### 2016 Multiple Locations Pharmacy Conference

<table>
<thead>
<tr>
<th>Date:</th>
<th>Friday, February 12, 2016</th>
</tr>
</thead>
<tbody>
<tr>
<td>Time:</td>
<td>8:00 am – 12:00 pm</td>
</tr>
<tr>
<td>Location:</td>
<td>Hyatt Regency Coconut Point Resort &amp; Spa, Fort Myers, Florida</td>
</tr>
<tr>
<td>Title:</td>
<td>Team Work: New Roles for Community Pharmacy in the Changing Health Care Environment</td>
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<tr>
<td></td>
<td>ACPE # 0207-0000-16-022-L04-P  0.4 CEUs</td>
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<td>ACPE # 0207-0000-16-022-L04-T  0.4 CEUs</td>
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<tr>
<td>Activity Type:</td>
<td>Application-based</td>
</tr>
<tr>
<td>Speakers:</td>
<td>David Pope, PharmD, CDE, chief of innovation, Creative Pharmacist</td>
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<tr>
<td></td>
<td>Ashley Branham, PharmD, Moose Compounding Pharmacy</td>
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<td></td>
<td>Joe Moose, PharmD, Moose Compounding Pharmacy</td>
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<tr>
<td></td>
<td>Bryan Ziegler, PharmD, Executive Director, Kennedy Pharmacy Innovation Center</td>
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</tbody>
</table>

**Pharmacist Learning Objectives:**

1. Review clinical opportunities available in your community pharmacy market and draft a plan of action for capitalizing on the available opportunities.
2. Discuss staff roles to facilitate and focus your resources to take the best advantage of clinical opportunities.
3. Review the components that as an independent you can bring to a health care partnership that differ from chain competition.
4. Discuss stages of involvement to phase in clinical programs.

**Disclosures:**

David Pope declares no conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

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NCPA is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education. This program is accredited by NCPA for 0.4 CEUs (4.0 contact hours) of continuing education credit.
Becoming Single (Store) Minded

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Topics

- Clinical Congruency
- TOC
- Appointment-Based Model

Becoming Single (Store) Minded

- Are all locations created equal?
- Most often…
  - One ‘flagship’ location carries the weight of the others
  - The other locations are considered rural
You Might Have a Clinical Flagship Location if…

- Your EQuiPP scores are strong with one pharmacy but struggle in your outlying locations
- Your adherence program is only implemented at 1 or 2 locations
- Your primary ‘clinical pharmacist’ only visits other locations on occasion
- You offer clinical or educational services at one location, but don’t advertise it in others

Creating Clinical Congruency

- Case Study
  - ABC Pharmacy with 6 locations
  - Of 6 locations, 1 location completed 65% of all immunizations, added at least 10% of base to adherence program, and had dedicated staff hours for clinical services
Creating Clinical Congruency

- Case Study
  - Pharmacy with 6 locations (one flagship)

Becoming Single (Store) Minded

- How would you rate your pharmacies in terms of clinical focus/management?
- Write your answers on your handout

Creating Clinical Congruency

- Connect with the ‘elephants’ and ‘riders’
- Don’t simply tell your stores to ‘increase your star ratings’
- Change can be most difficult in your satellite locations
Creating Clinical Congruency

- Perfect the process, then share it
  - Spend time discovering why one location is performing better than the other, then highlight it
  - Don’t give lots of options, offer a way

Script the Critical Moves

- If you were in this position, which path would you choose?

Creating Clinical Congruency

- Core Approach:
  - Develop one position to become responsible for ensuring congruency among all locations
  - Develops other staff members at individual locations to take ownership
  - Reports to you on a consistent basis, offering overall reports on clinical growth, including:
    - # of patients enrolled in medication adherence program
    - Review of monthly EQuiPP scores
    - # of outliers
Creating Clinical Congruency

✧ Individual Approach
  ✧ More difficult to manage, but offers greater returns
  ✧ Each location has a position dedicated to ensuring the *vision* is carried out
  ✧ Position reports to you and is responsible for similar monthly reporting

Creating Clinical Congruency

✧ What additional resources (people, technology, communication) do you need to develop clinical congruency?
✧ What are your ‘carrots’ and ‘sticks’ to encourage your staff to buy into your new model?

The Shift to the Appointment-Based Model

✧ Not just another name for medication synchronization
✧ Allows the pharmacist to identify, engage, and forecast medication/disease issues
✧ Results in improved outcomes and pharmacy income
The Shift to the Appointment-Based Model

Transitions of Care

HOSPITAL READMISSIONS

Costs the Healthcare System
$25 BILLION ANNUALLY

1 in 5 Elderly Patients Are
Readmitted Within 30 Days

1 in 3
Patients Don’t Fill Discharge
Medications As Prescribed

40% Are
Avoidable

Transitions of Care

A PROVEN MODEL

- Randomized trial (n=738)
- Patients receiving pharmacist intervention post-discharge showed a 30% reduction in readmission rates (p<0.001)
- Patients were more likely to understand their diagnosis, understand their medications, and follow up with their PCP
Transitions of Care

**ADVERSE DRUG EVENTS ARE COMMON POST DISCHARGE**

ADE's
- 12%-17% of general medicine patients experience ADE's after hospital discharge.
- (more than 50% are judged preventable)
- 6%-12% of ADE's result in ER visits and 5% in hospital readmissions.

Transitions of Care

**A PROVEN BUSINESS MODEL**

Beginning October 1st, 2013, Congress gave CMS the power under the Affordable Care Act to cut hospital pay by up to 3% for sub-par readmission rates for patients with heart failure, heart attack, or pneumonia.

**AFFORDABLE CARE ACT**

A hospital with 250 heart failure patients and a readmission rate 70% higher than predicted by CMS would lose $150,000 in Medicare pay.

Transitions of Care

**OUR APPROACH**
- Our clinical team works with patients who opt-in to the program and who fit inclusion criteria.
- We provide on-site and local interventions.
- We deliver medications to the bedside with personal medication counseling.
- We record relevant data points and interventions, reporting aggregate data back to the hospital.
Transitions of Care

 Payment models include:
 - Shared Risk
 - Fee-for-Service
 - Shared Risk + performance bonus
 - Many other ways!

 Who should you engage first regarding a TOC project?
 - Should you offer to have a technician/pharmacist on site?
 - How can you leverage technology to mitigate pharmacist time (and money)?
Have any of you developed a TOC partnership?
Pharmacies today must develop _______________ congruency across all locations.

*Rating My Locations*

<table>
<thead>
<tr>
<th>Locations</th>
<th>Your ad hoc ‘Clinical’ Rating (1-5...5 being great)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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</tbody>
</table>

Who will lead the challenge within your business to develop clinical congruency?

______________________________________________________________________

What additional resources (people, technology, communication) do you need to develop clinical congruency?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

What are your ‘carrots’ and ‘sticks’ to encourage your staff to buy into your new model?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

How *and when* will you engage your local hospital groups to provide a Transitions of Care (TOC) solution?

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

NCPA MULTIPLE LOCATIONS CONFERENCE 2016
Team Work: New Roles for Community Pharmacy in the Changing Health Care Environment

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4. Discuss stages of involvement to phase in clinical programs.
What’s the problem with the way it is?

• The core issue in this healthcare crisis is we can’t afford it anymore.
• So we have to increase the value of the care that we deliver.
• Improving value is the only real solution versus cost shifting or restricting services.


$100 Total Healthcare Spend

…And the Shift is a Fundamentally Different Approach to Payment and Delivery
White House Plans To Shift Medicare Away From Fee-For-Service; 50% Of Payments Tied To Quality By 2018

The Obama administration will push Medicare payment rapidly away from fee-for-service medicine within four years, outlining a plan to have half of all Medicare dollars paid by to doctors and hospitals via “alternative” reimbursement models by the end of 2018.

*A majority of Medicare fee-for-service payments already have a link to quality or value,” Barwell said in a perspective piece published in the Jan. 26 New England Journal of Medicine. “Our goal is to have 80% of all Medicare fee-for-service payments tied to quality or value by 2016, and 90% by 2018. Perhaps even more important, our target is to have 30% of Medicare payments tied to quality or value through alternative payment models by the end of 2016, and 50% of payments by the end of 2018.”

Enhanced MTM Model

...And the Shift is a Fundamentally Different Approach to Payment and Delivery

<table>
<thead>
<tr>
<th>Fee-For-Service</th>
<th>Population Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pre-Encounter</td>
<td>Pre-Encounter</td>
</tr>
<tr>
<td>Encounter</td>
<td>$5</td>
</tr>
<tr>
<td>Post-Encounter</td>
<td>$5</td>
</tr>
<tr>
<td>Disengaged</td>
<td>$5</td>
</tr>
</tbody>
</table>
**col·lab·o·ra·tion**

*kaˌlabəˈrāSH(ə)n/*

noun

1. The action of working with someone to produce or create something.

---

**About Moose Pharmacy**

- Established in 1882
- Business has expanded to
  - 5 pharmacies
  - 1 specialty pharmacy
  - 1 compounding pharmacy
- Residency site since 2002

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**With Whom Do We Work (Collaborate)?**

- How we work with other healthcare entities?
- How we work with School of Pharmacy?
- How we work with other pharmacies?
How we work with other healthcare entities?

We act as agents of efficiency by leveraging:

- Medication knowledge
- Accessibility as a healthcare profession
- Frequency of contacts, face-to-face
- Community care coordination

How we work with School of Pharmacy?

- Teaching
- Workload
- Students
- Residents
- New perspective on current practices
- Community connections
- Project coordination
- Teach more students
- Overarching research project
- Project coordination
Community Pharmacy Residency Program

• ASHP-accredited residency program
• Purpose Statement:
  • Prepare the resident to be an innovative clinical practitioner who can be a leader in the profession
  • Develop skills, confidence and experience to create change and advance patient care services in community pharmacy practice

How We Work With Other Pharmacies?

Community Pharmacy Enhanced Services Network
The North Carolina Experience
Opportunity Knocks...

<table>
<thead>
<tr>
<th>CCNC Enrollees</th>
<th>CCNC Enrollees with total medical cost &gt; $50,000</th>
<th>CCNC Priority B/M</th>
<th>Enrollees on TC/Priority list</th>
<th>Enrollees on Medication Management Priority list</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total number of members</td>
<td>1,340,229</td>
<td>125,328</td>
<td>17,705</td>
<td>154,241</td>
</tr>
<tr>
<td>Total medical costs</td>
<td>4,078$</td>
<td>27,527$</td>
<td>23,813$</td>
<td>18,215$</td>
</tr>
<tr>
<td>Total inpatient visits</td>
<td>0.11</td>
<td>0.32</td>
<td>0.45</td>
<td>1.04</td>
</tr>
<tr>
<td>Total inpatient costs</td>
<td>589$</td>
<td>3,464$</td>
<td>5,337$</td>
<td>2,924$</td>
</tr>
<tr>
<td>Total mental/health inpatient visits</td>
<td>0.15</td>
<td>0.06</td>
<td>0.04</td>
<td>0.04</td>
</tr>
<tr>
<td>Total ED visits</td>
<td>6.17</td>
<td>1.43</td>
<td>0.58</td>
<td>1.74</td>
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<tr>
<td>Total ED costs</td>
<td>376$</td>
<td>798$</td>
<td>3,207$</td>
<td>896$</td>
</tr>
<tr>
<td>Total outpatient visits</td>
<td>4.30</td>
<td>9.43</td>
<td>12.04</td>
<td>8.70</td>
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<tr>
<td>Total mental/health outpatient visits</td>
<td>0.62</td>
<td>1.88</td>
<td>1.04</td>
<td>1.53</td>
</tr>
<tr>
<td>Total PCP visits</td>
<td>2.09</td>
<td>2.91</td>
<td>2.53</td>
<td>2.65</td>
</tr>
<tr>
<td>Total Pharmacy visits</td>
<td>4.97</td>
<td>19.63</td>
<td>16.95</td>
<td>23.05</td>
</tr>
<tr>
<td>Pharmacy costs (Pre Rebate)</td>
<td>721$</td>
<td>5,177$</td>
<td>3,050$</td>
<td>3,268$</td>
</tr>
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</table>

North Carolina CPESN Overview

* Goal: create a network of pharmacies who are willing to provide services and care coordination that transcend currently offered outpatient pharmacy program requirements/contracts.

**This includes pharmacies that are willing and able to perform highly intensive, highly coordinated, and longitudinally-oriented medication optimization activities through a method of co-management with primary care providers, their care management teams, and the extended medical neighborhood**
Terminology

• **Community Pharmacy Care Management (CPCM):** A combination of clinical and enhanced services to optimize a patient’s medication use and achieve the best possible outcomes from therapy. These services are enhanced, longitudinal, and coordinated with the rest of the care team.

• **Enhanced Pharmacy Services:** Services that transcend currently offered outpatient program contracts and are not included in typical reimbursement constructs; these services synchronization, and adherence packaging.

### Types of Enhanced Services

<table>
<thead>
<tr>
<th>24 Hour Emergency Services</th>
<th>Adherence Packaging</th>
<th>Collection of Vital Signs</th>
<th>Compounding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Home Delivery</td>
<td>Home Visits</td>
<td>Long-Acting Injections</td>
<td></td>
</tr>
<tr>
<td>Multi-Lingual Capability</td>
<td>Naloxone Dispensing</td>
<td>Nutritional Counseling</td>
<td></td>
</tr>
<tr>
<td>Smoking Cessation</td>
<td>Standardized Assessments [PHQ-9]</td>
<td>Disease State Management Programs</td>
<td></td>
</tr>
</tbody>
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### Growth of the NC CPESN

Community Pharmacy Enhanced Services Network

- CPESE workgroups, initial collaboration and common informatics platform, and care team relationship building
- Payment for services standardized/required documentation, performance, measurement, quality assurance

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Community Pharmacy Enhanced Services Network (CPESN) Distribution

NC CPESN Participation Criteria

- Current registration with the BOP in good standing
- Current NC Medicaid pharmacy provider
- A signed agreement with CCNC that defines scope of work and CPESN participation
- Use of CCNC’s PHARMACeHOME application
- Agreement to provide a minimum set of enhanced services:
  1. Proactive waste management program
  2. Patient counseling and adherence coaching
  3. Assistance with medication reconciliation

The Collaboration Card

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Moose Midland Pharmacy</th>
<th>Moose Pharmacy</th>
<th>Mount Pleasant Moose Professional Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td>24 Hour Emergency Service (Dispensing)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>24 Hour Emergency Service (Non-Dispensing)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Adherence &amp; Packaging</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Patient Counseling and Medication Synchronization</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Collection of Vital Signs</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Compounding (Non-Sterile)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Compounding (Sterile)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Comprehensive Medication Review</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>DME Billing (Medicare and Medicaid)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home Delivery (Free)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Home Delivery (Fee Applies)</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>
Three Project Aims

- Test New Payment Models for Community Pharmacy
- Test New Relationship Models with Medical Homes
- Determine What IT Needs are Needed for Community Pharmacy

Importance of Targeting and Channeling Patients to High Performing Pharmacies

[Diagram showing population risk and return on intervention investment for different years and quality of care efforts, cost savings efforts]
Targeting Strategy

* Tiered Based on Performance on a Point System of 0-10

Operational Analytics: Patient Group Categories of Payment Methods

* New

High Level Pharmaceutical Review ($0.60 PMPM)

New

Drug Therapy Problem (DTP) w/ Follow Up $0.00-3.65* PMPM

May Lead To...

Comprehensive Medication Review (CMRx) $91 each

May Lead To...

Argumented Diagnoses (ADRx) $0.56 PMPM

May Lead To...
What’s Working

- Pharmacy Participation and Patient Flows
- Pharmacy Service Line Innovation
- Targeting Analytics
- High Level of Attention with Policy Makers/CMS/Other States/Value Purchasers

Feedback Thus Far From Community Pharmacies

- Protect Product Reimbursement
- Foster Referral Patterns
- Generate Ability to Differentiate High Performing Pharmacies
  - So Payers can differentiate relationships
  - So Providers can differentiate relationships

What Does Victory Look Like?

- Preserve Product Reimbursement
- Preserve In-Network Status with PBMs
- Penetrate Medical Benefit/Budget
- Distinguish High Performing Pharmacies from Everyday Pharmacies in Minds of Providers and Patients/Caregivers for At Risk Patients
A Day in the Life as a CPESN Pharmacy

CPESN Example Workflow

Key Responsibilities
- Determine if patient is on attribution list
- Assess profile for adherence when processing prescriptions
- Clean up medication lists (discontinue medications)
- Document identified DTPs on DTP Short Form
Technician Tool: DTP Short Form

- Form placed at technician work station
- Technician to complete form if potential DTP's are identified
- Technician to send form in basket to the pharmacist
- Pharmacist investigate the issue and takes necessary steps to resolve DTP
- DTP documented in platform

CPESN Example Workflow
Filling Technician

Key Responsibilities
- Accurately prepare medications for dispensing
- Answer phone
- Identify potential DTPs
- Document identified DTPs on DTP Short Form
- Alert pharmacists if consultation is needed

CPESN Example Workflow
Adherence Technician

Key Responsibilities
- Call patients on monthly basis
- Point of contact for medication changes during the month (Transition of Care)
- Handle Referrals from Provider(s)
- Determine medication lists to be sent to PASS machine
Monthly Follow-Up Calls

- Patients called prior to synch date each month to assess adherence and changes in medication regimen
  - Standardized script to fully assess
    - Problems with medications
    - Changes to medication regimen
    - Review of each specific medication
    - Evaluation of need of PRN medication

Evaluation of Adherence

- Integrate additional technology in dispensing process to access a comprehensive database for patient-specific prescription fill history, provider, pharmacy and adherence measures to prescribed therapy

CPESN Example Workflow

Dispensing Pharmacist

Key Responsibilities
- Final verification on all medications
- Review medication history
- Counsel patients
- Maximize encounters with attributed patients
- Alert Clinical Pharmacist when CIPA is needed
- Identify DTPs
- Resolve medication-related problems through care coordination
CPESN Example Workflow
Clinical Pharmacist

Key Responsibilities
- Prioritize attribution list
- Perform Comprehensive Initial Pharmacy Assessments (CIPA)
- Identify Drug-Therapy Problems (DTPs)
- Home Visits
- Perform Transition of Care Assessments
- Documentation and follow up with patients

CPESN Example Workflow
Administrative Assistant

Key Responsibilities
- Sort attribution lists
- Request labs and medication lists from provider(s)
- Assist with documentation of DTPs
- Builds medication matrix
- Schedule patient appointments

Comprehensive Initial Pharmacy Assessment (CIPA) Work Flow Process

- Attribution List received by pharmacy
- Complete Matrix in PH noting any non-clinical DTPs
- Review Matrix entered in PH noting clinical DTPs
- Complete CMR Summary Note and Publish all Material
- Complete CMR with patient/caregiver
- Call patients to schedule Face-to-Face CMR or complete CMR via telephone
- Work with healthcare team to resolve any DTP

Technician/Support Staff
Pharmacist
CPESN Example Workflow
Cashier

Key Responsibilities
- Review system flags with patients
- Notify pharmacist to counsel when DTP is identified
- Identify when medications are not picked up and alert pharmacists (especially if patient is enrolled in the adherence program)

CPESN Example Workflow
Delivery

Key Responsibilities
- Deliver medications to patient’s home
- Provide instructional video(s) through iPad
- Notify pharmacists through Face Time for consultations
- Report back signs of poor adherence to pharmacist(s)

Summary of Moose Pharmacy Learnings

• Frequently discuss initiative with entire team to create a culture of providing value-based care
  • Frequent Team Meetings
  • When you stop talking about it, staff resume “old” practices
  • Encourage everyone to work at the top of their degree
• Be efficient at dispensing medications fast, accurately and cheap
• Complex patients require time away from the workflow
  • Invest in resources when appropriate to assist with workflow
• Relationship building is key to successful intervention
Multi-State High Performing Community Pharmacy Learning Collaborative (MSPC)

- Facilitate expansion of high-performing networks*
- Provide a venue to connect pharmacists and other pharmacy stakeholders who have interest in delivery of financially sustainable, patient-centered care beyond traditional dispensing services

* High Performing Pharmacy Network to coalesce pharmacies based on the principle of providing value beyond selling drug product to effectuate health trajectory

Considerations with CPESN Development

- Architecture of a Network
  - Who will organize the network?
  - Who is interested in participating?
  - What is the minimum criteria to participate as a "high-performing pharmacy?"
- Analytics
  - What information do payers need to demonstrate ROI?
  - How do you package your capabilities to payers?
- Informatics
  - Data exchange
  - What do you need to do to move the needle on population-based metrics?
CPESN Activity

Quality Improvement & Assurance

- Readiness & baseline characteristics survey
- Audit Process
- Workflow support
- Develop process for informal continuous QI/QA process
  - Peer to Peer

Impacting Quality Together

- Create a structure of high-performing pharmacies that allow you to be autonomous to set standards that will ensure you can provide outcomes the payer require
- Process for quality improvement is critical
- Establish a process for various methods of communication to CPESN pharmacists
  - Webinars, newsletters, emails, conference calls
Unless everyone is making a quality product, the sector risks a consumer perception that craft beer is inconsistent. Hit-or-miss quality hurts the whole microbrew market.”

- Charles Papazian
  President, Brewers Association

Next Steps for Multi-State Learning Collaborative
- Launch of Pharmacy Locator App and Collaboration Site
- Release of Webinar Spring and Summer Series to engage others interested in network building
- CPESN Education Module Development
- Continued Support for CPESN development

Contact Information
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  VP, Moose Pharmacy
  Lead Community Pharmacy Coordinator, Community Care of North Carolina
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New Roles for Community Pharmacy in the Changing Health Care Environment

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NCPA Multiple Locations Conference 2016

Disclosure

• Bryan Ziegler has no disclosures to report.
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Fee For Service Model

Quantity Driven Model

Fee For Service Model

Quantity Driven Model
Mostly Product Driven Model

Transforming Community Pharmacy Practice

Pharmacy (Today)
- Dispense Rx
- Compounding
- MTM
- Adherence
- Vaccines
- Durable Med Equip

Product + Service Driven Model

Transforming Community Pharmacy Practice

Pharmacy (Tomorrow)
- Dispense Rx
- Compounding
- MTM
- Adherence
- Vaccines
- Durable Med Equip

Pharmacogenomics
- Transitions of Care
- Chronic Disease Mgmt
- Wellness Screenings

Mostly Product Driven Model

Transforming Community Pharmacy Practice

Pharmacy (Today)
- Dispense Rx
- Compounding
- MTM
- Adherence
- Vaccines
- Durable Med Equip

FFS
So...How do we measure Quality?

Pharmacy Quality Reporting
Challenges/Opportunities

- Today, the average primary care visit with a physician lasts 11 minutes.
- Appointments are typically scheduled in 15 minute increments, with double appointments sometime scheduled to allow for no-shows.

Value of Pharmacist in PCMH

- Quality of patient care
- Patient satisfaction
- PCMH revenue
- Physician productivity
- Cost Avoidance
Medication Management
Pharmacist Key Activities

• Obtain and evaluate patient history as it impacts medication management and patient care outcomes.
• Assess and manage medication therapeutic regimens of chronic conditions within written treatment guidelines.
• Provide patient counseling on medications, nutrition, lifestyle, and medication self-management.
• Conduct limited physical assessments per guidelines for managing medication therapeutic regimens.
• Order diagnostic tests and medical devices to support medication management of chronic conditions.

Other Key Community Pharmacist Activities: Team-Based Care

• Immunizations
• Smoking cessation
• Obesity/Weight loss
• Adherence
• Chronic disease targeted services

Service Location

<table>
<thead>
<tr>
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Key Definitions

Auxiliary Personnel means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner).

Source: 42 CFR 410.26(a)(1)

Key Definitions

General Supervision - means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required.

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Personal Supervision – means a physician must be in attendance in the room during the performance of the procedure.

Source: 42 CFR 410.32(b)(3)(i)-(iii)

Annual Wellness Visits –

Time/Payment

- Initial AWV (G0438) - one per lifetime
  - Avg payment = $166
- Subsequent AWV (G0439) – one per year
  - Avg payment = $111

Medicare Learning Network: The ABCs of the Annual Wellness Visit
Smoking Cessation - Medicare

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Not Billable by Pharmacists…yet

Obesity Screening & Counseling

• Medicare Part B covers up to 20 visits in a 12 month period
• Medicare - Visits must be provided in a primary care setting (Group or Individual)
• Elements:
  • Screening for Obesity (BMI)
  • Dietary Assessment
  • Behavioral Counseling and Therapy (diet, exercise, +/- drugs)

MLN Matters – Intensive Behavioral Therapy (IBT) for Obesity
2014 Obesity Counseling Reimbursement Fact Sheet. Ethicon

Obesity Screening & Counseling

• Billing: G0447 (HCPCS Code) – ‘Incident to’
• $26 avg payment

Note: In addition, Medicare may cover behavioral counseling for obesity services when billed by the one of the provider specialty types listed above and furnished by auxiliary personnel under the conditions specified under the regulation at 42 CFR Section 10.205(b) (conditions for services and supplies incident to a physician’s professional service) or 42 CFR Section 10.27 (conditions for outpatient hospital services and supplies incident to a physician service).

MLN Matters – Intensive Behavioral Therapy (IBT) for Obesity
2014 Obesity Counseling Reimbursement Fact Sheet. Ethicon
Chronic Care Management (CCM)

- Chronic care management services, at least 20 minutes of clinical staff time directed by a physician or other qualified health care professional, per calendar month, with the following required elements:
  - Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient.
  - Chronic conditions place the patient at significant risk of death, acute exacerbator/decompensation, or functional decline.
  - Comprehensive care plan established, implemented, revised, or monitored.
- Non-face-to-face service provided to Medicare beneficiaries.

Payment Options – Incident to/Contract

- If providing care to patients under Collaborative Practice Agreement and within Scope of Practice:
  - "Incident to"
  - Team-based care billing (99211-99215)
  - Contract model (FFS) with PCP

Transitional Care Management

- TCMI services are rendered following the beneficiary’s discharge from any of the following inpatient hospital settings:
  - Inpatient Acute Care Hospital
  - Inpatient Psychiatric Hospital
  - Long Term Care Hospital
  - Skilled Nursing Facility
  - Inpatient Rehabilitation Facility
  - Hospital outpatient observation or partial hospitalization, and
  - Inpatient hospice as an inpatient to a Community-Based Health Center
- Eligibility for discharge from one of the above settings:
  - In acute or or chronic illness
  - Ms or her name
  - Mr or her name
  - A need for or
TCM – Medicare Billing/Payment

- TCM Moderate Complexity (99495)
  - $135-164
  - Interactive comm w/in 2 business days
  - Face-to-face visit w/in 14 days
- TCM High Complexity (99496)
  - $198-231
  - Interactive comm w/in 2 business days
  - Face-to-face visit w/in 7 days

Where’s the Money? PCMH/ACO Models

- Increase Access to Care
- Improve Outcomes
- Reduce Costs

Where’s the Money? Transitions of Care

- Penalty avoidance
- Insurer/ACO TCM
Active Learning

• Who are your potential collaborative partners in primary care?

• What information about these potential partners do you likely have available at your fingertips today?
### Hemoglobin A1C level

<table>
<thead>
<tr>
<th>Service Description</th>
<th>Number of Services</th>
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<th>Average Submitted Charge</th>
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| HDL cholesterol level

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Active Learning

• What services do you currently offer in your pharmacy that could assist these collaborative partners?

• What additional services could you offer to enhance these collaborative opportunities?

Active Learning

• Where do you envision offering these services?
  • Is it feasible to offer them outside your pharmacy?

• What’s your value proposition when presenting your services to potential collaborative partners?

ACTION PLAN

• What are the first steps you plan to take in order to implement a collaborative working relationship with local primary care providers?
Finding a Collaborative Partner

- Shared patients with the pharmacy
- Providers shifting into new payment models
  - Search insurance list of providers
- Proximity to pharmacy
- Payer mix
- Interest in Collaborative relationship/Team-based care

Active Learning

- “What information about target physicians do you likely have available at your pharmacy today?”

  - Brief Discussion

Questions?

- Bryan Ziegler, PharmD, MBA
- zieglerb@kennedycneter.sc.edu
New Roles for Community Pharmacy in the Changing Health Care Environment

Bryan Ziegler, PharmD, MBA
Kennedy Pharmacy Innovation Center
University of South Carolina College of Pharmacy
zieglerb@kennedycennter.sc.edu

NCPA Multiple Locations Conference 2016

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- Time = ~30-45 minutes
- Initial AWV (G0438) - one per lifetime
  - Avg payment = $166
- Subsequent AWV (G0439) – one per year
  - Avg payment = $111

Billing

Medicare Part B covers AWV if performed by:
- Physician (a doctor of medicine or osteopathy);
- Qualified non-physician practitioner (a physician assistant, nurse practitioner, or certified clinical nurse specialist); or
- Medical professional (including a health educator, registered dietitian, nutrition professional, or other licensed practitioner), or a team of such medical professionals who are working under the direct supervision of a physician (doctor of medicine or osteopathy).

Direct Supervision

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CPT Code
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General Supervision

Direct Supervision
Transitional Care Management

TCM SERVICES SETTINGS

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- Inpatient Acute Care Hospital;
- Inpatient Psychiatric Hospital;
- Long Term Care Hospital;
- Skilled Nursing Facility;
- Inpatient Rehabilitation Facility;
- Hospital outpatient observation or partial hospitalization; and
- Partial hospitalization at a Community Mental Health Center.

Following discharge from one of the above settings, the beneficiary must be returned to his or her community setting, such as:

- His or her home;
- His or her domiciliary;
- A rest home; or
- Assisted living.

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