 4-6 months.
Psychiatric Disorders

- 1 in 5 adults will experience a mental health problem

- Persons with serious mental illness die on average between 13.5 and 32.2 years earlier than the general population

- 217 million days of lost productivity occur annually among workers with psychiatric disorder

- Mental illness accounts for 1/3 of adult disability globally

Langheim F., et al. (2014), Sarris, et al. (2013)
Unmet Needs in Mental Health Care

• Only 38% of individuals with mental health issues have received appropriate services
• Estimated 10.7 million Americans had an unmet need for mental health treatment
• 2/3 of all people with a diagnosable psychiatric disorder do not seek treatment

Behavioral Health Trends in the United States: Results from the 2014 National Survey on Drug Use and Health September 2015
**Patient-Level Factors**
- Not recognizing the problems
- Self-stigma
- Difficulties navigating the health system and scheduling
- Transportation
- Problems getting time off work

**Systems-Level Factors**
- Public stigma
- Lack of insurance
- Underinsurance
- Lack of mental health parity
- Fragmentation of services
- Inequalities within funding of the public health mental health system

**Provider-Level Factors**
- Limited appointment availability
- Customer service and quality concerns
- Problems with rapport and the therapeutic alliance
- Workforce shortages
Figure 2.12  Reasons for Not Receiving Mental Health Services in the Past Year among Adults Aged 18 or Older with an Unmet Need for Mental Health Care Who Did Not Receive Mental Health Services: 2011

- Could Not Afford Cost: 50.1%
- Could Handle Problem without Treatment: 28.8%
- Did Not Know Where to Go for Services: 16.2%
- Did Not Have Time: 15.1%
- Treatment Would Not Help: 10.4%
- Did Not Feel Need for Treatment: 8.5%
- Health Insurance Did Not Cover Enough Treatment: 8.3%
- Might Cause Neighbors/Community to Have Negative Opinion: 8.0%
- Did Not Want Others to Find Out: 7.1%
- Might Have Negative Effect on Job: 7.0%
- Fear of Being Committed/Having to Take Medicine: 7.0%
- Health Insurance Did Not Cover Any Treatment: 6.7%
- Concerned about Confidentiality: 5.9%

Percent among Adults Who Did Not Receive Mental Health Care
Association of American Medical Colleges Survey, 2015

• The total number of physicians in the U.S. increased by 45 percent from 1995 to 2013

• The total number of adult and child psychiatrists rose by only 12 percent

• During that span, the U.S. population increased by about 37 percent
Primary Care

• The World Health Organization has called for integrating mental health services into primary care as the most viable way of closing the treatment gap for untreated mental illness.

• Integrating mental health and primary health is a trend highly favored by the nation’s mental health advocacy organizations such as Mental Health America and the National Alliance on Mental Illness.

• Current health care reform stresses need for integration of mental health services into primary care.
Why Primary Care?

• Responsibility for providing mental health care is falling increasingly to primary care providers
• The non-psychiatric sector of health care is the default provider for mental health needs
• At least 30% of all primary care recipients have diagnosable mental health disorders
• Primary care is now the sole form of health care used by more than one-third of patients with a psychiatric disorder
Why Primary Care?

• Mental illness exacerbates morbidity from the multiple chronic diseases.

• Stigma, as well as benefits disparity, decreases access to mental health care in the specialty sector.
Why Primary Care?

- The provision of frontline mental health services in primary care settings (when appropriate) have positive impacts including:
  - Improvement of patient & provider satisfaction
  - Overall healthcare costs efficiency
  - Improved clinical & functional patient outcomes
  - Increases adherence to treatment
  - Reduces stigma

Collaborative Practice Model (CPM)

• “The continuous interaction of two or more professionals or disciplines, organized into a common effort, to solve or explore common issues with the best possible participation of the patient”
• Well-studied but under-used
• Reduces the burden of the primary care physician by providing a mental health care specialist within the primary care setting
• CPM may establish simple mental health treatment protocols, providing mental health screenings and education and conducting ongoing outcome management
• Numerous examples of successful collaborative practice models (CPMs) exist in the literature
• CPM have proven to improve both mental and physical health outcomes

Olfson, F. (2013)
Psychiatric Pharmacy

• A board-certified psychiatric pharmacist (BCPP) possesses specialized knowledge about treating patients affected by psychiatric illnesses
• BCPPs work with prescribers and members of other disciplines to optimize drug treatment by making pharmacotherapeutic recommendations
• Provide appropriate monitoring to enhance patient satisfaction and quality of life
Provision of Patient-Centered Care

• Referral from provider
• Patient seen by individual appointment
• Average number of patients seen/day = 10
• Disorders
  – Depression, bipolar, anxiety, dementia, schizophrenia, eating, seizure, sleeping, attention, addiction, chronic pain
Provision of Patient-Centered Care

• Documentation
  – NextGen® Electronic Health Record
  – Comprehensive patient notes and documentation
  – Integration of rating scales to track medication response
  – Immediate feedback from providers
  – Patient portal
Provision of Patient-Centered Care

- Patient/caregiver interview and assessment
- Comprehensive Medication Management (CMM) through collaborative care
- Ordering and evaluating laboratory testing
- Referral to onsite clinical psychologist or licensed clinical social worker for counseling or cognitive behavioral therapy (CBT)
- Telemedicine link to other clinics to provide consultation
Provision of Patient-Centered Care

• Patient assistance programs (PAP)
• ETSU Charitable Pharmacy
Provision of Education

- Interdisciplinary team
- Community
- Healthcare students
- Provision of monthly medication grand rounds for providers and students
- Patient medication education groups in collaboration with National Alliance on Mental Illness (NAMI) outreach
Outcomes

- Reimbursement
  - Billed incident to provider visit
  - Sliding scale cash charge
- Improved access to healthcare and appropriate medications
- Enhanced care through optimized drug therapy management
  - Decreased drug-related problems
  - Reduced costs through optimized medication regimens
- Through PAP, over $500,000 of medications are ordered and delivered to patients per year
Outcomes

• Experiential learning site
  – More than 25 students/year in IPPE/APPE rotations
  – Nursing, medical, social work, psychology students
  – Interprofessional clinic faculty
• On average, 5 interventions made per patient encounter
• High patient and provider satisfaction
Outcomes

• The clinical pharmacist is available to prescribers when the clinic is open (i.e., 64 hours per week) in person or via electronic communication

• The pharmacist also is accessible to patients electronically or via telephone (HIPAA forms completed for electronic correspondence)
Challenges

• Reimbursement challenging because pharmacists are not recognized as health care providers under CMS
  – Salary paid by College of Pharmacy
• Scheduling with teaching requirement
• Meeting demand to see patients for consultation in a timely manner
• Lack of access to services outside the CHC system
What’s Next?

• Continuation of Interprofessional “Student-Run” Clinic
• Transitions of care clinic with Woodridge – inpatient psychiatric facility
• Specialized child/adolescent mental health clinic with nursing, psychology, and social work
Conclusions

• Psychiatric pharmacists integrated in the ambulatory care setting provide effective bridge to treatment the medically underserved mentally ill

• Effective interdisciplinary team collaboration between a psychiatric pharmacist, primary care providers, and psychotherapy
Conclusions

• As a learning site for pharmacy students, the program provides real-life experiences in the provision of optimal, evidence-based, patient-centered care that addresses mental health and addiction disorders accompanied by cultural and economic challenges.

• Psychiatric pharmacists can be reimbursed for clinical services in the ambulatory care setting, but provider status is required for appropriate reimbursement levels.
Questions?