It’s impossible to live in West Virginia and not know someone affected by drug addiction. In 2018, West Virginia took the top spot once again as the state with the highest drug overdose rate.

That’s why, in the spring of 2016, pharmacists with Fruth Pharmacy in West Virginia welcomed the opportunity to offer hepatitis C virus (HCV) point-of-care testing (POCT) to high-risk patients in select store pharmacies, as well as out in the community. Because of grant money and other funding streams, the testing can be done at no cost to patients.

“In general, any service you offer needs to meet the demand of the community in order to be successful,” said Jamie Bennett, PharmD, from Fruth Pharmacy.

This is true for POCT in pharmacies, which has grown from A1C and cholesterol screenings to testing for infectious diseases, such as HCV and HIV. POCT by pharmacists for influenza and streptococcal pharyngitis infection has been especially well received, along with the ability of pharmacists in certain states to dispense needed medications when those tests come back positive.

Although some states have more barriers than others, pharmacists are allowed to administer POCT almost everywhere. POCT assays are waived under the Clinical Laboratory Improvement Amendments (CLIA) of 1988, and pharmacists who offer POCT must register with CMS as a CLIA-waived laboratory. More than 120 tests are considered CLIA-waived.

At Fruth pharmacies in West Virginia, Bennett said they would eventually like to offer more POCT besides just HCV.

Efficient and Close to Home

“Point-of-care testing lives at the state level,” said Kenneth Hohmeier, PharmD, who is an associate professor at the University of Tennessee Health Science Center (UTHSC) College of Pharmacy. “With the advent of collaborative practice agreements, there is more we can actuate.

“Screening will always be important with point-of-care testing, but the idea of providing a point-of-care test and then furnishing a medication based on...
workup and test results and having a patient walk away with the medication is ideal—this is what patients want.”

Whereas the traditional medical model has patients receiving health care within a prestigious institution or directly from a primary care physician, research finds that patients today, especially millennials, opt to receive care closer to home, where it is in their community and convenient.1

“The community pharmacist fits into that shift with the new generation, who will be driving health care into the future,” said Hohmeier.

Hamilton Borden, PharmD, from Blount Discount Pharmacy in Alcoa, TN, has seen firsthand that patients are ready for pharmacists to do more for them. Borden offered testing and treatment for influenza when the flu was widespread last year.

“It was pivotal when a local physician showed up to get the influenza test here,” he said. “She could have gone anywhere, but she felt comfortable enough coming to us. We even tested her daughter, and she sent one of her office staff to us as well.”

Borden has found that patients not only want the convenience but also willing to pay the $35 cash price for care from a pharmacist. The prevalence of high-deductible health care plans means that some patients pay almost the same copayment to see a physician.

“Patients are ready, and industry is ready … because of what the chains have created with minute clinics and the like,” said Borden. “Patients like the convenience factor, going to someone they trust, and getting taken care of efficiently.”

Allison Dering-Anderson, PharmD, a clinical associate professor at the University of Nebraska Medical Center’s College of Pharmacy in Omaha, said pharmacists who offer POCT should ideally be providing a service, not running a test.

“Without being trite, my decision-making tree for point-of-care testing services is, and always has been, ‘How do I want you to treat my mom?’” said Dering-Anderson (see sidebar).

Pharmacists interested in offering POCT should determine how they will get a patient the appropriate prescription—whether through a collaborative practice agreement or with independent prescribing authority—if a test result is positive.

Even if a test result comes back negative for any POCT, Dering-Anderson added that it’s an opportunity to interact with the patient and perhaps identify other needs.

“Patients want to know what is wrong; they want to know if they are contagious,” she said. “In the vernacular, they want to know if an NSAID or if oseltamivir is the right answer.”

In addition, antimicrobial stewardship must go beyond avoiding antibacterials for viral illnesses as well as antivirals to treat a virus that isn’t causing the problem.

Patients today, especially millennials, opt to receive care closer to home, where it is in their community and convenient.

“Point-of-care tests are quick, accurate, and give us those answers,” said Dering-Anderson.

SETBACKS AND STRIDES IN TENNESSEE

Thankfully this flu season has turned out to be a mild one so far, because Borden and other pharmacists in Tennessee who have been offering POCT and treatment for influenza and streptococcal pharyngitis have had to surmount some regulatory hurdles to continue to offer this care to patients.

The hurdles have been mainly over the interpretation of current board of pharmacy rules.

‘How do I want you to treat my mom?’

I want the service to be professional, including refusal to test if testing is inappropriate.

I want the test to be explained and to provide accurate, actionable results.

I want good pharmacotherapy based on the test results.

I want the service to have safeguards, such as recognizing when an emergency department referral is appropriate.

I want someone to call my mom a few days after the test to see how she’s doing.
“There’s been a bit of ambiguity [in Tennessee’s collaborative pharmacy practice law and rules] over the past year,” Borden said.

Even with use of a collaborative pharmacy practice agreement, there are questions about whether rapid diagnostic POCT is within a pharmacist’s scope of practice in Tennessee.

“With regard to preventive care, a pharmacist should be able to utilize a point-of-care test, along with a pharmacist’s professional judgment, to furnish drug therapy without a prescriber-provided diagnosis,” said Hohmeier.

“This is in contrast to a point-of-care test used for screening or management purposes—for screening we are using it to refer, and for management we are managing an existing prescriber-provided diagnosis.”

The Tennessee Board of Pharmacy Rules state that “all care and services provided, except immunizations, opioid antagonists, and preventive care, must be pursuant to a diagnosis appropriately made and documented by the physician, advanced practice nurse, or physician assistant.”

Pharmacists in Tennessee have had the authority to assist patients with CLIA-waived, Tennessee-approved POCT since 1996, but the implementation of collaborative pharmacy practice in 2017 allowed pharmacists to take patient care a step further. Working with prescribers, pharmacists have new opportunities not only to assist patients with POCT but to serve as essential providers and to offer more efficient and convenient treatment.

“The ambiguity is, are we diagnosing, or are we providing preventive care to reduce morbidity and hospitalization when we perform infectious disease-related point-of-care testing?” said Hohmeier.

The Tennessee Pharmacists Association (TPA) has been working with the Tennessee Board of Pharmacy to make this distinction clearer so that pharmacists, like Borden, can move forward.

“Although it’s a small thing, it does add months of waiting for pharmacists and patients to have these services,” said Borden. He plans to be up and running with influenza and streptococcus pharyngitis POCT next flu season.

Hohmeier encouraged pharmacists in other states interested in offering POCT to have conversations early and often with regulatory boards and, most important, to stay positive through the challenges.

“There will be barriers, but in the end, pharmacists just really want to take good care of their patients,” he said.

Behind the scenes in Tennessee, work is also under way to test more viable models for how POCT can work efficiently in a community pharmacy.

In a research paper Hohmeier and colleagues published in the Journal of the American Pharmacists Association (JAPhA) in 2017, pharmacists noted workflow barriers when asked about feasibility of POCT for influenza and streptococcus pharyngitis in a community pharmacy setting.

According to Hohmeier, they have begun to train pharmacy technicians in Tennessee to perform the technical aspects of POCT as well as to greet the patient, which frees up the pharmacist for counseling and oversight.

Hunter Hill, PharmD, a PGY-1 community-based pharmacy resident, is driving the pharmacy technician POCT training program at Kroger pharmacies in the greater Memphis area. Hill completed the National Association of Chain Drug Stores (NACDS) POCT certificate training program as part of the curriculum at UTHSC College of Pharmacy and has performed POCT.
services for more than 5 years. Using both online tools and hands-on training, he developed the program with Kroger and one of the diagnostic companies the pharmacy works with.

“The hands-on training piece seems to be key because we can gauge if the technicians are learning the material,” said Hill.

So far, 29 pharmacy technicians in 16 Kroger stores in Tennessee have completed the training.

Hohmeier and other pharmacy leaders are also working with TPA to develop a toolkit that will serve as a resource to help pharmacists get started with POCT.

“Once POCT is in the pharmacy it’s easy to get going, but it’s the front end that is more difficult,” said Hohmeier.

TRAINING PHARMACISTS IN KENTUCKY

Last year, legislators in Kentucky approved new board-authorized protocols in Kentucky’s pharmacy practice act. The protocols enable pharmacists in the state to provide certain services that have been outlined in a specific care protocol between a pharmacist and prescriber. Testing and treating for acute influenza is one of the 13 authorized conditions for which procedures set by the Kentucky Board of Pharmacy have been established.

Trish Rippetoe Freeman, RPh, PhD, director of the Center for the Advancement of Pharmacy Practice at the University of Kentucky, said the biggest challenge with implementation of flu POCT by pharmacists in Kentucky has been the training component.

“Our board-authorized protocol authority required that pharmacists receive education in the content of the protocol before they can get the protocol signed,” she said. In addition, access to training approved by the Accreditation Council for Pharmacy Education for influenza POCT, as required by the administrative regulation, was limited.

A training program has been set up through Kentucky’s unique pharmacy collaborative, the Advancing Pharmacy Practice in Kentucky Coalition, which consists of key pharmacy stakeholder groups in Kentucky. The collaborative offered the first session this past fall and, to date, has trained 60 or so pharmacists in influenza POCT.

Kentucky pharmacists also have the option to receive training through NACDS’s 20-hour POCT certificate program, which launched in 2015. In general, training programs are not mandatory before administering these tests unless a certain state requires it, such as Kentucky.

Freeman acknowledged that there was some pushback from physicians in the community when these new authorities were granted to pharmacists. Although the conditions of the regulation were extensively negotiated with medical groups beforehand and then disseminated to the physician community, many physicians were caught off-guard when they heard pharmacists were both testing and providing prescriptions for patients who tested positive for the flu.

FILLING A NEED

According to a 2015 study in JPhA that looked at how community pharmacists and physicians collaborate on POCT, more than 40% of patients who received influenza POCT in a pharmacy either did not have a primary care provider or visited their pharmacy outside of their primary care provider’s office hours.2

Cody Irick from West Towne Pharmacy in Johnson City, TN, said his pharmacy has been increasing access to care for patients since offering POCT and treatment for influenza HCV POCT result to a patient’s physician. However, most of the high-risk patients they see do not have an established provider.

“Our local health departments have been very receptive and helpful in these efforts.”

Fruth has also partnered with West Virginia Health Right, where patients are often referred to providers to receive the follow-up care they need.

References

Loren Bonner, senior editor

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