

Siloam Family Health Center
COLLABORATIVE PRACTICE AGREEMENT

A. AUTHORITY

As the Siloam Family Health Center (SFHC) Medical Director and a physician who holds an active license to practice from the Tennessee Board of Medicine, I, James Henderson, M.D., authorize the clinical pharmacists named herein, who hold an active license to practice from the Tennessee Board of Pharmacy, to manage and/or treat patients of SFHC pursuant to written, patient-specific orders from me or my designees. This authority follows Section §63-10-204 of the Code of Tennessee.

B. SCOPE OF PRACTICE

Patients who receive treatment from the clinic will be notified that a portion of their care may be provided by clinical pharmacists working in collaboration with the clinic medical director or his/her designee. This notification will take place by inclusion of the clinical pharmacists' names and credentials with all other clinicians' information posted in the lobby of SFHC, in accordance with recommendations from SVMIC. Clinical pharmacists will have the authority to manage and/or treat patients in accordance with this section. In managing and/or treating patients, the clinical pharmacists may modify or discontinue drug therapy, may order laboratory tests, and may exercise other patient care management measures related to monitoring or improving outcomes of drug or device therapy based on current literature and clinical judgment.

B.1. Diabetes¹

The clinical pharmacist will have authority to define therapeutic goals and manage diabetes therapy as outlined by the American Diabetes Association (ADA) Standards of Medical Care in Diabetes 2016, American Association of Clinical Endocrinologists and American College of Endocrinology (AAACE/ACE) Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan 2015, and other nationally recognized standards of care as supported by current literature. In doing so, they will have authority to manage the use of drugs for the treatment of diabetes according to standard SFHC practices, which may include, but are not limited to the following classes: sulfonylureas, biguanides, alphasglucosidase inhibitors, thiazolidinediones, insulin, meglitinides, amylin analogs, SGLT2 inhibitors, incretin mimetics, and dipeptidylpeptidase 4 inhibitors.

B.2. Dyslipidemia²

The clinical pharmacist will have authority to define therapeutic goals and manage dyslipidemia as outlined by the American College of Cardiology (ACC)/American Heart Association (AHA) Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults, the National Lipid Association (NLA) Recommendations for Patient Centered Management of Dyslipidemia: Part 1 Full Report, and other nationally recognized standards of care as supported by current literature. In doing so, they will have authority to manage the use of drugs for the treatment of lipids according to standard SFHC practices, which may include, but are not limited to the following classes: HMGCoA reductase inhibitors (statins), bile acid sequestrants, cholesterol absorption inhibitors, fibrates, omega3 fatty acids, niacin, and proprotein convertase subtilisin kexin type 9 (PCSK9) inhibitors.

B.3. Hypertension³

The clinical pharmacist will have the authority to define therapeutic goals and manage hypertension therapy as outlined in 2014 Evidence Based Guideline for the Treatment of High Blood Pressure in Adults, A Report from panel members of the Eighth Joint National Committee (JNC 8) and other nationally recognized standards of care as supported by current literature. In doing so, they will have authority to manage the use of drugs for the treatment of hypertension according to standard SFHC practices, which may include, but are not limited to the following classes: beta blockers, calcium channel blockers, ACE inhibitors, angiotensin II receptor blockers, direct renin inhibitors, diuretics, alpha blockers, and α 1 centrally active agents.

B.4. Drug Therapy Regimen Review⁴

The clinical pharmacist will have authority to perform drug overall therapy regimen review at each patient encounter. The goal of these reviews include: improving patient adherence with medical therapy, assuring use of the most cost effective therapeutic options, identifying opportunities to meet standards of care for each condition, streamlining unnecessary or duplicative therapies, and clarifying patient care goals with physicians, nurses and patients. In addition to patient interview and review of the complete medication history, these reviews may also involve, but are not limited to, clinical and laboratory monitoring for drug response and toxicity.

B.5. Hepatitis C Infection⁵

The clinical pharmacist will have limited authority to order laboratory tests and make adjustments to interacting non-prescription therapy in accordance with the SFHC Hepatitis C protocol. The clinical pharmacist may not provide additional Hepatitis C therapy modification without consulting with the patient's primary care provider.

B.6. Anticoagulation⁶

The clinical pharmacist will have the authority to define therapeutic goals and manage anticoagulation therapy as outlined in the 2012 Antithrombotic Therapy and Prevention of Thrombosis and other nationally recognized standards of care as supported by current literature. In doing so, they will have authority to manage the use of drugs for the treatment of anticoagulation according to standard SFHC practices, which may include, but are not limited to the following classes: coumarins, low molecular weight heparins, factor Xa inhibitors, anti-platelet agents, and direct thrombin inhibitors.

B.7. Depression/Anxiety⁷

The clinical pharmacist will have the authority to define therapeutic goals and manage depression/anxiety therapy as outlined in the American Psychiatric Association Practice Guideline for the Treatment of Patients with Major Depressive Disorder and other nationally recognized standards of care as supported by current literature. In doing so, they will have authority to manage the use of drugs for the treatment of depression/anxiety according to standard SFHC practices, which may include, but are not limited to the following classes: tricyclic antidepressants, selective serotonin reuptake inhibitors, and serotonin and norepinephrine reuptake inhibitors.

C. PROCESS OF CARE

Patients who receive care from SFHC providers will sign informed consent annually. New and existing SFHC patients may be referred to the clinical pharmacist by the primary care provider or designated prescriber if desired. Referral should include a detailed description of the referee's

request, specifying whether the consult is for drug therapy management or some other reason. A face to face appointment may be scheduled with the clinical pharmacist through a scheduling request. A phone appointment may be scheduled by message to the pharmacist. An ad-hoc appointment may be verbally arranged, on occasion, through verbal request. Activities of the clinical pharmacist may include gathering information to evaluate:

- Patient adherence
- Drug interactions
- Adverse drug effects
- Redundant or unnecessary therapy
- Need for preventative therapy
- Monitoring
- Cost saving opportunities

Unless otherwise directed by the referee, the patient will be seen by the clinical pharmacist for as many visits as necessary to achieve therapeutic goals. All patients will continue to see their primary care provider for new conditions, acute complaints, and as necessary for any new or ongoing health problems as deemed appropriate by the clinical pharmacist or primary care provider. Patients requiring additional services (education, medication therapy management (MTM), or phlebotomy) may be scheduled for additional appointments and may also be scheduled with the clinical pharmacist for follow up and/or medication adjustment. Healthcare providers not recognized by the medical director to make medication therapy changes under this or a similar agreement must contact the medical director or his/her designee for approval and verbal orders prior to implementing any changes.

D. PATIENT INFORMED CONSENT

The facility shall obtain written informed consent from the patient. Documentation of the referral and the informed consent shall be maintained in the patient's medical record and be available to the pharmacist.

E. DOCUMENTATION

The clinical pharmacist shall document each patient encounter in the permanent clinic medical record. That documentation will include, at a minimum, the reason for the encounter, any changes in the patient's condition, any test results, and any changes in the patient's treatment plan.

F. REPORTING

The pharmacist shall report any new patient complaints and/or deterioration in the patient's condition and any resulting change in the patient's treatment plan to the medical director or designee immediately after learning of the new condition or as soon as possible thereafter. The pharmacist shall not initiate or modify controlled, scheduled substances without a written prescription from the medical director or qualified designee.

G. QUALITY ASSURANCE

Care provided as a result of this collaborative practice agreement will be routinely evaluated to assure delivery of high quality patient care. Annual evaluation of clinical pharmacist providers may include clinical outcomes and satisfaction surveys of patients and providers, as appropriate.

H. AGREEMENT REVIEW AND DURATION

This agreement shall be valid for a period not to exceed two years from the effective date. However, it may be reviewed and revised at any time at the request of any signatories. In no case will the time between the reviews exceed one year.

I. RECORD RETENTION

Each signatory to this agreement shall keep a signed copy of this agreement on file at their primary place of practice. A copy of each order from the medical director or designee authorizing therapy for a specific patient shall be maintained in the patient's medical record. A copy of the informed written consent from the patient shall be maintained in the patient's medical record and kept on file along with the practitioner's order by the pharmacist in a way that is readily retrievable.

J. RESCINDMENT OR ALTERATION OF AGREEMENT

A signatory may rescind from this agreement or a patient may withdraw from treatment under this agreement at any time. The practitioner may override this agreement whenever he or she deems such action necessary or appropriate for a specific patient without affecting the agreement relative to other patients.

K. REFERENCES

Diabetes¹

- American Diabetes Association. Standards of Medical Care in Diabetes 2016. *Diabetes Care*. 2016; 39(Supp 1) S1-S119.
- Handelsman Y, et al. American Association of Clinical Endocrinologists and American College of Endocrinology Clinical Practice Guidelines for Developing a Diabetes Mellitus Comprehensive Care Plan 2015. *Endocrine Practice*. 2015; 21(1):187.
- Inzucchi Silvio, et al. Management of Hyperglycemia in Type 2 Diabetes: A Patient Centered Approach: Position Statement of the American Diabetes Association and the European Association for the Study of Diabetes. *Diabetes Care* . 2012; 35 (6): 13641379.
- American Association of Clinical Endocrinologists' Comprehensive Diabetes Management Algorithm 2013 Consensus Statement. *Endoc. Prac* . 2013;19 (Supp1):148.
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Dyslipidemia²

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- Jacobson TA, et al. National Lipid Association Recommendations for PatientCentered Management of Dyslipidemia: Part 1 Full Report. *Journal of Clinical Lipidology*. 2015.
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- Grundy S, Cleeman, Daniels S, et al. Diagnosis and Management of the Metabolic Syndrome: An American Heart Association/National Heart, Lung, and Blood Institute Scientific Statement. *Circulation* . 2005;112;27352752.

Hypertension³

- James P, et al. 2014 Evidence Based Guideline for the Treatment of High Blood Pressure in Adults, A Report from panel members of the Eighth Joint National Committee (JNC 8). *JAMA* . 2013 (online).
- Giuseppe M, et al. 2013 ESH/ESC Guidelines for the management of arterial hypertension: The Task Force for the management of arterial hypertension of the European Society of Hypertension and of the European Society of Cardiology. *J of Hypertension*. 2013;31: 12811357.
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Prevention, Detection, Evaluation, and Treatment of High Blood Pressure: the JNC 7 report. *Hypertension*. 2003;42:1206-1252.

- Rosendorff C, Black HR, Cannon CP, Gersh BJ, Gore J, Izzo JL, et al. Treatment of hypertension in the prevention and management of ischemic heart disease: a scientific statement from the American heart Association Council for High Blood Pressure Research and the Councils on Clinical Cardiology and Epidemiology and Prevention. *Circulation* . 2007;115:2761-2788.

Pharmacists Role in Chronic Disease State Management ⁴

- Smith M, Pharmacists' Role in Improving Diabetes Medication Management *Journal of Diabetes Science and Technology*. 2009 3(1):175-179.
- Nkansah N, et al. Effect of outpatient pharmacist's nondispensing roles on patient outcomes and prescribing patterns (Review). *The Cochrane Library*. 2011;1:188.
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Hepatitis C Infection⁵

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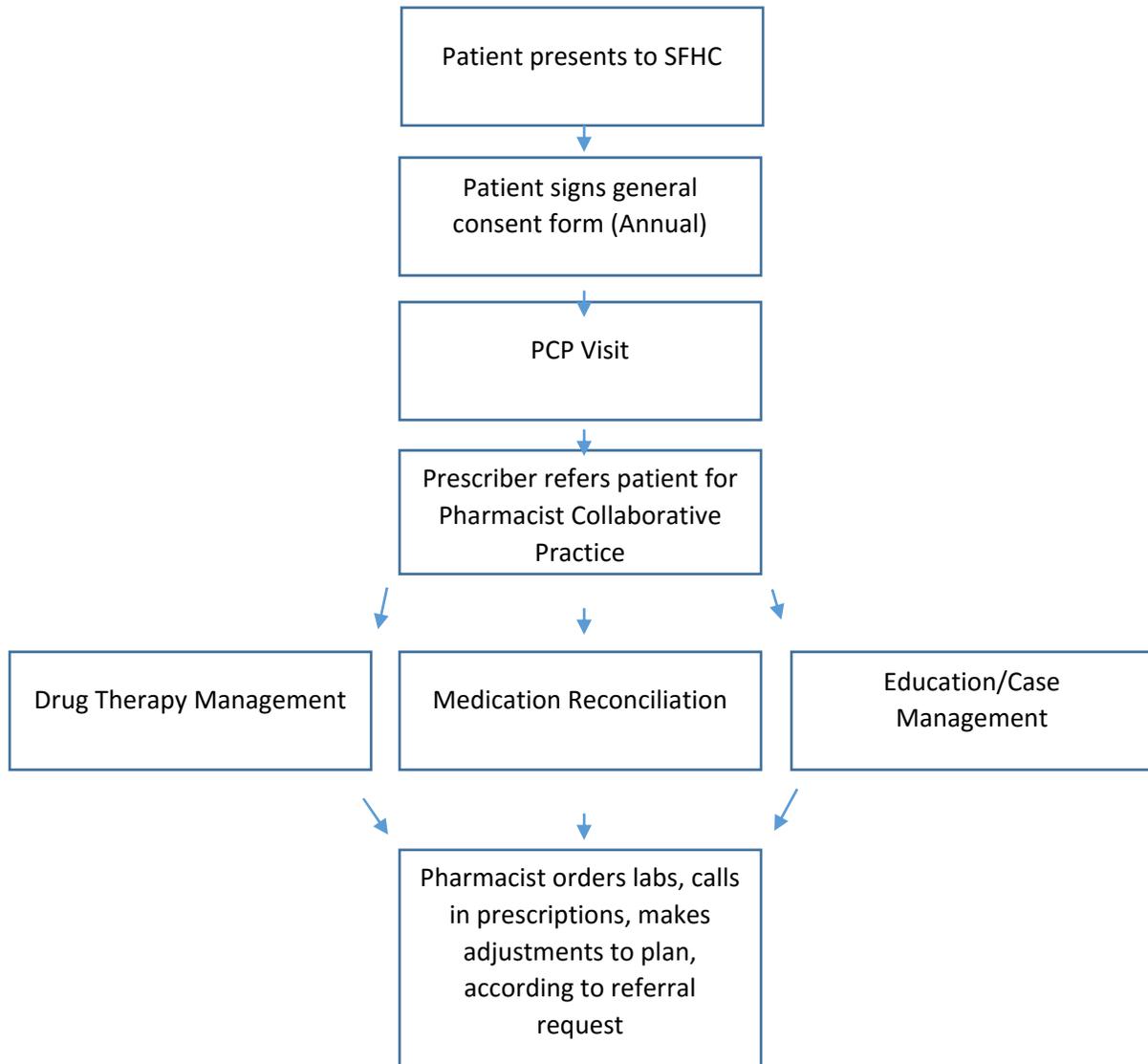
Anticoagulation⁶

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Depression/Anxiety⁷

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- Locke AB, et. al. Diagnosis and Management of Generalized Anxiety Disorder and Panic Disorder in Adults. *Am Fam Physician*. 2015. 91(9):617-24.

L. FIGURE 1: SFHC Collaborative Practice Patient Flow



M. AGREEMENT SIGNATURES

This agreement includes patients under the care of these practitioner(s) and extends for a period of two (2) years from this date unless rescinded earlier in writing.

Signatures:

_____	_____	_____
James Henderson, MD, Medical Director	License #	Date
_____	_____	_____
Elisa Greene, PharmD	License #	Date