

# The Role of the Pharmacist in CCNC

*Troy Trygstad, PharmD, MBA, PhD*

**T**he Community Care of North Carolina (CCNC) Network Pharmacist Program began in 2007 in response to two emerging needs among the 14 networks. The first was a paradigm shift in care management from a historical reliance on disease-specific, protocol-driven interventions to engagement of the whole patient, with multidisciplinary chronic care delivery for the most at-risk Medicaid enrollees. In large part, this population was represented by the categorically aged, blind, and/or disabled. The change in caseload catchment attracted patients with a remarkable diversity of medications and prescribers, making them particularly prone to polypharmacy-related problems.

In addition to meeting the pharmaceutical care needs of the medically complex patient, it became evident over time that network pharmacists could play a dual role and simultaneously manage drug costs. Educating CCNC case managers and prescribers about generic alternatives was a natural fit for the Network Pharmacist Program. Past experience working with pharmacists proved successful in saving over \$10 million in drug costs in the long-term care setting prior to the advent of Medicare Part D and the creation of a similar program for non-dually eligible ambulatory enrollees was a logical extension.

## **The CCNC Vision of Pharmaceutical Care**

While managing drug costs is an important programmatic element, it isn't the primary focus for CCNC. From the outset, the guiding principles of the Network Pharmacist Program have emphasized overall health care costs and global patient outcomes. Historically, pharmacist-led medication management programs have tended to focus on drug selection and related costs in a silo. There is no better example of this than the current Medication Therapy Management programs (MTMs) sponsored by Part D plans; these are completely separate from non-drug medical problems, costs, and outcomes. Rare is the pharmacy program or study whose primary endpoints are total health care costs and reductions in global events such as hospitalizations. Indeed, the Asheville Project in our own state has produced one of the rare examples that resulted in increased drug costs and decreased total health care cost.<sup>1</sup>

The CCNC networks seek to reduce costs of pharmaceuticals where appropriate and where it contributes to overall goals. Since the beginning of the program in 2007, CCNC enrollees have experienced a 10% absolute (16% relative) increase in generic utilization through the promotion of the Prescription Advantage List (PAL) along with other voluntary programs. This rate of increase is twice the national trend for fee-for-service Medicaid.

While drug cost savings are a convenient ancillary benefit to the program, the primary objective of CCNC pharmacy projects has never been to minimize drug costs, but rather to achieve therapeutic optimization to maximize health. This is a subtle but important distinction since the former invites perverse incentives and administrative hassles while the later allows for prescriber and patient-centered interventions such as coaching for adherence that in some instances actually increase drug costs when appropriate.

*From the outset, the guiding principles of the Network Pharmacist Program have emphasized overall health care costs and global patient outcomes.*

## **A Team-Based Approach that Connects the Dots**

A team-based approach that assists the primary care provider (PCP) in building a medical home for at-risk patients has been the hallmark of CCNC, and the pharmacy projects are designed accordingly. One example is an enhanced version of medication reconciliation. In order to manage patients over time as they traverse the health care system, multiple points of contact and sources of information are required to ascertain the actual drug use of the patient. This type of layered information

---

**Troy Trygstad, PharmD, MBA, PhD**, is the director of the Network Pharmacist Program for Community Care of North Carolina. He can be reached at troy.trygstad (at) t2email.com.

is far more valuable and usable to the PCP than a simple listing of medications. Drug use information tells a patient-specific story about drugs prescribed and not taken, drugs taken and not prescribed, side effects not reported to the prescriber, as well as fears, barriers, and attitudes towards their diseases as they relate to their prescribed medications. Sources of drug use information may include home visits with “brown bag” interviews,<sup>a</sup> pharmacy fill information, medical charts, discharge summaries, or interviews with caregivers. CCNC’s definition of medication reconciliation highlights the general approach: Medication Reconciliation Plus (Med Rec Plus) is the process of gathering, organizing, and sharing drug use information from multiple sources with community-based providers (including the patient, medical chart, prescription fill history, and discharge instructions) in order to identify and resolve urgent/emergent duplications, interactions, possible adverse events, poor adherence, or other suboptimal drug-taking behaviors.

Ultimately the goal for the pharmacist-case manager team is to synthesize the drug use information, make an assessment, and prioritize a set of bullet points that will best inform the PCP in the 6-13 minutes of face time he or she has with the patient. Though time intensive, the CCNC infrastructure makes this activity possible through its deployment of over 350 case managers working in conjunction with CCNC pharmacists in home, office, and hospital settings. It would be an otherwise impossible task for a PCP given limited time and ability to “reach outside the four walls” of his/her practice to perform Med Rec Plus.

## The Role of the Network Pharmacist in CCNC

Currently, there are 14 network pharmacists (one per network) who split their time between administrative/management activities and clinical activities. The network pharmacist is the lead project manager and facilitator of pharmacy-related activities within the geographic boundaries of the network. They are employed and supervised by the networks themselves. Network pharmacists are currently based in a variety of settings depending on the networks’ specific and diverse needs. Some are based in a practice, some are based in their central office, and some are based out of their home for geographic reasons to cover geographically large networks.

Their daily activities may include developing proposals for new initiatives, reporting to the network leadership on existing initiatives, or presenting at local medical management meetings about new and ongoing initiatives. Network pharmacist activities are necessarily managerial due to the number of CCNC projects that involve drug-related management and the entirety of human resources involved.

The breadth and scope of activities in the CCNC networks is uniquely challenging for pharmacists who are used to a well-defined, iterative process. Unlike traditional pharmacist settings, any day may bring a different palate of tasks since medication-related problems touch on so many different CCNC initiatives, settings, and issues—from care transitions in institutional settings, to drug and medical equipment coverage issues, to drug-disease specific education for case managers, to promoting and assisting with e-prescribing. Fortunately, the work histories of the network pharmacists prior to employment in the networks are quite varied, coming from every corner of the pharmacy profession including managed care, retail pharmacy, hospital pharmacy, specialty pharmacy, mail order pharmacy, HIV clinics, anti-coagulation clinics, diabetes clinics, and academic residency teaching. As such, it has evolved into an active learning community where network pharmacists from different networks rely on each other for resolution of daily requests for troubleshooting that come in from case managers and PCPs alike. Despite being employed by 14 different entities, CCNC pharmacists rely on each other daily for assistance in managing pharmacy projects that would have otherwise been outside their scope of experience.

## Dividing Time between Administrative and Clinical Activities

The single greatest barrier to expanding the scope, scale, and intensity of pharmacy-related activities in the CCNC networks is the limited number of pharmacists available to devote time to the many projects, initiatives, and programs that all involve medications and their use in some fashion. Across our networks we have a pharmacist-to-enrollee ratio as low as 1:35,000 and as high as 1:130,000. Currently network pharmacists often split their time between administrative and clinical activities, providing reviews of patients on referral from case managers or PCPs when time allows.

A scalable model would place clinically-oriented pharmacists in PCP medical homes, working under the direction of the practice but with activities facilitated and coordinated by their local network pharmacist to meet the medical home service needs of our practices.

As the need for more practice-based activities and clinical referrals have grown, networks have started to contract with clinically-oriented pharmacists who have work experience or residency training in primary care practice settings. Currently 10 pharmacists are engaged with projects that put them in direct contact with a medical home practice. Their effort includes activities ranging from Med Rec Plus, to group medical visits, to e-prescribing adoption and facilitation.

Though most medical home practices would welcome the notion of having a well-acclimated, clinically-oriented

---

a A “brown bag” interview is traditionally patient-facing and inquiry-based, focusing on what and how patients actually take their medications. The “brown bag” naming comes from the traditional brown paper bag that patients would customarily use to bring their bottles of medication to the interview.

pharmacist at their disposal, it is economically infeasible to do so without funding that is external to the practice. While the CCNC payment model has been able to support ancillary staffing of case managers in medical home practices, a multipayer medical home payment model would be required

for clinical pharmacists to be revenue-neutral or revenue-positive for the practice. Until such a time arrives, CCNC pharmacists continue to share time across practices and projects, ever looking for a model that would allow them to participate more fully in the medical home. **NCMJ**

## REFERENCE

- 1 Cranor CW, Bunting BA, Christensen DB. The Asheville Project: long-term clinical and economic outcomes of a community pharmacy diabetes care program. *J Am Pharm Assoc.* 2003;43(2):173-184.

Dave Malvern/Alamy

**Ad Council**

1 in 8 Americans is struggling with hunger. Including people like your neighbor's child playing outside, the parking attendant at your job, or the coffee shop employee around the corner. Who's the 1 in 8 in your life that needs help? Go to [feedingamerica.org](http://feedingamerica.org) to see how your support can help those in need.

**FEEDING AMERICA**  
Formerly named America's Second Harvest