

# Fight Tomorrow's Battle, Not Yesterday's: How Technology Can Advance Guideline Care Delivery in the Pharmacy

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Program



# One Little Story

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# Who is this guy?

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- Three jobs
  - Critical access hospital
  - Community pharmacy
  - Professional Organization
- Development and sales of clinical programs to payers for community pharmacies in North Dakota
- Work with state Medicaid plans and state employee health plans

# Goals

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## **How to capitalize on guideline care in pharmacy**

1. Why guidelines matter to pharmacies
2. How technology is used to makes guidelines-based care work in a pharmacy
3. Our efforts to bring guidelines to community pharmacy
4. Integration with other software--happening now or is needed
5. What pharmacies want and need



# Why Guidelines Matter to Pharmacies

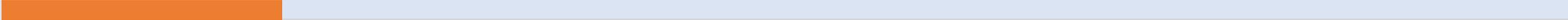
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# Why Guidelines Matter to Pharmacies

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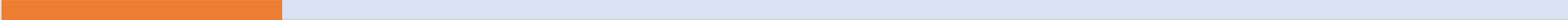
- Dispensing is under extreme pressure
- Rise of value-based payment models expected to accelerate
  - Pharmacy's role is a bit unclear (as far as what they'll get paid for)
- Change to optimization and monitoring and outcomes responsibility for meds

# Current State



- Pharmacies currently get paid to dispense and counsel on a drug; they check to see if a drug is safe largely based upon interaction checkers.
- They do NOT necessarily know or look for if the patient is getting a high enough dose of cholesterol medication, or the proper strength of asthma medication.

# Why Guidelines Matter to Pharmacies



- When we talk to payers, removing variability in care is of great interest
- Inappropriate prescribing is everywhere!
- Federal government knows guideline care is not happening—they tell you with their grants

# How Poor is the Care?

A recent NIH grant described how dismal guideline uptake can be in primary care:

“Despite the research supporting the use of evidence-based practice recommendations, clinical practice guidelines are rarely universally implemented in routine clinical care, resulting in gaps between recommendations and actual clinical practice.

**For example, despite the potential deaths prevented with implementation of cardiovascular disease guidelines, only 50-60% of patients with cardiovascular disease risk factors receive recommended treatment.**

**Only 50% of primary care physicians are aware that there are chronic obstructive pulmonary disease (COPD) guidelines; even among those who are aware of the clinical practice guidelines, only 25% actually use them.”**

(NIH PAR 18-133 Background)

# Not Good Enough!

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- Just imagine that—
  - Over 15 million Americans with COPD
  - #4 cause of death in America
  - At best, 12.5% of COPD patients treated properly

<https://www.cdc.gov/nchs/fastats/copd.htm>



# How Tech Can Make Guidelines-based Care Work

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# How Tech Can Make Guidelines-based Care Work



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- There are people in this room who are doing some of this work but a unified solution with large adoption hasn't arrived
- In one sense, we're discussing Clinical Decision Support (CDS) today
- CDS is a broad term more often used in electronic medical records (EMR) with prescribers

# How Tech Can Make Guidelines-based Care Work

- What CPOE CDS does
  - “Suggest next steps for treatments, alert providers to information they may not have seen, or catch potential problems, such as dangerous interactions.
  - Challenges creating intuitive, user-friendly, and effective protocols for decision-making pathways.
  - More often triggered by drug interactions, duplicate therapy, age restrictions, or lab data-based dosing issues.”

<https://healthitanalytics.com/features/understanding-the-basics-of-clinical-decision-support-systems>



# Our Efforts

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- Hypertension
- Diabetes
  - Adult and pediatric Type 1
  - Adult and pediatric Type 2
  - Gestational
- Asthma
- COPD
- Chronic pain
- Transitions of Care

# Our Efforts

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- Re-structured our programs from the common CMR to a structured, guideline intense program
- Results have confirmed that there is an immense opportunity for optimizing care through guidelines
- Single sign on
  - PDMP
  - IIS

# Our Efforts



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- Systems currently work to **prevent errors** but **not optimize care**
- In the example, no error has been committed by the pharmacy but it has not optimized
- Pharmacies rarely have the tools to optimize

# Example—Asthma, Diabetes, Hypertension, CHF

- **CURRENT THERAPY**

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- Albuterol 2 puffs every 4 hours as needed
- Potassium 20mEq twice daily
- Lisinopril 40mg daily
- Furosemide 40mg twice daily
- Metformin 1000mg twice daily
- Lantus insulin 45 units at bedtime
- Flovent 50mcg twice daily
- Lipitor 10mg daily

# Example—Asthma, Diabetes, Hypertension, CHF

## CURRENT THERAPY

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## OPTIMIZED THERAPY

- Albuterol 2 puffs every 4 hours as needed
- Potassium 20mEq twice daily
- Lisinopril 40mg daily
- Furosemide 40mg twice daily
- Metformin 1000mg twice daily
- Lantus insulin 45 units at bedtime
- Flovent 100mcg twice daily
- Lipitor 40mg daily
- Aspirin 81mg daily
- Brovana 15mcg twice daily
- Metoprolol ER 50mg daily

# That's Reality



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- This is not uncommon
- This is the missing opportunity in pharmacy
- This is what technology can do



# Integration With Other Software

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**Happening Now or is Needed**

# Integration With Other Software

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- EQuIPP
  - Patient outliers is a good start
  - Not optimizing the total treatment plan to guidelines
- STAR ratings
  - Measuring statin dispensing on diabetes patients is a good start
  - Other measures not guidelines based

# Integration With Other Software

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- Some recent M&A had interesting programs
  - Pharmacogenomics work
  - Adverse drug event prediction work
  - Patient education and chronic disease pathways work--an excellent start
- Some payment for true outcomes work (hypertension/glucose)
- eCare plan

# Integration With Other Software

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- Interesting cases of PMS having eMAR integration with a partner LTC facility
- State electronic medical records vendors
  - PDMP (integrated opioid risk assessment)
  - IIS (vaccine predictor)
  - This is supportive data but isn't driving gains in guideline migration



# What Pharmacies Want and Need

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- Pharmacies need integrated guideline care in their PMS
- Intuitive documentation of interventions in PMS
- Ultimately need access to EMR clinical data
- 2-way messaging is fragmented or non-existent
  - Most often it is currently between patient and pharmacist
  - Need linkage between pharmacist and prescriber



To the Masses

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# Bring This to the Masses

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- Pharmacists not confident they are up to date on every guideline
- There is a need in the payer space
- Large gaps in the software available to pharmacies to support value-based contracts
- Next step before pharmacy starts to truly take ownership for outcomes

Thank you