

# Community Care of North Carolina – A statewide initiative for innovative pharmacy practice with a behavioral health focus

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## ABSTRACT

Community Care of North Carolina (CCNC) is a state-wide public/private partnership, primarily serving North Carolina (NC) Medicaid recipients, which focuses on the Primary Care Medical Home model of care. The CCNC Behavioral Health Pharmacy Coordinator has a leadership role for the direction and management of Behavioral Health Initiative (BHI) pharmacy projects, while other CCNC clinical pharmacists work in a variety of settings and help to implement and support those BHI projects. CCNC clinical pharmacists also perform medication management in all settings, help to implement the NC Medicaid Preferred Drug List (PDL), support the care managers, and are involved with the transitional care (TC) process. Transitional care medication management focuses on the identification of medication list discrepancies after discharge from an acute care facility. Patients receiving TC were 20% less likely to return to the hospital in the coming year. We observed the same trend even when looking specifically at those patients who were discharged from a psychiatric unit (Wilcoxon-Gehan statistic = 21.22,  $p < .0001$ ). It is the goal of the CCNC behavioral health team to provide practicing pharmacists (those directly supported by CCNC and those collaborating with CCNC) with the tools to continue serving populations with behavioral health issues.

## KEYWORDS

patient-centered care, pharmacist, medicaid

## WHAT IS COMMUNITY CARE OF NORTH CAROLINA (CCNC)?

The CCNC is a public/private clinical partnership that primarily serves North Carolina (NC) Medicaid recipients that emphasizes improving quality and access to care through promotion of the Medical Home model. Total cost of care is contained through improving the quality and efficiency of care delivery, which results in improved wellness, and ultimately, decreased emergency department use and hospitalizations. CCNC has an existing infrastructure across the state consisting of 14 geographically defined networks with over 1,700 primary care practices, over 5,000 primary care providers (PCPs), and more than 600 care managers, representing greater than 90% of primary care in NC. This infrastructure has supported the chronic disease programs that have been a

successful part of CCNC for many years. In partnership with local communities, CCNC has brought together regional networks of physicians, nurses, pharmacists, hospitals, health departments, social service agencies and other community organizations. These professionals work together to provide cooperative, coordinated care to extend the Medical Home model and create the "Medical Neighborhood", a more community-wide and inclusive variant of the Medical Home. This approach matches each patient with a PCP who leads a health care team that addresses the patient's health needs in collaboration with other providers and provider types in their community.

## CCNC Network Pharmacist Program

In 2007, in response to a desire within the NC Legislature for CCNC to serve more complex Aged, Blind, and

Disabled (ABD) Medicaid recipients (complex patients with multiple comorbidities), the CCNC Network Pharmacist program was created. Each CCNC Network was delegated a portion of the Per Member Per Month Payment from NC Medicaid for population health management services specifically for pharmacist services to assist and support care management and Medical Home activities. Networks were given the flexibility to procure pharmacist time and services in the manner that best fit their needs, which resulted in a wide variety of remuneration and service delivery models in multiple different settings of care. This learning lab model persists today and many of the Behavioral Health Initiative (BHI) projects were born from localities that built their own innovative pharmacy-behavioral health collaborations early on.

### **CCNC Behavioral Health Initiative (BHI)**

In 2010, an Integrated BHI was started and the CCNC Central Office BHI team was formed. Each of the 14 networks hired at least one full-time Behavioral Health Coordinator and part-time psychiatrist in each of the 14 networks to work with the pharmacists and care managers in our system that have regular contact with each practice. The ability to take the BHI to scale and to inculcate it as part of the CCNC practices is a truly unique opportunity facilitated by the CCNC infrastructure.

The CCNC BHI centers on the need for preparation and infrastructure building for mental health and substance abuse services that are effective, well-coordinated, and have measureable outcomes. National Institute of Mental Health (NIMH) statistics point out that mental illness is common in the United States, and in a given year approximately one quarter of adults are diagnosable for one or more such disorders. NIMH conservatively estimated the total costs associated with serious mental illnesses, which are those disorders that are severely debilitating and affect about 6 percent of the adult population, to be in excess of \$300 billion per year.<sup>1</sup> Clearly this is a population that we can no longer afford to ignore, particularly within the Medicaid and newly eligible Medicaid population as a result of the Affordable Care Act. The one-year prevalence rate for depression in the U.S. is 6.7%, with a higher lifetime likelihood of occurrence in the 18-59 year old population.<sup>2</sup> This has significant implications for patients, families, employers, and payers. Individuals with depression and substance use issues often present to PCPs with somatic complaints and medical illnesses which often accompany behavioral health matters.

The NC Medicaid administrative claims data indicate that more than 40% of the ABD population has at least one significant behavioral health diagnosis, in addition to multiple medical comorbidities. Individuals with behavioral health disorders have categorically consumed disproportionate amounts of healthcare resources compared to age-matched control populations without such disorders.<sup>3,4</sup> Further, primary care and psychiatry providers have inadequate resources to effectively manage this population, and are poorly distributed geographically throughout the state. Studies have estimated that 67% of all psychopharmacologic medications are prescribed by primary care physicians, in part due to limited psychiatric service accessibility and attempts to meet a care need.<sup>5-7</sup>

### **BHI Projects**

Current core initiatives of the behavioral health team include promoting generic prescribing of antidepressants in the treatment of naïve patients or those not responding to current therapies, developing a safety monitoring process for antipsychotic agents used in children, and improving recognition and referral of patients with substance abuse disorders. In addition, ongoing efforts are in place to support a statewide initiative to more effectively and safely manage chronic pain.

One of CCNC's most well-known BHI projects is the A+KIDS program (Antipsychotics – Keeping It Documented for Safety), which was created in response to the rise in antipsychotic use among U.S. children.<sup>8,9</sup> This effort was co-founded by NC Division of Medical Assistance (DMA) and CCNC. A+KIDS is a novel web-based quality and safety monitoring program that was initially launched in April of 2011 and now includes all NC Medicaid recipients under the age of 18 who have been prescribed an antipsychotic medication. The format of this program allows provider choice in the selection of an antipsychotic medication while encouraging appropriate monitoring of potential side effects.<sup>10</sup> Clinical monitoring parameters and interactive educational features were developed for the A+KIDS registry with provider participation. By June 2013, a total of 1,650 providers participating in the program had submitted medication safety documentation in order to authorize antipsychotic prescriptions for 20,434 patients. Approximately 90% of all antipsychotic claims filed for NC Medicaid recipients under the age of 18 have been authorized through the web-based A+Kids registry. Further, the registry requires that appropriate clinical safety monitoring (body mass index, blood glucose/lipid checks, side effects and outcomes information) occurs and is documented in the

registry. Since the registry launched in April 2011, there has been a documented 16% increase in the frequency of blood glucose screening and a 44% increase in lipid screening as of March 2013. This information illustrates that the A+KIDS registry was implemented with a relatively high rate of uptake and provider acceptance.<sup>11</sup>

Next, CCNC helped to create Project Lazarus, a state-wide chronic pain initiative. In 2012, there were 1,101 unintentional poisoning deaths in NC; most of which can be attributed to opioid overdoses. This accounted for the third leading cause of injury related deaths in the state.<sup>12</sup> Unintentional poisoning deaths from opioid overdoses have been rapidly increasing over the past decade. Project Lazarus strives to reverse this trend through a broad partnership that includes CCNC, the NC Hospital Association, local hospitals and emergency departments, local health departments, primary care doctors, faith-based programs and law enforcement. CCNC is providing financial support through a \$2.6 million grant received from Kate B. Reynolds Charitable Trust and the NC Office of Rural Health and Community Care. Project Lazarus is also utilizing CCNC's local network infrastructure to help support their three state-wide initiatives: community-based coalitions, the clinical process, and program outcomes. Community-based coalitions aim to broaden awareness of the extent and seriousness of unintentional poisonings and chronic pain issues, and to support community involvement in prevention and early intervention. The clinical process focuses on the medical assessment and treatment of chronic pain by providing 40 trainings across the state which promote safe prescribing of opioids. In addition to the trainings, Chronic Pain Toolkits have also been developed to guide decisions by treating providers in emergency departments (EDs), primary care offices and care management settings. Program outcome goals will be measured through the University of NC Injury Prevention Research Center and will include measuring mortality due to unintentional poisonings; inappropriate utilization of ED for pain management; and use of the NC Controlled Substance Reporting System, among others.

Starting in 2011, all of our CCNC care managers received extensive training in motivational interviewing (MI), a collaborative, person-centered form of talking to individuals to elicit and strengthen motivation for change. MI has been shown to be an effective, goal oriented, evidence-based approach. The MI model offers professionals tools to generate change and to support our patient in informed decision making. In recognition of the importance of MI, a full day of MI training has been added

to New Hire Orientation. Each network has identified MI Champions who serve as mentors for education and practice.

Other CCNC BHI initiatives include developing a collaborative SBIRT (screening, brief intervention, referral, and treatment) project, which attempts to systematically identify, treat and refer individuals who are at risk for tobacco, alcohol, or other drug use problems through primary care screening. In addition, CCNC has created referral forms which allow for more efficient communication between PCPs and behavioral health specialists. CCNC has also developed a Depression Toolkit for PCPs, which was designed to help busy PCPs access practical, evidence based tools, to help them successfully treat Major Depression Disorder (MDD) in adults.

### **A Pharmacist's Role**

CCNC has a central office that acts as a shared services entity for each of the 14 CCNC Networks. The central office has two primary functions: Clinical program facilitation and provision of a shared informatics platform. The central office Behavioral Health Team, mirroring that of the networks, consists of a psychiatrist program director, a behavioral health program manager, a data analyst, and a board certified psychiatric pharmacist. The CCNC behavioral health pharmacy coordinator has a leadership role for the direction and management of behavioral health pharmacy projects as well as creating and managing programs that address new policies as DMA implements them. This position serves as a resource to network psychiatrists, pharmacists, and care managers on psychiatric and general drug information, as well as Medicaid pharmacy policy issues related to behavioral health. Further, educating and training, or coordinating the education and training of staff on BHI projects and support processes such as medication reconciliation are key aspects of his duties. Overarching objectives are to assure safe, effective, appropriate, and economical use of medications to improve continuity of care and outcomes.

Network pharmacists play an essential role in helping to implement the BHI Initiatives across the state of NC. Approximately 75 CCNC-supported pharmacists work in a variety of settings in all 14 networks across the state. Whether they are embedded in a hospital, ambulatory care clinic, or community pharmacy, or even working in a remote location away from a traditional care setting, the pharmacist is an integral part of the interprofessional care team. Although many of the pharmacists have not received specialty residency training in psychiatric pharmacy, a majority have completed, or are in the

process of completing, a year-long psychiatric pharmacy training program offered by CCNC through the College of Psychiatric and Neurologic Pharmacists. The goal of this training program is to improve their competency around behavioral health diagnosis and treatment issues in order to be better positioned to impact on this high risk group of patients with co-occurring physical and mental disorders.

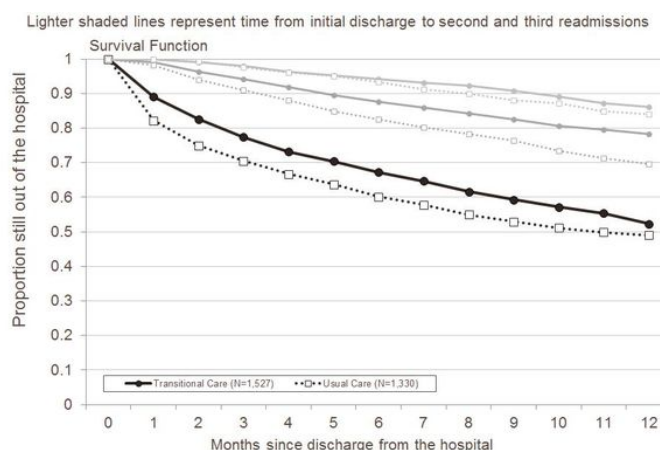
As part of the care team, pharmacists serve many functions. The main goals are to improve the quality of care, reduce preventable hospital readmissions, and reduce preventable ED visits. Medication management is the main focus of CCNC's clinical pharmacist and is performed in all settings. Using the "PHARMACeHOME" application, a secure, web based user portal that provides a shared platform for viewing claims-derived prescription fill history, CCNC pharmacists can assess adherence alerts and care gaps. This PHARMACeHOME application allows clinical pharmacists to find, document, and communicate potential drug therapy problems and discrepancies to those involved in the care of the patient. PHARMACeHOME is linked to our Case Management Information System (CMIS) where care managers can find a patient's medical history (based on paid Medicaid claims), document in a patient's CMIS record, and develop task notes for themselves or one another.

CCNC pharmacists are also involved with helping to implement NC DMA Preferred Drug List (PDL). In order to do this effectively, CCNC pharmacists focus their effort on educating physicians and pharmacists, preemptively targeting drug coverage problems prior to patient rejection at the pharmacy, providing on-call troubleshooting and case manager support, and creating and implementing programs to assist in efficient and effective implementation of the PDL. The goal of this service is to prevent the incidence of patients going to the pharmacy and not being able to pick up their medications in a timely manner.

Last, the pharmacist is highly involved with the transitional care (TC) process. Transitional care medication management focuses on the identification and correction of medication list discrepancies after patient discharge from an acute care facility. The TC model helps to quickly and accurately identify the patient's medication regimen when they go back home. When conducting a TC medication review, the pharmacist can obtain clinical information from the care manager, PCP, hospital or physical history, and/or discharge summary. Although not every transitional care patient is reviewed by a pharmacist, it is required that all TC

patients that are being actively managed, at a minimum receive medication reconciliation from a care manager within 15 days of discharge from a hospital. Cases meeting specific criteria are referred to a network clinical pharmacist for review. CCNC has already demonstrated that such care coordination activities are effective at reducing the likelihood of future hospital admissions. In the larger study evaluating the impact of TC, compared to a clinically similar cohort of patients who received usual care following hospital discharge, patients receiving TC were 20% less likely to return to the hospital in the coming year.<sup>13</sup> We observed the same trend even when looking specifically at those patients who were discharged from a psychiatric unit (see Figure 1; Wilcoxon-Gehan statistic = 21.22,  $p < .0001$ ).

**Figure 1. Readmissions by Care Type**



## WHAT DOES THE FUTURE HOLD?

With health reform challenging the traditional norms of risk sharing and payment, there is great opportunity to foster broader and more diverse interprofessional teams that include behavioral health and pharmacist service, both separately and combined. It is advantageous for the traditional medical provider construct to partner with all clinical service providers, including behavioral health specialists and pharmacists involved with behavioral health service provisions, since behavioral health disorders are similar to chronic medical illnesses such as diabetes in both the importance and difficulties of self-managing drug therapies. One of the challenges that may emerge as the demand for behavioral health pharmacy emphasis continues to grow is a shortage in the number of pharmacists willing and able to provide these types of services. In general, the comfort level with behavioral health service provision (i.e., more effectively interacting with this population, gaining a clearer understanding of psychopharmacology issues in order to provide effective medication management services, screening for and

recognizing behavioral health related illnesses, and understanding their local behavioral health referral system) lags in pharmacists who have not been specifically trained to provide these services. It is the goal of the CCNC behavioral health team to provide practicing pharmacists with the tools and supports to enable this step to occur.

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