Integrating Behavioral Health within Pharmacy Practice:
Establishing Behavioral Care Providers within Community Pharmacies to Collaboratively Deliver HIV Medication Adherence Counseling

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Presentation Objectives

- Why integrate behavioral care providers into pharmacy care for HIV adherence?
  - Treatment Adherence
  - Medication Therapy Management (MTM)
  - Concept Rationale

- The integrated behavioral/pharmacy model:
  - Assessment and Delivery
  - Outcomes

- IntegratED PharmaCare business start up:
  - Pilot Contract
  - Lessons Learned
HIV in the United States

- The CDC estimates that 1,148,200 persons aged 13 years and older are living with HIV infection – including 207,600 (~18% or 1 in 5) who are unaware of their infection.

- While the U.S. annual HIV prevalence since 2000 has been steadily rising due to increasingly effective HIV treatments, annual HIV incidence has remained relatively stable (~ 50,000 new HIV cases diagnosed each year).

Rates of Adults and Adolescents Living with Diagnosed HIV Infection, Year-end 2010—United States and 6 Dependent Areas

N = 888,921    Total Rate = 342.2

Rates per 100,000 population

- <100.0
- 100.0 – 199.9
- 200.0 – 299.9
- 300.0 – 399.9
- 400.0
- ≥400.0

Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting.
Rates of Diagnoses of HIV Infection among Adults and Adolescents, 2011—United States and 6 Dependent Areas

N = 50,007  Total Rate = 19.1

Note. Data include persons with a diagnosis of HIV infection regardless of stage of disease at diagnosis. All displayed data have been statistically adjusted to account for reporting delays, but not for incomplete reporting.
HIV in the United States

2010 National HIV/AIDS Strategy’s primary goals:

1. Reduce # of people who become infected with HIV;
   - Prevention messaging, PreP and knowing one’s status
   - VL suppression among people living with HIV (PLWH)

2. Increase access to healthcare for PLWH;
   - Public health policy/funding, including insurance coverage

3. Improve health outcomes for PLWH;
   - Treatment guidelines and treatment adherence

4. Reduce HIV-related health disparities
   - Public health policy and funding
   - Culturally competent care practices

Defining Treatment Adherence

The extent to which a client’s behavior coincides with the prescribed health care regimen determined through a shared decision making process between the client and health care provider


Adherence is dependent upon the interplay of the patient with his or her environment, health care professionals, clinical program, and medications

Significance of Tx Adherence

- Allows medical providers to:
  - Determine treatment efficacy
  - Assess treatment acceptability
  - Assess disease progression

- Enhances patient quality of life

- Increases cost savings to the health care system by:
  - reducing hospitalizations
  - reducing new prescriptions for opportunistic infections
  - reducing wasted medications
Tx Adherence Impacts HIV-Related Mortality and AIDS Progression*1

For every 10% decrease in adherence:

- 16% increase in HIV-related mortality
- 1.17 times higher likelihood of progression to AIDS and/or death

*Prospective, observational study of 950 ART-naive patients treated with triple-combination therapy; adherence was estimated by prescriptions dispensed.

HIV Treatment Adherence

Tight association between adherence and viral suppression

Source: Paterson et al. 6th CROI. 1999; Chicago. Abstract 92.
Why Isn’t HIV Medication Always Taken As Directed?

Possible Keys to Success
- simplify dosing schedule
- decrease pill burden
- other

Reasons given for missing antiretroviral doses (structured questionnaire)

Adapted from: Gifford AL et al. JAIDS 2000; 23: 386-395
Adherence Support Interventions

- Psycho-Social Counseling
  - Exploring impact of symptoms, treatment and side effects on self-image, psychological state and environmental functioning
  - Assisting in developing new and/or improving existing coping skills
  - Assisting with anticipatory planning and problem solving
  - Educating about community resources
Psych Themes in HIV Non-Adherence

- Need for information
- Empowerment and control
- Survivor guilt
- Grief and loss: self, others, resources
- Treatment failure
- Pain management
- Existential struggles

Associated Interventions for these psychological themes all lie within the Behavioral Care Provider’s traditional scope of practice
Adherence Support Interventions

- Medication Therapy Management (MTM)
  - Educating patients about the disease, potential co-morbidities, current treatments and appropriate side effects management
  - Educating providers about medication options
  - Educating patients about clinical importance of treatment adherence
  - Exploring how symptoms, treatments and side effects impact activities of daily living
  - Tailoring treatment options to current lifestyle
Primary MTM Concepts

- Patient-centered – empower patient to self-manage medications
- Emphasizes collaborative practice with healthcare providers
  - BCPs are not “officially” included in MTM literature
- Facilitate continuity of care practices
- Distinct from dispensing
Keys to Successful MTM Delivery

- Pharmacists given dedicated time during workday to provide MTM services
- Pharmacists allowed to bill for MTM service delivery
- Significant outreach to educate patients and physicians about the value of MTM services
- Risk stratification models used to identify patients who might benefit most from MTM services
- MTM services are documented in a consistent and efficient format useful for reimbursement
- Outcome measures designed to analyze MTM service impact by both health and cost factors
Requirements for Successful MTM Delivery

- Provider has dedicated time to provide MTM services
- Significant outreach to educate patients and physicians about the value of MTM services
- Risk stratification models to determine patients who could benefit most from MTM services
- A consistent, efficient format for documentation of MTM services
- Outcomes measures to measure the impact of MTM services
- Quality management program
MTM Core Elements

- Medication Therapy Review (MTR)
  - Annual and Targeted
- Personal Medication Record (PMR)
- Medication Action Plan (MAP)
- Intervention and/or referral
- Documentation and follow-up
Role of Pharmacist in HIV Care: Kaiser Data

- **OBJECTIVE**
  - To determine the association of clinical pharmacists with health outcomes and utilization measures among HIV-infected patients

- **METHODS**
  - Observational study of 1571 HIV-infected patients prescribed their initial highly active antiretroviral therapy (HAART)
    - 733 at sites with an HIV-trained pharmacist
    - 838 at sites without an HIV-trained pharmacist
  - Outcomes analyzed included
    - Changes in plasma HIV RNA level, CD4 T-cell counts, service utilization (hospital days, emergency department visits, and office visits) over 24 months

Kaiser Data

- **RESULTS**
  - Patients exposed to a clinical pharmacist were more likely to achieve an HIV RNA level <500 copies/mL at 12 months.
  - At 24 months, however, results depended on the provider panel size; the (Adjusted Odds Ratio) ORs for panel sizes ≤50 and >50 HIV-infected patients were 1.67 and 0.97, respectively.
  - CD4 T-cell counts were modestly but nonsignificantly higher for the patients exposed to a clinical pharmacist.

Kaiser Data

- Pharmacist exposure was also associated with a 19% decrease in office visits for panel sizes < or =50 HIV-infected patients, with minimal effect for larger panel sizes.

- Utilization also depended on the provider panel size; pharmacist exposure was associated with 64% and 9% increases in total hospital days for panel sizes < or =50 and >50 HIV-infected patients, respectively. (getting them into care vs. loosing them to care)

Kaiser Data - Limitations

- Not documented whether patients actually saw a pharmacist in every site where a pharmacist was present

- No collection of information on clinical interventions (Rx change recommendations-dosing etc.), drug acquisition cost data, etc.

Kaiser Data - Conclusions

- Positive association between exposure to clinical pharmacist and plasma HIV RNA control
- Decline in office visits at 12 months

So Why BCP Integration?

- Though every state mandates community pharmacists offer medication counseling, including MTM:
  - Pharmacists are paid by third-party providers for volume of pills dispensed and not for patients counseled
  - Pharmacists are neither academically nor clinically trained to deliver the effective behavioral interventions required for successful MTM

So Why BCP Integration?

- Poor patient counseling attitudes pervasive among community RPhs
  - Lack of financial compensation for delivering non-dispensing professional services in pharmacy setting

- Pharmacist discomfort counseling patients

- Poor understanding of the interactive role of a patient and poor communication skills
So Why BCP Integration?

- Low Patient Health literacy
  - Patients often have a poor understanding of their disease state(s) and reasons why adherence to prescribed medications is essential for achieving good health outcomes
  - Patients rarely (if ever) read package inserts to understand effective medication dosing and side effects management
  - Patients view of OTC products and/or complementary therapies as “safe” and “natural”
So Why BCP integration?

- Behavioral Care Providers:
  - Receive specific academic and clinical training in behavioral counseling, culturally sensitive practice and health literacy communication
  - Can be directly compensated for counseling patients through third party insurance
  - Have experience working collaboratively with medical providers on addressing behavioral issues related to primary care
Integrated BCP-RPh DM Program Model
Concept Framework

- BCPs and RPhs co-deliver MTM services
  - RPhs focus on pharmacological aspects of MTM
    - Proper medication dosing and re-fill monitoring
    - Managing side effects, adverse events and drug interactions
    - Screening for co-morbidities/provider consultation
  - BCPs deliver behavior-based MTM services
    - Patient health education
    - Assessment/resolution of identified adherence barriers
      - Individual/group behavior change counseling
      - Adherence-focused medical case management
Integrated BCP-RPh DM Program

Concept Background

- Despite advances in HIV treatment, adherence to anti-retroviral (ARV) regimens is often sub-optimal, leading to poorer patient health outcomes and higher HIV health system costs


- Federal, state & private funding increasingly aimed at developing effective HIV Adherence Programs
  - *Staying on Track* adherence program
  - *NJ Statewide HIV Pharmacy Training Program*
Integrated BCP-RPh DM Program
Concept Background

- “Staying on Track” HIV Adherence Program
  - 2007 PA-based adherence counseling study designed to examine impact of nurses and social workers at FQHCs collaboratively serving as adherence counselors
  - Poor outcomes led investigators to try a different approach: PharmD residents from one hospital-based HIV clinic in Philadelphia would deliver HIV adherence counseling – but without social work participation
  - Study results initially more successful, but varied by PharmD student communication aptitude and long-term improved patient health outcomes were un-sustained
Integrated BCP-RPh DM Program
Concept Background

- In 2005, NY/NJ AETC established statewide HIV pharmacy training program to improve delivery of HIV care services (incl. MTM) by clinical/community RPhs
  - Annual Training Needs Assessments kept including MTM
  - Annual Service Barrier Assessments kept including MTM

- 2007 Barrier analysis from two pharmacist focus groups:
  - Most RPhs lack enough education/training to provide effective HIV medication counseling to customers
  - Most RPhs do not receive financial compensation from third-party payers for time spent delivering MTM to HIV+ customers instead of dispensing pills
Integrated BCP-RPh DM Program

Concept Background

- Addressing Barriers via team of pharmacists and AETC staff from both NJ and PA:
  - RPhs would be effective MTM providers if extensively trained in HIV medications and counseling techniques
  - Community pharmacies would be ideal sites for MTM due to easy, routine and frequent patient access
  - Ryan White Program ideal source of funding for MTM training and compensation
- BCP integration not part of initial discussions
Integrated BCP-RPh DM Program

Concept Background

- 2008: NJ ADAP approached by “Concept Team”
  - Agrees to grant-fund RPh-compensated MTM project
  - 12 RPhs received 40 hrs training on HIV meds counseling
  - Post-training evals indicated RPhs remained significantly uncomfortable delivering behavior-change counseling

- 2009: Project halted before patient enrollment began due to administrative and funding issues at grantee site

- NJ Concept Team meets periodically throughout 2009-2012 to discuss alternative means for project re-launch
  - Setting up elective MI course in Pharmacy School
  - Approaching NJ Medicaid
  - Involvement of DBH Program at ASU
IntegratED PharmaCare, LLC

- Manages the staffing and human resource needs for employed (non-consultant) BCPs placed at pharmacy sites to work collaboratively with RPhs.
- Establishes a cooperative “time-share” where one BCP works across 1-3 pharmacies to deliver behavioral components of MTM to pharmacy pts.
- Participant pharmacies over time would become required to join a BCP-pharmacy cooperative, by paying a monthly fee to gain shared access to a dedicated BCP for up to three pharmacy sites.
Teams professionals with clinical expertise to anticipate med issues and access to med records (RPhs) with professionals who have clinical skills necessary to foster behavioral change in non-med adherent pts (BCPs)

Enhances quality outcomes for pts by providing a behavioral component that:

- IDs and resolves assessed pt adherence barriers
- Support pt adoption and continuation of adherence-promoting behavioral changes collaboratively developed by BCP and patients
Integrated BCP-RPh DM Program

Concept Model

- BCP as behavioral change gatekeeper:
  - Improves coordination, consultation and communication between primary care providers, specialists, pharmacists and patients on shared patient medication issues
    - distribution, consultation, adherence tracking, side effects mgmt & comprehensive med profiling
  - Confers “go-to” pharmacy status in the eyes of medical providers who will know the best place to send/refer non-adherent patients for extra adherence support
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Service Features

- **Medication Adherence Management**
  - Monthly and/or drop-in live pt contacts offered in real-time at sites in close proximity to pt home and/or work
  - Bi-monthly phone/email pt re-fill reminders & other contacts
  - Bi-annual adherence barrier assessments/service planning
  - Monthly service plan monitoring/patient health advocacy
  - Monthly individual/group counseling for Pts and caregivers
  - Patient care provider consultation
  - Patient care provider technical assistance/training
  - Care coordination across patient care providers
  - Care linkages and referrals
Integrated BCP-RPh DM Program
Med Adherence Counseling Scope

Behavioral Care Providers

- Access third-party payments for delivery of individual/group behavioral interventions related to med adherence mgmnt
- Assess for med adherence barriers (MH, SA, Phys, etc.)
- Develop adherence management plans to foster adherence-supportive behaviors
- Serve as a more accessible liaison between severely time-limited medical providers and pharmacists
- Engage in QM activities for adherence program that directly relate to ensuring patient health improvements occur
- Along with RPhs: provide culturally competent adherence-promoting social services to patients (e.g., indiv/group sessions, Rx delivery, re-fill reminder contacts, provider case conferences, etc.)
Integrated BCP-RPh DM Program
Med Adherence Counseling Scope

Community Pharmacists

- Unequalled command of pharmacological considerations regarding side effects management, adverse events, OTC use and drug interactions
- Unique ability to track patient adherence in real time via prescription re-fill patterns
- Clinical expertise to serve as consultants for medical providers with regard to alternative treatment recommendations for Pts with physiological complications to medications, such as drug resistance
- Expertise in navigating complex drug benefit plans to reduce fiscal barriers to Pt medication access
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Required Physical Resources

- Counseling space separate from pharmacy counter to conduct adherence activities;
- Accessible password protected and HIPAA-compliant computer system;
- Locked file cabinets to store paper-based files;
- Phone system with speaker phone capability, password-protected VM system and at least one dedicated direct line for each BCP;
- Sufficient free/low-cost parking options to enable pts to receive program services at pharmacy without experiencing a negative financial impact.
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Med Adherence Management Products

- Web-based adherence counseling patient health record system
- Med adherence bio-psycho-social assessment tool
- Med management service plan tool
- Psycho-educational group curriculum
- QM plan protocol
- Pill boxes, timers, and other adherence-promoting products
- Patient incentives (gift cards, etc.)
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Anticipated Patient Health Outcomes

- stabilize patient health and wellness
- increase quality of life indicators
- raise patient CD4/decrease VL
- decrease neg. symptoms (i.e., depression, stress)
- decrease instances of hospitalizations
- decrease instances of co-infection
- resolve medication side effects
- increase medication adherence behaviors
- increase OTC usage safety
- decrease negative drug-drug interactions
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Expected Financial Value to Society

- Reduce hospitalizations for disease progression
- Reduce medical procedures and added meds to Tx advanced and/or additional co-morbidities
- Reduce need for personal care services/DME as patient mobility declines slow or cease
- Reduced need for nursing home &/or hospice care as conditions no longer significantly deteriorate
- Fewer wastages of dispensed butuntaken meds at a rate of ~$165/missed dose for expensive ARVs
Integrated BCP-RPh DM Program

Expected Value to Pharmacies

- Offers a competitive advantage to community pharmacies over mail-order counterparts:
  - Delivers face-to-face counseling to capture physical and environmental assessment data;
  - Capable of identifying non-adherence behaviors such as late re-fill requests and pick-ups;
  - Creates a treatment alliance with patients based upon building of personal relationships;
  - Offers potential for better adherence results with cost savings in future healthcare procedures greater than savings gained from lower pill-dispensing rates commonly negotiated by third party insurance carriers with designated mail order pharmacies.
Integrated BCP-RPh DM Program

Market Competition

- HIV med adherence counseling is not new to NJ but services are not currently designed for delivery via an integrated community-based BCP-RPh system

- Interventions delivered mostly in alignment with scheduled medical visits by non-RN case managers:
  - Co-located within HIV clinics but not integrated into the care delivery system
  - Lack formal training in medical terminology
  - Lack skill set to effectively consult with HIV providers on a clinically appropriate level
  - Case loads typically exceed 120 clients/CM
Integrated BCP-RPh DM Program
Marketing Strategies

- Dissemination of provider-targeted letters and Pt-targeted brochures describing the services and benefits to both from program participation
- Face-to-face visits to Pt groups, providers and CMs to describe program, offer Q/A and encourage Pt enrollment
- Face-to-face visits to RW grantees, NJ Medicaid admins and third party carriers to provide data-driven evidence of pt health outcome improvements and cost-savings
- Face-to-face visits to Pharma reps to illustrate benefits to bottom line from incr. adherence, so as to recruit their sales force to pitch benefits to prescribers for referring HIV pts
- Presenting program details and outcomes at conferences and training workshops for professional associations
Integrated BCP-RPh DM Program

Concept Strengths

- Effective means for integrating pharmacy care into medical care without disrupting existing businesses
  - Med practices lacking space/funds to bring a community pharmacy on-site gain enhanced RPh access
  - Community pharmacies continue to operate in current neighborhoods but work collaboratively with medical practices rather than simply dispense script orders

- Addition of the BCP enhances quality outcomes for HIV patients by providing a clinically effective behavioral component to MTM services

- Mail order pharmacies cannot address adherence as effectively/efficiently
Integrated BCP-RPh DM Program

Concept Limitations

- Re-align Pt thinking on healthcare role of pharmacies to alter typical “run in/run out” behaviors when getting meds
- Model requires highly competitive pharmacies to be willing to share BCPs rather than operate independently
- Initially, 3rd party payers will expend more monies paying for integrated BCP-pharmacy care than they’d receive in cost savings from producing better pt health outcomes
  - Requires these carriers to be committed to a process where long-term outcomes are the goal rather than short-term financial gains, as is unfortunately the case with their negotiating low reimbursement rates for current pharmacy medication benefits
RM (Hispanic Male, 46 yo, MSM, single)

- Dx HIV+ in 2003; Dx AIDS in 2011
- Current HIV-related Meds: Atripla (qd), Bactrim (M, W, F morning)
- At intake:
  - CD4 127 and VL 79,000
  - Self-reports missed 3 of past 7 doses of Atripla, none for Bactrim
    - Self-reports typically missing 1-2 doses of ARV per week, doesn’t miss Bactrim
  - No reported side effects from any meds
- Recent Dx of Syphilis, completed 3rd antibiotic Tx 2 days earlier
- RPh refer for safer sex discussion – refill patterns indicated adherence

Presenting Issues: Non-adherence to ARVs, HIV disease progression, unsafe sex
Assessment examined contributing factors to missed doses and to lack of safe sex:

- Unexpected stay-overs with hook-ups, unplanned family outings with son, too drunk to remember to retrieve pill bottle from inside medicine cabinet
- Misunderstanding of adherence (doubled doses the next day so never saw self as non-adherent)
- Only has sex w/ HIV+ men so saw no need to use condoms

Counseling Plan:

- Intake and one additional weekly 30 minute session
- Enrollment in weekly HIV+ MSM adherence support group to begin after second individual session
- Third individual session at week 12 post-intake, close if OK
Integrated BCP-RPh DM Program
DBH Culminating Project Case Studies

- Counseling Interventions
  - Health Education on HIV medications, HIV disease progression and adherence
  - Health Education on Safer Sex
  - Motivational Interviewing to develop adherence plan
  - Check-in monitoring via Text messages

- 3-month outcome
  - CD4 increased to 240; VL undetectable, taken off Bactrim
  - Now keeps meds bottle out on sink counter next to toothbrush and keeps 2 spare med doses in knapsack he never leaves home without; self-reports in past week, no missed med doses; case closed
  - Now keeps condoms in sight on side-table next to bed and self-reports no instances of unsafe sex in past 3 months
Integrated BCP-RPh DM Program
DBH Culminating Project Case Studies

- **SJ** (African American Female, 41 yo, heterosexual, single)
  - Dx HIV+ in 1989; Dx AIDS in 1996
  - Dx with Diabetes and High BP, takes Cozzar and Metformin (both qd)
  - Current HIV-related Meds: Truvada, Norvir and Reyetaz (all qd)
    - CD4 300 and VL 121,000
    - Self-reports missed 5 of past 7 ARV doses – none of other meds
      - Self-reports typically missing 4-5 doses of ARV per week, never other meds
    - No reported side effects from any meds
  - RPh referred for adherence – refill patterns were inconsistent

**Presenting Issues:**

Non-adherence to ARVs, HIV disease progression
Integrated BCP-RPh DM Program
DBH Culminating Project Case Studies

- Assessment examined contributing factors to missed doses:
  - Doesn’t like to be reminded of being HIV+ and taking HIV meds makes her remember and then she feels depressed
  - Misunderstanding of need to take meds as prescribed – sees missing HIV meds as no different than missing a BP med

- Counseling Plan:
  - Intake and three additional weekly 30 minute sessions over next 4 weeks
  - Concurrent enrollment in weekly HIV+ women’s support group
  - Bi-weekly individual sessions during months 2 and 3
  - If appropriate, monthly thereafter
Integrated BCP-RPh DM Program
DBH Culminating Project Case Studies

- Counseling Interventions
  - Health Education on HIV medications, HIV disease progression and adherence
  - Counseling focused on fears and discomfort about being HIV+
  - Check-in monitoring via Text messages

- 3-month outcome
  - CD4 increased to 660; VL decreased to 124
  - Now keeps framed photo of her best friend from group next to meds bottle to remind herself that she would not have this woman in her life were it not for HIV and so she now recognizes that HIV can bring good things into her life; self-reports anytime she feels urge to skip a dose, looks at photo and reminds herself she has a reason to stay healthy; in past week, no missed med doses; placed on monthly F/U schedule
IntegratED PharmaCare, LLC and Integrated MTM Adherence Project
Pilot Project Deliverables:

May 2012 – July 2013

1. Review health data for 3,577 Pts to identify both at-risk patients in need of adherence intervention and health insurance carrier data system issues

2. Contact High-risk Pts and their MDs about program

3. Enroll Pts and assess for clinical and non-clinical issues impacting medication adherence

4. Deliver adherence interventions and analyze outcomes
Case Studies

1. SR & HR

(M 53yo; F 48yo; Hispanic, married heterosexuals)

- Not enough $$ for co-pays – stretches by skipping weekend doses

- Decided to switch to an IntegratED PharmaCare Pharmacy from chain pharmacy and both Pts report significant increases in happiness doing so

- Pts med adherence increased w/co-pay cards, still problem with medical costs

- MDs have been spoken with and extremely happy with assistance insurance carrier is addressing with middle class population
2) **LO** (F, 62yo, White, Heterosexual Widow)

- Once affluent, now works PT, so on HICP and wrap-around ADAP but may lose it once COBRA period ends
- Skips month of meds whenever lapse in ADAP coverage occurs during annual renewal period
- $2500 deductible for medical care – pushed off MD visit and needed lab work b/c no $$ for deductible
- ID numerous drug interaction issues w/OTC vitamins
- Worried about disclosure so never sought support groups
- Low HIV health literacy never ID by chain pharmacy RPh; received Prevention for Positives education from IntegratED PharmaCare team
Case Studies:

3. DD

(M, 52yo, African American, MSM, Civil Union)

- Non-adherent due to ARV side effects; did not discuss w/ID over 4-month time-period between visits; but stated that he would have discussed side effects w/ RPh, had he had a direct relationship with a RPh through his mail order pharmacy

- MD contacted and Pt switched to a more tolerable regimen

- Pt pleased to enroll b/c worried about new side effects, pain management and believes this program will provide him with needed support
Identified Challenges:

1. System-level Barriers
   - Health information
   - Contact info
   - HIPAA
   - Health Plans

2. Patient-level Barriers
   - Provider Relationship
   - Health Beliefs/Education
   - Confidentiality
   - Finances
Moving Forward:
Proposed Phase II Plan

- Restrict ARV med distribution to IntegratED PharmaCare-associated pharmacies
  - Confirmation of HIV diagnosis
  - Develops relationship/ builds trust w/ Pts
  - Establishes MD communication route for med info share
  - Easier adherence monitoring, ID non-SOC/fraud/abuse
  - Develop protocol to clinical/behavioral manage PrEP Pts
- Monitor Pt eligibility for ADAP/HICP enroll/lapse prev
- Create sub-set med insurance program for ARV Pts to resolve finance-based non-adherence issues
Our gratitude to our founding partners at IntegratED PharmaCare for helping to make not only this presentation possible, but for helping to realize this DM Program Concept:

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Questions?