

# Pharmaceutical Care Patient Management Pilot Project

A Cooperative Effort Between Brackenridge Hospital  
and the Indigent Care Collaboration

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# ICC Pharmacy Solutions for the Central TX Region

- Expand use of manufacturers' free drug programs (PAPs) for uninsured patients
- Maximize use of federal 340B program, which allows discounted drugs to select providers (e.g., FQHCs, DSH, Family Planning) who serve uninsured patients
- Create a "340B network" for 340B providers to combine retail and in-house pharmacies, allowing patients expanded access to affordable prescription medications
- Proposed – improve outcomes and lower costs through pharmacist-provided pharmaceutical care

# Current Applications for the I-Care System

- Patient and diagnosis mapping for health and mental health care planning and research.
- Documenting, monitoring, and managing diseases in the population and community.
- Measuring the effects of policy changes on populations in a local region.
- Improving understanding and treatment of individual patients

# Current System-wide Challenges

- Rate of uninsured is increasing across the region
- Cases of medically managed chronic diseases among the uninsured are also rising
- Safety-net providers need to develop more efficient programs to manage their chronically ill patients

# Assumptions

- A small population of more severely ill patients uses disproportionately more services within the system
- Pareto's Principle, 80-20 Rule
- Greatest impact will be seen if most of the attention focuses on the few that matter

# Key Assumptions

Optimizing patients' pharmaceutical care will

- Reduce Outpatient and Clinic visits
- Reduce Emergency Room visits
- Reduce the number of Inpatient days
- Lower overall costs of care, despite possible increase in drug costs

# The Plan

- Apply 80/20 Rule: Focus on managing populations with high-cost disease states
- By addressing the prescriptive needs of these patients, the pharmacist can better manage the complex conditions, improve outcomes, and prevent/alleviate potential adverse events in partnership with the physician-provider

# The Plan

- Select two disease groups that include complex medical cases and frequent “hits” on the system – Asthma and Uncontrolled Hypertension
- Identify 100 patients (50 from each disease group) who have been the highest users of the system during the previous year
- Create a clinical pharmacist’s position that would act as care intermediary between physician and patient

# The Plan

- Purpose of the new Pharmacist's role:
  - Monitor medical histories
  - Prevent drug-drug interactions
  - Eliminate preventable adverse drug events
  - Assure the appropriateness of care
  - Assure drug compliance
  - Reduce care complications
  - Recommend and manage changes in care
  - Promote patient education

# The Plan

- Pharmacist's clinical oversight could potentially allow access to 340B discounted medications to patients registered with I-Care and managed by Brackenridge
  - For all ICC patients where access to their histories has been granted by the patient
  - Through the Brackenridge 340B privilege

# Primary Values

- Though access to 340B discount is a major potential benefit, the **primary goal is improved patient care** and disease state management through the prudent use of pharmaceuticals
- Improved care will elevate the quality of life and lower costs for payers
- Access to 340B discounted medications could lower the patients' costs of community-acquired medications by as much as 50%

# Leadership

- The practice model will be designed by Suzanne Novak M.D., Ph.D., of UT School of Pharmacy
- Later (December 2005) Pharmacist-leadership will likely be provided by Patricia Harrington, Pharmacist, and UT Ph.D. candidate
- ICC and Brackenridge would share the personnel costs for the first year - \$55,000 from each - but the position must be on the Brackenridge payroll to allow future 340B access

# Timeline

- ✓ Proposed Demonstration Project to last for one year
  - 3 months to create the design and select patient pool
  - 9 months to perform Clinical Pharmacy interventions and evaluation
  - Upon completion, ICC to perform outcomes analysis and estimate cost/benefit and return on investment

# Future Possibilities

- Potential for NIH Grant to underwrite program expansion
- Joint effort between Brackenridge and UT School of Pharmacy in program expansion
  - UT College of Pharmacy is prepared to place senior-level students in future pharmacist-supervised clinics beginning September 2006

# Things to Consider Related to the Pilot Program

- To support a decision to proceed, we believe that at least three key questions must be satisfied

# Key Question Number One

- Does the medical evidence support the notion that a pharmacist-run disease management program, or clinic, can improve care and lower costs for community-based patients?

# Key Question Number Two

- Does the answer to the first question alone without regard to 340B drug access support the pharmaceutical care pilot project implementation, especially if 340B access to the ICC population is denied?

# Key question number three

- Does the premise that all patients in ICC who allow access to their records support 340B access to the entire population, even though only the most severely ill patients are actually treated at any point in time?
  - Predicated on the idea that any ICC network patient has the same chance of selection for care management solely based on their unique illness and resource utilization.

# Final question

- Does the pharmaceutical care pilot project add enough potential value to ICC members to support its development?