LAW: Medical-Legal Considerations of Aging Patients for Pharmacists

Presented by

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For the UConn School of Pharmacy's

Henry A. Palmer CE Finale 2024

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Attorney Osowiecki has no financial relationships with ineligible companies.

Objectives

At the conclusion of this CPE activity, participants should be able to:

List at least three common medical-legal concerns associated with aging.

Identify what constitutes elderly abuse or neglect and describe whether the pharmacist has a reporting obligation.

Discuss the likelihood of polypharmacy and measures that pharmacists can employ to facilitate better medication management and compliance for elderly patients and their caregivers.

The Elderly Patient: How to Age Well?

- Complicated management of health conditions and medications
  - Concomitant chronic conditions
  - Multiple medications
  - Pharmacokinetic concerns
- Social Determinants (Influences)
  - Financial resources
  - Adequate/appropriate housing
  - Food insecurity
  - Functional limitations (hearing, seeing, mobility)
  - Caregiver availability
  - Social interactions

Social Determinants (or Influencers) of Health (SDOH)

- Why consider SDOH in the elderly?
  - To develop better screening tools to achieve better health outcomes
  - To allocate resources to meet basic needs for aging well
- SDOH research uses hierarchical categories
  1. Structural determinant factors of socioeconomic position typically include education, occupation, gender, ethnicity, income, and social class
     a) Governance, social, and public policies
     b) Social and cultural values
  2. Intermediary determinants of socioeconomic position
     a) Material factors typically include housing, diet, clothing, work environment, and health systems
     b) Psychosocial and behavioral factors typically include stress level, social support, use of tobacco, alcohol or other drugs, diet, and physical activity

Social Determinants of Health - World Health Organization (2017)

	Social determinants of health*
1	Income and social protection
2	Education
3	Unemployment and job insecurity
4	Working life conditions
5	Food insecurity
6	Housing, basic amenities and the environment
7	Early childhood development
8	Social inclusion and non-discrimination
9	Structural conflict
10	Access to affordable health services of decent quality

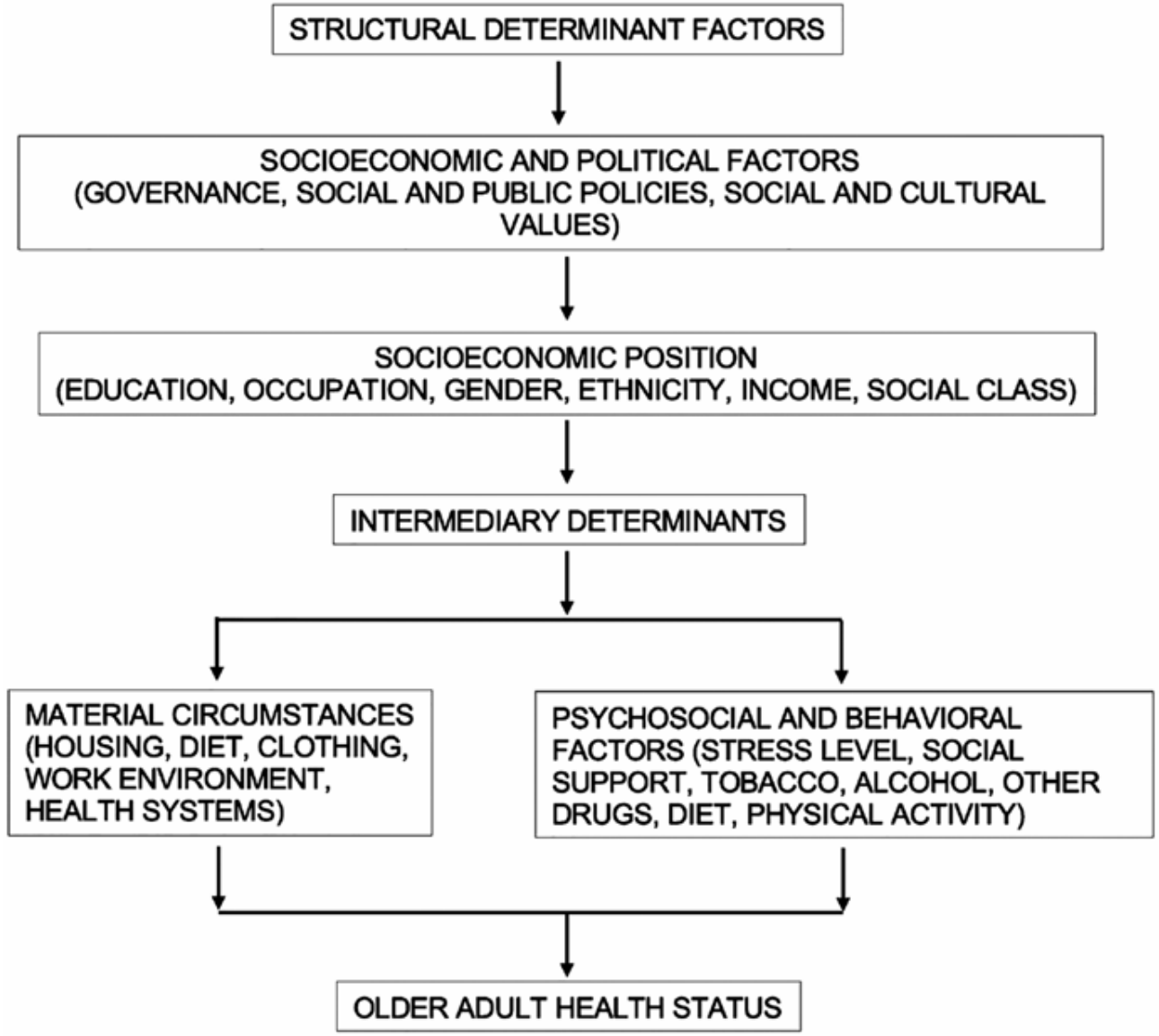


Figure 1.
Sequence of the effects of the social determinants of health on the older adult health status.

https://pmc.ncbi.nlm.nih.gov/articles/PMC9681180/pdf/nihms-1850883.pdf

Good News for Pharmacists

- Occupation is associated with health outcomes and life expectancy
  - White collar workers ages 50-75 had life expectancy of ~4.5 years more than workers in low-skilled blue-collar occupations
- Level of education is a significant determinant of health
  - More educated individuals have lower morbidity from the most common acute and chronic diseases (e.g., heart conditions, stroke, hypertension, cholesterol, emphysema, diabetes, asthma, and ulcers)
  - Education level does not affect risk of cancer or suffering from hay fever
- Retirement
  - Poor health and early retirement have some relationship
  - "Normal" retirement decreases probability that individuals will report their health as fair, bad, or very bad

Key Point for Pharmacists Helping Aging Patients

Good health outcomes in the elderly are not solely dependent on adherence to medication therapy or access to health care

The New York Times | https://www.nytimes.com/2024/11/23/health/elderly-health-appointments-burdens.html

THE NEW OLD AGE

So Many Days Lost at the Doctor's Office

Medical care can be wearying and time-consuming, especially for seniors. Researchers are beginning to quantify the burdens.

By Paula Span
Nov. 23, 2024

Deana Hendrickson sometimes feels daunted by the demands of the medical system. "Every body part has a doctor," she lamented. "I hate it."

Ms. Hendrickson reeled off a long list of her health care providers: a primary care doctor; a cardiologist, because she has mild heart disease and a concerning family history; a lung surgeon and a pulmonologist who oversee an annual scan because of her family history of lung cancer.

Plus an ophthalmologist, a gynecologist, a urologist, a podiatrist, a gastroenterologist — "and I just came back from the dentist."

Medical-Legal Concerns Associated with Aging

https://www.americanbar.org/groups/law_aging/publications/bifocal/vol_37/issue_6_august2016/six-situations-attorney-physician-collaboration/

- Many Social Determinants of Health (SDOH) in the elderly involve legal issues as much as they involve medical issues. The medical-legal concerns with aging include:
  - Mistreatment of the elderly (abuse & need for protective services)
    - Physical
    - Psychological
    - Financial
  - Self-neglect
    - Physical limitations
    - Financial Constraints
    - Housing options (or lack thereof)
  - Cognitive issues and meaningful decisional capacity
    - Medical
    - Residential
    - Financial
    - Difficulties with Technology
  - Appropriate planning and documentation address common events of aging
    - Advance Directives (Living Wills)
    - Healthcare Representative
    - Power of Attorney
    - Trusts

Test Your Knowledge

In Connecticut, a pharmacist is a mandatory reporter of elder abuse, neglect, or need for protective services. What is the youngest age at which a person meets Connecticut's definition of elderly?

A.55
B.60
C.62
D.65
E.67

Elder Mistreatment

https://www.americanbar.org/content/dam/aba/publications/bifocal/bifocaljuly-august2016.pdf

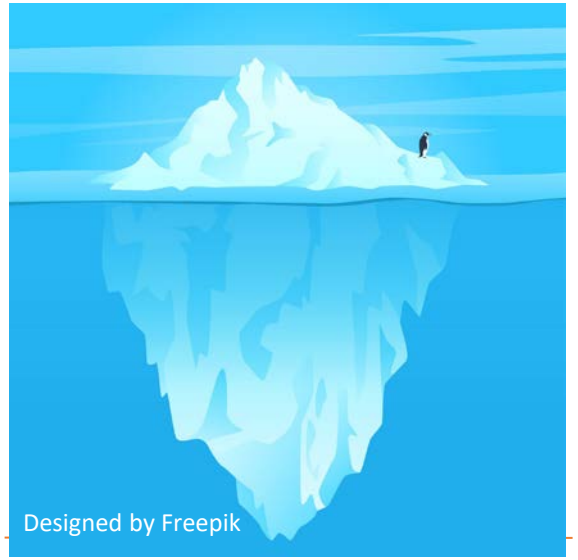
- Older individuals are vulnerable to the risks of physical, psychological, and financial mistreatment by family members and others
  - Older adults with cognitive decline are especially vulnerable
- Elder mistreatment most often presents as a pattern of acts or omissions rather than a single instance
  - In the older person's home
  - In the home of a relative with whom the older victim resides
- Compounding factor: Victim's reluctance to cooperate in reporting abuse/neglect

  EXAMPLE: a competent but physically-vulnerable older adult may passively accept physical or emotional abuse, financial exploitation, or neglect of basic needs like hygiene or medications at the hands of a family caregiver out of fear that making a report to Protective Services might result in removal from the home environment to a nursing home

How Common is Elder Abuse or Neglect?

https://www.centeronelderabuse.org/docs/Elder-Abuse-Pharmacist-Role.pdf

- Estimates from 2003-2004 indicate that:
  - 2%-10% of 65+ adults are victims of some sort of abuse or neglect
    - 2022 US Census: 58 million adults 65+
  - In 2004: 1-2 million Americans 65+ had been injured, exploited, or otherwise mistreated by someone on whom they depended for care or protection
    - Today estimates could be 1.1-5.8 million
- The "iceberg theory of elder abuse" estimates that for every report of elder abuse or neglect, at least 5 instances go unreported
- Underreporting may be due to:
  - Victim's reluctance to report because of shame, fear of losing independence, fear of being moved
  - Victim is too incapacitated to report
  - Signs may be missed/mistaken for "usual aging"



Common Causes of Elder Abuse and Neglect

https://www.centeronelderabuse.org/docs/Elder-Abuse-Pharmacist-Role.pdf

- Greed
- Ageism
- Payback
- Entitlement
- Power and control
- Resentment
- Ignorance/untrained/undertrained
- Untreated mental illness/substance abuse
- Caregiver stress

OFFERED BY Office of the Attorney General

PRESS RELEASE

Three Plymouth Women Arraigned On Charges Related To Fatal Elder Neglect Case

Defendants Allegedly Neglected Elderly Victim Resulting in Death, Submitted False Claims to MassHealth

FOR IMMEDIATE RELEASE:
11/22/2024 Office of the Attorney General

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BROCKTON — Massachusetts Attorney General Andrea Joy Campbell and Plymouth County District Attorney Timothy Cruz today announced that Eva Cardoso, Kayla Cardoso, and Lisa Hamilton were indicted and arraigned in Brockton Superior Court on various charges including manslaughter, caretaker neglect of an elder, larceny, and Medicaid fraud. The Attorney General's Office (AGO) and Plymouth County District Attorney's Office (DAO) allege that the three women were responsible for the wellbeing of Dinora Cardoso, 79, but that their failure to properly care for her ultimately led to her death.

Key Point for Pharmacists Assessing Elder Abuse or Neglect

Pharmacists can directly help by preparing in advance and practicing the CARD method: Care, Assess for Safety, Refer patients to local resources, and Document as appropriate for the practice setting.

Test Your Knowledge

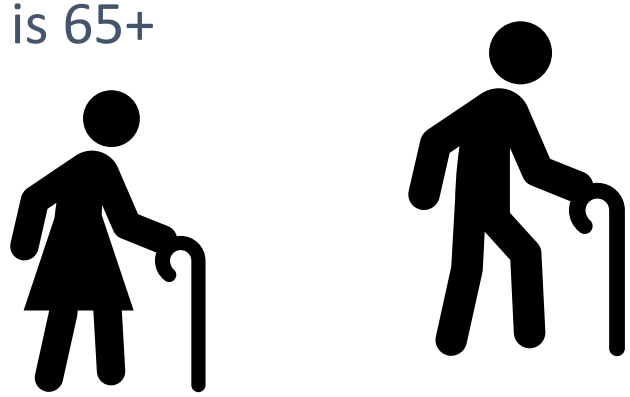
When a pharmacist in Connecticut suspects that an elderly patient is being mistreated, neglected, abused, or is in need of protective services, what is the timeframe that the pharmacist has for making a report to Connecticut's Department of Social Services?

A. 24 hours
B. 48 hours
C. 72 hours
D. 5 calendar days
E. 5 business days

Pharmacists As Mandatory Reporters of Elderly Abuse & Neglect

https://www.japha.org/article/S1544-3191(20)30334-4/fulltext

- Pharmacists are specifically identified as mandatory reporters of elderly abuse/neglect in 20 US States and territories
  - Connecticut specifically names pharmacists in its list of mandatory reporters
- "Healthcare providers" (which, depending on the specific jurisdiction, may include pharmacists) are named as mandatory reporters of elderly abuse/neglect in 47 US States and territories
- Who is "elder"?
  - Varies by jurisdiction, but generally it is an individual who is 65+
  - BUT, in Connecticut, it is anyone 60+



Connecticut's Mandatory Reporter Laws on Elderly Abuse & Neglect

Chapter 319dd - Protective Services for the Elderly

- Anyone 60 years old or older is an "elderly person"
- "An elderly person shall be deemed to be 'in need of protective services' if such person is unable to perform or obtain services which are necessary to maintain physical and mental health"
- "protective services" means services provided by the state or other governmental or private organizations or individuals which are necessary to prevent:
  - abuse
  - neglect
  - exploitation
  - abandonment

Test Your Knowledge

Select all that apply.

Which of the following statements is/are TRUE about HIPAA's Privacy Rule and a pharmacist using protected health information (PHI) to report elderly abuse?

A. Because the report is required by law, the patient's consent is not required to use PHI to report elderly abuse.

B. A mandatory reporter of elderly abuse is expected to promptly inform the patient that a report has been or will be made except under certain circumstances.

C. A pharmacist has no obligation to report elderly abuse if the pharmacist reasonably believes that making a report will place the individual at serious risk of harm.

D. If communications are with a caregiver because the patient has cognitive deficiencies, and the pharmacist suspects that the caregiver is responsible for an elderly patient's neglect, the pharmacist does not need to inform the patient that a report has been or will be made.

CT Reporting Requirement and Penalties for Failure to Report

DSS Summary of Protective Services for the Elderly Program

- A mandatory reporter with "reasonable cause to suspect or believe" an elderly person
  - has been abused, neglected, exploited or abandoned, or
  - is in a condition that is the result of abuse, neglect, exploitation or abandonment, or
  - is in need of protective services [think self-neglect]
- Must – within 24 hours -- make a report to Connecticut's Department of Social Services (DSS) Protective Services for the Elderly (PSE) Program.
- Penalty for first-time failure to report is to attend and successfully complete DSS' elder abuse training module
  - Subsequent failure(s) to report suspected or known abuse = $500 fine
- Make report (telephone reports are preferred) by calling:
  - DSS' PSE Program at 1-888-385-4225 (during business hours)
  - Infoline at 2-1-1 (after business hours)
  - 1-800-203-1234 if outside Connecticut

A Note About HIPAA Compliance with Elderly Abuse & Neglect Reports

45 CFR 164.512(c)(2)

(c) ***Standard: Disclosures about victims of abuse, neglect, or domestic violence*** —

Except for reports of child abuse or neglect …

(2) **Informing the individual**. A covered entity that makes a disclosure permitted by paragraph (c)(1) of [45 CFR 164.512] must promptly inform the individual that such a report has been or will be made, except if:

(i)The covered entity, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

(ii) The covered entity would be informing a personal representative, and the covered entity reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing such person would not be in the best interests of the individual as determined by the covered entity, in the exercise of professional judgment.

Medical-Legal Concerns Associated with Aging

https://www.americanbar.org/groups/law_aging/publications/bifocal/vol_37/issue_6_august2016/six-situations-attorney-physician-collaboration/

- Mistreatment of the elderly (abuse & need for protective services)
  - Physical
  - Psychological
  - Financial
- Self-neglect
  - Physical limitations
  - Financial Constraints
  - Housing options (or lack thereof)
- Cognitive issues and meaningful decisional capacity
  - Medical
  - Residential
  - Financial
  - Difficulties with Technology
- Appropriate planning and documentation address common events of aging
  - Advance Directives (Living Wills)
  - Healthcare Representative
  - Power of Attorney
  - Trusts

Medical-Legal Partnerships

https://medical-legalpartnership.org/about-us/faq/

- Medical-legal partnerships embed lawyers as specialists in health care settings
  - Allow clinical staff to refer patients directly for legal services
  - Legal staff are also a resource for clinical and non-clinical staff to consult about system and policy barriers to care
    - A medical-legal partnership can also leverage their knowledge and expertise to advance local and state policies that lead to safer and healthier environments
- Different model than referring patients to "legal aid" services
  - With a medical-legal partnership, a "lawyer in residence" works on-site in the health care setting, not only providing legal services to patients, but also participating in clinical meetings and providing trainings to health care clinicians and staff.
  - Formal processes and agreements are established to screen patients' health-related social and legal needs, share data between health care and legal partners, communicate about patient-clients, and jointly set service and evaluation priorities that reflect their shared mission.

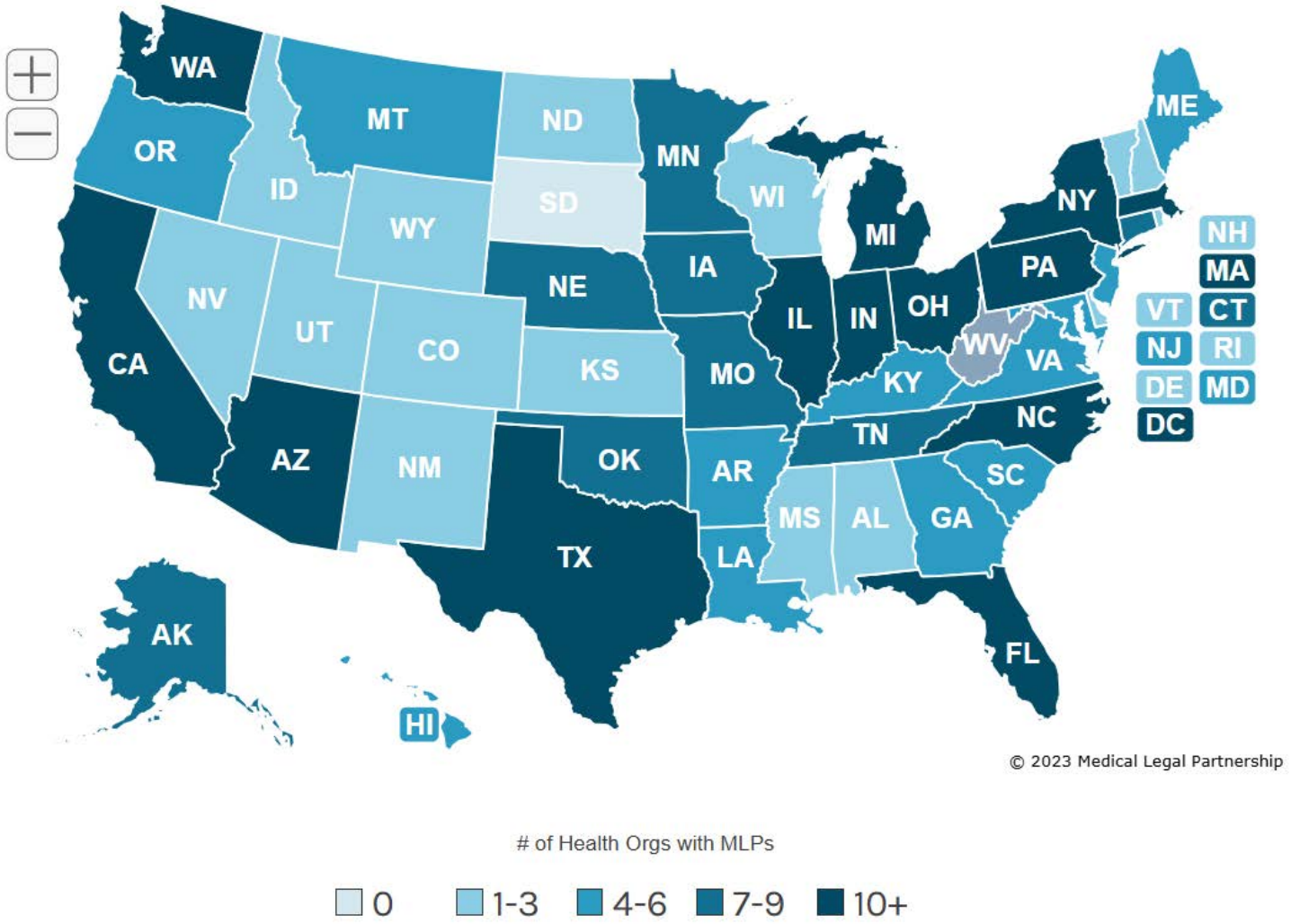
Typical Settings for Medical-Legal Partnerships (MLPs)

- Health Systems & Hospitals
- Federally Qualified Health Centers
- Children's Hospitals
- VA medical centers
- Organizations serving the elderly

Focus of MLPs can vary:

- Pediatrics
- Behavioral Health
- Housing and Civil Rights
- Advance Planning

Medical-Legal Partnerships Across the U.S.



Test Your Knowledge

Select all that apply.

Which of the following is/are NOT a medical-legal concern associated with the elderly patient?

A. Level of education.
B. Financial resources.
C. Retirement status.
D. Cognitive abilities.
E. Housing options.

Key Point for Pharmacists

Don’t forget about the family caregivers

Family Caregivers in America

- As of 2020, approximately 53 million Americans (1 in 5) is a family caregiver
- Caregivers are providing care for”
  - Parent (41%)
  - Special-needs child (29%)
  - Spouse/Partner (18%)
  - Someone else (20%)

Resources that Caregivers Commonly Need

- Meal & nutrition programs
- Transportation services
- Assistive devices & technologies
- Health & wellness programs
- Senior Centers & social opportunities
- Cleaning & yardwork services
- Adult day care
- Respite care

Test Your Knowledge

What percentage of individuals over the age of 65 are estimated to be taking five or more medications regularly?

A.24%
B.33%
C.41%
D.57%
E.66%

How Pharmacists Can Help Caregivers

1. Establish communication with both the patient and the caregiver
2. Train on the administration of medications
3. Monitor costs and provide information about cost saving programs
4. Compile a medications list
5. Reconcile medications
6. Assist with organizing medications
7. Provide advice on new technologies and how to improve a patient's adherence
   - Compliance packaging
   - Free delivery
   - Lift-assist devices and chairs
   - Grab bars and raised toilet seats

https://www.pillpack.com/how-it-works

Compliance Packaging and "Redispensing": Definitions and Requests

[Public Act 24-73 (SB 133), Section 4, effective 10/01/2024]

- "Compliance packaging" defined in CGS 20-571 as prepared at a pharmacy as a single package with separate compartments for solid oral dosage forms
  - May have different drugs is same compartment, but each compartment must identify drug name and strength (PA 24-73, Section 4(b)(4)]
  - May be either reusable or nonreusable (disposable)
  - May be used to group different medications by prescribed time of administration (e.g., take at bedtime)
    - Pharmacist must verify that all drugs in a single compartment are "compatible" and that none are to be administered PRN
    - Cannot combine controlled substances with noncontrolled drugs or different controlled drugs in same compartment (but can combined same controlled substance with different dose in same compartment per prescription, e.g., diazepam 5mg & 10mg can be in the same compartment)
  - Must be tamper-evident
  - Must be "child-resistant" unless pharmacy obtains a waiver acknowledged by the patient
  - Entire package shall not contain more than a 90-day supply unless another federal or state law allows for a greater days' supply
  - Must comply with all applicable USP chapters [specific chapters not enumerated in the law]
- Patient, patient's representative, or prescriber may request compliance packaging
  - Pharmacist or "advanced pharmacy technician" can dispense single or multiple prescriptions for single patient in compliance packaging per request

Compliance Packaging and “Redispensing”: SOPs

[Public Act 24-73 (SB 133), Section 4, effective 10/01/2024]

- Pharmacy that provides compliance packaging must have “dedicated” area for preparing it and “standard operating procedures” that address:
  - Inspections of compliance packaging integrity
  - Cleaning (of area and equipment)
  - Labeling (of compliance packaging)
  - Dispensing and redispensing
  - Proper hand hygiene
  - Quarantine
  - Handling of returned and “redispensed” drugs
  - Specifically which drugs are not compatible, are suitable to be dispensed/redispensed in compliance packaging, or require special consideration to be placed in compliance packaging

Compliance Packaging and "Redispensing": Returned Meds & Labels

[Public Act 24-73 (SB 133), Section 4, effective 10/01/2024]

- Allows original dispensing pharmacy to accept medication already dispensed in compliance packaging for return and to then be "redispensed" when patient has a new or changed prescription
- Any medication accepted from patient for redispensing must be returned to patient (return to pharmacy's stock is expressly prohibited) unless another law provides otherwise (e.g., Medicaid program may require pharmacy to accept certain dispensed medications for return and credit to the Medicaid program)
  - If the medication(s) being returned to the pharmacy in its original compliance packaging has been deprescribed, discontinued, or inappropriate for inclusion in the new compliance packaging, the drug(s) must be placed in a separate containers where each container is for a single drug type or dosage (e.g., Prozac 20mg in separate container from Prozac 10mg) that is labled with: patient name, original RX number, drug name, dosage form, quantity *redispensed*, instructions for use (or disposal).
  - If drug is to be disposed, must also include "procedures for any lawfully available means for destroying such drug … at home" and nearest location where drugs are accepted for destruction (e.g., police station or retail pharmacy collector)
- The opioid warning label required under CGS 20-636 may be affixed to the compliance packaging only once, and does not need to be placed on each comparmtnet if an opioid is dispensed/redispensed

Compliance Packaging and "Redispensing": Records

[Public Act 24-73 (SB 133), Section 4, effective 10/01/2024]

- A pharmacy that provides compliance packaging services must keep detailed records of all drugs dispensed to a patient in compliance packaging that include:
  - Patient's name and address
  - The ID number of each compliance packaging used and date of dispensing
  - The initials of the pharmacist or advanced pharmacy technician who prepared the compliance packaging
  - The serial number of each prescription for each drug dispensed in compliance packaging
  - A visual description of each drug dispensed in compliance packaging
- For each original compliance packaging that a pharmacy accepts for return and redispensing, the record must include:
  - Patient's name and address
  - The ID number of the original compliance packaging
  - The date the original compliance packaging was accepted for return
  - The name of the pharmacist or pharmacy technician who accepted the compliance packaging for return and redispensing
  - The name, formulation, and quantity of each drug accepted for return in the original compliance packaging and whether any drug was discontinued or deprescribed
- Records of compliance packaging and redispensing must be kept for at least 3 years. If DCP requests a copy of any of these records, the pharmacy must provide a copy (electronic, preferred; paper if unable to provide electronically) within 48 hours

Polypharmacy & Medication Management

- Medications are first line treatment for 88% of chronic diseases
- ~40.7% of persons 65+ take 5+ medications
- Polypharmacy has strong associations with increasing risk of falls, emergency care, and hospitalizations in older adults, all resulting in high health care costs

- Current recommendations for reducing polypharmacy
  1. Assess and interview of the patient
  2. Reconcile medications, assess adherence, and systematically identify drug therapy problems
  3. Choose pharmacotherapy that avoids problems and risk of rehospitalization, including tapering of benzodiazepines, opioids, and other identified risks
  4. Simplify the regimen for ambulatory and long-term care patients whenever possible

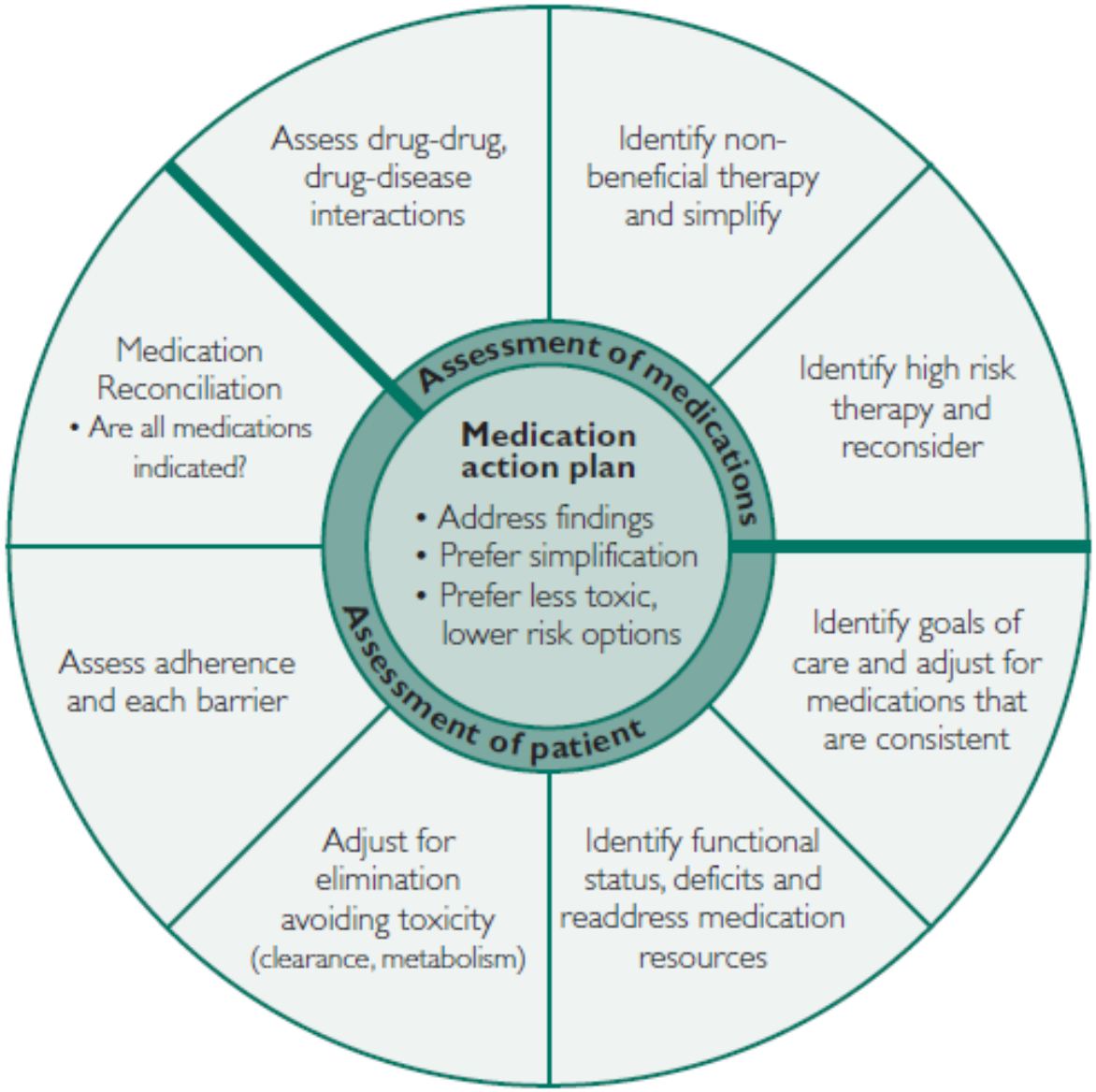


FIGURE. Polypharmacy consultation summary.

TABLE 3. Deprescribing in the Older Adult

Medications: pharmacologic examples	Risks in older adults	Tools: deprescribe methods
Anticholinergic medications	Broad muscarinic receptor blockade	Taper if using routinely and avoid
Old antihistamines: diphenhydramine, hydroxyzine	CNS impairment: delirium, slowed comprehension; impairs vision, urine retention, constipation, sedating, falling	Beers Criteria, STOPP Criteria, Anticholinergic Burden Scale; suggestion: avoid, use safer drugs
Muscle relaxants: cyclobenzaprine, metaxalone, and others		
Overactive bladder: oxybutinyn		
NSAIDs: indomethacin, naproxen, ibuprofen, and others	Worsens clearance in kidney disease, hypertension, heart failure, GI ulceration/bleeding	Avoid
Sulfonylureas: glyburide, glipizide	Accumulation in CKD with higher risk of hypoglycemia	Taper, and substitute safer agents
Short-acting insulins, peak insulins	Accumulation and resulting hypoglycemic risk in AKI and as CKD progresses	Modify to avoid hypoglycemia
Antihypertensive drugs for hypotension or orthostatic blood pressure	Any/all classes can result in blood pressure drops with falls, injury, orthostasis	Monitor, adjust doses or deprescribe; titrate to control hypertension but avoiding hypotension
Multiple vitamin/mineral supplements, general use	Contributes to medication burden and occasionally anorexia without substantiated benefit	Exception: Vitamin D has evidence for bone health; Ca/Vitamin D studied with bisphosphonates
Herbal supplements: not regulated by FDA to provide evidence of claims: glucosamine, turmeric, gingko, and many antioxidants	Have actual drug interaction concerns, adds to medication burden and expense; poor to no evidence of pharmacological benefit	Stop and consider healthy dietary intake
Opioids: Short-acting, slow-release	Morphine, oxycodone, codeine, shared sedation, anticholinergic properties, addictive; withdrawal syndrome; cognitive impairment, falls	Avoid or taper gradually, as permitted
Benzodiazepines: avoid long- acting agents (diazepam) Moderate action: lorazepam, clonazepam Benzo- like GABA receptor hypnotics: zolpidem, zaleplon	Sedating, cognitive impairing, unsafe mobility with injurious falls, motor skill impairment; habituating, withdrawal syndromes including sleep disruption	Beers, STOPP criteria: avoidance. EMPOWER: taper technique; consider safer therapy; for anxiety and sleep: taper, consider cognitive behavioral therapy and adjuncts
Antipsychotics: for cognitive behavioral problems Typical agents: chlorpromazine, haloperidol long-term use Atypical agents: quetiapine, risperidone, olanzapine, and others	Avoid most sedating agents; they worsen cognitive function in dementia	Beers Criteria: taper/avoid if possible, especially as pharmacological behavioral control in cognitive disease; use redirection and other agents. FDA Box warning: risk of death when used for dementing disorders
Cholinesterase inhibitors: donepezil, galantamine: indicated for mild to moderate dementia (eg, Alzheimer disease).	Adverse effects: nausea, vomiting, diarrhea, nightmares, bradyarrythmia Lacking long-term benefit, particularly in advanced dementia	Safe to taper to off, especially when there is perceived lack of benefit

Mayo Clin Proc ■ January 2021;96(1):242-256 ■ https://doi.org/10.1016/j.mayocp.2020.06.012
www.mayoclinicproceedings.org

PHARMACISTS' COLLABORATIVE PRACTICE IN CONNECTICUT

CT's Collaborative Drug Therapy Management by Pharmacists

[CGS 20-631; RCSA 20-631-1 to RCSA 20-631-3]

A "**qualified pharmacist**" is authorized to manage a patient's drug therapy and prescribed devices, order associated lab tests, and/or administer drugs (but NOT establish a port to administer parenteral drugs) under either:

- A CDTM **policy** adopted by a care-giving institution (e.g., hospital, LTCF), or
- a CDTM **agreement** with one or more prescribing practitioners (can include: practitioners from another US jurisdiction; any practitioner "who is authorized to issue a prescription within the scope of the individual's practice"); or
  - Per the regulations, a CDTM AGREEMENT must include:
    1. Types of prescriptive authority decisions pharmacist is allowed to make (initiate, modify, continue, discontinue or deprescribe)
    2. Patients who are eligible for treatment
    3. Types of diseases/drugs/drug categories involved
    4. Procedures, decision criteria, plans and guidelines for therapeutic decisions (especially to initiate or modify drug therapy)
    5. Required training
    6. Plan for periodic review, feedback & quality assurance
    7. Procedures for documenting prescribing decisions
- Per the 2022 change to CT's statute, a CDTM agreement/policy may address issues and concerns arising during medication reconciliation or about polypharmacy and allow the qualified pharmacist to "initiate, modify, continue, discontinue or deprescribe drug therapy"

Pharmacist Collaborative Drug Therapy Management

[CGS 20-631; RCSA 20-631-1 to RCSA 20-631-3; https://jcpp.net/patient-care-process/]

- *"'Qualified pharmacist' means a pharmacist who (A) is deemed competent under regulations adopted by the commissioner pursuant to subsection (e) of this section, and (B) has reviewed the latest edition of the 'Pharmacists' Patient Care Process' published by the Joint Commission of Pharmacy Practitioners."*
- The regulations provide that, to qualify, a pharmacist must be one of the following:
  - BS with 10 years of experience, or PharmD
  - Certified by one of the following
    - Board of Pharmaceutical Specialties
    - Commission for Certification in Geriatric Pharmacy
  - Credentialed in disease state management by National Institute for Standards in Pharmacist Credentialing
  - In a pharmacy residency accredited by ASHP
  - Successfully completed disease state management certification program approved by ACPE

Pharmacist Collaborative Drug Therapy Management

[CGS 20-631; RCSA 20-631-1 to RCSA 20-631-3]

- In addition to the CDTM agreement/policy, must have one of the following:
  - Patient-specific written ***protocol***
  - Patient population-specific ***protocol***
  - Collaborative drug therapy ***care plan***
- Each protocol and care plan must include (at a minimum):
  1. Specific drug(s), therapeutic class(es), and/or devices to be managed by the pharmacist
  2. Terms & conditions to initiate, modify, continue, discontinue, or deprescribe a drug therapy and/or the use of a device
  3. Conditions/events upon which the pharmacist must notify the prescribing practitioner
  4. Lab tests that may be ordered by pharmacist
  5. A definition of the patient population included in the protocol/care plan
  6. Drugs that may be administered by the pharmacist (if it is a patient-specific protocol)
- A copy of the protocol must be filed in the patient's medical record
- Pharmacist's activities must be documented in the patient's record in accordance with prescriber's/institution's policies
- If discontinuing or deprescribing, pharmacist must give notice to prescribing practitioner **within 24 hours**
- All CDTM agreements, policies, protocols, and care plans must be available for inspection by DCP and DPH
- Prescribing practitioner must have provider-patient relationship with the patient
  - Patient does NOT need to consent to collaboration between pharmacist and prescribing practitioner

QUESTIONS?