Breaking Trail: Pharmacists Lead the Way

Indiana Pharmacists Annual Convention and Expo
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ASSISTANT SURGEON GENERAL
US PUBLIC HEALTH SERVICE COMMISSIONED CORPS
Learning Objectives

Outline how pharmacists can participate in sustainable partnerships within communities.

Describe advanced primary care medical home models that aims to strengthen primary care through multipayer payment reform and care delivery transformation.

List specific actions that would support advancement of public health.

Describe evolving and expanding roles of pharmacists within the healthcare system.

Discuss naloxone use as an opioid antagonist.
Mount Rainier - training
Department of Health and Human Services (DHHS)
HHS Corps Leadership

ADMIRAL BRETT GIROIR
ASSISTANT SECRETARY FOR HEALTH

VICE ADMIRAL JEROME ADAMS
20TH SURGEON GENERAL

Senior Advisor to the Secretary for Opioid Policy

“Better Health Through Better Partnerships”
Where USPHS officers serve – 26 agencies
Public Health Emergency Responders - Deployments

- Hurricane(s)
- Ebola
- Zika
- Fire(s)
- Special events
WHAT CAN YOU DO TO PREVENT OPIOID MISUSE?

TALK ABOUT IT.
Opioids can be addictive and dangerous. We all should have a conversation about preventing drug misuse and overdose.

BE SAFE.
Only take opioid medications as prescribed. Always store in a secure place. Dispose of unused medication properly.

UNDERSTAND PAIN.
Treatment rather than opioids are effective in managing pain and may have less risk for harm. Talk with your healthcare provider about an individualized plan that is right for you.

KNOW ADDICTION.
Addiction is a chronic disease that changes the brain and alters decision-making. With the right treatment and supports, people do recover. There is hope.

BE PREPARED.
More opioid overdose deaths occur at home. Having naloxone, an opioid overdose reversing drug, could mean saving a life. Know where to get it and how to use it.

For help, resources, and information:
https://www.hhs.gov/opioids/
1-800-662-HELP (4357)

https://addiction.surgeongeneral.gov/
Innovation

Automation for filling/dispensing of prescriptions

Solutions/automation to allow for aging in place.

Changing practice of pharmacy
- Team-based care
- Prevention/public health
- Collaboration with community partners

Precision medicine - identifying which approaches will be effective for which patients based on genetic, environmental, and lifestyle factors.

Specialty drugs

Science – new drugs and delivery systems
Smart Medication Monitoring and Management – Technology Enabled Care

Smart Patch
• Date/time applied
• Duplicate patch?
• Temperature
• Expiration date
• Wireless data transfer

Smart Package
• Pill removed
• Date/time log
• Temperature
• Expiration date
• Wireless data transfer

Data flowing back from “Smart” medications are presented in exception management dashboards for review by Care Team members
## Caring Healthcare Providers

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>Caring</th>
<th>Non-Caring</th>
</tr>
</thead>
<tbody>
<tr>
<td>Voice</td>
<td>Talks at same level as patient; concerned voice</td>
<td>Talks down</td>
</tr>
<tr>
<td>Availability</td>
<td>Is available when needed</td>
<td>Limited availability</td>
</tr>
<tr>
<td>Presence</td>
<td>Listens, spends time with patient</td>
<td>Is in a hurry, rushes in and out.</td>
</tr>
<tr>
<td>Attitude</td>
<td>Shows patience when waiting for patient to make a decision</td>
<td>Lectures patient, is pushy.</td>
</tr>
<tr>
<td>Touch</td>
<td>Shakes hand, gentle touch</td>
<td>Afraid to touch</td>
</tr>
<tr>
<td>Respect</td>
<td>Respectful to elders</td>
<td>Criticizes or shames elder or family</td>
</tr>
<tr>
<td>Visit</td>
<td>Connects with patient; shares something about themselves.</td>
<td>All business; no connection.</td>
</tr>
</tbody>
</table>
Connecting with the Patient
Historic Chilkoot Trail (33 miles): Golden Staircase
Upstream care
Story of 3 Friends

Quadruple AIM

Improve outcomes including less preventable illness, improving patient experience with healthcare system, appropriate spending and utilization, provider/clinician and staff satisfaction (retention)
Building a Culture of Health

CULTURE OF HEALTH ACTION FRAMEWORK

ACTION AREA
1
MAKING HEALTH A SHARED VALUE

ACTION AREA
2
FOSTERING CROSS-SECTOR COLLABORATION TO IMPROVE WELL-BEING

OUTCOME
IMPROVED POPULATION HEALTH, WELL-BEING, AND EQUITY

ACTION AREA
3
CREATING HEALTHIER, MORE EQUITABLE COMMUNITIES

ACTION AREA
4
STRENGTHENING INTEGRATION OF HEALTH SERVICES AND SYSTEMS

EQUITY

EQUITY
CDC resources for pharmacists

A PROGRAM GUIDE FOR PUBLIC HEALTH

Partnering with Pharmacists in the Prevention and Control of Chronic Diseases

https://naspa.us/resource/pharmacist-resources-information-cdc/#tobacco
National diabetes prevention program (DPP)

Goal: Preventing type 2 diabetes in individuals with an indication of pre-diabetes.

Failed summit attempts

The most certain way to succeed is to try one more time.

*Thomas Edison*
The Nation’s Health Dollar, Calendar Year 2016: Where It Came From

- Health insurance 75%
- Medicaid 17%
- Medicare 20%
- Private health insurance 34%
- VA, DOD, and CHIP 4%
- Other third-party payers and programs 8%
- Public health activity 2%
- Investment 5%
- Out of pocket 11%

NOTES: “Other third-party payers and programs” includes Worksite health care, Other private revenues, Indian Health Service, Workers’ compensation, general assistance, Maternal and child health, Vocational rehabilitation, Substance Abuse and Mental Health Services Administration, School health, and other federal and state local programs.

Out of pocket includes co-payments, deductibles, and any amounts not covered by health insurance.

Note: Sum of pieces may not equal 100% due to rounding.

What’s coming...

- employers/payers looking for solutions for high health care costs; becoming more prudent purchasers.

- HSA’s – health savings accounts

- referenced-based pricing

- price transparency –

- millennials – more engaged; will try and find cost before seeking care; will check quality rating; research on-line; will pass up baby boomers in 10 years;

- employers recognize value-based payment models – tied to risk and reward

- bundled payments – example of risk and reward; needs to be tied to value-based outcomes;

- employers are paying for virtual care; 150 million –largest providers of healthcare; Insurance premiums have increased by 55% over past decade;

- rebate-driven supply chain is antiquated – expect change
“If you want to go fast, go alone. If you want to go far, go together”
Care delivery and Payment Design

- Value-based healthcare
- Risk-stratified care management
- Enhanced Medication Therapy Management
- Comprehensive Primary Care Plus (CPC+)
- Preventative care
- Social determinants of health
Alternative Payment Models (APMs)

Accountable Care Organizations (ACOs)
Patient Centered Medical Homes (PCMHs)
Bundled Payment models
Other value-based platforms

From 2019-2024, qualified participants will receive an annual 5 percent lump-sum incentive payment based on costs from physician fee schedule. The fee schedule increases annual payments to those participants starting in 2016 at the 0.75 percent rate.

Can choose to be excluded from MIPS and instead participate in certain APM’s.

Project from 41 million ACO-covered lives to 177 million ACO-covered lives by 2020.
Mount Rainier – Packed and ready
Gift from Mom

Death, Daring, & Disaster

Charles R. "Butch" Farabee, Jr.

Search and Rescue in the National Parks
REVISED EDITION
Part D Enhanced Medication Therapy Management Model

Model began January 1, 2017, in 5 Part D regions:

Payment incentives for basic stand-alone prescription drug plans (PDP’s).

Testing new approaches for integrating pharmacists into physician medication management workflows.

Plan-specific prospective payment to support extensive MTM interventions.

https://innovation.cms.gov/initiatives/enhancedmtm/

- Blue Cross and Blue Shield Northern Plains Alliance
- Blue Cross and Blue Shield of Florida
- CVS Health
- Humana
- UnitedHealthcare
- WellCare Prescription Insurance
Clinical Pharmacy Services

Medication Access Services
Patient Counseling
Preventative Care Programs
Drug Information to Patients
Medication Reconciliation
Medication Optimization

Provider Education
Retrospective Drug Utilization Review
Medication Management Therapy
Disease State Management
Prospective Chart Review and Provider Consultation
Expanding Scope of Pharmacy Practice

CMCS Informational Bulletin

DATE: January 17, 2017

FROM: Vikki Wachino, Director
Center for Medicaid and CHIP Services (CMCS)

SUBJECT: State Flexibility to Facilitate Timely Access to Drug Therapy by Expanding the Scope of Pharmacy Practice using Collaborative Practice Agreements, Standing Orders or Other Predetermined Protocols.

This guidance addresses flexibilities that states may have to facilitate timely access to specific drugs by expanding the scope of practice and services that can be provided by pharmacists, including dispensing drugs based on their own independently initiated prescriptions, collaborative practice agreements (CPA) with other licensed prescribing healthcare providers like physicians, “standing orders” issued by the state, or other predetermined protocols. These practices can facilitate easier access to medically necessary and time-sensitive drugs for Medicaid beneficiaries.

Reference: CMCS Bulletin, January 17, 2017
Legal definition of “furnishing” services

Provider “furnishing” services must:
- have an NPI on the claim (431.107(b))
- be enrolled in Medicaid (431.107(b))

• The service done, not the provider type, is what determines “furnishing provider”. If a provider “furnishes services” then, on that claim, that provider is the “furnishing provider”.
• Only providers or organizations eligible to enroll in Medicaid may be furnishing providers.
• Only one provider per service is the furnishing provider.
• How do we determine who/what provider is the furnishing provider? See decision tree.

Is the provider eligible to enroll in Medicaid?

The state billing manual specifies that RN Services are covered as a standalone service and the RN can bill for this. In this example the RN is the “furnishing provider”.

The state billing manual specifies that RN Services are covered as a package of physician services and can be billed by the physician. In this example the RN acted as an agent on behalf of the physician, therefore the physician is the “furnishing provider”.

The state billing manual specifies that RN Services are only covered as a package of physician services which must be billed by an agency. In this example the RN acted as an agent on behalf of the physician’s group, therefore the physician’s group is the “furnishing provider”.

Let’s use an example. A claim specifies that RN services were furnished. An RN worked directly with the beneficiary, a physician supervised the RN, and both are part of a physician’s group. Which one is the “furnishing” provider?

The provider is not a furnishing provider.
**Medicaid: Other Licensed Practitioner (OLP)**

- State Plan Amendment
- Services provided within scope of practice
- Collaborative practice agreement/protocol
- 85-100% of physician services fee schedule
- 1115 waiver opportunities

Indiana: locations in need of providers

Risk
“It does not matter how slowly you go as long as you do not stop.”

Confucius
Opportunities

Changing relationships with health care providers

Public health - Leverage access to community pharmacists

New business model – value-based payments

Improve health care delivery, fill gaps.
  ◦ Role of pharmacy technicians, automation

Newer areas
  ◦ Precision medicine, genomics
  ◦ Connected health, telemedicine
  ◦ Health information technology
  ◦ Data, population health
  ◦ Healthcare finance
“One may walk over the highest mountain one step at a time.”

JOHN WANAMAKER
On the Summit!
Sunrise from the top of Mt Kilimanjaro