Innovative Solutions: Best Practices and Bypassing the Barriers: Keys to Turning Your Pharmacies into Enhanced Service Providers

www.ncpanet.org/multiplelocations

Disclosures

• Ashley Branham 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.

• Joe Moose 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.
Learning Objectives

- Discuss the major barriers to implementing enhanced services in your community pharmacy.
- Strategize methods to engage pharmacy staff in the enhanced services mission.
- Outline workflow process areas of backlog and determine effective fixes.
- Discuss useful protocols to assess and improve processes.
- Outline key factors that make the establishment of enhanced services networks valuable to the independent community pharmacy.

Preparing Staff to Embrace a CPESN Mindset
The current reality is we have to . . .

- remain relevant to stay in business
- recognize problems, even when they are not ours
- maintain a high standard for service
- address preventable medical problems

Find Your Own Story & Share It

- Blah, blah, blah
- And on, and on, and on
- Yah, yah, yah
- Yada, yada, yada
- Yick yak, yick yak, yick yak
IBM 2010 Global CEO Study: Creativity Selected as Most Crucial Factor for Future Success

Fewer than half of CEOs Successfully Handling Growing Complexity; Diverging priorities in Asia, North America, and Europe
Our charge is to...

... look at patients, not prescriptions
... identify and fill existing gaps in care
... be completely committed to every patient
... provide value beyond efficiency

Re-engineer your pharmacy by...

... training all employees as clinicians
... utilizing everyone to their highest potential
... taking advantage of every patient interaction
... using technology to its fullest extent
Value Stream for Observed Pharmacy

ID Opportunity Point

Identify Opportunities for Improvement
I made the background white on these words so they would be easier to read.

Katy Smith, 1/25/2017
### Pharmacy Demographics

<table>
<thead>
<tr>
<th>Pharmacy</th>
<th>A</th>
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<td>Resources</td>
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<tr>
<td>Number Pharmacists</td>
<td>2</td>
<td>2</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>3</td>
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<td>Number Technicians</td>
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<td>10</td>
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<td>4</td>
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<tr>
<td>Number Students</td>
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<td>1</td>
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<td>4</td>
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<td>Resources for MTM</td>
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<td>Clinical Pharmacist</td>
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<td>Outcomes</td>
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<tr>
<td>Percent Non-Value Added Time for Workers</td>
<td>14%</td>
<td>11%</td>
<td>9%</td>
<td>6%</td>
<td>8%</td>
<td>6%</td>
<td>19%</td>
</tr>
<tr>
<td>Average Wait Time for Patients (minutes)</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>6</td>
<td>2</td>
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### Comprehensive Initial Pharmacy Assessment

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<tbody>
<tr>
<td>Identifying patients for CIPA with attribution list</td>
<td>✓</td>
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<td>Identifying patients for CIPA in the workflow</td>
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<tr>
<td>Flagging identified patients</td>
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<td>Flagging identified patients within software</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<td></td>
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<tr>
<td>Contacting patients during fill visit</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Contacting patients over the phone</td>
<td>✓</td>
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<tr>
<td>Scheduling patient visits and/or calls</td>
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<tr>
<td>Contacting providers about DTPs</td>
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<td>✓</td>
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<tr>
<td>Contacting providers who don’t respond about DTPs</td>
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<tr>
<td>Contacting providers about DTPs</td>
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<td>Contacting providers who don’t respond about DTPs</td>
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### Medication Synchronization

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<td>✓</td>
<td>✓</td>
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<tr>
<td>Starting patients on Med Sync with software</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Calling patients monthly before filling meds</td>
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<td>✓</td>
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### Medication Delivery

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<th>E</th>
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</tr>
</thead>
<tbody>
<tr>
<td>Calling patients before sending delivery</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Drivers calling pharmacists during delivery if patients have questions</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Drivers taking notes to bring back about patient’s medication</td>
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<td>N/A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Drivers checking in on patients who are difficult to contact</td>
<td>N/A</td>
<td>N/A</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
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</table>
## Clearly Defined Processes & Roles

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<th>Pharmacy</th>
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<tbody>
<tr>
<td>Defined roles</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Defined responsibilities</td>
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<td>✓</td>
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<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Defined processes</td>
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<td>✓</td>
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<td>✓</td>
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<td>✓</td>
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<tr>
<td>Defined processes that adapt situationally</td>
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<td>✓</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Documented processes</td>
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<td>✓</td>
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</table>

### Utilizing Staff Members at Highest Ability

- Only pharmacist is in charge of all aspects of CIPA: ✓
- Pharmacy students are in charge of all aspects of CIPA: ✓
- Pharmacist utilizes other staff members for CIPA tasks: ✓
- Staff members besides students are engaged in CIPA tasks: ✓
- Technicians target patients from attribution list: ✓
- Technicians perform patient outreach for CIPA: ✓
- Technicians fill out PharmaceHome Matrix: ✓
- Technicians fill out PharmacyHome DTPs: ✓
- Technicians identify patients for med sync: ✓
- Technicians perform monthly med sync calls: ✓

## The Right Path: Triple R

**Robust**

to variability, change, interruption

**Responsive**

to patients and care team

**Resilient**

to disruptions and changing landscape
The solution begins with . . .

. . . utilizing all available resources
. . . collaborating with healthcare partners
. . . sharing strategies to evolve

Challenges with Providing Enhanced Services

www.ncpanet.org/multiplelocations

Multiple Locations Conference | February 16–19, 2017
San Diego
California

NCPA
National Community Pharmacists Association
Failing Forward: Our Guide to Prepare Community Pharmacy for Delivering Value

- Rethink Workflow Operations
- Population Management Strategies
- Shifting the Patient’s Expectation of the Pharmacy Experience

Different Approach to Payment and Delivery

Fee-For-Service

<table>
<thead>
<tr>
<th></th>
<th>Pre-Encounter</th>
<th>Encounter</th>
<th>Post-Encounter</th>
<th>Disengaged</th>
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<tr>
<td></td>
<td>X</td>
<td>$$$$$</td>
<td>X</td>
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Population Management

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<tr>
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<th>Encounter</th>
<th>Post-Encounter</th>
<th>Disengaged</th>
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We Are Moving Away From…

Bad Pizza  Good Pizza

...Same Reimbursement
(not related to medical outcomes)

Rethink Workflow Operations

• Involvement of Pharmacy Staff

“This CPESN model will remain a disruption until all staff are educated to participate”. Pharmacists need to engage and train pharmacy technicians, delivery drivers, and cashiers for roles supporting CPESN.

“You go into this project thinking you can be a super pharmacist, but you quickly realize that it needs to be a team effort.”
Glimpse into Operations

Input & Counting Typical Day

8:30AM-6:00PM – Run queue for the day. Drug therapy problems DTPs identified in adherence and medication list discrepancy.

11:00AM-6:00PM- DTP follow up queue in dispensing system. Call patients, physicians offices, insurance and comment on progress in dispensing system. Assist pharmacist with inputting matrices for CMRsAs
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

Glimpse into Operations

Adherence Technician Typical Day

8:30-9:30AM: Identify patients for phone calls. Attributed patient noted in profile.

9:30-1:30PM: Call patients-DTPs identified in adherence and medication list discrepancy. DTPs input added to dispensing system DTP queue via MTM Actions. Advise pharmacists on complex medication list and therapeutic considerations

1:30PM-5:00PM: Process patient medications-primary DTPs during this part of the day will be system failure (insurance reject, PA required) DTPs added to dispensing system DTP queue via MTM Actions. Help with DTP queue as allowed
Scripts for Techs Calling/Meeting With Patients

**Heart Failure:**

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
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</thead>
<tbody>
<tr>
<td>Do you wash yourself every morning?</td>
<td></td>
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<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you have &lt; 2 lbs in one day or &gt; 5 lbs in a week?</td>
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<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you had recent or current swelling of ankles, feet or stomach that becomes worse even after rest and leg elevation?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you had recent or current shortness of breath that won't go away with rest or worsening?</td>
<td></td>
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<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Do you recently or currently find it harder to walk long distances or exercise than usual?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you been waking up at night recently with shortness of breath or cough, or needing more than usual number of pillows to sit up and sleep?</td>
<td></td>
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<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Have you had to take more of your diuretic (water pill) than your normal dose?</td>
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<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you limiting your fluid intake to no more than 6-8 (8oz) glasses of water per day?</td>
<td></td>
</tr>
<tr>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Are you limiting your daily salt intake to less than 2,000 mg (a little less than a 1 tsp) and not adding salt to foods?</td>
<td></td>
</tr>
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</table>

Glimpse into Operations

**Dispensing Pharmacist**

8:30AM-9:30AM – Work on DTP follow up queue

9:30AM-6:00PM - Identify DTPs while dispensing. DTP score of 75 warrants checking to see if a CMR has been completed within a year.

- If no CMR, notify cashier or delivery drive and attempt to complete if time permits or schedule.
- Notify cashier if RPh needs to speak with patient to address DTP when in the store.
- Delivery driver to call RPh when he arrives at patient home to address DTP.
- Scheduled CMR should be added to dispensing system queue. If dispensing pharmacist is unable to complete, then clinical pharmacist will complete.
Glimpse into Operations

Cashier

8:30-9:30AM: Tag bags for potential face to face CMRs from report given by pharmacist or technician

8:30AM: Schedule CMR for pharmacist at point of sale if no time to do “on the fly” CMR

• Notify staff if attributed patient chooses not to get a drug at register or if brought back by delivery driver

Glimpse into Operations

Delivery Drivers

• Call pharmacist or technician after arrival at patient home per pharmacist/technician request
• Share any compelling social/health status changes with pharmacist
• Notify technicians of new phone numbers of any points of contact for patient (extended family, neighbor) for difficult to reach patients
• Notify cashier of address change so it can be changed in dispensing system
If we are going to be different in the marketplace…

...We need to deliver services differently

Meet Karrie

“We take a proactive approach for our patients. We start the process by calling them each month and finding out what medications they need, what has changed and what concerns they may have…

They feel like they know me and they feel like they have a connection with our pharmacy. They know when they call Moose Pharmacy, they are more than a refill number.”
• Prescription **ON HOLD** for Simvastatin 40mg and Aspirin 325mg

• Prescriber office (different from the PCP) was contacted. Told that the patient was recently discharged from the nursing home.

• Patient’s PCP was also notified to discuss discrepancies in medication regimen. PCP unaware of patient's most recent discharge from nursing home.

• Patient was notified and fill was initiated.

• Medication was delivered to the patient’s home.

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**Identifying Drug Therapy Problems- It’s a Team Approach**

**Student Pharmacist** Discovery through Data Mining Project
Identifying Drug Therapy Problems - It's a Team Approach

- Prescription ON HOLD for Simvastatin 40mg and Aspirin 325mg
- Prescriber office (different from the PCP) was contacted. Told that the patient was recently discharged from the nursing home

Consulted with Pharmacist and Adherence Technician Notified Prescriber
• Prescription **ON HOLD** for Simvastatin 40mg and Aspirin 325mg
• Prescriber office (different from the PCP) was contacted. Told that the patient was recently discharged from the nursing home
• Patient’s PCP was also notified to discuss discrepancies in medication regimen. PCP unaware of patient’s most recent discharge from nursing home.

Consulted with **Pharmacist** again and **Adherence Technician** Notified PCP

• Patient was notified and fill was initiated
• Medication was delivered to the patient’s home

**Pharmacist** discussed with patient and alerted **Technician** to fill the medications

**Delivery Driver**
Panel Management & Risk Stratification

• Managing a panel of patients is new to community pharmacy
  • Adequate training is needed to acclimate to this model

• Patients at different levels of risk need different types of intensities of services from enhanced service pharmacies
  • Assists with targeting intensive activities toward highest risk, most complex patients

**Patient Risk Scores: They Are Important to Your Sustainability**

* A bifurcating marketplace for pharmacy site products and services delivery

* Composite Score: 81

* Very High Risk: 91-100
Using Risk Scores in Our Community Pharmacy

Figure 1: Adherence Program Selection Tool

<table>
<thead>
<tr>
<th>Patient Risk Score</th>
<th>80-100</th>
<th>60-79</th>
<th>40-59</th>
<th>20-39</th>
<th>0-19</th>
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<table>
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<th>Medication Possession Ratio (MPR)</th>
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<td>80-100%</td>
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</table>

Using Risk Scores in Your Community Pharmacy

Obtain report with spreadsheet of risk scores organized from highest to lowest

Proactively engage patients at high risk (alert staff, conduct medication reviews, reach out by phone for check-in)

For those not reached, flag in the system to alert staff at next point of contact
No Population Management Tool?

Do you have patients that fit any of the following criteria?

- Trends of poor adherence to chronic medications
- Recurrent visits to ED or hospital
- Transportation challenges
- Literacy challenges
- Complex medication regimens
- Looking to reduce number of visits to the pharmacy

Changing Patient Expectations

- The patient experience in the CPESN model may be different than how the patient previously worked with his or her pharmacy.
Strategies for Patient Engagement

- Leverage information about their recent health care utilization or concern with their medications
- Leveraging a referral from their care manager or provider
- Using a connection point such as an immunization or assistance with Medicare Part D plan selection to build trust

Building Provider Relationships

www.ncpnet.org/multiplelocations
Patient Focused Teams

Best Practices from North Carolina

- Make the visit
  - Meet the provider champion, lead provider or office manager
  - “Show and tell” adherence packaging
  - Make the ask- “Refer one of your most complex patients and let’s see what happens”

- Practice visits are not a “one and done” event
  - Visit the practice repeatedly
  - Staff turnover
Referral from Provider to Provider

Best Practices from North Carolina

- What performance measures or performance-based payments affect your practice? Ask them!

- Most providers have difficulty going through a complex med list to address drug-therapy problems
  - Educate practices on how pharmacists can “tee up” the med list for provider visits

- Some practices have a clinical pharmacist.
  - Communication between the ambulatory care pharmacist and community pharmacist can be an important practice linkage
Getting Useful Information to the Prescriber

The Patient Adherence Report Card can be used to enlist prescribers in medication therapy management for their patients. The patient report card is grouped by therapeutic class for each prescriber, giving an overall view of their patients' medication adherence.

Best Practices from North Carolina

- Where is the pharmacy in my area that offers medication synchronization?
  - Do not assume that providers know about your value-added services.
More Learnings…

• Pharmacies report a widespread failure of prescribers to communicate discontinuation of meds to the pharmacy.
  • This information is integral to improved relationships and better patient care.
• Practices are used to receiving numerous faxes about medications (e.g., DUR alerts) that are not seen as helpful by the providers.
  • Explicitly tell the practice that your goal is to only send them important, actionable information.

Final Tips

• Ask providers what they want to be called about in terms of high risk situations, and find out the key contact person and phone number to use for those occasions
• Create a “do not fax list” for providers who do not want to receive any fax communications (and stick to it)
• Find an issue for one of the practice’s patients and resolve it to build trust one patient at a time
• Make sure written recommendations are clear and precise
It’s Not Only About Community Pharmacy…It Takes the Entire Team

Enhanced Medication Therapy Management for medicareblue rx\textsuperscript{sm}

Joshua Johnson, PharmD

www.ncpanet.org/multiplelocations
Disclosure

Joshua Johnson, PharmD, RPh, is a clinical pharmacist with Clearstone Solutions. The conflict of interest was resolved by peer review of the slide content.

BCBS Northern Plains Alliance

- The Northern Plains Alliance (NPA) is comprised of the 6 Blues plans in the 7 states in Medicare Part D Region 25:
  - Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota & Wyoming
  - Formed to offer a Medicare Part D Prescription Drug Plan (PDP) in all 7 states of Region 25
- Five Star rating from CMS for 5 out of 7 years
- ClearStone Solutions is the Part D Administrator for NPA
  - Contracts with vendors, such as PBMs
  - Provides administration and oversight for client Plan
Center for Medicare & Medicaid Innovation (CMMI)

- Enhanced Medication Therapy Management (EMTM) is a 5-Year Pilot starting in 2017 and ending in 2021
  - 5 Part D regions: Region 7 (Virginia), Region 11 (Florida), Region 21 (Louisiana), Region 25 (Iowa, Minnesota, Montana, Nebraska, North Dakota, South Dakota, Wyoming), and Region 28 (Arizona)
  - PDPs in all Regions: CVS Health, Humana, United Healthcare and Wellcare Prescription Insurance
  - PDPs in one Region: BCBS Florida (11), BCBS Northern Plains Alliance (25)
- Goal is to innovate MTM programs to improve quality of care while also reducing healthcare costs for Medicare Parts A & B by at least 2%
- Objectives for stand-alone basic PDP sponsors are:
  - Identify innovative ways to optimize medication use
  - Improve care coordination and strengthen health care system linkages

What Are The Problems With Regular MTM?

- In general, PDPs do not have access to Parts A & B claims information
- Prescriber communication overload
  - Multiple programs from multiple sources
  - Prescribers may be avoiding recommendations due to volume
- Relevance of the prescriber communication
  - Will the prescriber use what is being sent?
- Strict regulation has resulted in limited to no innovation
  - Always the same criteria for Comprehensive Medication Reviews (CMRs)
    - Plan specified # of medications
    - Plan specified # of diseases - must include at least 5 from approved CMS list
    - At least $3,919 in yearly prescription costs (2017)
- Pharmacists may not have complete medication or claims information

How can these problems be overcome?
How Will CMMI Allow Innovation?

- Greater flexibility in deciding which members get interventions
  - Who is not being targeted when they could be?
- Waivers for many current design restrictions to open up new ideas
- SNOMED-CT: EMTM uses this new and innovative nomenclature to document any interventions and outcomes
- Plans can refine the program and make changes
  - On a yearly basis, and also mid-year through a separate approval process
- Provide PDPs with Medicare Parts A & B claims data
  - This will give a broader outlook on member health
- Have community pharmacists also evaluate for socioeconomic barriers to care and to help incorporate into a healthcare team approach
  - Pharmacists see their patients much more frequently
  - Are there issues like mobility, high cost, or cognitive issues affecting care?

CMMI Examples Of Possible Programs

- Targeted services: different programs for different populations
- Copay assistance or other cost sharing
- Targeted interventions after transitions of care
- Physician and pharmacist engagement and participation
- New technologies for interactions and communications
- Medication optimization
- Synchronization of medication use
- Reduction of adverse drug events
- Use of financial incentives to engage member participation
- Social support services such as home delivery or rides to the pharmacy

NPA partnered with Tabula Rasa Healthcare to deliver these innovations
Helping payers prevent adverse events and reduce healthcare costs with novel pharmacy risk management analysis and interventions

Tabula Rasa is a leading provider of innovative pharmacy solutions ...

... we use novel technology to address the physiological risks of multi-drug use

... our platform increases quality and substantially reduces cost of care

... we customize analytics and interventions to fit your processes and deliver value
Tabula Rasa HealthCare

- Founded in 2009 by the core management team that built and sold excelleRx/Hospice Pharmacia (founded in 1996)
- Public (listed on NASDAQ as TRHC in 2016)
- $60M+ annual revenues and 200+ employees
- Headquarters in Moorestown, NJ – operations in Boulder, CO; Charleston, SC; San Francisco, CA; St. Louis, MO; Phoenix, AZ

*Tabula Rasa management has deep medication expertise and is committed to bringing a fresh approach to healthcare challenges*

Many Americans take many medications at the same time

- **15%** of Americans take five prescription medications in any given month
- **50%** of individuals 65+ take five or more medications per month
- **82%** risk of an adverse drug event (ADE) with seven or more medications
Medication ‘cocktails’ have negative impacts on the brain and heart

Side effect accumulation harms the central nervous system and heart rhythm:

- Increased sedative burden
- Risk of unintentional overdose
- Pathways to misuse and abuse
- Prescribing Cascade (side effects result in more prescriptions, increasing ADE risk)
- Increased risk of ADEs for frail, elderly patients with multiple chronic conditions

Physiological risks of multi-drug use drive health care utilization / cost

1. Increased hospitalizations due to ADEs
2. Increased number of ER visits
3. Inability to manage symptoms due to ineffectiveness of drugs
4. Excess utilization of ineffective medication
5. More pathways to unintended misuse and abuse
The status quo fails to address this issue... we have a better solution

**Legacy drug interaction software**
- One-to-one drug analysis
  - 30+ years old
  - Drug-centric; misses cumulative effect
  - Analysis only; pharmacists only act on 50% risks

**Tabula Rasa platform**
- Multi-drug analysis
  - Novel, proprietary technology
  - Patient-centric; simultaneous multi-drug analysis
  - Analysis + intervention (expert PharmD support & escalation)

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Our algorithm assesses pharmacy claims to flag physiological risks

**A Impairment from sedative burden**
- The accumulation of unintended side effects of multiple drug-drug interactions can impair the physical and cognitive function of the body, increasing the risk of falls and other injuries

**B Accidental overdose from competitive inhibition**
- The speed of drug activation and elimination is impacted by other drugs a patient is taking (e.g. two or more drugs can compete for the same enzyme); this can influence medication efficacy
- Removing a drug that was previously competing with another medication can effectively increase dosage, which can lead to accidental overdose
Prescribers, pharmacists, and patients are often unaware of polypharmacy risks related to sedative burden and competitive inhibition.

Existing drug-drug interaction systems, MRM platforms, and other tools lack the scientific capabilities to capture these risks.

Tabula Rasa’s proprietary coefficients precisely identify multi-drug risk, and specialized pharmacists intervene to reduce risk.

Year 1 - The Year Of The Member

- Focus is on engaging the member as an active participant in their care
  - Calls, mailers, motivational interviewing, and member portal access
- Tabula Rasa has created a call center for Year 1
- At the initial call, a Medication Reconciliation (MedRec) is performed by a pharmacy technician or scheduled for a later time
- After the MedRec, a CMR is scheduled and performed by a pharmacist
  - Medication Action Plan and Personal Medication List mailed to member
  - Recommendations for clinical interventions sent to prescribers
- Follow up via phone call and/or mailers to prescriber as needed
- Training Year 2 community pharmacists to conduct CMRs
- Targeted outreach to prescribers and pharmacies for cooperation
- Working to solidify prescriber/pharmacist team in each subsequent Year
Plans For Years 2-5

- Year 2: Year of the Pharmacist
  - Some CMRs to be done by community pharmacists & expands each year
  - More health care provider engagement, both targeted and general
  - Additional risk factors considered
  - Pharmacogenomics (PGx) for select members
  - High cost A & B outliers
- Year 3: Year of the Prescriber
  - Prescriber portal to check interactions, suitability, formulary in real time
  - Encouraging active prescriber participation
  - Different targeting, programs, sub-populations, or modifications
- Year 4: Year of Results
  - What did or did not work in Years 1-3? Ironing out the details
- Year 5: Year of Finalization
  - Bring lessons learned together for a comprehensive EMTM program

Anticipated Outcomes

- Improve patient care
  - Decrease adverse events, drug interactions, and excess therapy
  - Decrease ED visits, hospitalizations, and even primary care visits
  - Improve patient satisfaction with results that make a difference
- Decrease Parts A & B spend by 2% to achieve goal set by CMMI
- Possibly show decrease in Part D spend
  - Dependent on better therapy vs excess therapy
- Targeted, patient-specific options for PGx recipients
- Solid prescriber-pharmacist relationships working in tandem
- Potential for one platform for healthcare and members to use together
- All CMRs done by community pharmacists
- Elevation of the role of the pharmacist in healthcare