PQA23 ANNUAL MEETING
NASHVILLE, TN | MAY 10–12, 2023

Breakout Session Slide Decks

Slide decks are included in alphabetical order by session title.

Click on the session title below to navigate directly to that slide deck.

Advancing Health Equity in PBM Programs

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Objectives

- At the completion of this program, pharmacists will be able to
  - Define health equity.
  - Outline Humana's health equity strategy and areas pharmacy benefits managers (PBMs) and health plans can influence.
  - Identify lessons learned during the health equity council's effort to imbed health equity awareness and prioritization into the organizational culture.

Defining Health Equity

- **Health disparities:** preventable differences in the burden of disease, injury, violence, or opportunities to achieve optimal health that are experienced by populations that have been disadvantaged by their social or economic status, geographic location, and environment
- **Health equity** is the state in which everyone has a fair and just opportunity to attain their highest level of health

Center for Disease Control [Internet]. Available online: What is Health Equity? | Health Equity | CDC. Accessed March 13, 2023.

Health Inequities: Why We Are Here

UPSTREAM DETERMINANTS	MIDSTREAM DETERMINANTS	DOWNSTREAM DETERMINANTS
Discrimination Racism Poverty	Food insecurity Unsafe housing Education Healthcare inaccessibility Low quality healthcare Income inequality Unemployment	Obesity Heart disease Cancer diagnoses Cancer deaths Low medication adherence COVID-19 deaths Type 2 diabetes Kidney Disease

Robert Wood Foundation. What is Health Equity? Available Online: What is Health Equity? A Definition and Discussion Guide (rwjf.org) Accessed March 13, 2023
Center for Disease Control [Internet]. Available online: What is Health Equity? | Health Equity | CDC. Accessed March 13, 2023.
National Library of Medicine [Internet]. Available Online: The Root Causes of Health Inequity - Communities in Action - NCBI Bookshelf (nih.gov). Accessed March 13, 2023

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Our Mission

Help people achieve life-long well-being through **delivering patient-centered whole person care** (physical, mental, social) and that must include advancing health equity

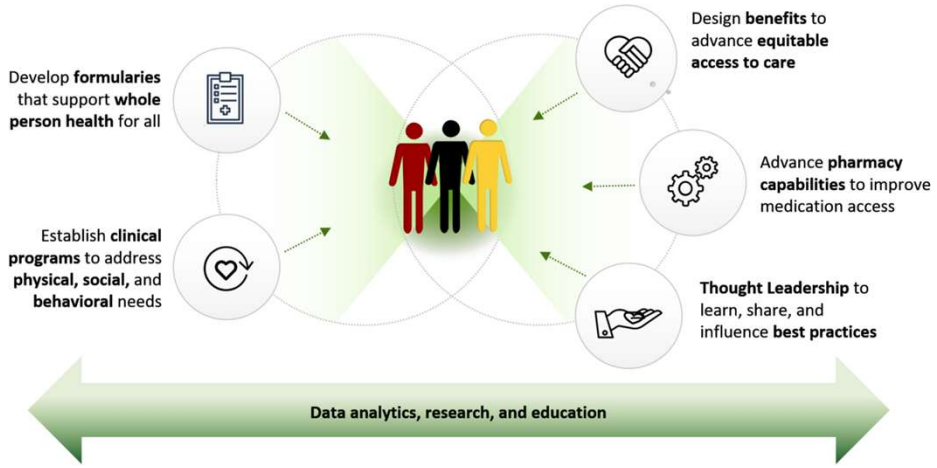
We're working to influence and enable health equity as a business driver by delivering on our strategic priorities

Improve access to care

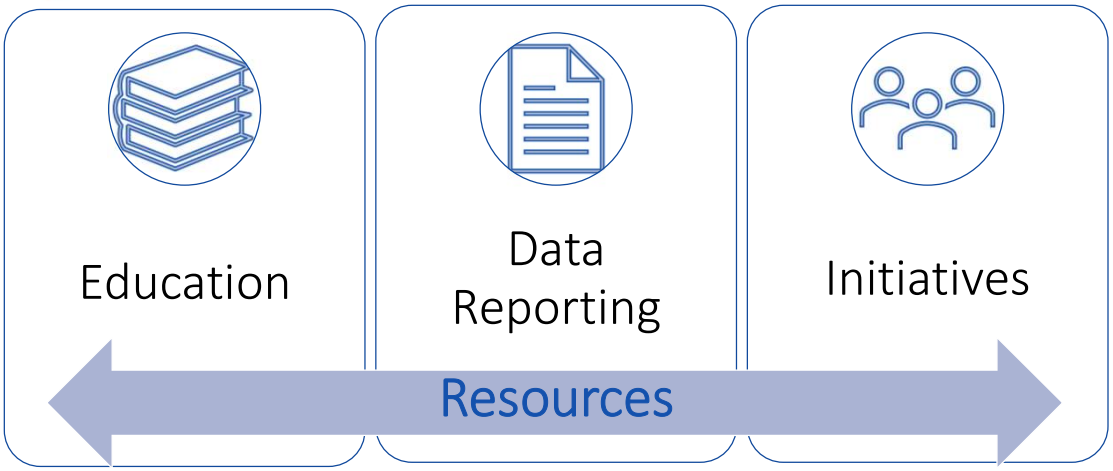
Improve quality of care

Address barriers to healthy living

PBM: Pharmacy Health Equity Council Areas of Focus



Health Equity Approach



Health Equity Spotlight: Medication Adherence Pilot

Human Problem

Factors that contribute health inequities may negatively impact medication adherence such as unmet social needs that interfere with optimal health behaviors

Humana Challenge

Individuals with social determinants of health (SDOH) often have decreased medication adherence compared to those who do not have identified SDOH

Solution

Humana leveraged pharmacists to identify and address SDOH in a member-centric medication adherence program

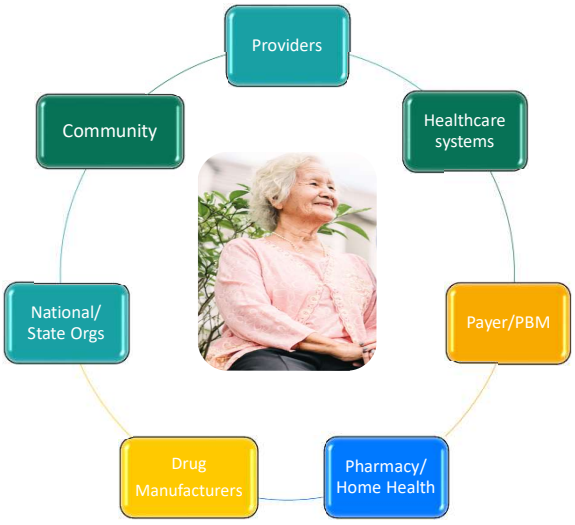
Lessons Learned

Education is key

Culture of equity shift

Gaps exist, focus on short and long term

Cross collaboration is critical



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Approach to Advance Health Equity in PBM Programs

FOCUS — Focus on your unique population and their priority needs

MOBILIZE ▶ Leverage community and collaborative industry relationships

BALANCE — Balance quality, financial outcomes and research for whole-person care

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Thank You!

- "There comes a point where we need to stop just pulling people out of the river. We need to go upstream and find out why they're falling in."

  Desmond Tutu

- " It is time to refocus, reinforce, and repeat the message that health disparities exist and that health equity benefits everyone."

  Kathleen Sebelius, former U.S. Secretary of Health & Human Services

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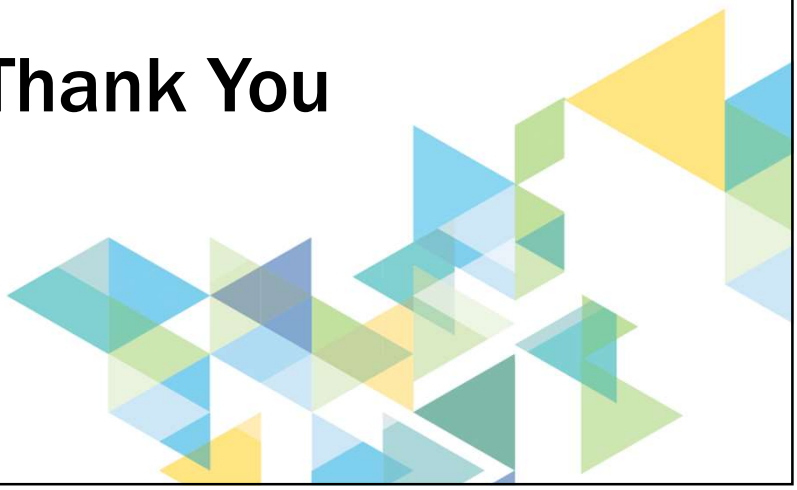
Thank You



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Advancing the Quality of Oral Anticancer Medication Use

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Objectives

- At the completion of this program, pharmacists will be able to
  - Identify quality issues related to oral anticancer medication use.
  - Discuss the challenges related to measuring the quality of oral anticancer medication use.
  - Describe efforts to address the quality of oral anticancer medication use.

Quality Issues

Oral Anticancer Medication Use

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Overview of Quality Issues Associated with OAM Use

- Adherence & persistence
- Disparities
- Patient education and consent
- Time-to-treatment
- Dosing errors
- Toxicity monitoring and management
- Drug interactions
- Drug waste management

Adherence and Discontinuation Rates to OAMs

Cancer type	n	PDC: Mean (SD)	Median time to discontinuation	% of patients filling only a single Rx
Chronic myeloid leukemia	1,650	69% (32)	84 days	12%
Multiple myeloma	7,461	58% (31)	98 days	17%
Metastatic prostate cancer	6,998	69% (29)	120 days	12%
Metastatic renal cell carcinoma	2,553	61% (33)	84 days	28%
Metastatic breast cancer	1,214	52% (29)	103 days	17%

Doshi et al., 2021[1]

- Retrospective analysis of 100% Medicare Chronic Condition Data Warehouse (CCW) Parts A, B, and D **and** a 5% random FFS sample for five cancer types

Disparities in OAM Treatment

PQA's Medication Access Patient Journey Framework[2]

Economic Stability	Neighborhood and Physical Environment	Education	Food	Community and Social Context	Health Care System
Employment	Housing	Literacy	Hunger	Social integration	Health coverage
Income	Transportation	Language	Access to healthy options	Support systems	Provider availability
Expenses	Safety	Early childhood education		Community engagement	Provider linguistic and cultural competency
Debt	Parks	Vocational training		Discrimination	
Medical bills	Playgrounds	Higher education		Stress	Quality of care
Support	Walkability				
	Zip code / geography				

KFF's Social Determinants of Health Framework[3]

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Toxicity Monitoring and Management

Clinical practice guidelines may provide guidance for monitoring laboratory values but usually do not provide guidance on processes to proactively identify and manage toxicity

Patient Education and Consent

- Lack of discussion and consent documentation with OAM use[4]
- Pharmacist-provided OAM education can increase comprehensive education and consent rate **from 18% pre-intervention to 87%**[5]

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Time-to-Treatment (TTT)

Prescribing date → Prescription received by pharmacy → Ready for pick-up/delivery → Prescription filled/sent → Patient takes first dose

Defined as number of days between prescribing date and the first fill date

Study	TTT results
Doshi, 2018[6] Claims-based study, 2014-2015 N=31,201 patients	**Mean (SD) TTT in days = 34.8 (18.4)**
Academia, 2021[7] Single-center retrospective study HSSP, 2019-2020 N=758 patients	Median (IQR) TTT in days: **Internal HSSP** = **5** (2-13) **External HSSP** = **27** (2-82) *P*<0.01
McCabe, 2020[8] Single health system retrospective chart review using prescription claims data, 2018 N = 164 patients	Mean (SD) TTT in days: **Internal HSSP** = 6.9 (8.0) **External HSSP** = **10.9 (12.9)** *P*=0.102
Tran, 2019[9] Single center retrospective chart review, 2014-2016 N=55	Median (IQR) TTT in days: **On-label** = 8 (4.0-**15.0**) **Off-label** = 12.5 (3.3-**30.8**) *P*=0.327

HSSP: Health-System Specialty Pharmacy;
N: sample size;
SD: standard deviation;
IQR: interquartile range;

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Dosing Errors

- Pharmacist-driven medication therapy management can detect dosing errors in prescription records in up to 40% of patients[10,11]
- Pharmacist-driven oral chemotherapy programs consisting of a comprehensive review of prescription order sets resulted in a median 2 safety-related interventions per prescription (n=51 prescriptions reviewed)[12]

Drug Interactions

- Badowski 2019[13] assessed antiretroviral therapy and OAM pairings to identify the number and type of interactions and presence of recommendations for dose adjustments
  - 90 FDA-approved OAMs reviewed
    - 43 OAMs identified as having dosing adjustment recommendations in literature and drug interaction databases
    - **47 OAMs identified as "potential interactions expected" but no further information or guidance provided**

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Drug Waste Management: Cost Savings

Monga 2019[14] and Khrystolubova 2022[15] highlight the potential cost savings from proactive management of OAM drug waste

41% (n=36) of the patients had drug wastage detected[14]

- **Total pills/tablets that could have been saved = 1,179**
- **Total cost that could have been averted = $248,595.69**

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Measuring Quality

Oral Anticancer Medication Use

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Why Do We Measure?

- Aim to improve the quality of healthcare received by patients and improve patients' health.
- Measurement is a quality improvement tool.
- Measures provide a method to help quantify healthcare processes, outcomes, patient perceptions, and organizational structure and/or systems to improve processes and promote better quality of care.

Understanding the Current Measures Landscape

- Identify measurement gaps
- Evaluate measures for potential adaptation and harmonization
- Avoid reinventing the wheel or duplicating effort

Measure Scanning

12
Sources Scanned

121
Potentially Relevant Oncology Measures Identified

- 79 unrelated to medication use
- 11 related to medication use but out-of-scope (not oral agents)
- 31 related to medication use and in-scope

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Measure Scan Results – Representative Domains





Receipt or Recommendation of Therapy	Side Effect Management	Therapy-Related Documentation	Patient-Provider Communication	Monitoring of Therapy
e.g., initiation or recommendation of tamoxifen	e.g., appropriate antiemetic use	e.g., plan, dose, indications	e.g., chemotherapy intent discussion	e.g., assessment of adherence

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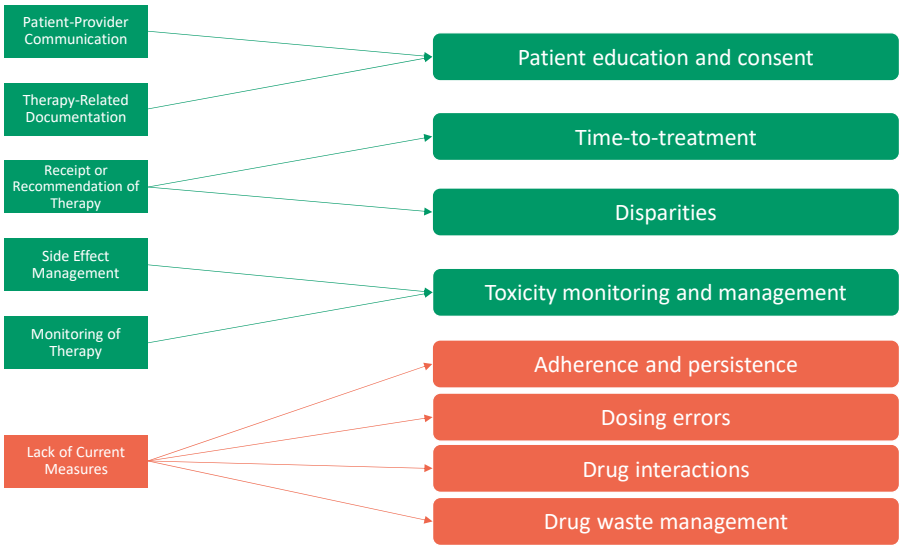
Mapping Measure Domains to Quality Issues



Measurement Considerations and Challenges

- Level of accountability
  - Ability to influence performance on the measure
  - Ability to access the data needed to calculate the measure
  - Target population (denominator) size
- Measure criteria
  - Importance, feasibility, scientific acceptability, usability
- PQA priorities and expertise

In Scope	Out of Scope

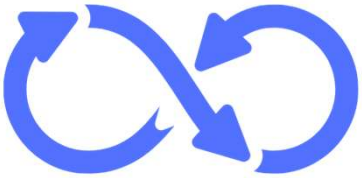
• Health plan
• Pharmacy
  ○ Community pharmacy
  ○ Medically integrated dispensing
  ○ Specialty pharmacy
	• Physician
	• Physician group
	• Accountable Care Organizations (ACOs)

Efforts to Address Quality

Oral Anticancer Medication Use

PQA's Oncology Journey

- Complex, resource intensive, iterative path to improving the quality of OAM use
- Requires both research and measurement initiatives
- Research will:
  - Help to build the evidence base for measurement
  - Investigate methodologies to consider for measurement
  - Assist with pilots for gathering more information about data/testing/specifications
  - Explore novel ways to improve the quality of OAM use not associated with measurement

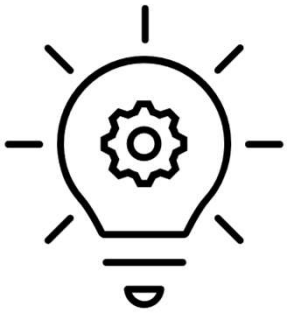


PQA Convenes - Oncology

- Recognized need for improving quality of oral anticancer medication (OAM) use
  - Measurement
  - Research
- Invited multi-stakeholder experts to prioritize efforts
- Conducted an environmental scan identifying:
  - Quality issues in OAM use
  - Existing measures and measurement programs for oncology measures
  - Key considerations for measurement

Purpose of PQA Convenes Oncology

- Prioritize research and measure concepts
- Measures were not developed during this workshop series
- Prioritized measure concepts will go through PQA's standard measure development process



Approach

Workshop 1 Virtual

- Reviewed measure fundamentals
- Prioritized quality issues
- Assessed existing measures

Workshop 2 In-Person

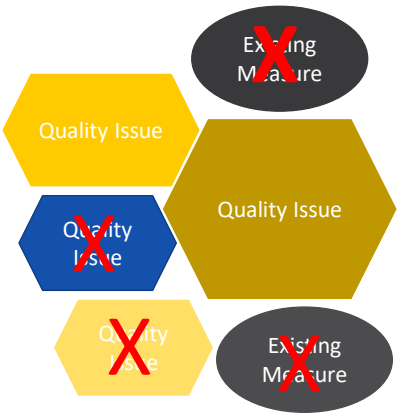
- Discussed measure criteria
- Prioritized quality issues based on criteria
- Created case for measures

Workshop 3 Virtual

- Discussed research priorities
- Built consensus

Process of Prioritizing

1. Identify quality issues and existing measures



2. Apply measure criteria

- **Importance**
- **Feasibility**
- **Usability**
- **Scientific Acceptability**

3. Build the case and create consensus

Prioritized Measure Concepts

Concepts Prioritized By Large Group

- **Adherence/Persistence (Health Plan)**
- **Initiation of Therapy/Time to Treatment (Pharmacy)**
- Initiation of Therapy/Time to Treatment (Health Plan)
- Prescription Abandonment Rate/Primary Medication Nonadherence (Health Plan)
- Adherence/Persistence (Pharmacy)
- Drug Waste Management (Health Plan)
- Prescription Abandonment Rate/Primary Medication Nonadherence (Pharmacy)
- Toxicity [clinical] Monitoring and Management (Health Plan)
- Drug Waste Management (Pharmacy)
- Toxicity [clinical] Monitoring and Management (Pharmacy)

Other Efforts to Improve OAM Use

- Federal Level
  - Cancer Moonshot
  - Enhanced Oncology Model
  - FDA efforts to improve product development
- Associations and Practices
  - Collaborative practice models
  - Oncology Medical Home (ASCO)
  - Oral Chemotherapy Education (NCODA)
  - Hematology, Oncology clinical pharmacists (HOPA)

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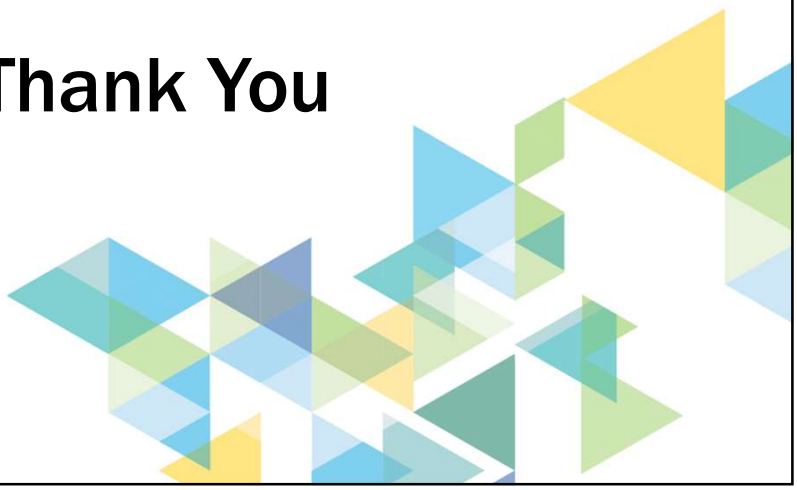

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Best Practices in Pharmacist Collaboration with Physicians and Payers to Improve Quality

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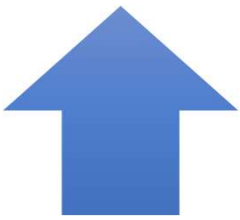
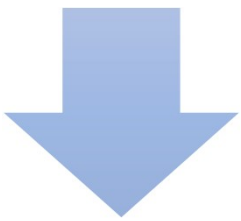
Objectives

- At the completion of this program, pharmacists will be able to
  - List opportunities for pharmacists to improve care in collaboration with physicians or health plans.
  - Describe how these collaborations benefit patients, physicians, pharmacists and health plans.
  - Discuss example best practices to improve value-based care within these collaborations.

Value-Based Healthcare



Pay for Performance



Fee for Service

Payer Expectations from a Provider Perspective

Acute Care Needs

Chronic Condition Control

Accurate Diagnosis/Risk Coding

Preventing Hospitalizations & Readmissions

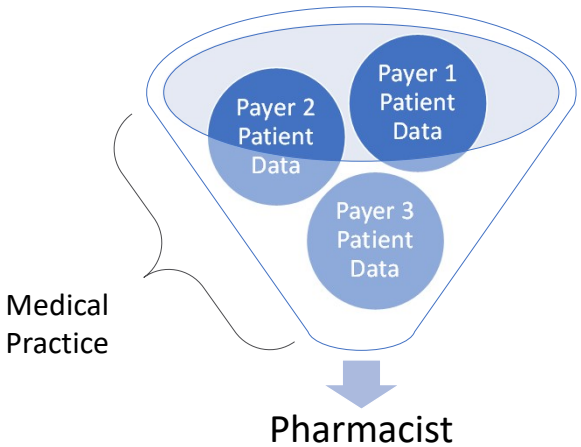
Annual Exams & Well Visits

Medication Adherence

Preventive Screenings & Immunizations

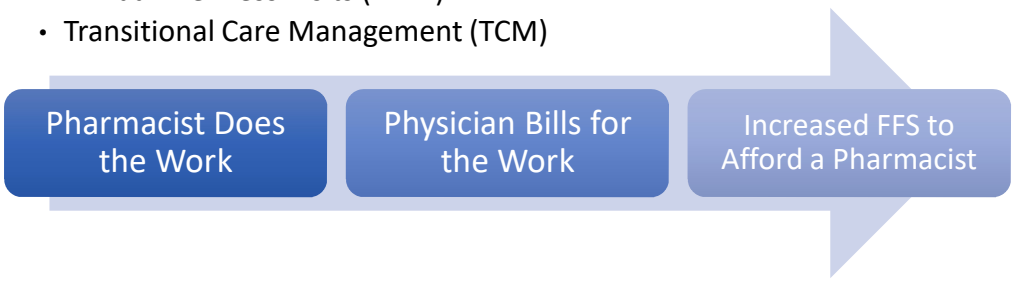
Patient Experience

The Pharmacist as the "Funnel"



Where We Started…

- Pharmacist-led services for Medicare patients
  - Chronic Care Management (CCM)
  - Remote Physiologic Monitoring (RPM)
  - Annual Wellness Visits (AWV)
  - Transitional Care Management (TCM)



Where We're Headed…

- Pharmacist-Led Care Management
  - All payers (Medicare, Medicare Advantage, Medicaid, Commercial)
  - Pharmacist determines necessary clinical activities based on payer data
  - Focus is on increasing quality dollars over increasing FFS payments

A Pharmacist's Value-Based Toolkit

Medication Adherence

- CCM (Medicare)
- Adherence calls and barrier assessments (All payers)
- Coordinating pharmacy services (All payers)
- Pharmacist-led medication optimization clinic (All payers)

A1c and BP Control

- CCM & RPM (Medicare)
- Pharmacist-led diabetes management and/or HTN clinic (All payers)

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A Pharmacist's Value-Based Toolkit

Preventive Screenings & Immunizations

- AWV (Medicare)
- Screening education and scheduling (All payers)
- Immunization education and administration or scheduling (All payers)

Preventing Readmissions

- TCM (Medicare)
- Post-discharge med review and self-management education (All Payers)

Risk Coding

- Reviewing coding for existing conditions not yet addressed during current calendar year during AWV and co-visits (no new Dx for pharmacist)
- Coding education for providers

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Quality Dollars – Sample Programs

Payer Program	Value-Based Payment Structure
Medicare Shared Savings Program	• Annual payment based on performance as an ACO compared to benchmarks
UHC Medicare Advantage Primary Care Physician Incentive (MA-PCPi) Program	• Bonus payments for Annual Care Visits (AWVs & physicals) • Overall care gap closure performance bonus (PMPY) • Quarterly payments + annual bonus
WellCare Partnership for Quality (P4Q) Program (Medicare & Medicaid)	• Payment per care gap closed (e.g., $50 per completed breast cancer screening) • Payment per care gap increases after a certain threshold of gaps closed • Rolling payments

Provider Expectations from a Payer Perspective

Troy Medicare

- Troy Medicare leverages the **local community pharmacies** as frontline providers to fundamentally impact both the quality and cost of care
- To accomplish this, Troy Medicare has created a technology solution to communicate with pharmacists about patient & plan needs in real-time

Key Concepts

- Pharmacists are willing, educated, and accessible
- On average, patients see their PCP 3 times each year, and they see their local, community pharmacist **18 times** each year
  - The goal is to extract as much value as possible from each one of those touchpoints
- Troy Medicare pays pharmacies out of the **Part B** dollar to perform targeted clinical interventions

Healthcare Effectiveness Data and Information Set (HEDIS)

- Of the approximate 100 HEDIS measures, **52** can be impacted by community pharmacy
- In order to do so, payers must be willing to provide access to the proper data and technology

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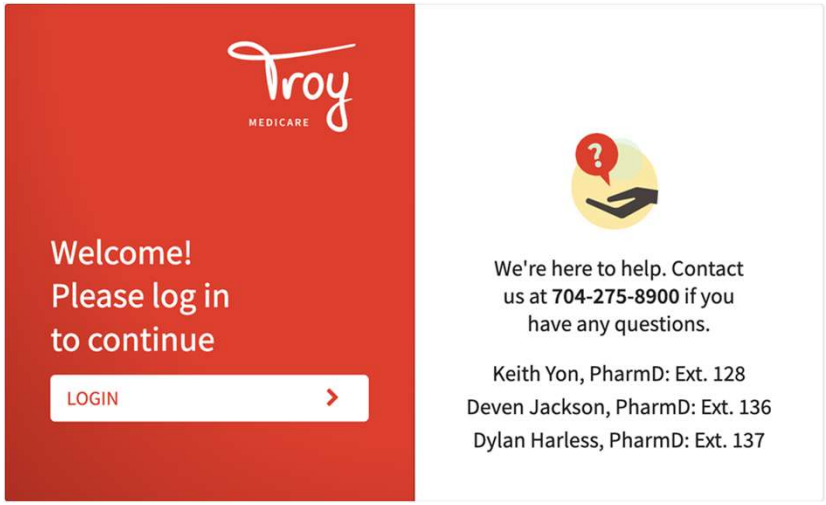
Troy.AI



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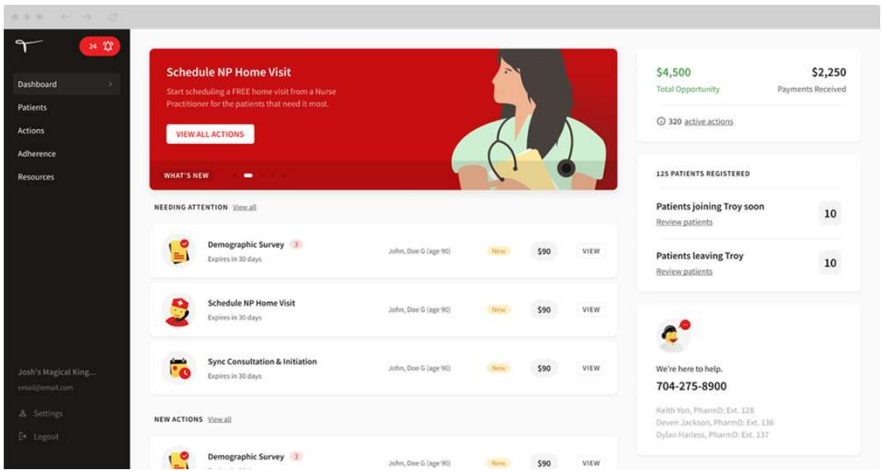
The Pharmacist as the “Funnel”



Point

Click

Complete

Get paid within 30 days!

Chronic Condition Control

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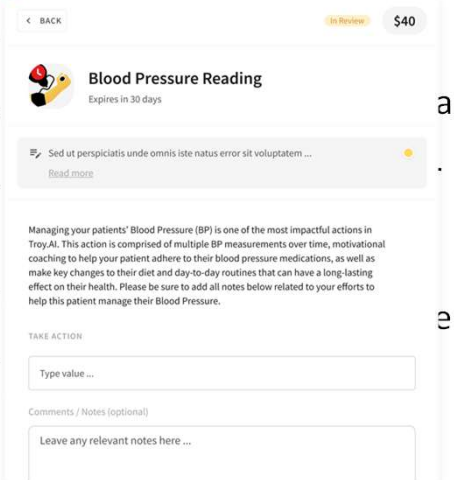
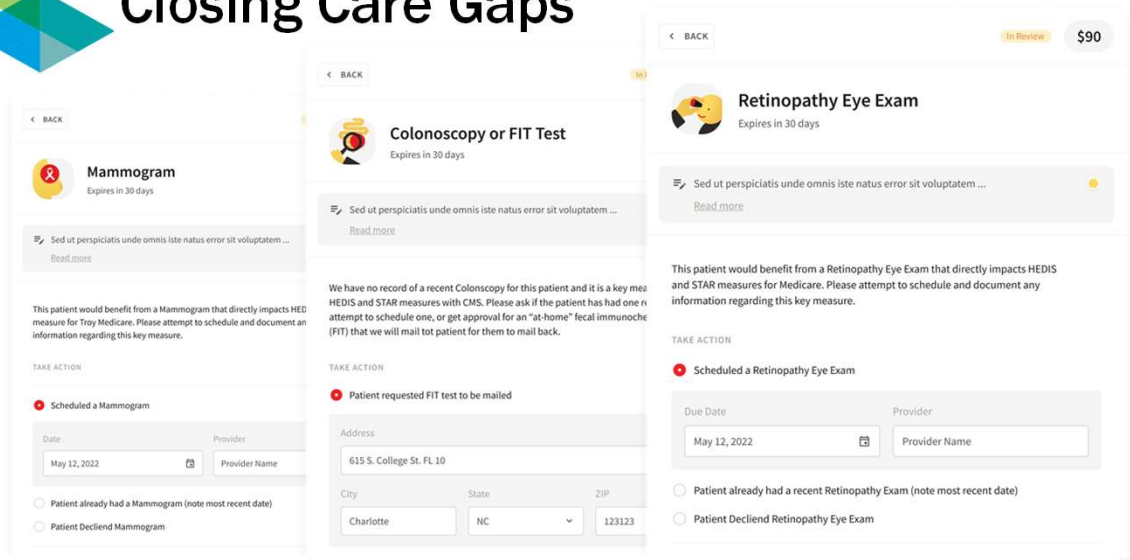
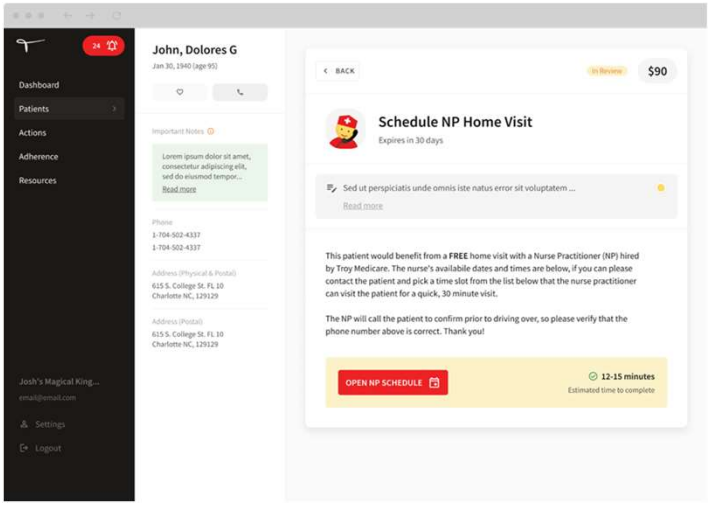


Closing Care Gaps



Accurate Diagnosis/Risk Coding



Medication Adherence

Adherence
Hypertension
3.5
88.5%
3 Patients to the next cutpoint
VIEW ALL PATIENTS
Monthly Bonus
$50
10 Patients * $2 PMPM
How it works →

Cholesterol adherence currently at: **92.5%**

STARS	PMPM BONUS	CUTPOINTS
5.0	$10	92% or more
4.0	$5	90% - 92%
3.5	$2	88% - 90%
3.0	$0	Below 88%

Monthly Bonus
$150
10 Patients * $5 PMPM
Close

Adherence
Diabetes
5.0
98.5%
Adherence is at it's best!
VIEW ALL PATIENTS
Monthly Bonus
$250
10 Patients * $10 PMPM
How it works →

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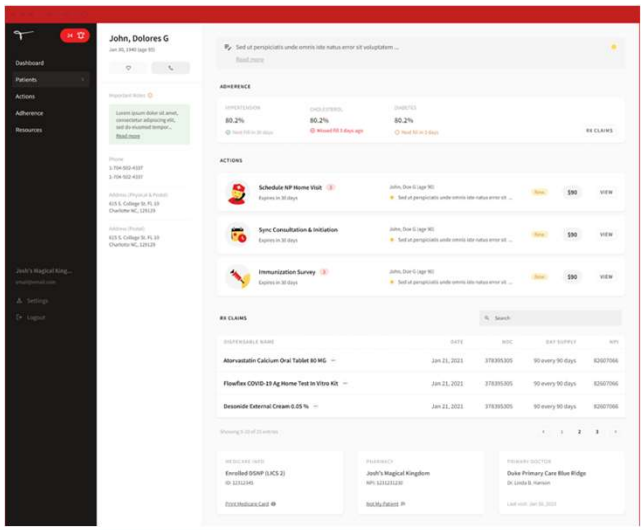
Beyond Dispensing



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Thank You

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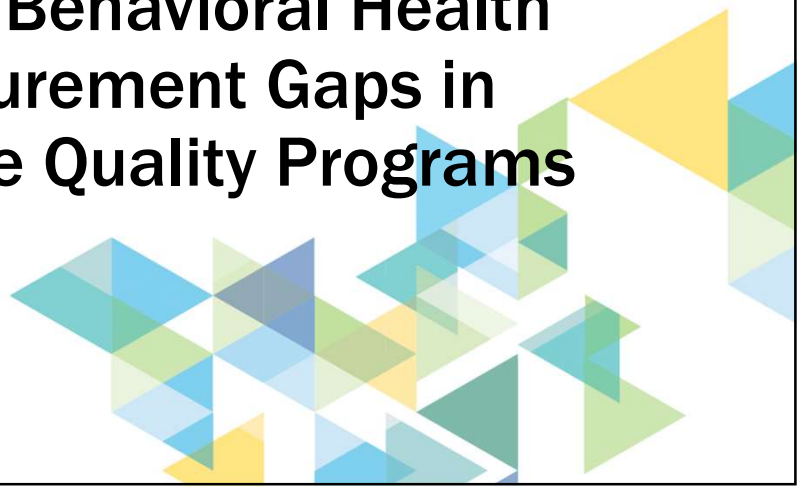
Closing Behavioral Health Measurement Gaps in Medicare Quality Programs



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Objectives

- At the completion of this program, pharmacists will be able to
  - Identify behavioral health measurement gaps in Medicare programs.
  - Describe opportunities and challenges associated with behavioral health quality measures.
  - List quality improvement opportunities associated with behavioral health measurement (e.g., screening, adherence).

Behavioral Health Quality: Why Focus Here?

- Behavioral health conditions are prevalent among Medicare beneficiaries and contribute significantly to costs:
  - Research has indicated that the number of people over 55 years living with schizophrenia are expected to double to 1.1 million by 2025[1]; 18.4% of all Medicare fee-for-service beneficiaries had a diagnosis of depression in 2018[2]
  - Approximately 1.7 million Medicare beneficiaries were estimated to have past-year substance use disorder, and few patients who needed treatment received it[3]
  - Nearly 13% of Medicare spending is associated with mental health disorders, emphasizing the urgent need to measure and improve the quality of care delivered to patients with serious mental illness[4]
- Psychiatrists are more likely than other specialists to "opt out" of Medicare, accounting for 42% of the more than 10,000 physicians opting out of Medicare in 2022, creating access issues for Medicare beneficiaries who need mental health services[5]

How Has CMS Focused on Behavioral Health?

- The current Medicare Advantage Part C and D program does not use behavioral health measures to calculate Star Ratings[6]
- In CMS's "2022 Measures Under Consideration Program-Specific Measure Needs and Priorities" document, Behavioral Health is the only Meaningful Measures 2.0 Healthcare Priority with zero measures in Star Ratings[7]
- CMS has flagged "Prevention and Treatment of Opioid Use Disorders" as a high priority area for future measure consideration in Star Ratings[7]
- CMS's Behavioral Health Strategy states its objective to "improve quality measurement in behavioral health and pain management across CMS programs"[8]
- CMS has stated its commitment to "aligning a core set of measures across all programs" to "reduce provider burden while also improving the effectiveness of quality programs"[9]
  - To achieve this, CMS is considering a "Universal Foundation" of quality measures that is a core set of measures aligned across all program, and in which depression screening and initiation and engagement of substance use disorder treatments

"Medicare Advantage plans must focus on measures included in the Star Ratings to compete, since Star Ratings are tied to plan payment rates. The Medicare Advantage Star Ratings system lacks strong behavioral health measures. We therefore are not seeing progress on behavioral and mental health care results that enrollees urgently need."

National Committee for Quality Assurance, excerpt from letter to Seema Verma, former CMS Administrator (2017)[10]

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Use of Behavioral Health Measures in Health Plan Programs

D = Display page only
P = Proposed for Star Ratings or Display
R = Reported, but not scored
† = Commercial and Medicaid lines only
§ = Medicaid lines only

Measure	Steward	CQMC[11]	FEHB QCR[12]	HEDIS[13]	HPR/ HPA[14]	Medicaid[15]	Star Ratings[16-18]	QRS[19]	UF[18,20]
General Behavioral Health Measures									
Diabetes Care for People with Serious Mental Illness: HbA1c Poor Control (>9.0%)	NCQA					X			
Diagnosed Mental Health Disorders	NCQA			X					
Follow-Up After Emergency Department Visit for Mental Illness	NCQA	X	X	X	X	X			
Follow-Up After Hospitalization for Mental Illness	NCQA	X		X	X	X	D	X	X
Improving or Maintaining Mental Health	NCQA						D		
Depression Measures									
Antidepressant Medication Management	NCQA		R	X	X	X	D	X	
Depression Remission or Response for Adolescents and Adults	NCQA			X					
Depression Response at Six Months	MNCM	X							
Depression Response at Twelve Months	MNCM	X							
Depression Screening and Follow-Up for Adolescents and Adults	NCQA			X			P		X

CQMC = Core Quality Measure Collaborative; FEHB QRC = Federal Employees Health Benefits Carriers Quality, Customer Service and Resource Use Measures; HEDIS = Healthcare Effectiveness Data and Information Set; HPR = Health Plan Ratings; HPA = Health Plan Accreditation; NCQA = National Committee for Quality Assurance; PQA = Pharmacy Quality Alliance; QRS = Quality Rating System; UF = Universal Foundation

PQA 23 ANNUAL MEETING

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Postpartum Depression Screening and Follow-Up	NCQA			X					
Prenatal Depression Screening and Follow-Up	NCQA			X					
Screening for Depression and Follow-Up Plan	CMS	X				X			X
Utilization of PHQ-9 to Monitor Depression Symptoms for Adolescents and Adults	NCQA			X					
Psychoses and Related Conditions Measures									
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	CMS	X							
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	NCQA			X	X	X			
Antipsychotic Use in Persons with Dementia	PQA						D		
Cardiovascular Monitoring for People with Cardiovascular Disease and Schizophrenia	NCQA			X					
Diabetes Monitoring for People with Diabetes and Schizophrenia	NCQA			X					

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Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	NCQA	X		X	X§	X			
Metabolic Monitoring for Children and Adolescents on Antipsychotics	NCQA	X		X	X†				
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	NCQA			X	X†				X
Substance Use Disorder Measures									
Annual Monitoring for Persons on Long-Acting Opioid Therapy	PQA							X	
Concurrent Use of Opioids and Benzodiazepines	PQA					X	P		
Deprescribing of Benzodiazepines in Older Adults	NCQA			X					
Diagnosed Substance Use Disorders	NCQA			X					
Follow-Up After Emergency Department Visit for Substance Use	NCQA		X	X	X	X			X

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Measure	Steward	CQMC[11]	FEHB QCR[12]	HEDIS[13]	HPR/ HPA[14]	Medicaid[15]	Star Ratings[16-18]	QRS[19]	UF[18,20]
Follow-Up After High-Intensity Care for Substance Use Disorder	NCQA			X	X				
Initial Opioid Prescribing at High Dosage	PQA								
Initial Opioid Prescribing for Long-Acting or Extended Release High Dosage	PQA								
Initial Opioid Prescribing for Long Duration	PQA						D		
Initiation and Engagement of Substance Use Disorder Treatment	NCQA			X	X	X	D	X	X
Pharmacotherapy for Opioid Use Disorder	NCQA	X		X	X				
Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults	PQA						P		
Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults	PQA						P		
Risk of Continued Opioid Use	NCQA		R	X	X				
Unhealthy Alcohol Use Screening and Follow-Up	NCQA			X					
Use of Opioids at High Dosage	NCQA			X	X				

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Measure	Steward	CQMC[11]	FEHB QCR[12]	HEDIS[13]	HPR/ HPA[14]	Medicaid[15]	Star Ratings[16-18]	QRS[19]	UF[18,20]
Use of Opioids from Multiple Providers	NCQA		R	X	X				
Use of Opioids at High Dosage and from Multiple Providers in Persons Without Cancer	PQA								
Use of Opioids at High Dosage in Persons Without Cancer	PQA					X	D		
Use of Opioids from Multiple Providers in Persons Without Cancer	PQA						D		
Use of Pharmacotherapy for Opioid Use Disorder	CMS					X			

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Behavioral Health Measures on the Star Ratings Display Page

Display measures on CMS.gov are published separately from the Star Ratings and include measures that are transitioned from inclusion in the Star Ratings, new or updated measures before inclusion into the Star Ratings, and informational-only measures.[21]

Part C Display Page[22]

- DMC01 – Follow-up Visit after Hospital Stay for Mental Illness (within 30 days of discharge)
- DMC02 – Antidepressant Medication Management (6 months)
- DMC12 – Initiation of Alcohol or other Drug Treatment
- DMC13 – Engagement of Alcohol or other Drug Treatment
- DMC28 – Improving or Maintaining Mental Health

Explored, but not implemented:[23]
- Adherence to Antipsychotic Medications for Individuals with Schizophrenia

Part D Display Page[22]

- DMD08 – Antipsychotic Use in Persons with Dementia
- DMD09 – Antipsychotic Use in Persons with Dementia – for Long-Term Nursing Home Residents
- DMD10 – Concurrent Use of Opioids and Benzodiazepines
- DMD11 – Use of Opioids at High Dosage in Persons Without Cancer
- DMD12 – Use of Opioids from Multiple Providers in Persons Without Cancer
- DMD13 – Polypharmacy: Use of Multiple Anticholinergic Medications in Older Adults
- DMD14 – Polypharmacy: Use of Multiple CNS-Active Medications in Older Adults
- DMD15 – Initial Opioid Prescribing

What May be Changing with Star Ratings?

- **In the 2024 Part C and D proposed rule, CMS proposes to:**[24]
  - Move the *Concurrent Use of Opioids and Benzodiazepines*, *Polypharmacy Use of Multiple Anticholinergic Medications in Older Adults*, and *Polypharmacy Use of Multiple CNS Active Medications in Older Adults* measures from the display page to the 2026 Star Ratings
- **In the 2023 Advance Notice, CMS stated it is considering whether to:**[25]
  - Add the *Depression Screening and Follow-up for Adolescents and Adults* measure to the 2026 Star Ratings display page
  - Add the *Initiation and Engagement of Substance Use Disorder (SUD) Treatment* measure to Star Ratings in future rulemaking
  - Broaden the mental health items in the Health Outcomes Survey (HOS) to ensure CMS has data to assess whether enrollees with social risk factors are experiencing more issues with poor mental health and measure a broader array of mental health conditions by adding the 2-item measure of the Generalized Anxiety Disorder
  - Explore an HOS mental health care access measure

Health Plan Concerns with Behavioral Health Measures

Adherence to Antipsychotic Medications for Individuals with Schizophrenia[26]

- Population is difficult to perform outreach and accept prolonged change
- Medicare Advantage plans are limited in their abilities to share behavioral health diagnosis information with providers
- Preference for CMS to provide data in patient safety reports only
- Concern for focusing measurement on a relatively small patient population (compared to populations for depression or substance use)
- Day-to-day support needed to manage schizophrenia critical for adherence given behavioral health concerns such as substance abuse issues, arrests for violent behavior, hospitalization for manic-depressive episodes, unstable housing and disorganized living situations, financial constraints, and other logistic problems that health plans cannot manage
- Medically necessary antipsychotics may be discontinued in line with competing Part D polypharmacy measures

Behavioral Health Quality Challenges[27]

- Encompasses a broad set of complex conditions
- Burden of social needs, trauma, grief, and other factors compound presentation and treatment
- Conditions drive utilization beyond primary care throughout the healthcare system
- Impacted by workforce issues and incomplete integration of behavioral health services
- Uncertainty about which outcomes are patient-centered, clinically relevant, and sensitive to improved care processes
- Variability in treatment models, ranging from pharmacotherapy and psychotherapy to new technology
- Disagreement on approaches to treatment in absence of evidence-based guidelines
- Psychotherapy is delivered in a variety of setting by many clinicians complicating measurement
- Insurance benefits often do not align across market segments to cover beneficiary needs
- Visibility challenges make behavioral health difficult to recognize (e.g., no reliable biomarker)
- Hard to rely on administrative coded data to identify patient cohorts due to issues such as stigma

Magellan Healthcare: Whole Health – Why Pharmacy?

Magellan's Whole Health pharmacy program focuses on three key components:

- Access and adherence to medications
  - 50% of patients with chronic illness do not take them as prescribed.[28]
- Resolution of polypharmacy
- Non-evidence-based prescribing of opioids and psychotropics

4%

Return on Investment

Polypharmacy alone or in combination with concomitant psychotropics was associated with greater likelihood of being a high-cost patient[29]
Medicaid Pharmacotherapy Research Consortium

Estimated 70 – 80% of total healthcare expenditures for polypharmacy patients has been found to be drug related[29]
Medicaid Pharmacotherapy Research Consortium

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Magellan Healthcare: Whole Health – Why Pharmacy?

Of patients with medication adherence problems, the studies found:

- 20% had emergency room visits.[30]
- 12.7% were hospitalized.[30]
- 23% had side effects significantly worsen — interfering with functioning and outweighing therapeutic benefits.
- 22% had an increase in suicidal ideation or behavior.
- 15% had an increase in violent ideation or behavior.
- 3% became homeless for more than 48 hours.

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Whole Health Program Overview

Clinical Data

Utilizes health plan pharmacy claims data

Evidence-Based Algorithms

Algorithms identify non-evidence-based prescribing patterns

Clinical Outreach

Pharmacist led outreach to providers

- Telephonic
- Provider letters

Improved Patient Outcomes

Dedicated analytics team compiles outcome data

- Activity tracking
- Prescribing patterns
- Medical and pharmacy savings

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Evaluation Methodology

Objective	To assess the clinical and economic impact of the clinical and economic impact of the Whole Health academic detailing program on prescribing trends for all closed consultations between July 1, 2021 – December 31, 2021
Methodology	• Cross-sectional analysis, comparing pharmacy and medical utilization before and after intervention • Generated visualizations to show the rate in which gaps in care were closed over time
Analysis Population	**Inclusion criteria:** • Received at least 1 intervention, defined as a fax or call to their provider during the intervention period between (July 1, 2021 – December 31, 2021), for the selected algorithms • Continuously eligible for the analysis period, according to the enrollment data with 1 medical and pharmacy claim in the pre-period as evidence member is still active with provider **Exclusion criteria:** • Members without any claims in the pre or post-intervention period were excluded from the analysis.
Evaluation Period	**Intervention period:** July 1, 2021 – December 31, 2021 **Pre-intervention period*:** 90 days before first intervention – adjusted to 3 months due to artificially low utilization during COVID in early 2021 **Post-intervention period:** 180 days after last intervention
Data	• Plan enrollment data • Behavioral health-related pharmacy claims data (LAI antipsychotic claims not available) • Behavioral health-related medical claims data

*A pre-intervention period of 90-days was selected to account for potential impact of COVID-19 on healthcare utilization. Analyses for medication adherence algorithms compare a 180-day pre-intervention period and a 180-day post-intervention period.

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Antidepressant Adherence

- **45** Distinct Prescribers
- **283** Distinct Members

- **22% increase** in the mean PDC, from 63.1% to 76.9%*
- The proportion of members with PDC ≥ 80 increased from 17.9% to 58.2%*
- Most utilized medications were escitalopram, fluoxetine, and sertraline

- **38% increase** in spend for antidepressants where the PEMPM pharmacy costs increased from $20.35 to $28.29

*PDC calculation includes members with at least 1 claim for target medication in the pre and post periods (n = 201), comparing 6-month pre-period with 6-month post-period.

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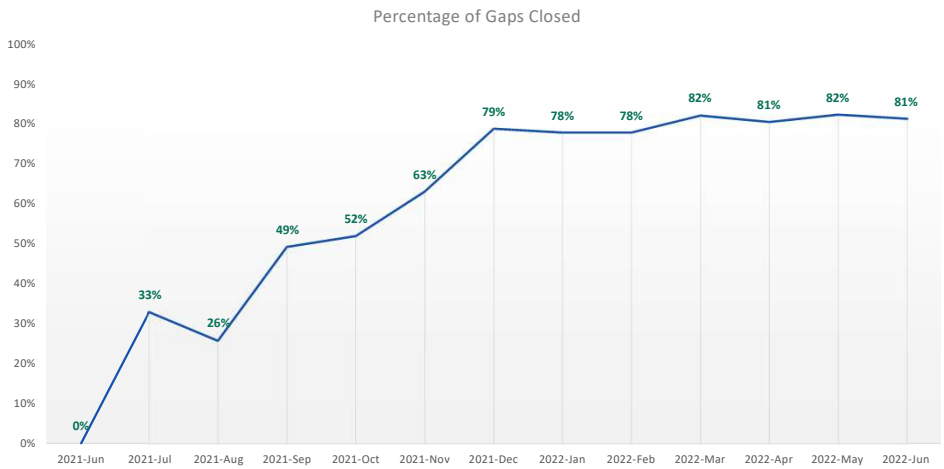
Antidepressant Adherence



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Antipsychotic Adherence

- **39** Distinct Prescribers
- **152** Distinct Members

- **27% increase** in the mean PDC, from 61.7% to 78.7%*
- The proportion of members with PDC ≥80% increased, from 18.9% to 58.1%*
- Most utilized medications were, aripiprazole, quetiapine, and olanzapine

- **12% decrease** in PEMPM spend for oral antipsychotics, driven by decreased utilization of Rexulti (-13%) and Latuda (-25%)
- Decrease in spend may also be attributed to discontinuation of orals and switching to LAI, but LAI data is not available

*PDC calculation includes members with at least 1 claim for target medication in the pre and post periods (n = 74) comparing 6-month pre-period with 6-month post-period.

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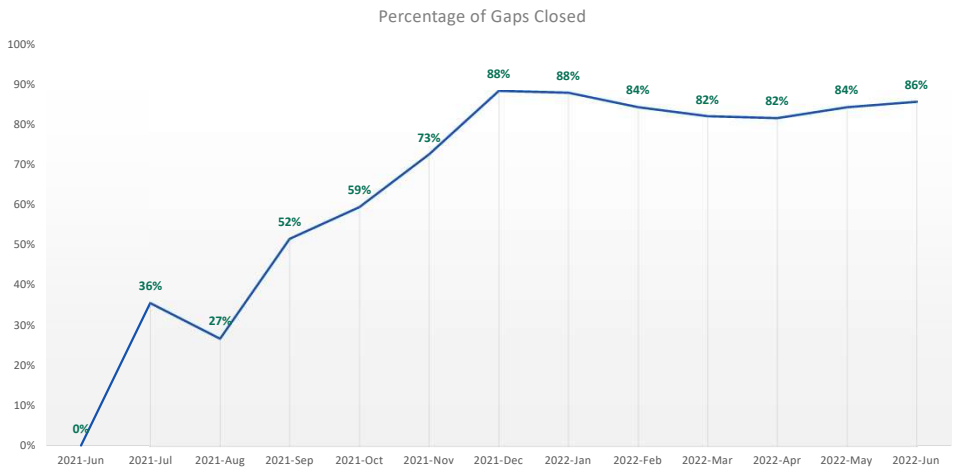
Antipsychotic Adherence



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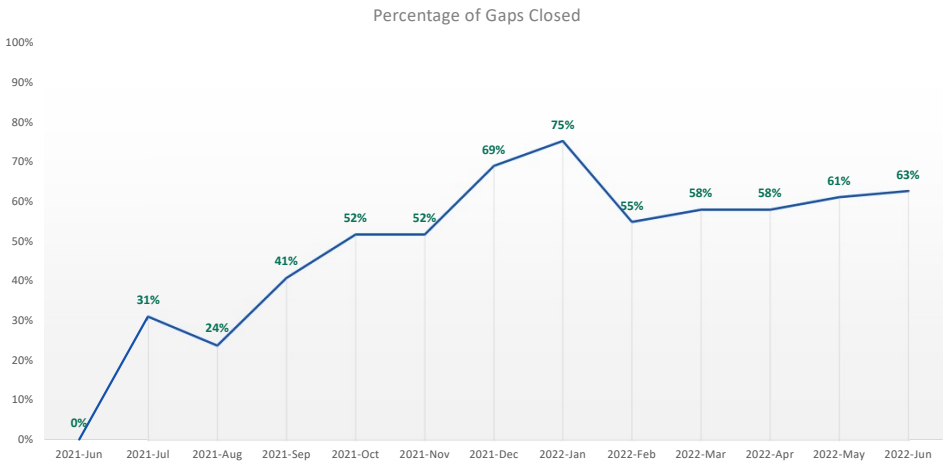
Atypical Antipsychotic Polypharmacy

- **28** Distinct Prescribers
- **65** Distinct Members

- **23% decrease** in utilization of target antipsychotics when comparing PEMPM claim count (2.2 vs 1.7)
- **48%** of members were on the top 3 most utilized drug combinations: lurasidone/quetiapine, aripiprazole/quetiapine, quetiapine/risperidone

- **24% decrease** in BH pharmacy spend where the PEMPM pharmacy spend decreased from **$994.99 to $804.68**

Atypical Antipsychotic Polypharmacy



Polypharmacy, 5 or More BH Medications

- **33** Distinct Prescribers
- **85** Distinct Members

- **17% reduction** in BH medications where the PEMPM claim count decreased from **7.2 to 5.9**
- **22% decrease** in PEMPM utilization of stimulants

- **11% reduction** in BH pharmacy spend where the PEMPM pharmacy spend decreased from **$905.31 to $807.67**

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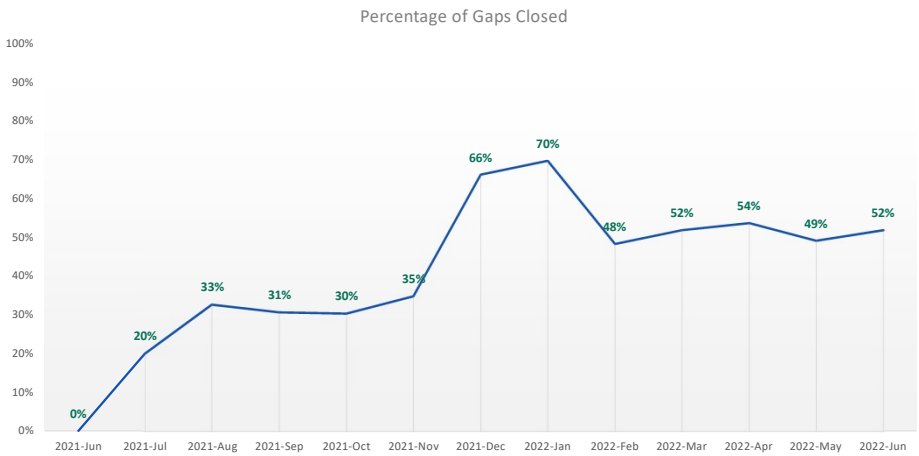
Polypharmacy, 5 or More BH Medications



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Low Dose quetiapine

- **32** Distinct Prescribers
- **70** Distinct Members

- **20% of members discontinued quetiapine** (defined as 0 claims in the post period)
- **3% increase** in average daily quetiapine dose

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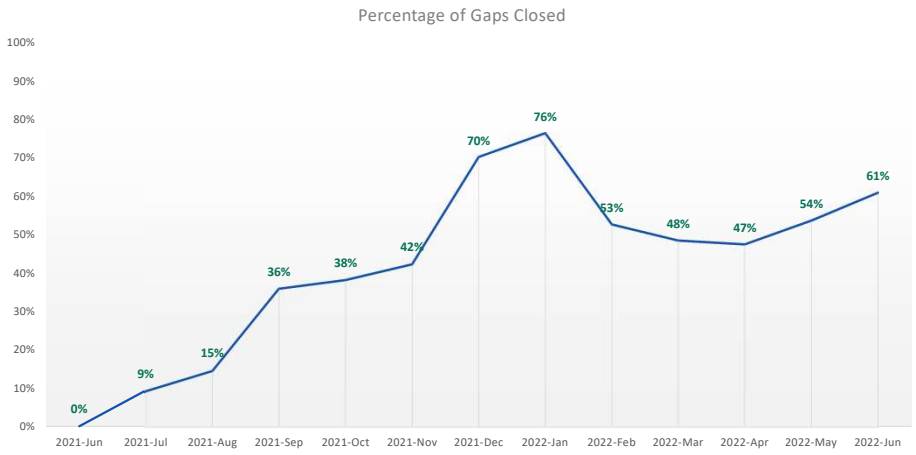
Low Dose quetiapine



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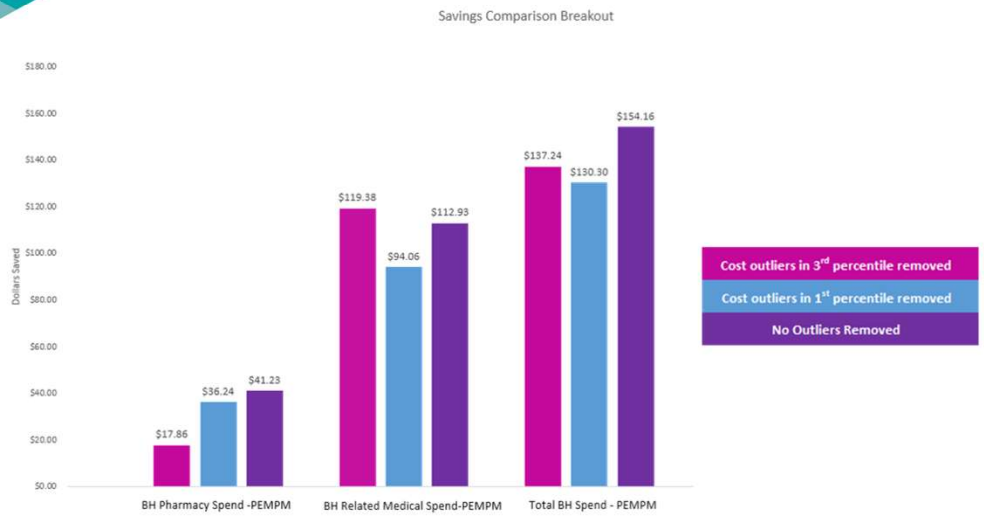
Comparison: Cost Savings Summary



Behavioral Health Quality Best Practices

Provider: EHR Flags for Population Health Management

Plans: Innovative Contracting on Outcomes and Intermediate Outcomes

Pharmacy: Partnerships with Extenders

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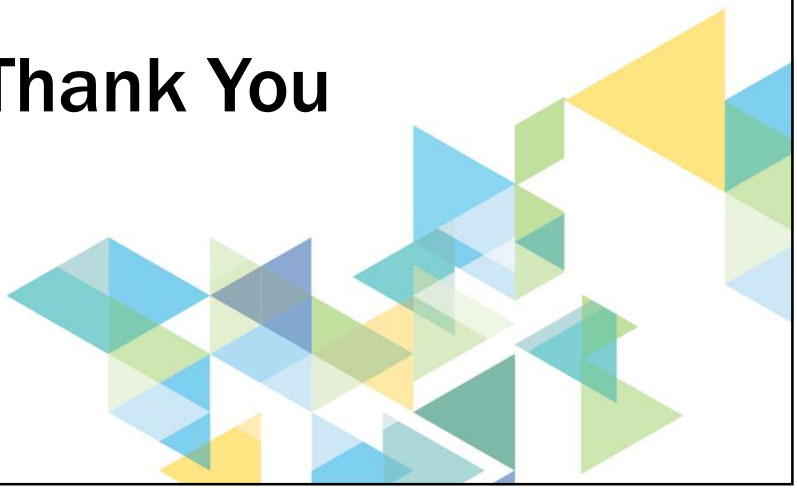
Thank You



PQA23
ANNUAL MEETING

Deprescribing: How to Ensure that Older Adults Take the Right Amount of Medications. Nothing more, nothing less.

Priscilla Franco, PharmD
Clinical Pharmacist, SCAN Health Plan
PFranco@scanhealthplan.com

Objectives

- At the completion of this program, pharmacists will be able to
  - Review the growing issue of polypharmacy and its impact on older adults.
  - Explain the process of deprescribing and how it is designed to address polypharmacy.
  - Describe how managed care organizations can institute deprescribing initiatives and be enabled to reduce unnecessary medications, particularly for older adults.

About SCAN

SCAN is one of the largest not-for-profit Medicare Advantage Prescription Drug plans in the country, serving nearly 285,000 members in California, Arizona, Nevada and Texas. Our mission is to keep seniors healthy and independent.

All SCAN plans build upon the strong foundation built over 45 years of senior-focused service, recognized in California with:

Recognized Brand
"Best" MAPD in CA
Five years in a row!

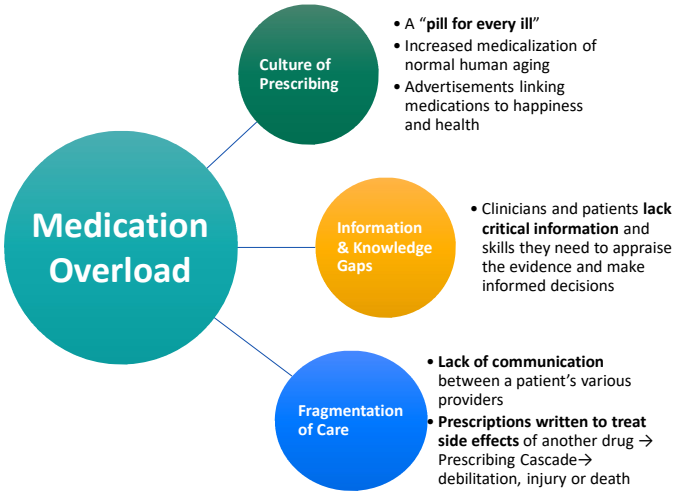
4.5 Stars
Quality care & service
Six years in a row!

91% Satisfaction
(Medicare & You, 2023)
Member Rating of Health Plan

Employer of Choice
Great Place to Work
Certified

In the senior population, polypharmacy and "medication overload" is prominent.

A broad array of forces is at work, with **three overarching aspects of our health care system** contributing to the epidemic:



PQA23 ANNUAL MEETING

The health and well-being of so many older adults hinges upon medications.

"It is an art of no little importance to administer medicines properly: but, it is an art of much greater and more difficult acquisition to know when to suspend or altogether to omit them." - Philippe Pinel, 1809

750 adults aged 65 and older are hospitalized every day due to serious side effects from one or more medications.

≥ 40% take five or more prescription medications a day, a 200 percent rise over the past 20 years.

7-10% increased risk of a person suffering an adverse drug event for every additional medication initiated.

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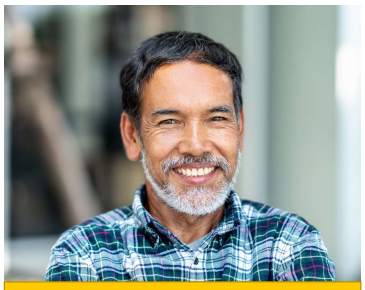
A day in the life of our average patient…



"Mr. H" *early 70s male*

- Diabetes
- High Cholesterol
- Hypertension
- Cardiac Arrythmia
- Chronic Kidney Disease
- Insomnia
- PTSD
- Depression
- Neuropathy
- Benign Prostate Hyperplasia
- History of Falls

*"…sometimes when I stand up, I **black out** and **fall**…"*

*"…both of my legs **tingle** and **burn**…"*

*"I'm so worried about my wife's health…**my thoughts are always racing**…"*

Mr. H's Medication List:

- Acetaminophen 325 mg
- Albuterol HFA inhaler
- Atorvastatin 20 mg
- Bumetanide 0.5 mg
- Citalopram 40 mg
- Cyanocobalamin 1000 mcg
- Dapagliflozin 10 mg
- Fluticasone nasal spray
- Humalog insulin
- Lantus insulin
- Lisinopril 5 mg
- Oxycodone/acetaminophen 5/325 mg
- Nitroglycerin 0.4 mg
- Tamsulosin 0.4 mg
- Trazodone 50 mg
- Dulaglutide 0.75 mg
- Venlafaxine 150 mg

PQA 23 ANNUAL MEETING

Deprescribing: "Stopping or reducing the dose of unnecessary or potentially harmful medications" – The Lown Institute

SCAN's Deprescribing Vision

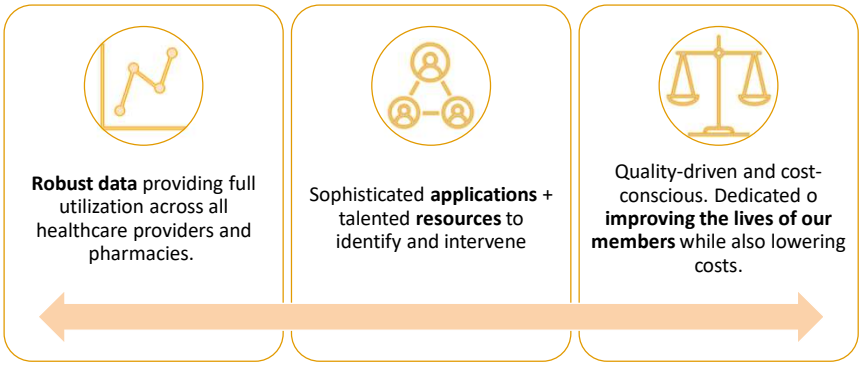
Ensuring that our members are taking the medications they need to stay healthy and independent. Nothing more, nothing less.

Moving from this → To this, when appropriate

Image: Medication Overload and Older Americans. Lown Institute.

PQA 23 ANNUAL MEETING

Health plan pharmacists are uniquely positioned to reduce "medication overload"



Our deprescribing approach began with simply reducing the number of medications our members were on.

Medication Count Summary (2021):					
Medication Count	1 – 4 meds	5 – 9 meds	10 – 14 meds	15 – 19 meds	≥ 20 meds
Member Count	91,136	72,502	18,651	3,344	685
% of Total Membership	49%	39%	10%	1.7%	0.3%
Average Prescriber Count	1.5	3	4	5	6

- 51% of members were experiencing ***polypharmacy*** (5+ meds).
- 12% of our members were experiencing ***hyperpolypharmacy*** (10+ meds).

SCAN 2021 Goal: Reduce the total number of unnecessary medications in 20% of members experiencing hyperpolypharmacy.

Our 2021 goal was achieved, and we further refined our approach going forward.

SCAN 2021 Goal: Reduce the total number of unnecessary medications in 20% of members experiencing hyperpolypharmacy.

Targeted ~17,600 members who were on 15+ medications. By year-end, **92% discontinued** at least 1 drug from baseline.

- **3%** stopped an unnecessary stomach acid-reducing medication (proton pump inhibitors [PPIs])
- **19%** stopped an unnecessary fall-inducing medication (central nervous system [CNS] depressants)

Our goal of reducing ***any*** medication was too broad. There is greater value seen with intentionally reducing ***specific types*** of unnecessary medications.

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In 2022, we centered our focus on therapies where older adults are not reassessed enough

SCAN 2022 Goal: Reduce waste and inappropriate medications by 10%, highlighting the following drug classes:

Sleep Aids/Hypnotics	Stomach Acid-Reducers	Duplicate Diabetes Treatment	High-Risk Diabetes Drugs
• Fall-inducing medications such as zolpidem, eszopiclone, temazepam, triazolam	• Proton-pump inhibitors (PPIs) such as omeprazole, pantoprazole, lansoprazole, etc	• Being on two different diabetes drugs that work similarly, yet don't provide additional benefit	• Drugs such as glyburide and glimepiride which causes lower blood sugar in older adults

Targeted drug classes were selected based on the prevalence in our utilization.

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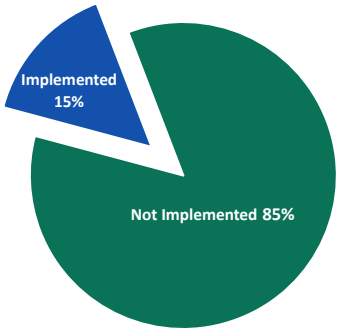
In 2022, approximately 15% of our deprescribing recommendations were accepted by our providers.

Total Deprescribing Recommendations = ~16,000

~2,300 members positively impacted

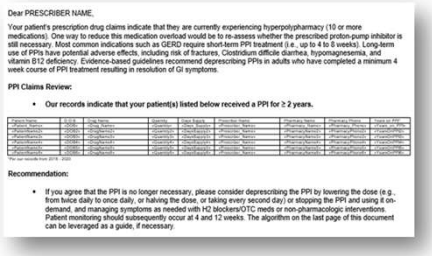


Main Takeaways

Clinical	Cost	Remaining Opportunity
Member Impact Further reduced risk of: • ER visits due to low blood sugar • Fractures • Falls • Adverse drug events	~$50,600 annualized member-out-of-pocket cost savings ~$385,950 annualized plan cost avoidance	~13,500 members with remaining deprescribing Opportunities ~$126,850 remaining annualized member-out-of-pocket cost savings ~$1.96M remaining annualized plan cost avoidance

Our interventions have been relatively basic in design to date.

1. Provider-Facing Communication



Dear PRESCRIBER NAME,

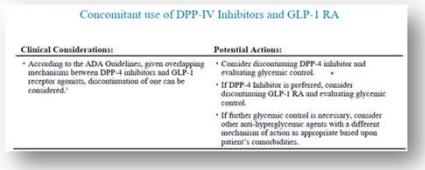
Your patient's prescription drug claims indicate that they are currently experiencing hyperpotyphamacy (10 or more medications). One way to reduce this medication overload would be to re-assess whether the prescribed proton-pump inhibitor is still necessary. Most common indications such as GERD require short-term PPI treatment (i.e., up to 4 to 8 weeks). Long-term use of PPIs have potential adverse effects, including risk of fractures, Clostridium difficile diarrhea, hypomagnesemia, and vitamin B12 deficiency. Evidence-based guidelines recommend deprescribing PPIs in adults who have completed a minimum 4 week course of PPI treatment resulting in resolution of GI symptoms.

PPI Claims Review:

- **Our records indicate that your patient(s) listed below received a PPI for ≥ 2 years.**

Recommendation:

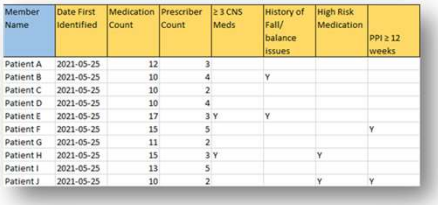
- If you agree that the PPI is no longer necessary, please consider deprescribing the PPI by lowering the dose (e.g., from twice daily to once daily, or halving the dose, or taking every second day) or stopping the PPI and using it on-demand, and managing symptoms as needed with H2 blockers/OTC meds or non-pharmacologic interventions. Patient monitoring should subsequently occur at 4 and 12 weeks. The algorithm on the last page of this document can be leveraged as a guide, if necessary.



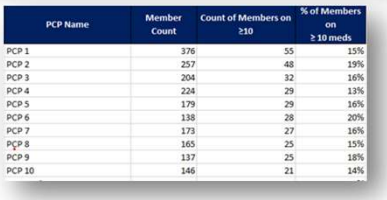
Concomitant use of DPP-IV Inhibitors and GLP-1 RA

Clinical Considerations:	Potential Actions:
• According to the ADA Guidelines, given overlapping mechanisms between DPP-4 inhibitors and GLP-1 receptor agonists, discontinuation of one can be considered.[1]	• Consider discontinuing DPP-4 inhibitor and evaluating glycemic control. • If DPP-4 Inhibitor is preferred, consider discontinuing GLP-1 RA and evaluating glycemic control. • If further glycemic control is necessary, consider other anti-hyperglycemic agents with a different mechanism of action as appropriate based upon patient's comorbidities.

2. Medical Group Care Coordination



Member Name	Date First Identified	Medication Count	Prescriber Count	≥ 3 CNS Meds	History of Fall/ balance issues	High Risk Medication	PPI ≥ 12 weeks
Patient A	2021-05-25	12	3				
Patient B	2021-05-25	10	4		Y		
Patient C	2021-05-25	10	2				
Patient D	2021-05-25	10	4				
Patient E	2021-05-25	17	3	Y	Y		
Patient F	2021-05-25	15	5				Y
Patient G	2021-05-25	11	2				
Patient H	2021-05-25	15	3	Y		Y	
Patient I	2021-05-25	13	5				
Patient J	2021-05-25	10	2			Y	Y



PCP Name	Member Count	Count of Members on ≥10	% of Members on ≥ 10 meds
PCP 1	376	55	15%
PCP 2	257	48	19%
PCP 3	204	32	16%
PCP 4	224	29	13%
PCP 5	179	29	16%
PCP 6	138	28	20%
PCP 7	173	27	16%
PCP 8	165	25	15%
PCP 9	137	25	18%
PCP 10	146	21	14%

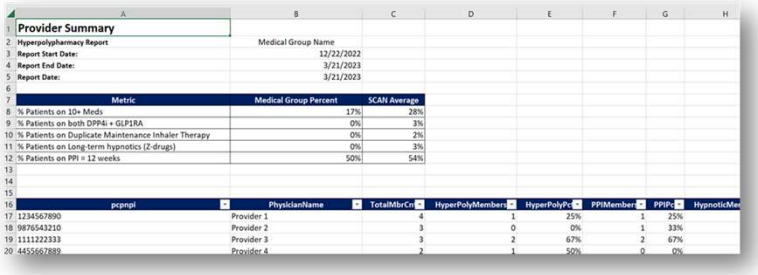
We are advancing our efforts by deploying various engagement strategies to further reduce unnecessary medications

Providers	• Faxes ✓ • Medical Group Tools & Reports ✓ • EMR Direct Messaging ✓ • Deprescribing workshops ☐ • Incentive programs ☐
Partners	• Expanded point-of-sale safety edits ☐ • Retail Pharmacy Enablement ☐
Patients	• MTM Reviews ✓ • Medication Reconciliation ✓ • Targeted Conversations ☐

✓Deployed ☐Exploration

Medical Group engagement is a key component of our efforts

Supplementing our faxes, our groups now receive **monthly deprescribing reports** *informing them of their members' various opportunities:*



Provider Summary

Hyperpolypharmacy Report — Medical Group Name
Report Start Date: 12/22/2022
Report End Date: 3/21/2023
Report Date: 3/21/2023

Metric	Medical Group Percent	SCAN Average
% Patients on 10+ Meds	17%	28%
% Patients on both DPP4i + GLP1RA	0%	3%
% Patients on Duplicate Maintenance Inhaler Therapy	0%	2%
% Patients on Long-term hypnotics (Z-drugs)	0%	3%
% Patients on PPI > 12 weeks	50%	54%

pcpnpi	PhysicianName	TotalMbrCn	HyperPolyMembers	HyperPolyPct	PPIMembers	PPIPct	HypnoticMe
1234567890	Provider 1	4	1	25%	1	25%	
9876543210	Provider 2	3	0	0%	1	33%	
1111222333	Provider 3	3	2	67%	2	67%	
4455667889	Provider 4	2	1	50%	0	0%	

✓ Leveraging the relationship of the Medical Group with both the Patient and Provider

✓ Ensures full visibility across all stakeholders

We'll also focus on the dose-reduction of medications.

- Sometimes, unnecessary medications = unnecessary dosing and frequency.
- Many medications are essential and can't be stopped abruptly or at all, but a dose can be reduced and continue providing benefit.

Common areas where doses can be reduced:

Drug / Drug Class:	Commonly Used For:
Gabapentin	Nerve Pain
Opioids	Acute & Chronic Pain
Antipsychotics	Sleep / Agitation
Sedatives	Sleep / Anxiety
Stomach Acid-Reducers (PPIs)	Heartburn

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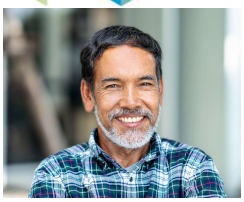
We expanded our areas of focus to include other opportunities where senior care needs to improve

Sleep Aids/Hypnotics	Stomach Acid-Reducers	Duplicate Diabetes Treatment	High-Risk Diabetes Drugs
Chronic Medications	Duplicate Anticholinergic drugs	Duplicate CNS drugs	Duplicate Inhalers

PQA23 ANNUAL MEETING

Our pharmacist's power and impact on members' lives



When we met Mr. H, he complained of episodes during which he stands up, "**blacks out**" and **falls**.

He also had **tingling** and **burning** in both legs.

He was having **racing thoughts** about his wife's health.

Med List Before:

Acetaminophen 325 mg
Albuterol HFA inhaler
Atorvastatin 20 mg
Bumetanide 0.5 mg
Citalopram 40 mg
Cyanocobalamin 1000 mcg
Dapagliflozin 10 mg
Fluticasone nasal spray
Humalog insulin
Lantus insulin
Lisinopril 5 mg
Oxycodone/acetaminophen 5/325 mg
Nitroglycerin 0.4 mg
Tamsulosin 0.4 mg
Trazodone 50 mg
Dulaglutide 0.75 mg
Venlafaxine 150 mg

3 Months

Med List After:

Acetaminophen 325 mg
Albuterol HFA inhaler
Atorvastatin 20 mg
Citalopram 20 mg
Cyanocobalamin 1000 mg
Dapagliflozin 10 mg
Fluticasone nasal spray
Gabapentin 100 mg
Humalog insulin
Lantus insulin
Dulaglutide 1.5 mg
Venlafaxine 150 mg

- **6 medications stopped.**
  - Tamsulosin caused the "black outs" and falls.
  - Stopping did not affect his urinary symptoms (from BPH)
- Adjusted diabetes medications → **better sugar & weight control** (↓17 lbs)
- **Started gabapentin** for tingling in legs due to diabetes.

Mr. H now **feels more independent** w/improved mood and **resumed his favorite pastime of playing the keyboard.**

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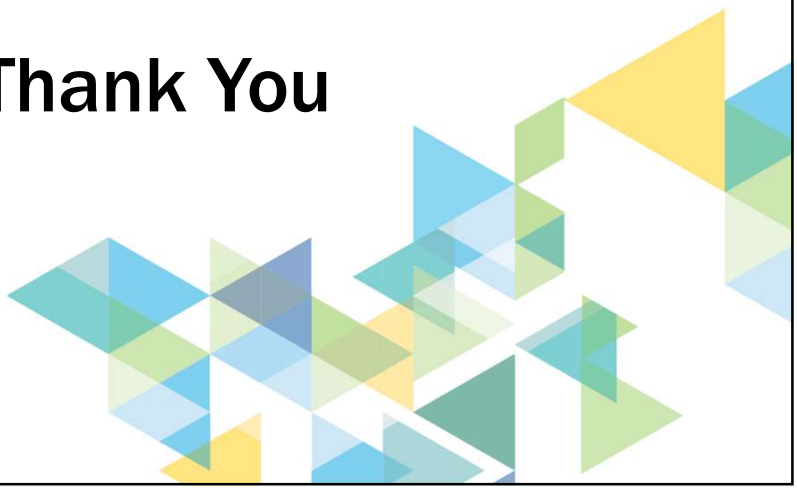
Thank You



PQA23
ANNUAL MEETING

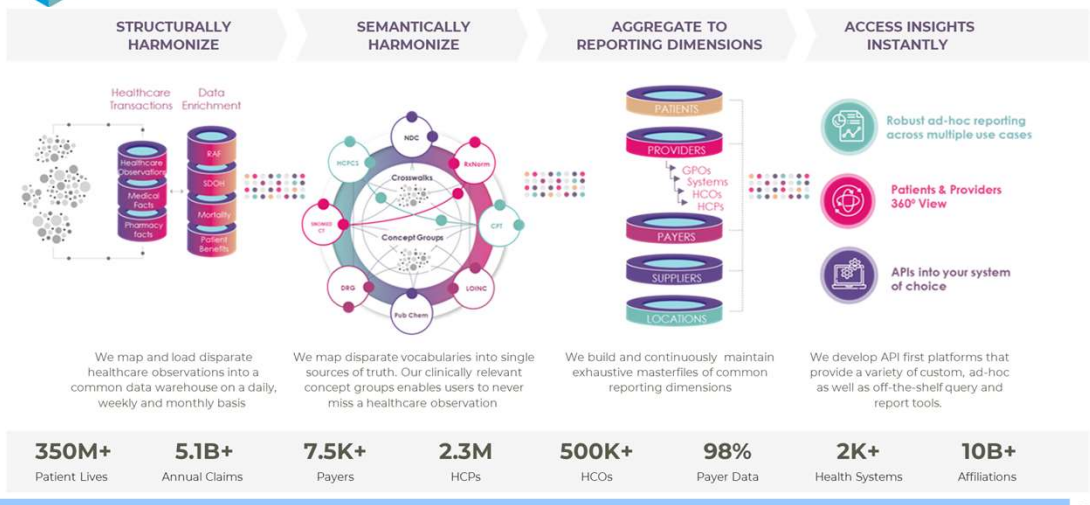
Impact of Applying SDOH on Prescription Fill Rate Analysis

Russell D. Robbins MD, MBA
Chief Medical Information Officer, PurpleLab
rrobbins@purplelab.com

Objectives

- At the completion of this program, pharmacists will be able to
  - Discuss options to prioritize SDOH variables in prescription fill rate analyses for actionability
  - Identify strategies for SDOH inclusion when assessing medical and pharmacy claims
  - Explain methods for assessing barriers to patient medication access

Connected RWD: Trailblazing Healthcare Analytics



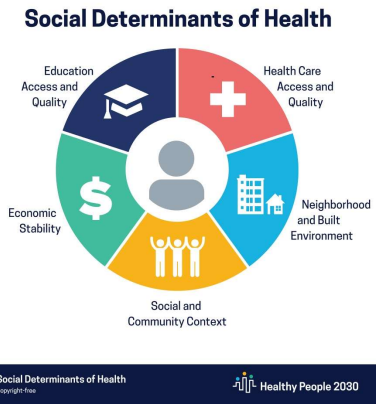
Determinants of Health

- Genetics
- Gender
- Behavior
- Environmental & physical influences
- Medical care
- Social factors

Social Determinants of Health: Environmental Factors

Definition

- Birthplace
- Live
- Learn
- Work
- Play
- Worship
- Age



Social Determinants of Health: Attributes

SDOH Attributes

- Race
- Ethnicity
- Education
- Occupation
- Marital Status
- Income

Patient Level SDOH Scores Indexed Against Population Normative Means

1. Generalize

- Race
- Ethnicity
- Education
- Occupation
- Marital Status
- Income

2. Calculate

- Per Occupant Income
  - Household # Occupants
  - Household Income
- Medicaid Eligibility
  - Per Occupant Income
  - State-level guidelines

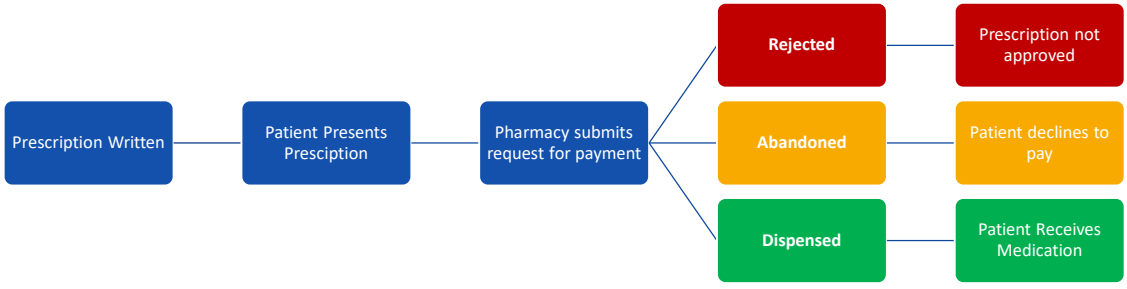
3. Measure

- Measure Medicaid Benefits
- Determine adverse health outcomes
  - Are there patterns in which SDOH determines access to healthcare and adverse health outcomes?

The Patient Journey

- Prescriptions written
- Prescription presented to retail or mail order pharmacy
- Validation
  - Eligibility
  - Formulary
  - Plan design
- Prescription
  - Filled
  - Abandoned or Reversed
  - Rejected

The Patient Journey



Dispensed, Abandoned and Rejected Summary Table

Final Summary Table								
Product / Patient	Written		Dispensed		Abandoned		Rejected	
	Cnt	%	Cnt	%	Cnt	%	Cnt	%
OVERALL	1,841	100.00%	685	37.21%	343	18.63%	813	44.16%
Drug A	65	100.00%	27	41.54%	22	33.85%	16	24.62%
Drug B	1,150	100.00%	374	32.52%	148	12.87%	628	54.61%
Drug C	435	100.00%	183	42.07%	110	25.29%	142	32.64%
Drug D	164	100.00%	86	52.44%	58	35.37%	20	12.20%
Drug E	27	100.00%	15	55.56%	5	18.52%	7	25.93%

Days between First Attempt to Fill and the Final Status								
Product / Days			Dispensed		Abandoned		Rejected	
			Mean	Median	Mean	Median	Mean	Median
OVERALL			11	2	3	1	11	1
Drug A			5	3	1	1	7	1
Drug B			7	2	3	1	7	1
Drug C			26	6	3	1	28	1
Drug D			2	2	1	1	2	1
Drug E			2	2	1	1	2	1

Reject, Abandon, Dispense - Reject Reason

Product / Reject Reason		Primary	Secondary	Tertiary	Quaternary	Quinary	Senary	Septenary	Octonary	Nonary	Denary
OVERALL	Reason Desc	Product/Service Not Covered	Prior Authorization Required	Product/Service Not Appropriate For This Location	Plan Limitations Exceeded	Must Fill Through Specialty Pharmacy	Product Not On Formulary	Cost Exceeds Maximum	DUR Reject Error	Submit Bill To Other Processor Or Primary Payer	Pharmacy Not Contracted With Plan On Date Of Service
	Patient Cnt	436	281	239	134	80		56	55	38	33
Drug A	Reason Desc	Product/Service Not Covered	Prior Authorization Required	Non-Matched Product/Service ID Number	Product Not On Formulary	Product/Service Not Appropriate For This Location	Plan Limitations Exceeded	Must Fill Through Specialty Pharmacy	DUR Reject Error	QMB (Qualified Medicare Beneficiary)-Bill Medicare	Cost Exceeds Maximum
	Patient Cnt	12	8	6	3	2	2	1	1	1	1
Drug B	Reason Desc	Product/Service Not Covered	Product/Service Not Appropriate For This Location	Prior Authorization Required	Plan Limitations Exceeded	Must Fill Through Specialty Pharmacy	Product Not On Formulary	Cost Exceeds		Pharmacy Not Contracted With Plan On Date Of Service	Days Supply Exceeds Plan Limitation
	Patient Cnt	292	214	189	79	67			24	23	21

Product Not On Formulary	
0	66

- Sample of “Reject Reason” and Patient Counts per “Reject Reason”
  - *Product Not on Formulary*

Changing the *Status Quo*

- Dispensed 90%
- Abandoned 8%
- Rejected 2%

- What happens when you apply SDOH information to this?

Methodology

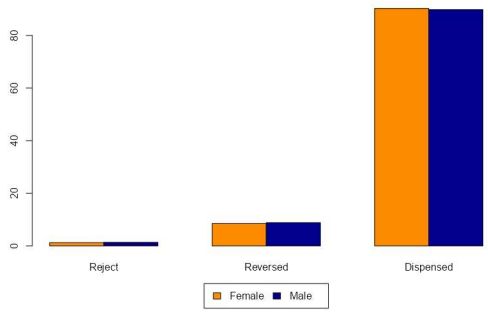
- 3.5 million people taking anti-coagulant medication
- Tokenized linkage with Datavant software
  - Pharmacy claims
  - Deidentified patient information
  - Disaggregation of patient information
- Analysis of 3 stages of patient journey
  - Filled
  - Abandoned
  - Rejected
- Overlay of SDOH attributes

SDOH Variables

- Marital Status
  - Single
  - Married
- Gender
  - Male
  - Female
- Income
  - <$20,000/year
- Race
  - White
  - Black
  - Asian-American
  - Other
- Ethnicity
  - Hispanic
  - Non-Hispanic

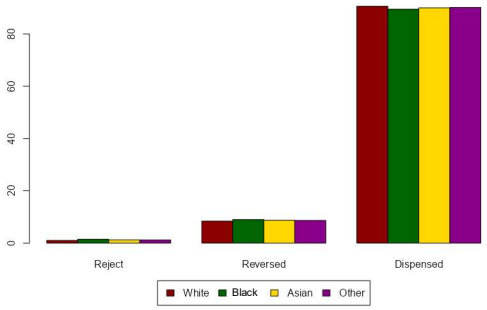
Outcome by Gender

	Reject	Abandoned	Dispensed
Female	1.23%	8.51%	90.26%
Male	1.34%	8.84%	89.82%
Mean	1.29%	8.68%	90.04%



Outcome by Race

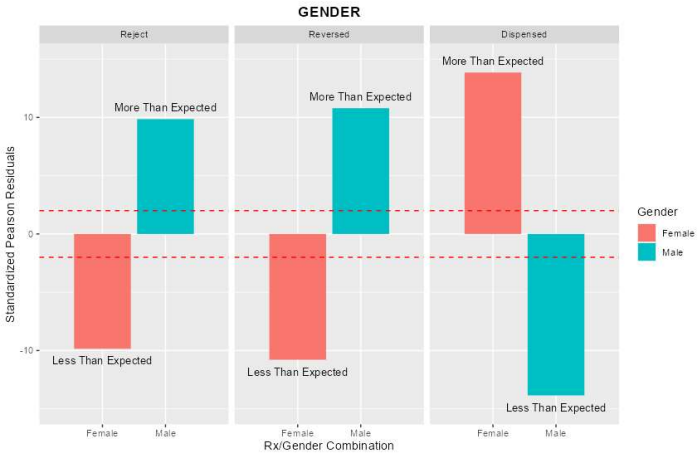
	Reject	Abandoned	Dispensed	Total
White	1.02%	8.40%	90.58%	100%
Black	1.49%	9.01%	89.50%	100%
Asian	1.23%	8.77%	90.00%	100%
Other	1.21%	8.65%	90.14%	100%



Adjusted Standardized Pearson's Residuals (ASPR)

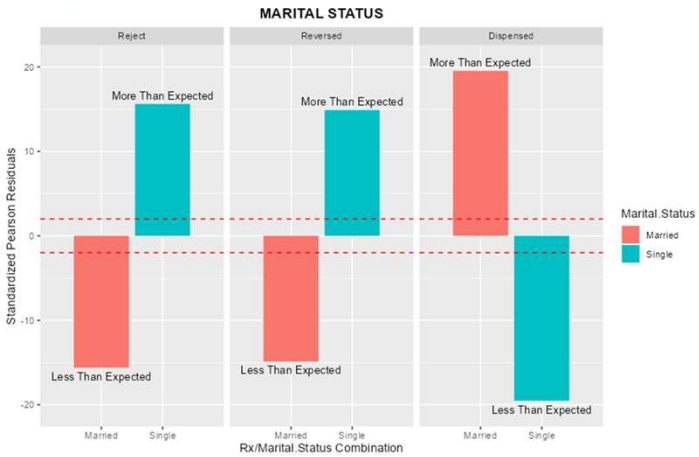
- Raw Residuals
  - Difference between observed and expected
  - Largest differences
- Adjusted Standardized Pearson Residual (ASPR)
  - Standardized to allow comparisons
  - Absolute value >2
    - Significant discrepancy
    - Cannot be explained by randomness alone

Gender



- Male patient is **1.1 times higher** among rejected patients than dispensed patients

Marital Status

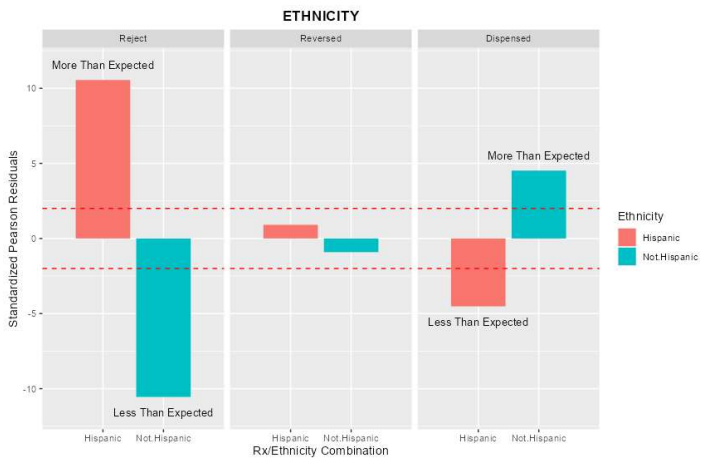


- Single patient is **1.3 times higher** among Reversed patients than dispensed patients

Applying SDOH

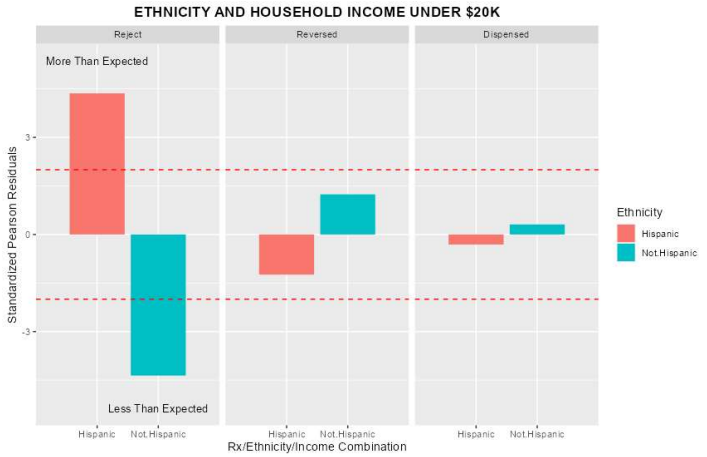
- Impact individual variables
  - Race
  - Ethnicity
  - Income
- Combining variables
  - Race & Income
  - Ethnicity & Income

Ethnicity



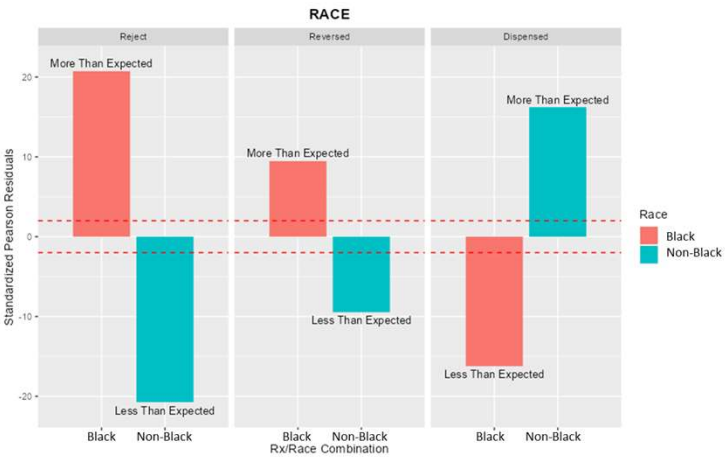
- Hispanic is **1.25 times higher** among rejected patients than dispensed patients.

Income & Ethnicity



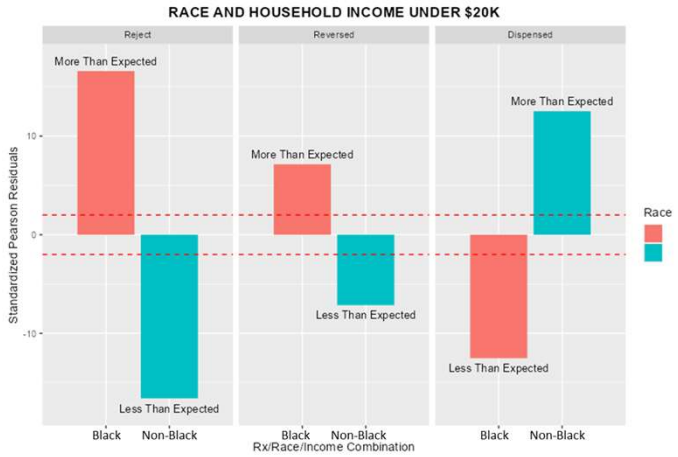
- Patients who earn less than $20K a year, the odds of being Hispanic is **1.2 times higher** among rejected patients than Abandoned patients

Race



- Black patients are **1.49 times higher** among rejected patients than dispensed patients

Income & Race



Patients who earn less than $20K a year, the odds of being Black is **1.67 times higher** among rejected patients than dispensed patients

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Making the Data Actionable

- Rejection
  - Plan design changes
  - Rebates
  - Co-pay waivers
- Abandonment
  - Educational materials
  - Physician outreach
  - Plan design changes

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Summary

- Traditional views overlook impact of race & ethnicity
- Income can play a significant role in some groups
- Acknowledging inequities & disparities can lead to changes
  - Removing barriers
  - Educating physicians, patients, & pharmacists

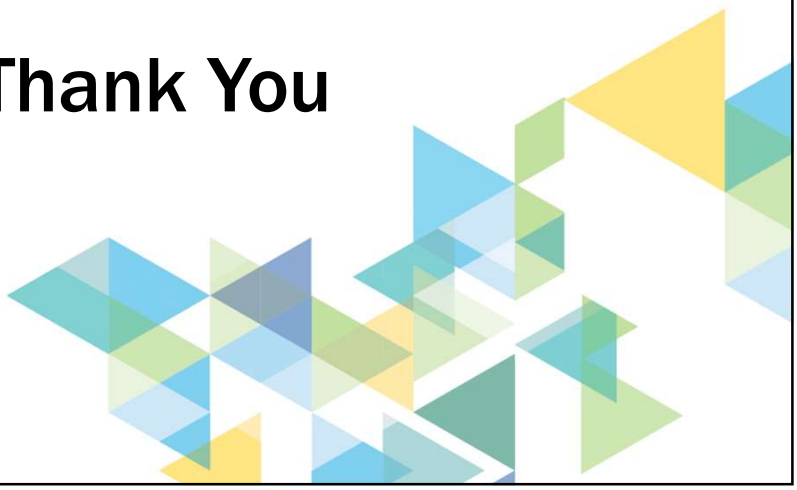
References

https://www.who.int/news-room/questions-and-answers/item/determinants-of-health

https://health.gov/healthypeople/priority-areas/social-determinants-health

https://cscu.cornell.edu/wp-content/uploads/95_conttableresid.pdf

Thank You



PQA23
ANNUAL MEETING

Integrating Clinical Service Initiatives to Improve the Member Journey and Reduce Abrasion

PQA23 ANNUAL MEETING

Co-Presenters

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Objectives

- At the completion of this program, pharmacists will be able to
  - Identify how mapping clinical interventions leads to an enhanced patient experience.
  - Discuss strategies for reducing member abrasion in a health plan setting, and the downstream impact they have on the patient experience.
  - Discuss the impact of potential changes to the Medicare MTM Program in 2024 and how organizations should consider approaching this expansion while maintaining a high-touch, high-quality approach to CMR completions.

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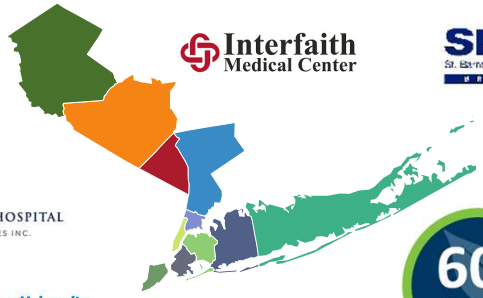
healthfirst
Health Insurance for New Yorkers

Healthfirst is one of the largest not-for-profit health insurers in the region, sponsored by New York City's leading hospitals, offering affordable health plans to its members for 30 years.

NYC HEALTH+ HOSPITALS
NYU Langone Health
Northwell Health
BronxCare HEALTH SYSTEM
SUNY Downstate Medical Center
Montefiore
Stony Brook Medicine
JAMAICA HOSPITAL MEDICAL CENTER
Interfaith Medical Center
SBH St. Barnabas Hospital BRONX
Maimonides Medical Center
ST. JOHN'S EPISCOPAL HOSPITAL EPISCOPAL HEALTH SERVICES INC.
NuHealth Together through life. Nassau University Medical Center



1.8+ Million Members*

- More than one-third (1.47 Million) of NYC's Medicaid Population
- 200k Medicare Members
- 31% of the dual eligible Medicare/Medicaid population in NYC

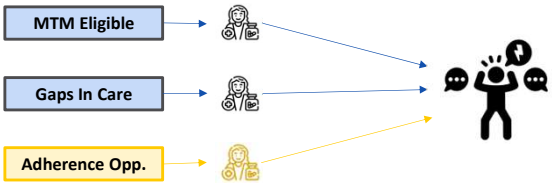
5,000+ Employees
In New York, Florida and Connecticut

60+ Hospitals in-network

*As of December 2022

Partnering to Reduce Member Abrasion: What Is Healthfirst Solving For?

Problem	Solution



- *Member bombarded with multiple outreaches*
- *Despite internal success in connectivity, external vendors unable to reach members leading to poor performance*
- *Over-calling resulted in member abrasion*

- *MTM Eligibility projection of >30K*
- *Population of 50% Spanish and 10% native Mandarin/Cantonese speakers*
- *4-Star completion rate goal*
- *Existing relationships can be leveraged to support connectivity*
- *Identified platform to support enhanced adherence and MTM bundling*
- *Scalable solution to ensure unexpected MTM volumes can be adequately managed*

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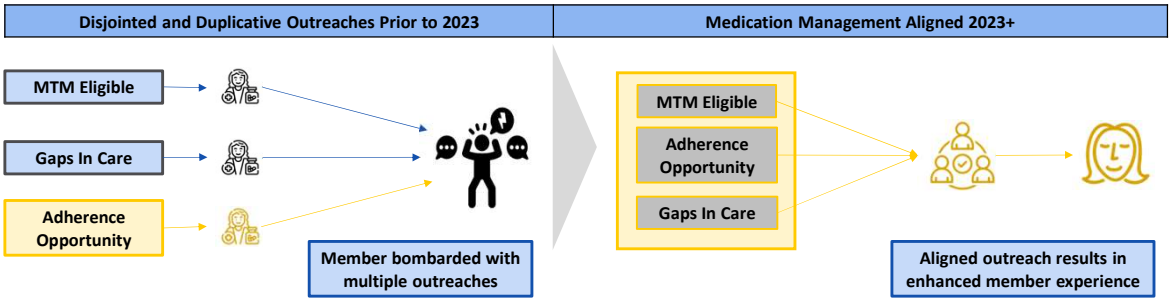
Partnering to Reduce Member Abrasion: What Are We Solving For?

Aspen RxHealth's Perspective:

- *Designed a model that enables Healthfirst's in-house team to use Aspen RxHealth tech platform*
- *Healthfirst MTM pharmacists can complete as many consultations as possible with help from Aspen RxHealth's 7,000+ pharmacists*
- *Capability to match Healthfirst members to Aspen RxHealth pharmacists based on language, location, and pharmacist area of specialty*
- *Diverse Pharmacist Community, speaking 25+ languages*
- *Keeps control with health plan, and provides Aspen RxHealth Pharmacist Community as a safety net, called upon at any time to deliver bundled services*

PQA23 ANNUAL MEETING

Comprehensive In-House Medication Management Aligns Quality Priorities



Aligned Outreaches from Within the Plan Results In:				
Information sharing between internal teams	Reduced duplicative outreaches	Ability to impact access to care CAHPS measures	Leveraging existing relationships and trust	Build future relationship with plan

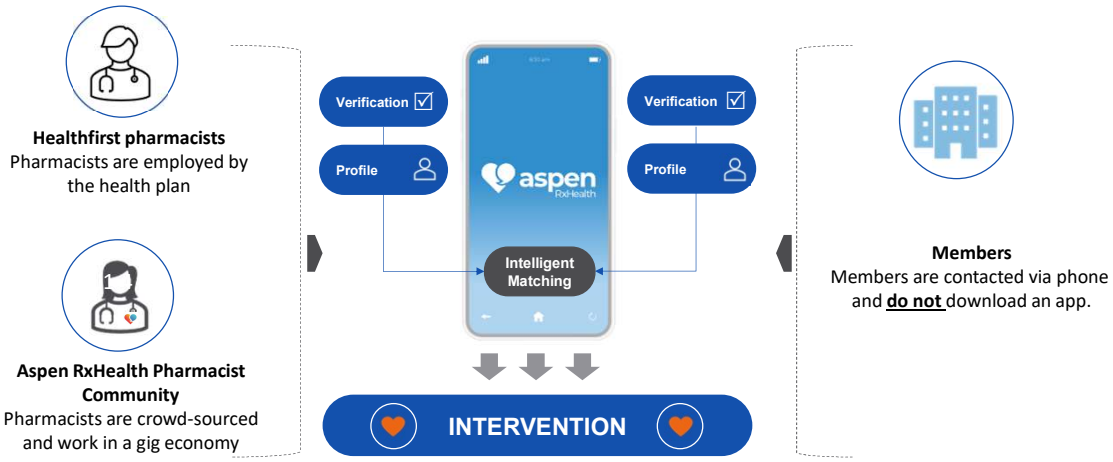
healthfirst
Health Insurance for New Yorkers

aspenRxHealth

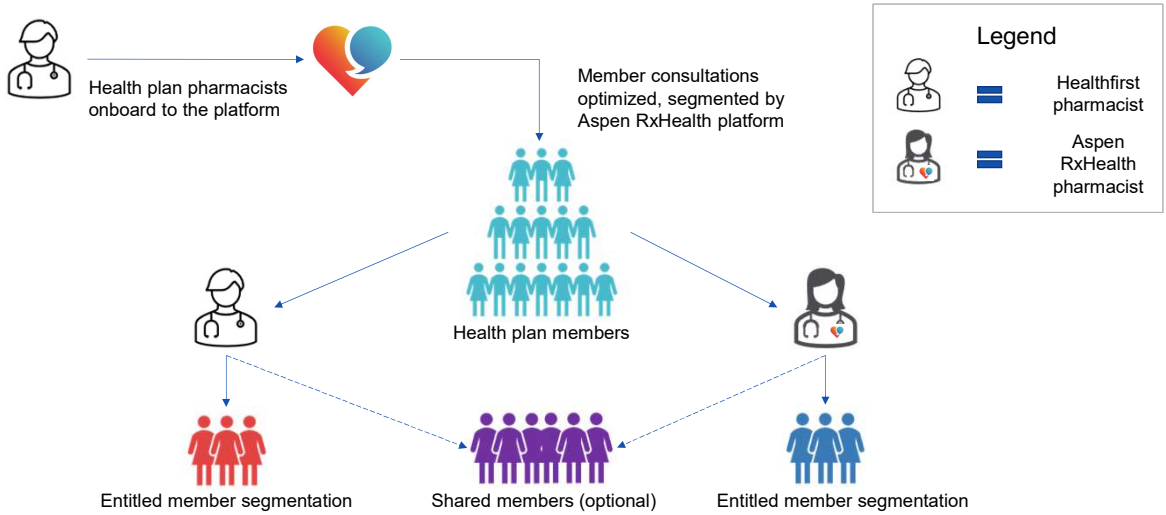
1. **Comprehensive platform – End to end solution**
   Configurable tech platform ready to support in-house pharmacist teams. Supports member consult generation, delivery of consults, and outcomes reporting.
2. **Share subject matter experts (clinical and operational)**
   Provides a secondary team with member engagement expertise, to assist in addressing feedback loops, monitoring quality, and improving programs as a shared partnership goal.
3. **Bundling efficiencies = scale**
   Focus on driving scale, efficiency, and member-centric engagements via bundling model with current and future contracted consultation types. Reduced member abrasion leads to improved experience.
4. **Strategic segmentation options**
   Evolve and adapt with ease. An alliance allows flexible assignments of member segmentations to in-house and Aspen RxHealth pharmacists.
5. **Partners in success, risk mitigation**
   An alliance between Healthfirst and Aspen RxHealth provides flexibility to design and test programs with operational risk impunity.

The Service Delivery Model

A tech-enabled service supporting in-house pharmacy operations delivery of member-facing pharmacist consultations.



Member Segmentation

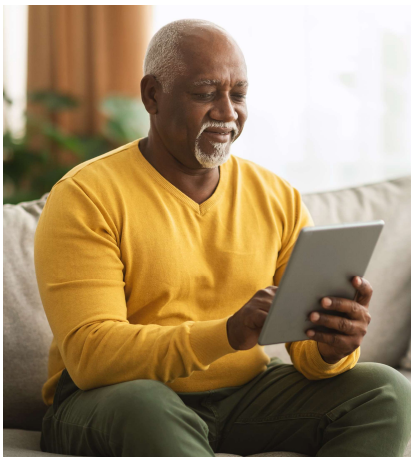


A Real-World Example

JP is a 56-year-old English speaking male, with a past medical history of:

- Hypertension
- Diabetes
- Cholesterol
- COPD
- Acid Reflux
- Depression
- Glaucoma

He completed a comprehensive medication review with a Healthfirst Clinical Pharmacist on 1/19/23.



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A Real-World Example

Indicates gap closure possible via internal program only | Gap closure possible via delegated or internal program

Issue	Barrier	Resolution	Outcome
Lack of access to prescription drugs	Non-DME pharmacy **charging member for nebulizer**	Pharmacist coordinated DME pharmacy transfer	Member happily received nebulizer free of charge to support COPD
Lack of access to prescription drugs	Member is **immobile and Pharmacy refused to deliver**	Contacted pharmacy to provide delivery services and pill box	Member received free delivery of medications resolving adherence and access barriers
Duplicate drug therapy/ member confusion	Member **using two** maintenance inhalers daily from **different MDs**	Alerted and coordinated treatment plan with both prescribers	Formulary-preferred inhaler continued and prevented adverse effects of overuse

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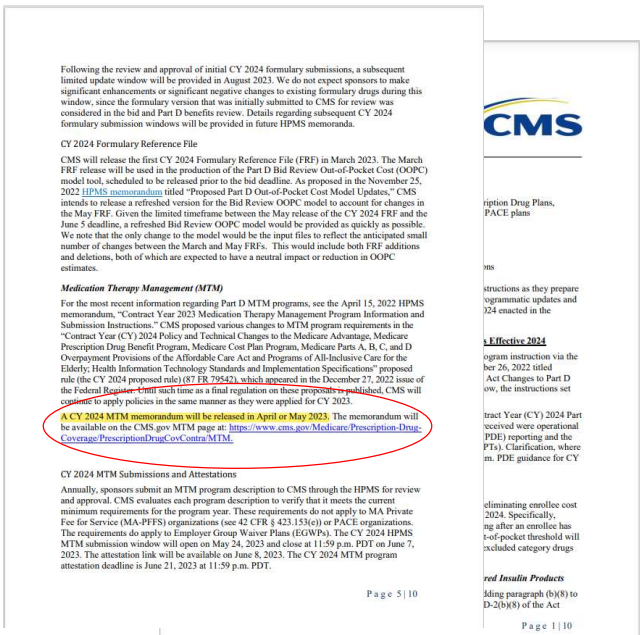
Potential for MTM Expansion as a result of CMS' Proposed Rule



Following the review and approval of initial CY 2024 formulary submissions, a subsequent limited update window will be provided in August 2023. We do not expect sponsors to make significant enhancements or significant negative changes to existing formulary drugs during this window, since the formulary version that was initially submitted to CMS for review was considered in the bid and Part D benefits review. Details regarding subsequent CY 2024 formulary submission windows will be provided in future HPMS memoranda.

CY 2024 Formulary Reference File

CMS will release the first CY 2024 Formulary Reference File (FRF) in March 2023. The March FRF release will be used in the production of the Part D Bid Review Out-of-Pocket Cost (OOPC) model tool, scheduled to be released prior to the bid deadline. As proposed in the November 25, 2022 HPMS memorandum titled "Proposed Part D Out-of-Pocket Cost Model Updates," CMS intends to release a refreshed version for the Bid Review OOPC model to account for changes in the May FRF. Given the limited timeframe between the May release of the CY 2024 FRF and the June 5 deadline, a refreshed Bid Review OOPC model would be provided as quickly as possible. We note that the only change to the model would be the input files to reflect the anticipated small number of changes between the March and May FRFs. This would include both FRF additions and deletions, both of which are expected to have a neutral impact or reduction in OOPC estimates.

Medication Therapy Management (MTM)

For the most recent information regarding Part D MTM programs, see the April 15, 2022 HPMS memorandum, "Contract Year 2023 Medication Therapy Management Program Information and Submission Instructions." CMS proposed various changes to MTM program requirements in the "Contract Year (CY) 2024 Policy and Technical Changes to the Medicare Advantage, Medicare Prescription Drug Benefit Program, Medicare Cost Plan Program, Medicare Parts A, B, C, and D Overpayment Provisions of the Affordable Care Act and Programs of All-Inclusive Care for the Elderly; Health Information Technology Standards and Implementation Specifications" proposed rule (the CY 2024 proposed rule) (87 FR 79542), which appeared in the December 27, 2022 issue of the Federal Register. Until such time as a final regulation on these proposals is published, CMS will continue to apply policies in the same manner as they were applied for CY 2023.

A CY 2024 MTM memorandum will be released in April or May 2023. The memorandum will be available on the CMS.gov MTM page at: https://www.cms.gov/Medicare/Prescription-Drug-Coverage/PrescriptionDrugCovContra/MTM.

CY 2024 MTM Submissions and Attestations

Annually, sponsors submit an MTM program description to CMS through the HPMS for review and approval. CMS evaluates each program description to verify that it meets the current minimum requirements for the program year. These requirements do not apply to MA Private Fee for Service (MA-PFFS) organizations (see 42 CFR § 423.153(e)) or PACE organizations. The requirements do apply to Employer Group Waiver Plans (EGWPs). The CY 2024 HPMS MTM submission window will open on May 24, 2023 and close at 11:59 p.m. PDT on June 7, 2023. The attestation link will be available on June 8, 2023. The CY 2024 MTM program attestation deadline is June 21, 2023 at 11:59 p.m. PDT.

Page 5 | 10

CMS

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structions as they prepare ogrammatic updates and 024 enacted in the

Effective 2024

ogram instruction via the ber 26, 2022 titled Act Changes to Part D ow, the instructions set

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eliminating enrollee cost 2024. Specifically, ng after an enrollee has t-of-pocket threshold will xcluded category drugs

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PQA23 ANNUAL MEETING

Thank You

PQA23 ANNUAL MEETING

Integrating Pharmacists in Team-Based Care: Opportunity to Improve Health Outcomes

PQA23 ANNUAL MEETING

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The findings and conclusions in this presentation are those of the presenters and do not necessarily represent the official position of the Centers for Disease Control and Prevention.

This presentation is not intended to promote any particular legislative, regulatory, or other action.

Objectives

- At the completion of this program, pharmacists will be able to
  - Describe the role of pharmacists in team-based care and associated evidence in improving health outcomes.
  - Identify practical strategies that can be applied to address the challenges of incorporating pharmacists into team-based care.
  - Describe how policies can be used to leverage pharmacist-provided patient care services.

Outline

- Background
- Stories from the Field
- Legal Mechanisms
- Breakout Activity

Background

CDC's Division for Heart Disease and Stroke Prevention

Our Vision

A heart-healthy and stroke-free world

Our Mission

Provide national leadership, public health & scientific expertise, and program support to optimize cardiovascular health for all

https://www.cdc.gov/dhdsp/about_us.htm

PQA23 ANNUAL MEETING

Cardiovascular disease (CVD) is the leading cause of death in the US

National Center for Health Statistics. https://wonder.cdc.gov/mcd.html

PQA23 ANNUAL MEETING

CVD is costly

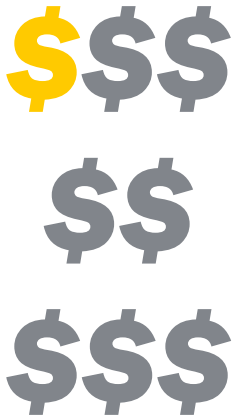
For every **eight** dollars spent on health care in the US,

Tsao et al. *Circulation*. 2023. doi:10.1161/cir.0000000000001123

PQA23 ANNUAL MEETING

CVD is costly

For every **eight** dollars spent on health care in the US, **one** is spent on CVD-related health care



Tsao et al. *Circulation*. 2023. doi:10.1161/cir.0000000000001123

PQA23 ANNUAL MEETING

Declines in heart disease deaths reversed in 2019 to 2020

Woodruff et al. *Circulation.* 2022. doi:10.1161/circ.146.suppl_1.9853

PQA23 ANNUAL MEETING

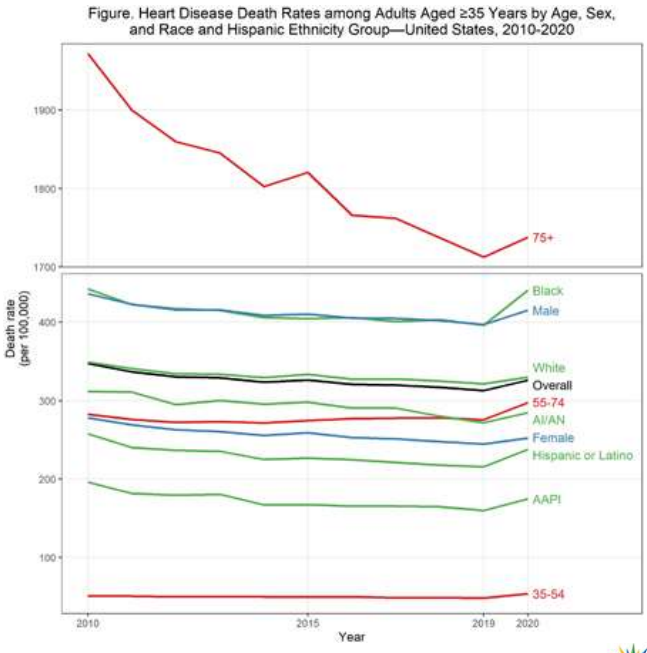
Declines in heart disease deaths reversed in 2019 to 2020

These setbacks represented 5 years of lost progress

Woodruff et al. *Circulation.* 2022. doi:10.1161/circ.146.suppl_1.9853

PQA23 ANNUAL MEETING

Clinical and public health efforts may need to be modified to reverse negative trends in heart disease mortality



Woodruff et al. *Circulation.* 2022. doi:10.1161/circ.146.suppl_1.9853

CVD is the greatest contributor to racial disparities in life expectancy

Purnell et al. *Health Affairs.* 2016. doi:10.1377/hlthaff.2016.0158; Carnethon et al. *Circulation*. 2017. doi:10.1161/cir.0000000000000534

CVD is the greatest contributor to racial disparities in life expectancy

Uncontrolled hypertension is the primary contributor to the morbidity and mortality rate disparities in CVD between Black and White Adults in the US

Purnell et al. *Health Affairs.* 2016. doi:10.1377/hlthaff.2016.0158; Carnethon et al. *Circulation*. 2017. doi:10.1161/cir.0000000000000534

PQA 23 ANNUAL MEETING

Hypertension is common; control is not

Nearly

1 in 2

US adults have hypertension

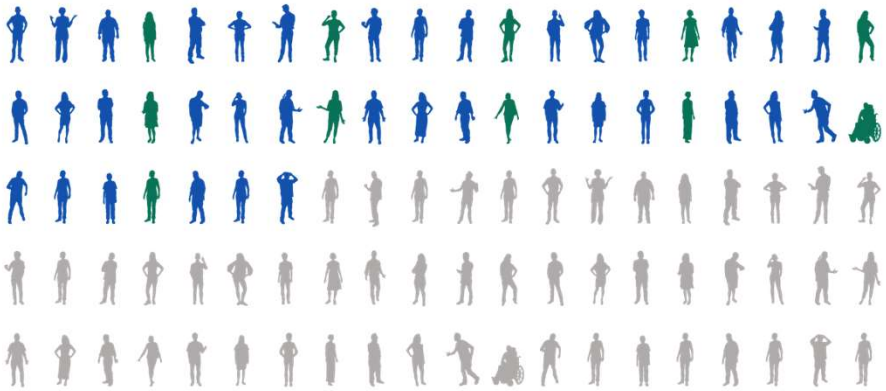
Centers for Disease Control and Prevention. https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html

PQA 23 ANNUAL MEETING

Hypertension is common; control is not

Most

US adults with hypertension do not have it controlled



Centers for Disease Control and Prevention. https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html

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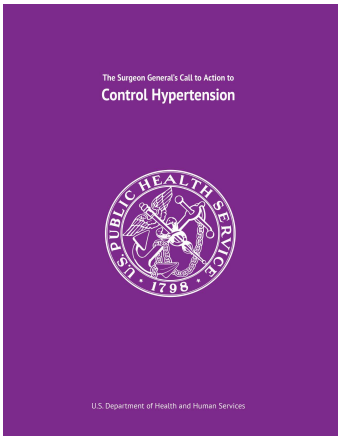
The Surgeon General's Call to Action to Control Hypertension

Key Messages

- **Hypertension control is possible.**
- Hypertension is common; control is not; **together we can change that.**
- Progress has stalled and **disparities persist.**
- **We know what works** to control hypertension; we must tailor, replicate and scale those interventions.
- **Partners are critical to achieving hypertension control among all US adults.**



U.S. Department of Health and Human Services. 2020. https://www.cdc.gov/bloodpressure/CTA.htm

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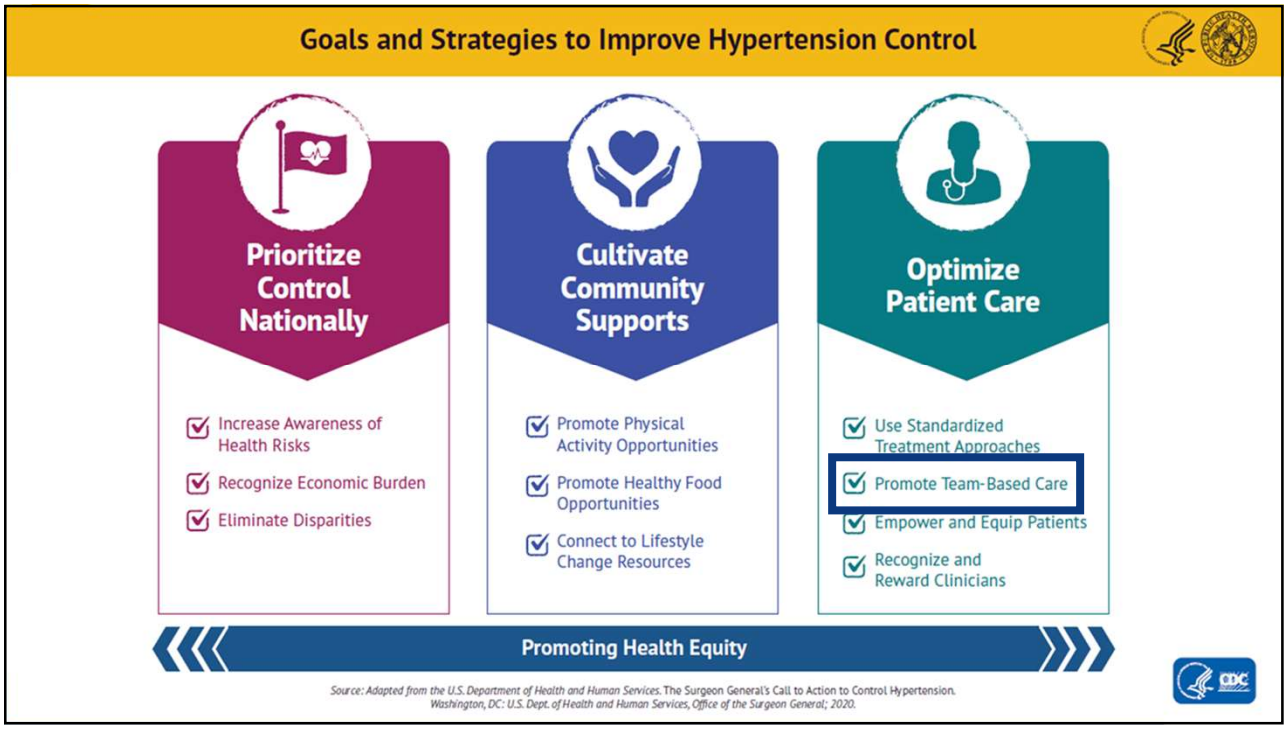

Team-Based Care

aims to enhance patient care by having health professionals from different disciplines work collaboratively with the patient and the patient's primary care clinician

Centers for Disease Control and Prevention. 2022. doi:10.15620/cdc:122290

Team-Based Care

There is strong evidence for the positive impact of TBC on

Health

Health Equity

Economic Outcomes

Centers for Disease Control and Prevention. 2022. doi:10.15620/cdc:122290

PQA23 ANNUAL MEETING

Team-Based Care

There is strong evidence for the positive impact of TBC on

Health

- Improves patient knowledge, health behaviors & medication adherence
- Improves blood pressure, cholesterol, & diabetes control
- Reduces stroke, heart attack, heart disease, heart failure
- Reduces morbidity and mortality

Centers for Disease Control and Prevention. 2022. doi:10.15620/cdc:122290

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Team-Based Care

There is strong evidence for the positive impact of TBC on

Health Equity

Effective for improving blood pressure control for Black, African American, Hispanic, and Latino populations

When implemented by health care professionals who serve patients from racial and ethnic minority groups, TBC is likely to improve health equity and reduce health disparities

Centers for Disease Control and Prevention. 2022. doi:10.15620/cdc:122290

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Team-Based Care

There is strong evidence for the positive impact of TBC on

Economic Outcomes

- Can reduce overall health care costs
- Cost-effective to improve blood pressure control

Centers for Disease Control and Prevention. 2022. doi:10.15620/cdc:122290

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Integration of Pharmacists into Team-Based Care:

Stories from the Field

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Overview

- Explore innovative integration of pharmacists into team-based care initiatives across the United States
- Identify program implementation facilitators and barriers

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Methodology

- Seven programs were selected as case studies
- Representatives from each program were interviewed
- Qualitative data were thematically analyzed

Key Considerations

1) Shared understanding of pharmacists' patient care services, scope of practice, and evidence for improved health outcomes.

2) Communication mechanisms/access to data, data systems, outcome reporting, and financial arrangement in early conversations, agreements, and pilots.

Lessons Learned: Collaboration and Education

- Demonstrate clinical, financial, and operational value
- Collaborate with physicians during early program development
- Understand various roles in a clinical care team
- Leverage partnerships
- Generate awareness of the Pharmacists Patient Care Process

Lessons Learned: Communication and Data Utilization

- Promote data sharing
- Quantify health and economic outcomes
- Observe patient and physician satisfaction
- Track process and outcome measures related to primary/initial program goals
- Discuss the timeline and plan for payments
- Determine initial referral pathways

Successful expansion of evidence-based pharmacist patient care services requires **multi-sector collaboration**

Field Notes

Rural Arizona Medication Therapy Management (RAzMTM) Program

https://www.cdc.gov/dhdsp/docs/Field_Notes_RAzMTM-508.pdf

Geisinger Ambulatory Pharmacy Care Program

https://www.cdc.gov/dhdsp/docs/Field_Notes_Geisinger_Ambulatory-508.pdf

Legal Mechanisms to Expand Pharmacist's Role in Team-Based Care

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Legal Mechanisms to Expand Pharmacist's Role in Team-Based Care

- Collaborative Practice Agreement
- Statewide Protocol
- Standing Order

Centers for Disease Control and Prevention. Advancing Team-Based Care Through Collaborative Practice Agreements: A Resource and Implementation Guide for Adding Pharmacists to the Care Team. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2017
Adams AJ, Weaver KK. The Continuum of Pharmacist Prescriptive Authority. Ann Pharmacother. 2016 Sep;50(9):778-84. doi: 10.1177/1060028016653608. Epub 2016 Jun 15. PMID: 27307413.

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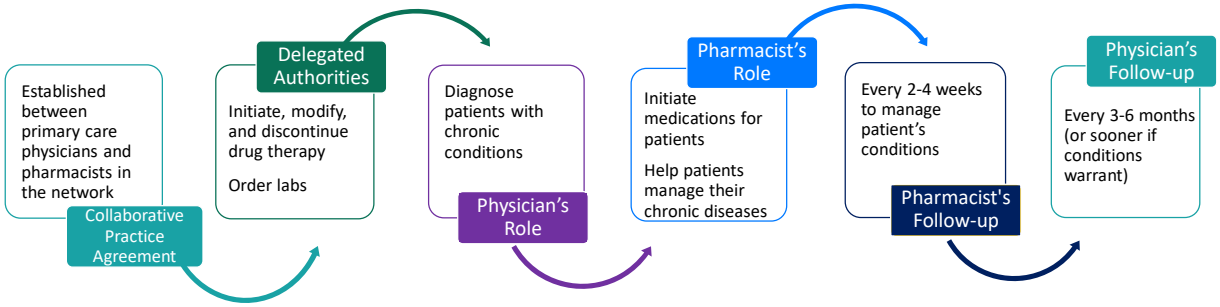
State laws and regulations vary widely

Collaborative Practice Agreement	Statewide Protocol	Standing Order
Formal practice between a pharmacist and a prescriber wherein specific patient care services are delegated to the pharmacist	Issued by an authorized state body that may be followed by any pharmacist who meets criteria specified in the protocol	Approved by a prescriber or issued by a public provider, such as the director of the state's health department
Services are provided under the direct supervision of the collaborating prescriber	No direct supervision or collaborating prescriber required	No direct supervision or collaborating prescriber required
Usually in the context of drug therapy management	Usually for preventive care or for self-limiting conditions that require no diagnosis or are easily diagnosed	Usually limited to a specific medication or category of medications

Centers for Disease Control and Prevention. Advancing Team-Based Care Through Collaborative Practice Agreements: A Resource and Implementation Guide for Adding Pharmacists to the Care Team. Atlanta, GA: Centers for Disease Control and Prevention, U.S. Department of Health and Human Services; 2017
Adams AJ, Weaver KK. The Continuum of Pharmacist Prescriptive Authority. Ann Pharmacother. 2016 Sep;50(9):778-84. doi: 10.1177/1060028016653608. Epub 2016 Jun 15. PMID: 27307413.

Example: Story from the Field

Program Type: Integrated network of 8 federally qualified health centers



Breakout Activity

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Your group has been assigned a partner sector

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You have been asked to develop a **new partnership** to implement a pharmacist-led program for hypertension management in a community-based setting

References

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2. Tsao CW, Aday AW, Almarzooq ZI, et al. Heart Disease and Stroke Statistics—2023 Update: A Report From the American Heart Association. *Circulation*. Published online 2023. doi:10.1161/cir.0000000000001123
3. Woodruff RC, Tong X, Jackson SL, Loustalot FV, Vaughan AS. Abstract 9853: Trends in National Death Rates From Heart Disease in the United States, 2010-2020. *Circulation*. October 30 2022;146:A9853. doi:10.1161/circ.146.suppl_1.9853
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5. Carnethon MR, Pu J, Howard G, et al. Cardiovascular Health in African Americans: A Scientific Statement From the American Heart Association. Circulation. Nov 21 2017;136(21):e393-e423. doi:10.1161/cir.0000000000000534
6. Centers for Disease Control and Prevention. Hypertension Cascade: Hypertension Prevalence, Treatment and Control Estimates Among US Adults Aged 18 Years and Older Applying the Criteria From the American College of Cardiology and American Heart Association's 2017 Hypertension Guideline—NHANES 2015–2018. Accessed March 14, 2023. https://millionhearts.hhs.gov/data-reports/hypertension-prevalence.html

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8. U.S. Department of Health and Human Services. The Surgeon General's Call to Action to Control Hypertension. Washington, DC: U.S. Department of Health and Human Services, Office of the Surgeon General; 2020.
9. Centers for Disease Control and Prevention. Best Practices for Heart Disease and Stroke: A Guide to Effective Approaches and Strategies. Centers for Disease Control and Prevention; 2022. doi:10.15620/cdc:122290
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11. Adams AJ, Weaver KK. The Continuum of Pharmacist Prescriptive Authority. Ann Pharmacother. 2016 Sep;50(9):778-84. doi: 10.1177/1060028016653608. Epub 2016 Jun 15. PMID: 27307413.

Resources

- Best Practices for Heart Disease and Stroke: A Guide | CDC
- Pharmacists' Patient Care Process Approach Guide | cdc.gov
- Evaluation Spotlights & Strategies | cdc.gov
- Pharmacy Resources | cdc.gov
- Community Pharmacy Policy Resources | cdc.gov

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Thank You

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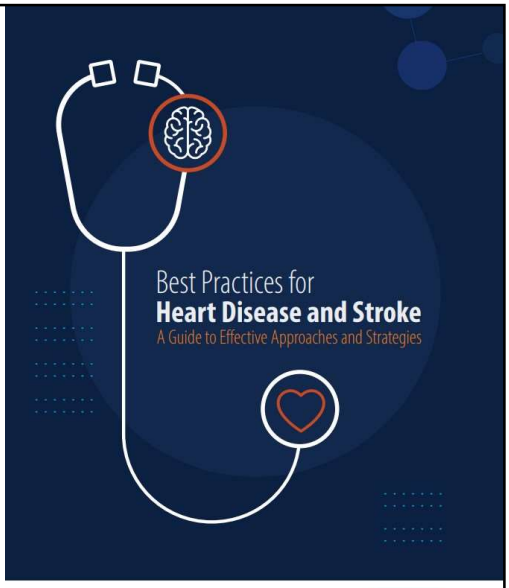
Resources

Best Practices Guide for Heart Disease and Stroke

In this resource, you will find strategy summaries based on evidence reviews for **18 evidence-based strategies**:

- Brief description of the strategy
- Short summary of the findings
- Strength of research evidence
- Evidence of impact
- Best Practice in Action stories
- Implementation considerations



https://www.cdc.gov/dhdsp/pubs/guides/best-practices/index.htm

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Best Practices Guide for Heart Disease and Stroke

Coordinating Services for Cardiovascular Events
- Cardiac Rehabilitation
- Emergency Medical Service Systems
- Public Access Defibrillation
- Stroke Center Certification

Engaging Organizations to Promote Cardiovascular Health
- Reducing Sodium
- Workplace Health Promotion

Implementing Technology-Based Strategies to Optimize Cardiovascular Care
- Clinical Decision Support Systems
- Telehealth

Leveraging Community and Clinical Public Health Workforces
- Community Health Workers
- Community Paramedicine
- Collaborative Drug Therapy Management
- Community Pharmacists
- Tailored Pharmacy-based Interventions
- Team-based Care

Supporting Patients in Cardiovascular Disease Self-Management
- Lifestyle Modification Programs
- Reducing Out-of-Pocket Costs
- Self-Management Support and Education
- Self-Measured Blood Pressure Monitoring

https://www.cdc.gov/dhdsp/pubs/guides/best-practices/index.htm

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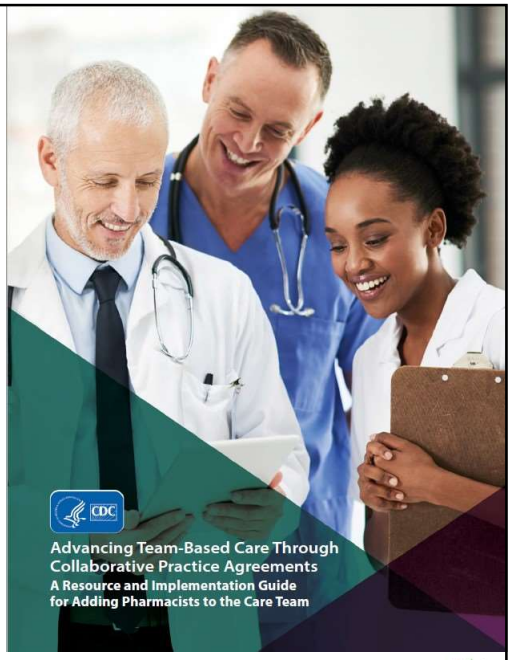
Advancing Team-Based Care Through Collaborative Practice Agreements

In this resource, you will find information about:

- How to use CPAs to facilitate team-based care
- Developing collaborative relationships
- Adapting a template CPA for heart disease
- Considerations for facilitating the use of CPAs
- Legal authorities



https://www.cdc.gov/dhdsp/pubs/docs/CPA-Team-Based-Care.pdf

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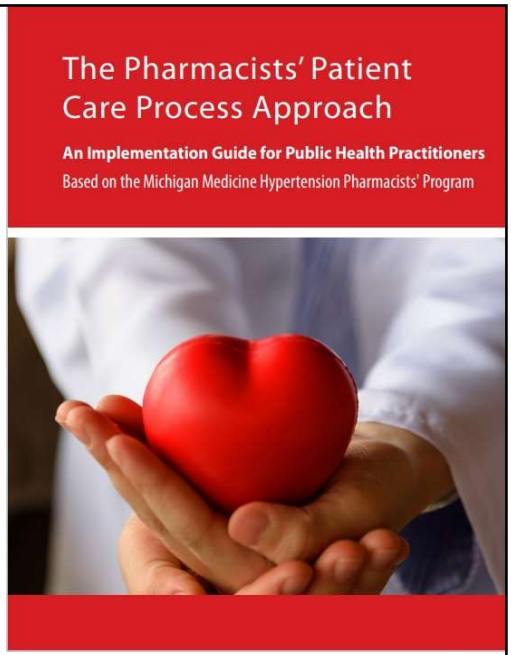
The Pharmacists' Patient Care Process Approach

In this resource, you will find information about:

- The Pharmacists' Patient Care Process Framework
- Overview of the Michigan Medicine Hypertension Pharmacists' Program (MMHPP)
- Findings from rigorous evaluation of MMHPP
- Core elements of the MMHPP
- Considerations for starting a hypertension pharmacists' program



https://www.cdc.gov/dhdsp/evaluation_resources/guides/pharmacists_patient_care.htm

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Medication Adherence: A Force Multiplier for Star Ratings Success

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Chief Executive Officer, AdhereHealth

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Objectives

- At the completion of this program, pharmacists will be able to
  - Investigate important trends in the 2023 Star Ratings performance data.
  - List all the areas of the Star Ratings framework that medication adherence directly influences.
  - Analyze how medication adherence is the catalyst to improve overall Star Ratings performance and acts as a "force multiplier".
  - Review multidisciplinary, data-driven strategies to drive medication adherence among high-risk populations, improve Star Ratings, and jumpstart a positive feedback loop.

The Crippling Impact of Nonadherence

50% of chronic disease patients fail to take their medications as prescribed[1]

50-70%
picked up

25-30%
taken as directed

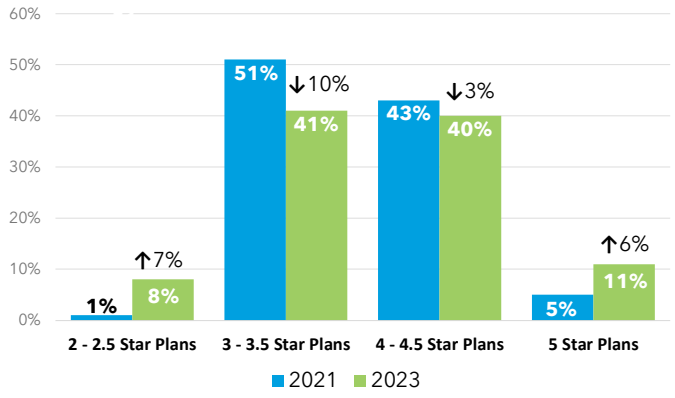
15-20%
refilled[2]

MA Stars Distribution: 2023 vs 2021 Star Ratings

2021 Star Ratings
Plans +/- 4 Stars[3]

2023 Star Ratings
Plans +/- 4 Stars[4]

Plan Performance Distribution
2021 to 2023[4]



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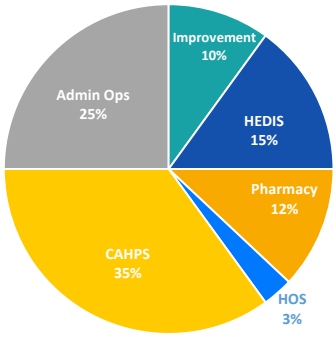
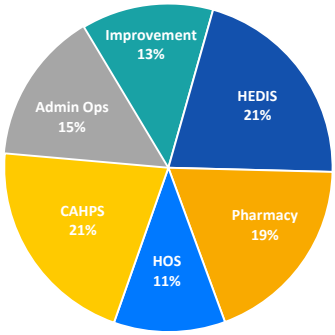
CMS Consistently Demands Increased Performance

Experience measures continue to emphasize performance excellence:
Increased from 75% to 85% in MY24[5]

MY22/SY24
Star Ratings Composition



MY24/SY26
Star Ratings Composition + Proposed Changes



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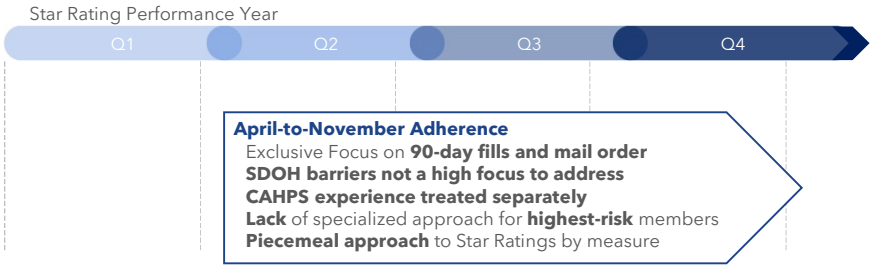
"One-Size-Fits-All" Approach to Adherence Won't Work for Nonadherent Members

CMS Realities

- Cut points continue to rise
- Competition for QBP is increasing
- Adherence, Quality and CAHPS measures drive majority of Star Rating
- Existing approaches don't address challenges with highest-risk members
- Plans achieving higher adherence improve other measures through "force multiplier" effect

Highest-risk, unengaged members require a different approach



Health plans must adjust approach to remain competitive

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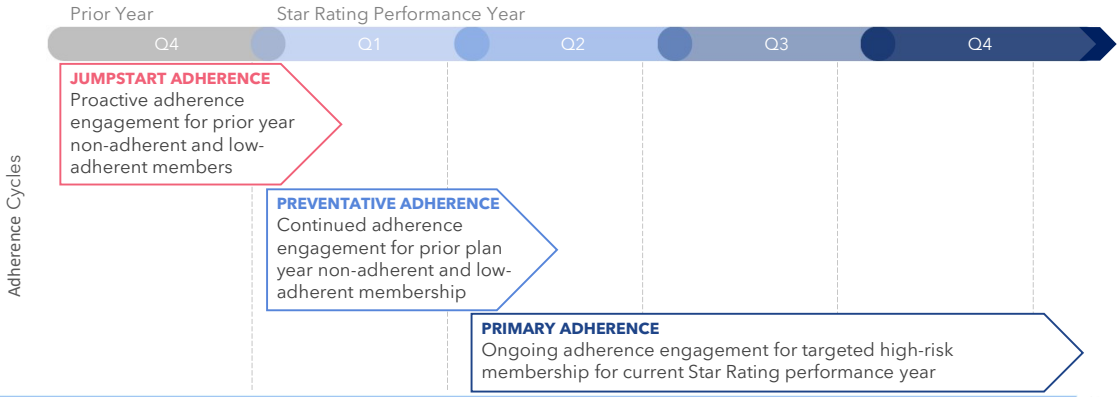
Year-Round Adherence Builds Momentum for High-Risk Members

A 15-month adherence journey guides highest-risk, unengaged members to overcome SDOH



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Medication Adherence is a "Force Multiplier" That Drives Compounding Change

Beyond their 3x scoring power, Part D adherence measures heavily influence additional measures that impact overall Star Rating performance.[6]

32% Of Star Rating
CAHPS/HOS Patient Experience

CAHPS improvement driven by SDOH-focused adherence improvement, especially in highest-risk

4.2% Of Star Rating
Part C Intermediate Outcomes Measures

Diabetes blood sugar control and controlling blood pressure closely tied to adherence

13% Of Star Rating
Drug Plan Quality Improvement

Part D measurement year-over-year momentum heavily influenced by adherence and CAHPS scores

2.1% Of Star Rating
Statin Use in Persons w/Diabetes and Statin Use in Persons w/CVD

Directly influenced by improved Statin medication adherence

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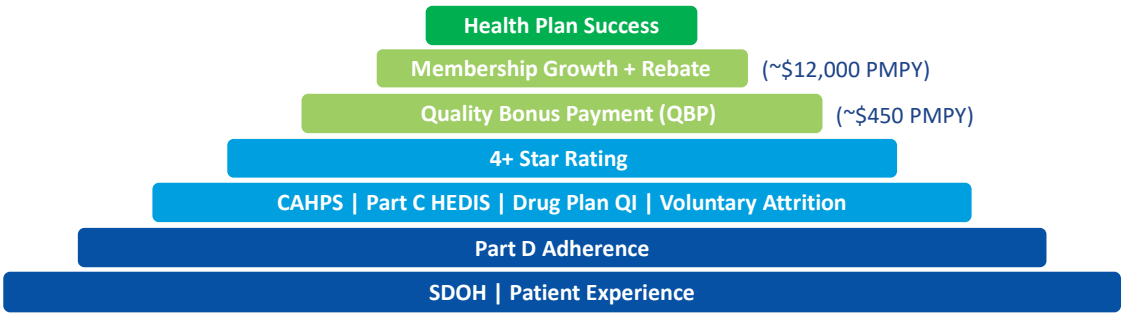
Star Ratings Influence ~$50 Billion in Revenue for MA Plans

- The **relationship of adherence** to CAHPS, QI and attrition is not just about quality bonus payment (QBP), but **also about increased enrollment**.
- According to JAMA[7] and Guidehouse/Navigant[8] studies, "a 1 star increase in Star Rating is associated with an 8 to 12 percent increase in beneficiary enrollment."



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Example: Projected Star Rating Improvement

Example deidentified MA plan with 25,026 members.

Projections based on historical performance for similar health plans.

Projected Improvement in Triple-Weighted Adherence Measures

- **Diabetes**: from 3 to 4
- **RAS**: from 4 to 5
- **Statin**: from 3 to 5

*Mock health plan used for illustration. When presented to a client, actual data from their health plan(s) used.

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Achieving 4 Stars Enables 25k Member Plan to Achieve $24.9 Million ROI

Based on projected adherence Star Rating improvement, and applying projected "Force Multiplier" metrics

Projected Star Ratings improvement and ROI:

- **Star Rating Improvement**: +0.5
- **New Star Rating**: 4.0
- **QBP + Rebate Revenue**: $9.76M
- **New Member Revenue**: $15.14M

TOTAL ROI: $24.9M

*Mock health plan used for illustration. When presented to a client, actual data from their health plan(s) used.

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References

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3. Centers for Medicare & Medicaid Services (CMS). Fact Sheet – 2021 Part C and Part D Star Ratings. 2020. pg 2. 2021 Star Ratings Fact Sheet (cms.gov)
4. Centers for Medicare & Medicaid Services (CMS). Fact Sheet – 2023 Medicare Advantage Part D Star Ratings. 2022. pg 5. 2023-medicare-star-ratings-fact-sheet.pdf (cms.gov).
5. Centers for Medicare & Medicaid Services (CMS). Medicare Program; Contract Year 2024 Policy and Technical Changes to the Medicare Advantage Program. 2023. 539-545. https://public-inspection.federalregister.gov/2022-26956.pdf

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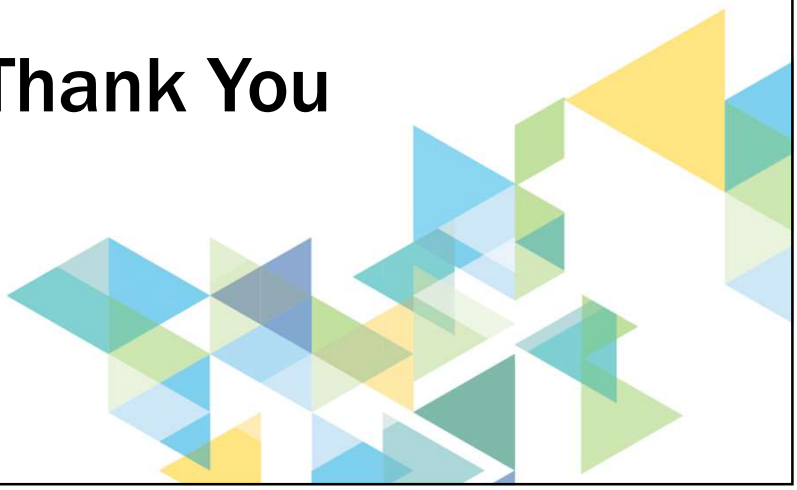
6. Rose J. Contributor: Medication Adherence Is a "Force Multiplier" for Medicare Advantage Profitability, Enrollment, Star Ratings. American Journal of Managed Care (AJMC). January 2023. Contributor: Medication Adherence Is a "Force Multiplier" for Medicare Advantage Profitability, Enrollment, Star Ratings (ajmc.com)
7. Reid R, Deb P, Howell, B. Association Between Medicare Advantage Plan Star Ratings and Enrollment. JAMA. 2013. 267-274. JAMA Network
8. Bajner R, Meinkow E, Munroe J, Smith J, Stanley D, McHugh J. The Impact of Star Ratings on Rapidly Growing Medicare Advantage Market. Guidehouse Media. February 2018. Guidehouse website

Thank You



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One Size Does Not Fit All: Value-Based Pharmacy Payment Models in Practice

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Objectives

- At the completion of this program, pharmacists will be able to
  - Describe the most common value-based pharmacy payment models.
  - Evaluate the input variables needed for drafting value-based pharmacy payments
  - Recommend differences in measurement criteria based on virtual or live pharmaceutical care.

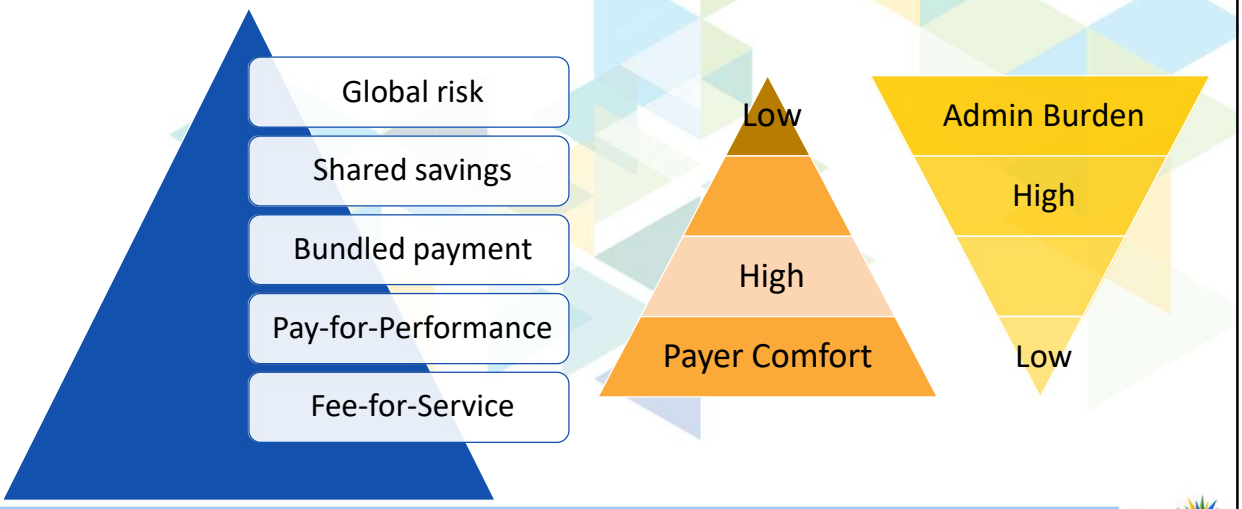
What is value?

val·ue

/va · lyoo/

the regard that something is held to deserve; the importance, worth, or usefulness of something

Value Continuum



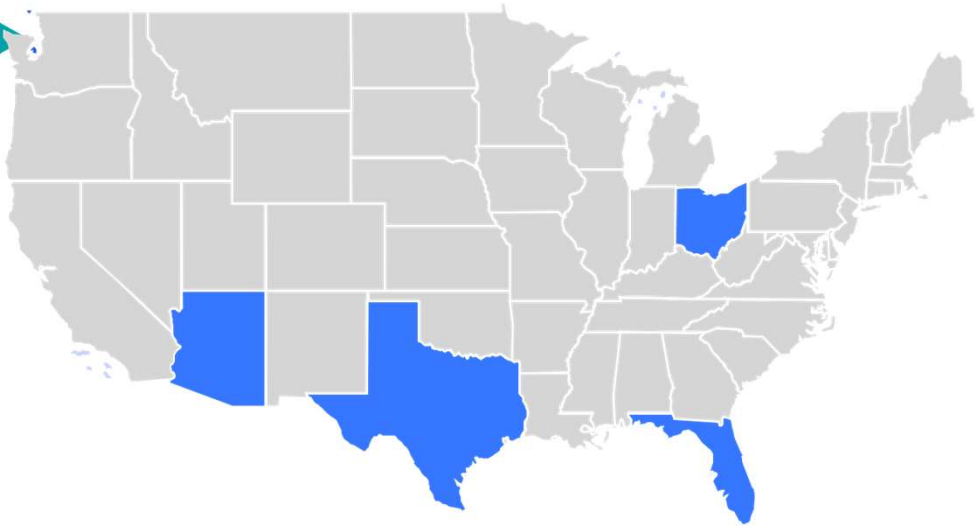
VBA Model Design Considerations

ADMIN
- Network
- Budget
- Geography
- Oversight
- Risk contracting

TECH
- Data exchange
- Outcomes measurement
- Assignment

CLINICAL
- Outcomes alignment
- Outcomes attribution
- Clinical context sharing

Community Pharmacy VBA Program | Population



Medicare Advantage • 67,000 Total Members • 1,400 Enrolled

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Community Pharmacy VBA Program | Model Design

Interventions

2021 Services

- Adherence
- Blood Pressure
- Hemoglobin A1c
- Statin Use
- Annual Flu Vaccine

2022 Expansion

- Osteoporosis Management
- Breast Cancer Screening
- Colon Cancer Screening
- Diabetes Eye Exam

Measurement

Part C – STAR

Part D - STAR

Payment Model

2021: Capitated + Bonus

2022: Fee-for-service

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Community Pharmacy VBA Program | Outcomes

2,572	Pharmacist encounters
43%	Care gaps acted on
757	BP and HbA1c reported

Adherence	BP & HbA1c	Screenings & Exams	Influenza Vaccine	Osteoporosis Management	Statin Use
+1.21%	*N/A*	*+1.14%*	*+7.32%*	*-6.27%*	*+7.55%*

Findings based on a cohort analysis of 1,400 CVBA enrolled members versus non-enrolled population

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Community Pharmacy VBA Program | Learnings

Wins

Service Expansion
Network Engagement
Robust Data Sharing

Challenges

Network Coverage
Performance Oversight
Incentive Structure

Opportunities

Continuity|In-House & Network
Leverage Supplemental Data
Integrating SNOMED CT

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Considering Delivery Setting

- Pharmacy intervention can be delivered virtually or in-person
- Dynamism in omnichannel strategy increases opportunity for engagement

Virtual Care Settings

- Flexible communication windows
- Rapid access to most targeted patients
- Shorter care cycles
- Quality metrics are adopting virtual check-ins

In-Person Care Settings

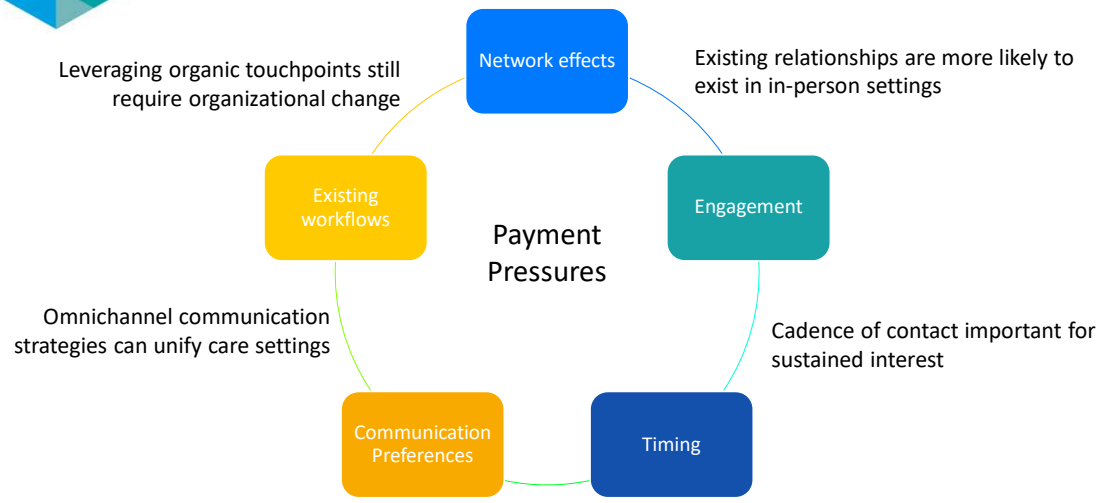
More effective show and tell

Target patient traffic is inbound

Allows for more complex interactions

Physical assessment and non-verbal observations

Delivery Setting Influence on Payment Models



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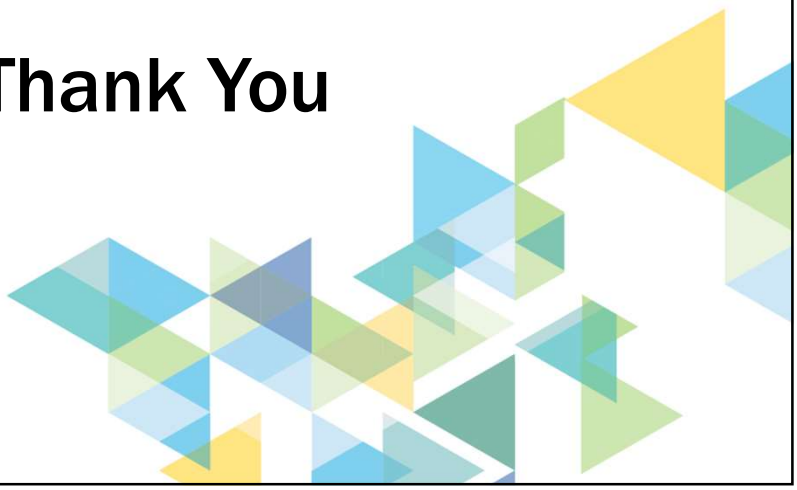

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Overcoming Regulatory Constraints While Delivering Pharmacist-Provided Care and Services

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Objectives

- At the completion of this program, pharmacists will be able to
  - Identify value-based care pharmacy practice opportunities.
  - Describe collaborative practice agreements (CPAs), statewide protocols, and standing orders.
  - Discuss opportunities to address current legislative and regulatory constraints related to pharmacist-provided care and services.

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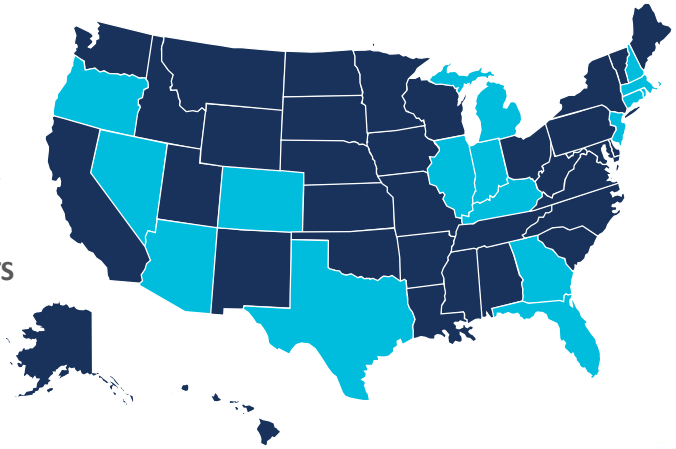
Introduction to VillageMD

20,000+
WORKFORCE

680 PRACTICE LOCATIONS

26 ACTIVE MARKETS



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Introduction to VillageMD

Village Medical™

CLINIC

Access and convenience for patients and physicians, with a continuum-of-care model, delivering far better outcomes in a clinic setting.

VIRTUAL VISITS

Visits on a computer or smartphone for patients who want quality care from experienced providers without traveling to a clinic.

HOME

An extension of the primary care physician's office, meeting patients where they are most comfortable – in their home.

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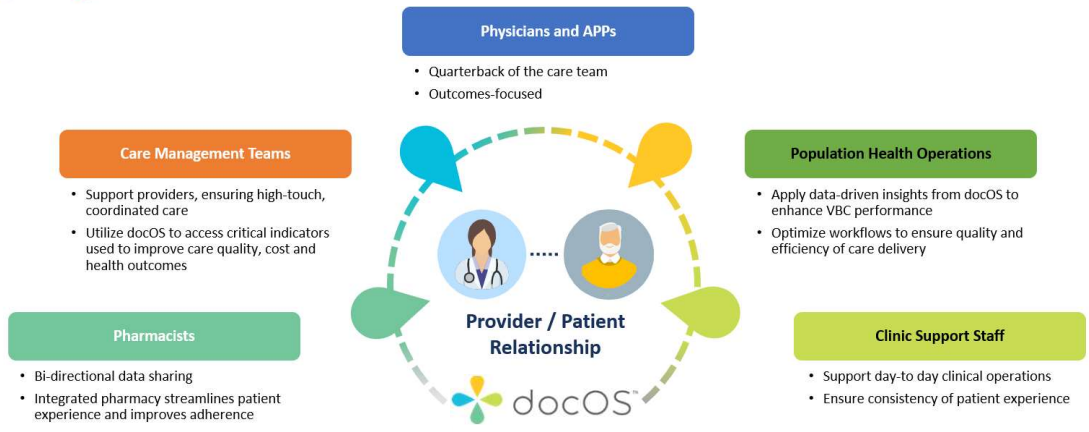
Introduction to VillageMD



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Healthcare's Shift to Value-Based Care

In the past, physicians were rewarded for how many services they delivered to their patients.

Now, physicians are beginning to be rewarded for how well they take care of their patients.

CMMI Objective:
100% of Medicare beneficiaries in an accountable care relationship by 2030

Healthcare's Shift to Value-Based Care

Fee-for-Service (FFS)

- Reimbursement based on the number of health care services
- Model does not incentivize health systems for quality
- Model does not always correlate to high value healthcare with optimal health outcomes

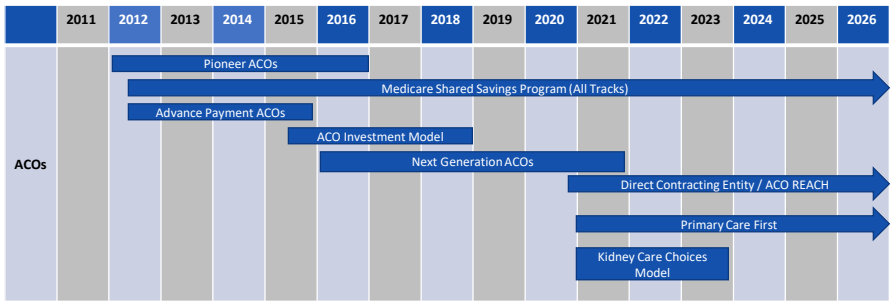
Value-Based Care (VBC)

- Reimbursement is **not** based on the number of health care services
- Fosters accountability throughout the entire health care system
- Promotes clinical innovations and coordination of care

Regardless of model, the patient is always at the center of care

Healthcare's Shift to Value-Based Care

Timeline: Accountable Care Organizations



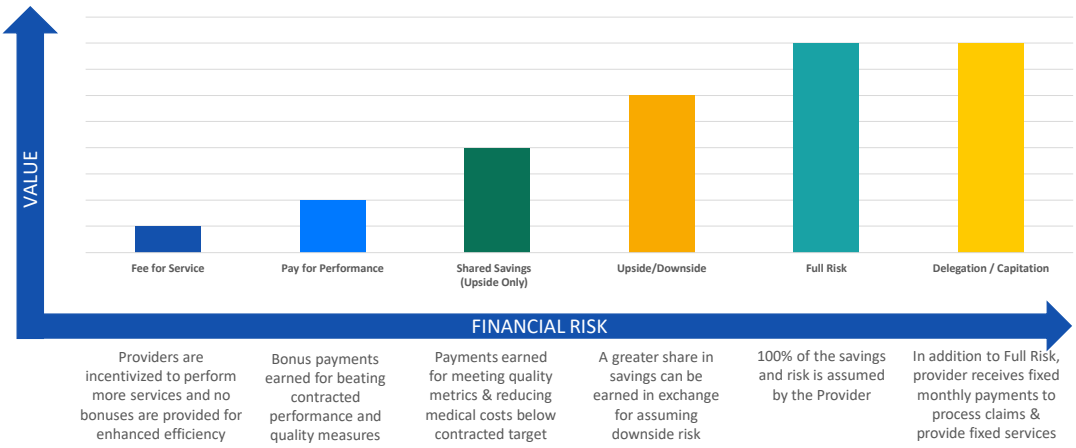
*CMS BPCI Model 2-4: Year 5 Evaluation and Monitoring Annual Report

What is a Value-Based Contract?

- Targets are set for quality metrics and medical costs. If providers achieve these quality targets and **actual costs** come in below the **medical cost target** for a defined measurement period, they have an opportunity to share in those savings while improving healthcare costs and patient quality outcomes.

Meet Quality Targets + Reduce healthcare costs compared to a benchmark = Savings

What is a Value-Based Contract?



Pharmacy Practice Opportunities in Value-Based Care

Achieve Quality Targets	Improve Health Outcomes	Reduce Total Cost of Care	Decrease Administrative Burden
Medicare Advantage Star Ratings	Diabetes and Hypertension Control	Admissions	Protocols (Refills, PAs)
ACO REACH Quality Withhold	Medication Adherence	Specialty Spend	Collaborative Practice Agreements

Pharmacy Practice Opportunities in Value-Based Care

- Without fee-for-service revenue, the return on investment for adding a pharmacist will likely only be generated with more significant shared savings (i.e., more advanced financial risk models).
- How can groups not as far along in their risk journey benefit?

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Pair and Share

- **Design a pharmacy service that would improve quality in your organization.**
- **What are the top 3 barriers to launching this service?**

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Pharmacist-Provided Services and Care

Community Pharmacy	Ambulatory Care
• Chronic Care management • Immunizations • Medication therapy management • Point-of-care testing • Test to treat	• Chronic disease state management • Comprehensive medication management • Medicare annual wellness visits • Transitions of care

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Pathways for Providing Care

- Federal Authorizations
- Provider Status
- Collaborative Practice Agreements
- Standing Orders
- Statewide Protocols
- Prescriptive Authority

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Federal Authorizations

COVID therapeutics

Vaccine Authority

Medicare Provider Status

- Restrictive CPT codes
- Must bill as "qualified non-physician provider"
- Other healthcare professionals may bill for services pharmacists provide for free

Current Billing Strategies for Clinical/Cognitive Services?

Bill sent to: THIRD PARTY on behalf of the physician. Payment sent to: Physician Applications

Bill sent to: THIRD PARTY Payment sent to: Pharmacist or Pharmacy Applications: Limited to approved categories

Provider status (Cognitive Skill Reimbursement)

Nevada	• Prescribe and dispense hormonal contraceptives, PrEP, PEP • Permit pharmacists in outpatient settings to be reimbursed for hormonal contraceptive and HIV preventive services
Washington	• all practice settings can enroll in commercial health plan provider networks and bill for covered patient care services within the pharmacist's scope of practice
Wisconsin	• Non-physician providers under Medicaid • Immunizations, medication injections, travel medicine visits, comprehensive medication management, point-of-care testing with management, and chronic disease management

CPA – Provider Specific

Disease State Management	Medication Therapy Management	Chronic Condition Management	Patient Care Services
Therapeutic Interchange	Bridge Refill	Prior Authorizations	Gap Closures
	Test and Treat	Point-of-Care Testing	

Credential versus Privilege

Credential	Privilege

• Board of Pharmacy Specialties
• PharmD
• Residency
• State Specific
  • California: Advanced Practice Pharmacist
  • Florida: Pharmacist Collaborative Practice Certification
  • North Carolina and Montana: Clinical Pharmacist Practitioner
	• Collaborative Practice Agreements
	• Special Waiver Allowance
	• Standing Orders

Language is Crucial: Each State is Different

Restrictive

- Physicians only CPAs
- Pharmacist requirements
  - ASHP Residency
  - Onsite supervised clinical practice
  - Board Specialty certification
- Requiring patient-provider relationships for PCOT
- Different requirements for different practice settings
- Requiring each provider or pharmacist to sign CPA

Ideal

- Allowing CPAs to be electronic
- Allowing all providers with autonomous practice authority able to enter CPAs
- Patient Informed Consent to apply for all services
- Allowing Medical Directors and Pharmacist-In-Charge to sign CPAs
- Including Class of Medications and Conditions
- Allowing Patient Care Services in addition to Medication Therapy Management

Standing Orders

Maryland and Wisconsin

- Naloxone

North Carolina

- Nicotine Replacement Therapy
- Prenatal Vitamins
- Glucagon for the treatment of severe hypoglycemia
- Self-administered oral or transdermal contraceptives
- PEP

Statewide Protocols

Colorado

- Hormonal contraceptives
- Smoking Cessation
- HIV prophylaxis
- Statin Therapy

Iowa

- Naloxone
- Tobacco Cessation
- Immunizations
- PCOT and Treat: Influenza, Strep A, and COVID

Virginia

- Devices
- Controlled paraphernalia

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Benefits vs Restrictions

	Benefits	Restrictions
CPA	Pharmacists can provide pharmaceutical care services	State-specific guidelines
Standing Order	Gives all Pharmacists in state ability to use	State Public Health Officer authorizes
Statewide Protocols	Services are predictable across the state	Must meet requirements set by BOP, Board of Nursing, and Board of Medicine

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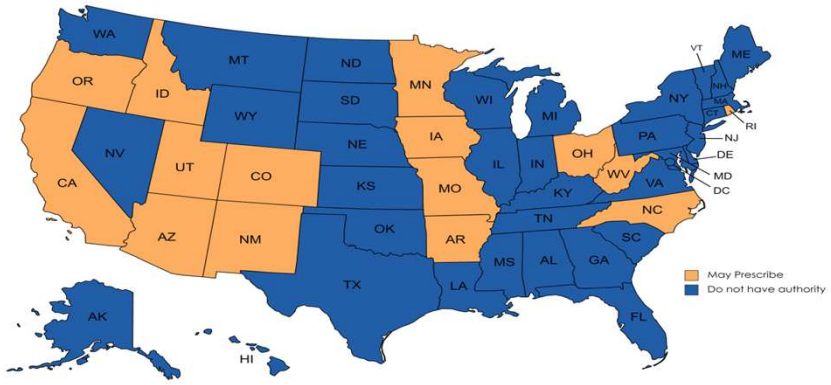
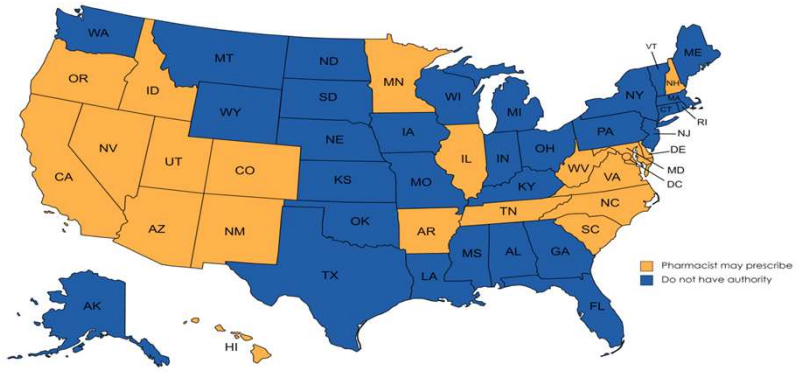
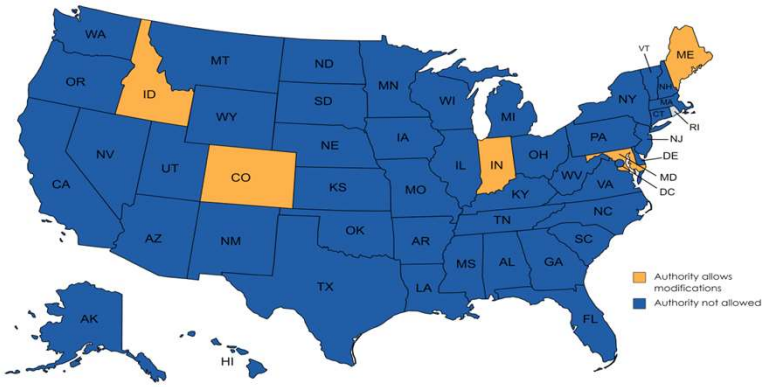
Prescriptive Authority: Tobacco Cessation Therapy



Prescriptive Authority: Hormonal Contraception



Therapeutic Modifications

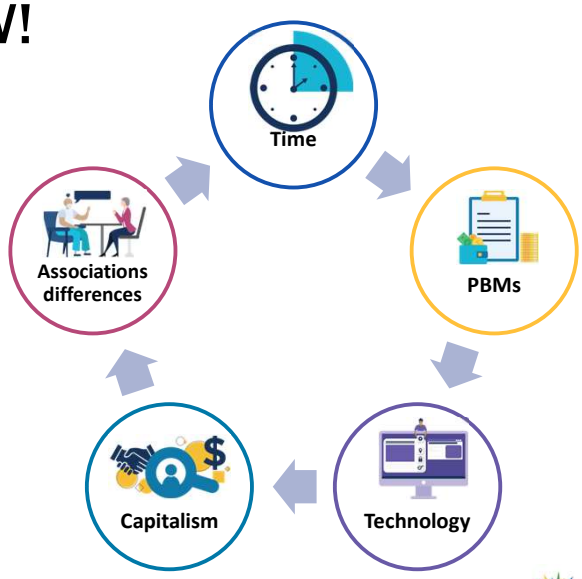


Technicians

- Stats
  - Almost 300,000 PTCB-certified pharmacy technicians
  - Only 3 states do not require pharmacy technicians to be registered or licensed (HI, PA, and WI)
  - Vaccine Administration Authority in 21 states
- Duties
  - Taking medication histories
  - Final product verification
  - Managing inventory
  - Managing patients in a medication synchronization program
  - Sterile and nonsterile compounding
  - Technology Assisted Verification of Final Product

WE MUST ACT NOW!

- **Regulatory changes that allow CPAs, standing orders, statewide protocols, and prescriptive authority**
- **Advocate how pharmacists are improving patient care**



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- Urick BY, Meggs EV. Towards a Greater Professional Standing: Evolution of Pharmacy Practice and Education, 1920-2020. Pharmacy (Basel). 2019 Jul 20;7(3):98. doi: 10.3390/pharmacy7030098. PMID: 31330761; PMCID: PMC6789879.
- U.S. Centers for Medicare & Medicaid Services. Accessed March 29, 2022. https://innovation.cms.gov/

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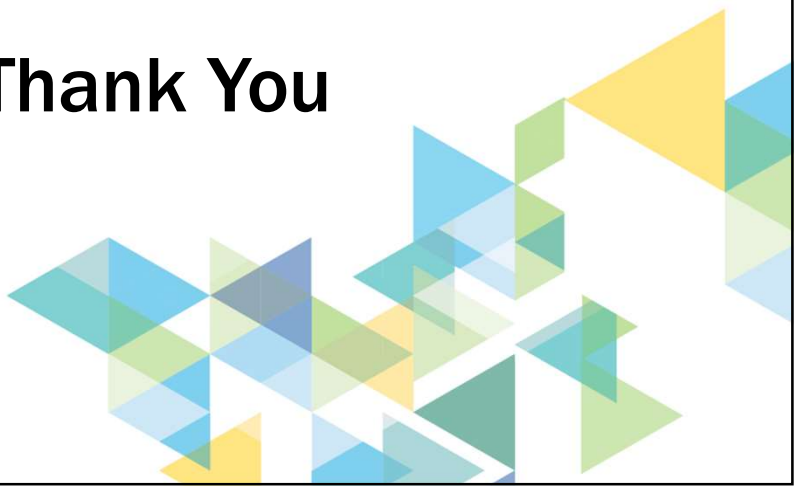
Thank You



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Pharmacy and Beyond: Advancing the Quality of Pharmacist-Provided Care by Optimizing Multidisciplinary Strategies

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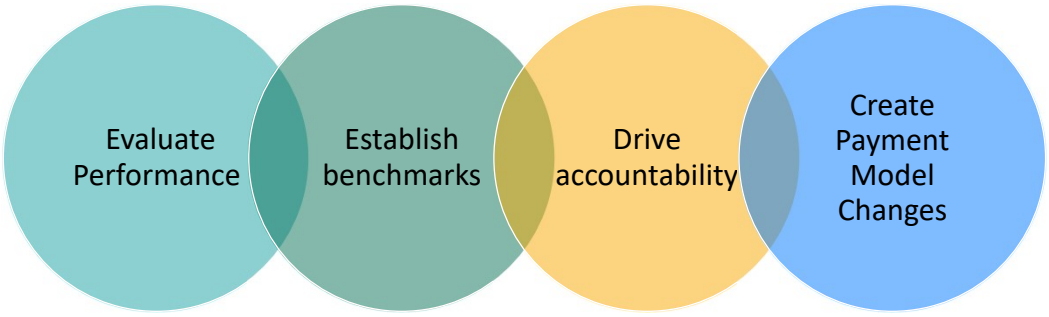
Objectives

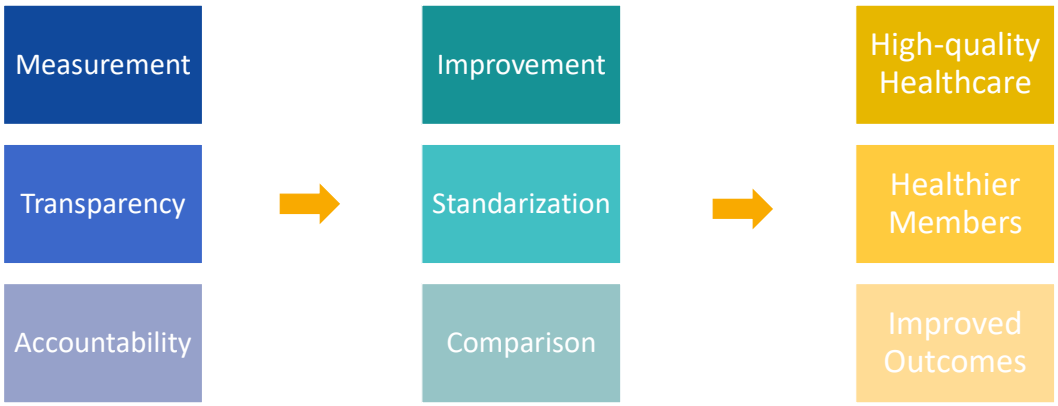
- At the completion of this program, pharmacists will be able to
  - Discuss the impact of quality ratings on overall quality of care provided to members.
  - Identify multidisciplinary strategies to address quality measures and positively impact quality of care.
  - List strategies for promoting multidisciplinary approaches to improving quality of care provided.

Quality Measures

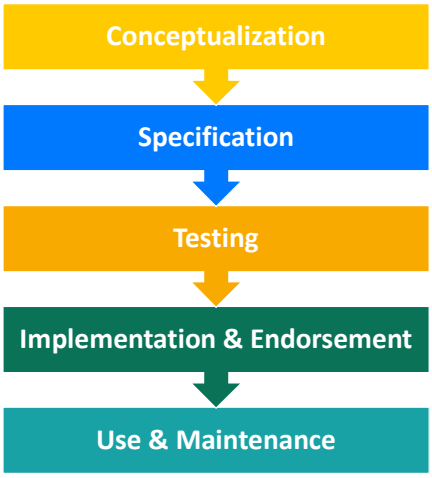


Quality Measures. Washington, DC: American Pharmacist Association. Available from: https://www.pharmacist.com/Practice/Practice-Resources/Quality.

Quality Measurement



Quality Measure Development



Developing Measures That Matter. Alexandria, VA: Pharmacy Quality Alliance; 2022. Available from: https://www.pqaalliance.org/measure-development.

Measurement Categories

Structure Measures

- Describe the presence of something that is associated with quality

Process Measures

- Actions associated with quality

Outcome Measures

- End results related to products and/or service

Quality Measures. Washington, DC: American Pharmacist Association. Available from: https://www.pharmacist.com/Practice/Practice-Resources/Quality.

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National Quality Strategy Goals (CMS)

Embed quality into the care journey	Advance health equity	Promote safety	Foster engagement
Strengthen resilience	Embrace the digital age	Incentivize innovation & technology	Increase alignment

CMS Quality Strategy. Baltimore, MD: U.S. Centers for Medicare & Medicaid Services; 2022. Available from: https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/CMS-Quality-Strategy

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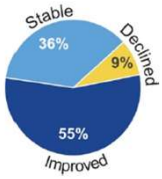
Impact on Care

Measure Performance Trends



Medication Therapy Management

- Improved appropriateness of and adherence to medication
- Narrowed or removed disparities

Patient & Caregivers

- Measure relevance to patient journey
- Improved screening, monitoring and treatment rates

Providers

- Clinically important
- Associated with improved care

2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report. Baltimore, MD: U.S. Department of Health and Human Services; 2021.

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Impact on Cost

Medication Adherence

Improved adherence to specific drug classes associated with avoided costs (from 2013-2018):

- Statins: $5.4 billion - $13.7 billion
- Diabetes medications: $3.4 billion - $7.2 billion
- RAS antagonists: $18.2 billion - $25.7 billion

2021 National Impact Assessment of the Centers for Medicare & Medicaid Services (CMS) Quality Measures Report. Baltimore, MD: U.S. Department of Health and Human Services; 2021.

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Pharmacist-Provided Care

"*Efficient, coordinated care that meets the needs of patients*"

Medication dispensing and counseling → Integral part of the clinical care team

Strategies to Expand Value-Based Pharmacist-Provided Care: Action Guide. Alexandria, VA: Pharmacy Quality Alliance; 2019. Available from: https://www.pqaalliance.org/pharmacist-provided-care

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Meet Jane

- 68-year-old female
- PMH: HTN, recent history of MI, Dyslipidemia, Schizophrenia
- Current medications:
  - Lisinopril-Hydrochlorothiazide 20mg –25 mg qd
  - Metoprolol succinate 50 mg qd
  - Aspirin 81 mg qd
  - Aripiprazole 10 mg qd
  - Docusate sodium 100 mg bid prn
  - Zolpidem 10 mg qhs prn

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Jane's Care Team

Quality Measures Relevant to Jane's Care

- MTM Program Completion Rate for CMR

MTM Program Completion Rate for CMR

- Medication Therapy Management Program
  - Help beneficiaries manage their medications
- Plan-established criteria based on CMS guidance
  - Number of chronic disease states
  - Number of chronic medications
  - Total drug expenditure
- Numerator: Comprehensive medication review (CMR) completed
  - Personal medication list and list of 'next-steps'
  - Medication-related problems

Medicare 2023 Part C & D Star Ratings Technical Notes. Baltimore, MD: U.S. Centers for Medicare & Medicaid Services; 2023.

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MTM Program Completion Rate for CMR

CMR Recipient

- Patient
- Caregiver
- Nurse

CMR Provider

- Retail pharmacist
- MTM/PBM vendor
- Ambulatory care pharmacist
- Health plan pharmacist
- LTC/consultant pharmacist

Recipient of Intervention

- PCP
- Specialist
- Pharmacy
- Care manager (health plan)
- Patient
- Caregiver

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Jane

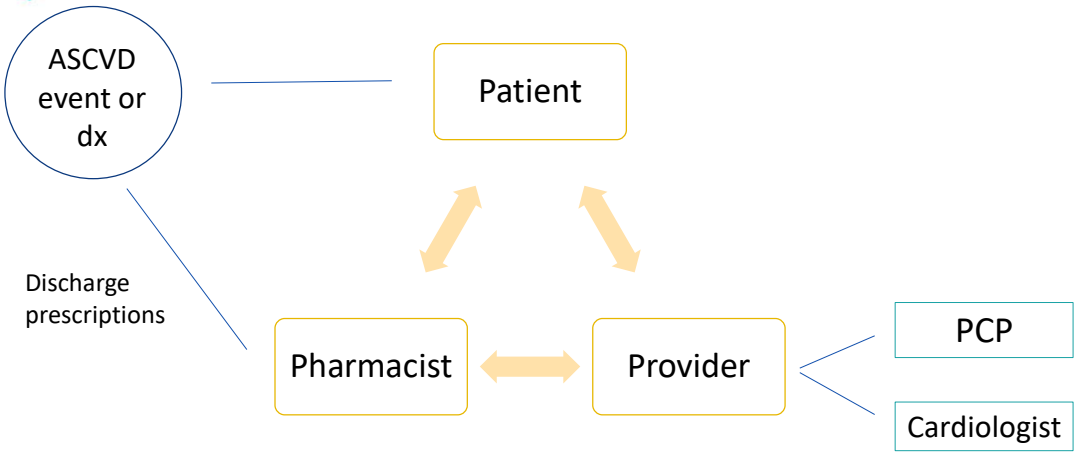
- CMR completed with MTM pharmacist
- Number of medication-related problems and gaps and care identified
- Collaborate to close gaps and impact care provided to Jane

Statin Therapy for Persons with Cardiovascular Disease (SPC)

- Age
  - Males: 21–75 years of age
  - Females 40–75 years of age
- Identified as having clinical atherosclerotic cardiovascular disease (ASCVD)
- Numerator: Dispensed at least one high or moderate-intensity statin medication

Medicare 2023 Part C & D Star Ratings Technical Notes. Baltimore, MD: U.S. Centers for Medicare & Medicaid Services; 2023.

Statin Therapy for Persons with Cardiovascular Disease

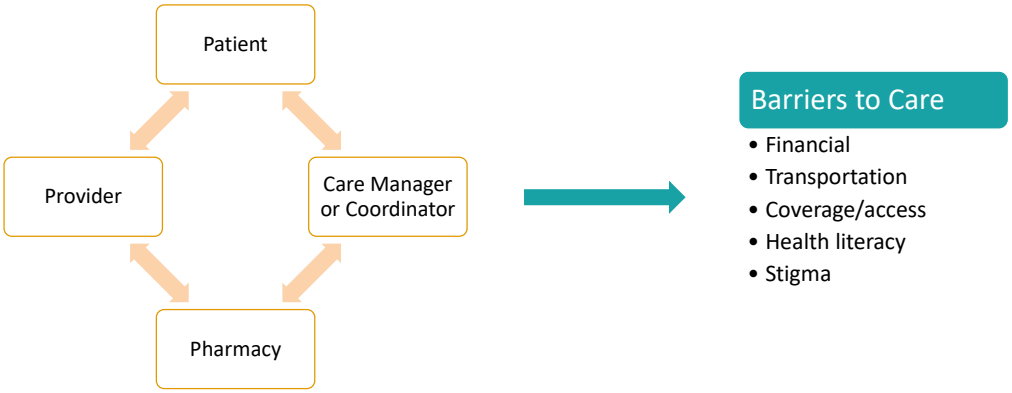


Adherence to antipsychotic medications for individuals with schizophrenia (SAA)

- Age: 18 years of age and older
- Diagnosis: schizophrenia or schizoaffective disorder
- Antipsychotic medication
- Numerator: Adherence rate >80%

HEDIS® Measurement Year 2023 Volume 2: Technical Specifications for Health Plans. Washington, DC: National Committee for Quality Assurance; 2023.

Adherence to Antipsychotic Medications for Individuals with Schizophrenia



Barriers to Care

- Financial
- Transportation
- Coverage/access
- Health literacy
- Stigma

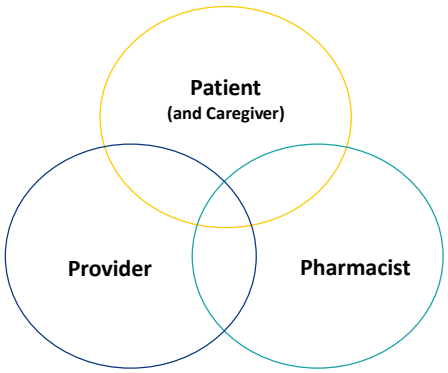
Use of High-Risk Medications in Older Adults (DAE)

- Age: 67 years of age and older
- Numerator:
  - Two dispensing events for
    - Medications in the same high-risk medication class
    - Medications in different high-risk medication classes
- **Note:** A lower rate represents better performance.

High Risk Medications

- 1st generation antihistamines
- Antiparkinson agents
- Antispasmodics
- Antithrombotic
- Alpha agonist, central
- Antidepressants
- Barbiturates
- Vasodilators
- Estrogens with or without progestins
- Sulfonylureas
- Nonbenzodiazepine hypnotics
- Skeletal muscle relaxants

Use of High-Risk Medications in Older Adults (DAE)

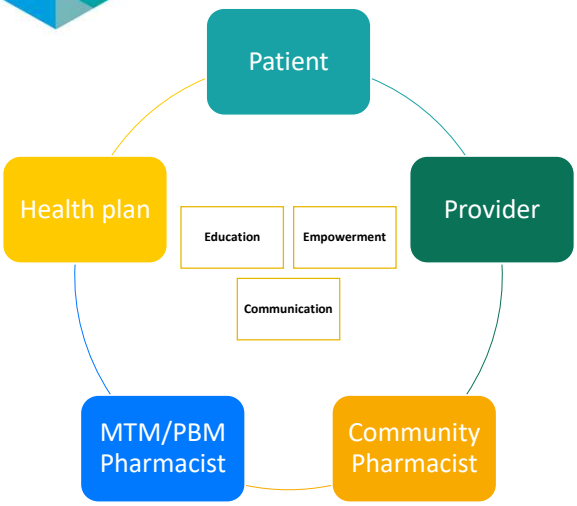


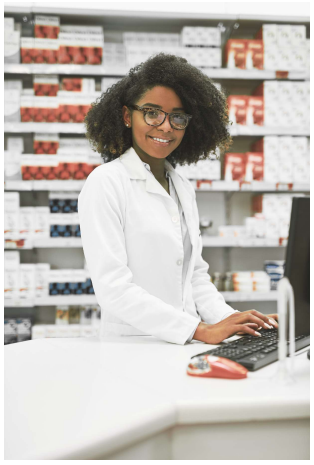
Controlling High Blood Pressure (CBP)

- Age: 18–85 years of age
- Diagnosis of hypertension (HTN)
- Numerator: blood pressure was adequately controlled (<140/90 mmHg)

Medicare 2023 Part C & D Star Ratings Technical Notes. Baltimore, MD: U.S. Centers for Medicare & Medicaid Services; 2023.

Controlling High Blood Pressure (CBP)





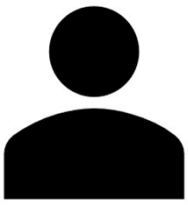
Quality Measures Relevant to Jane's Care

- MTM Program Completion Rate for CMR
- Statin Therapy for Persons with Cardiovascular Disease (SPC)
- Adherence to antipsychotic medications for individuals with schizophrenia (SAA)
- Use of High-Risk Medications in Older Adults (DAE)
- Controlling High Blood Pressure (CBP)

Jane: Follow-Up

- **Pharmacy claims review**:
  - Statin therapy initiated
    - Refill past due
  - Aripiprazole filled monthly
  - Zolpidem dose reduced to 5mg
- **Medical claims review**:
  - Recent hospitalization for fracture of hip

Jane's Care Team



Jane

PCP | Psychiatrist | Cardiologist | Physical Therapist

Care Manager | Daughters | Pharmacist | Orthopedic

Medication Adherence for Cholesterol (Statins)

- Age: 18 years and older
- Prescribed drug therapy for statin cholesterol medications
- Numerator: Adherence rate ≥ 80%

Medicare 2023 Part C & D Star Ratings Technical Notes. Baltimore, MD: U.S. Centers for Medicare & Medicaid Services; 2023.

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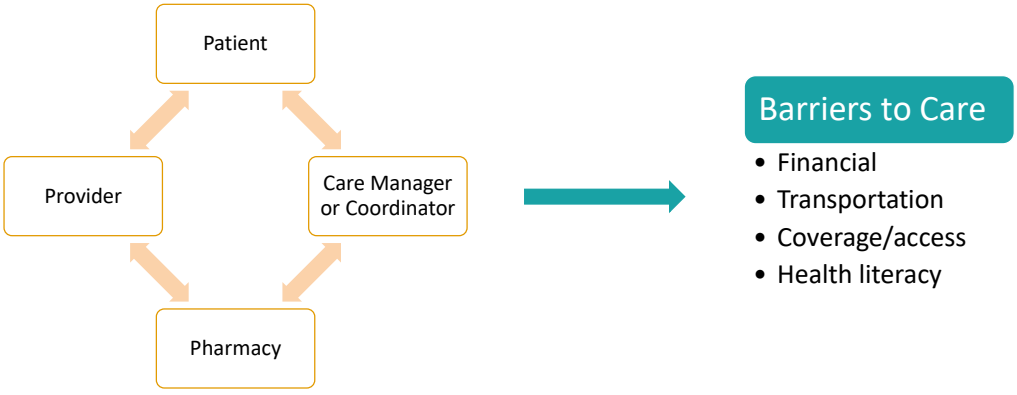
Medication Adherence for Cholesterol (Statins)



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Osteoporosis Management in Women who had a Fracture (OMW)

- Female
- Age: 67 - 85 years of age
- Suffered a fracture
- Numerator: had either a **bone mineral density (BMD) test** or prescription for **a drug to treat osteoporosis** in the 6 months after the fracture

Medicare 2023 Part C & D Star Ratings Technical Notes. Baltimore, MD: U.S. Centers for Medicare & Medicaid Services; 2023.

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Osteoporosis Management in Women who had a Fracture (OMW)

Patient	Orthopedic	Primary Care Provider
Health plan	Pharmacist	Physical Therapist

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Reducing the Risk of Falling

- Age: 65 years and older
- Had a fall or problems with balance and walking
- Numerator: received a recommendation for how to prevent falls or treat problems with balance or walking

Medicare 2023 Part C & D Star Ratings Technical Notes. Baltimore, MD: U.S. Centers for Medicare & Medicaid Services; 2023.

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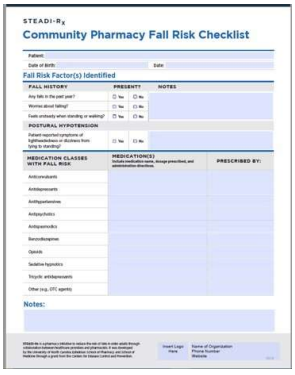
Reducing the Risk of Falling

Talk to our patients:

- A fall is when your body goes to the ground without being pushed. In the past 12 months, did you talk with your doctor or other health provider about falling or problems with balance or walking?
- Did you fall in the past 12 months?
- In the past 12 months have you had a problem with balance or walking?
- Has your doctor or other health provider done anything to help prevent falls or treat problems with balance or walking?


STEADI-Rx

Community Pharmacy Fall Risk Checklist

Patient:

Date of Birth: Date:

Fall Risk Factor(s) Identified

FALL HISTORY	PRESENT?	NOTES
Any falls in the past year?	☐ Yes ☐ No	
Worries about falling?	☐ Yes ☐ No	
Feels unsteady when standing or walking?	☐ Yes ☐ No	
POSTURAL HYPOTENSION		
Patient reported symptoms of lightheadedness or dizziness from lying to standing?	☐ Yes ☐ No	

MEDICATION CLASSES WITH FALL RISK	MEDICATION(S) Include medication name, dosage prescribed, and administration directions.	PRESCRIBED BY:
Anticonvulsants		
Antidepressants		
Antihypertensives		
Antipsychotics		
Antispasmodics		
Benzodiazepines		
Opioids		
Sedative hypnotics		
Tricyclic antidepressants		
Other (e.g., OTC agents)		

Notes:

Insert Logo Here

Name of Organization Author(s) Name Website

Medicare 2023 Part C & D Star Ratings Technical Notes. Baltimore, MD: U.S. Centers for Medicare & Medicaid Services; 2023.

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Quality Measures Relevant to Jane's Care

- MTM Program Completion Rate for CMR
- Statin Therapy for Persons with Cardiovascular Disease (SPC)
- Adherence to antipsychotic medications for individuals with schizophrenia (SAA)
- Use of High-Risk Medications in Older Adults (DAE)
- Controlling High Blood Pressure (CBP)
- Medication Adherence for Cholesterol (Statins)
- Osteoporosis Management in Women who had a Fracture (OMW)
- Reducing the Risk of Falling (FRM)

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Takeaway

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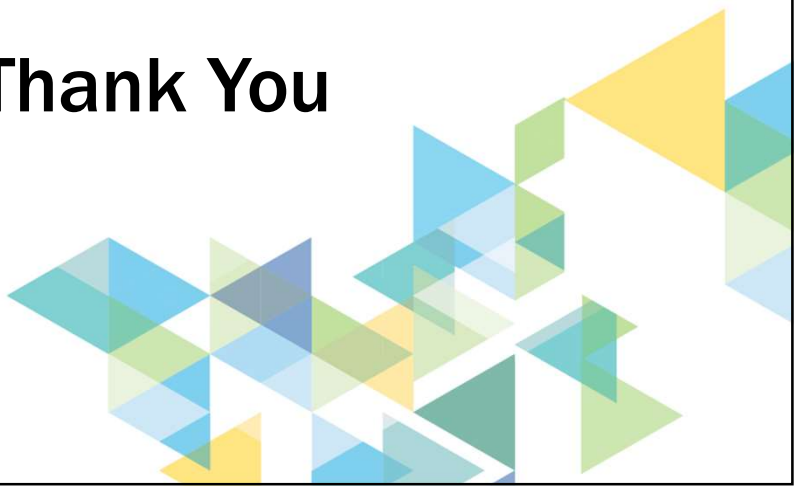
Thank You



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Population Health Strategies to Improve Health Outcomes and Reduce Medical Costs in the US Employer Group Sector

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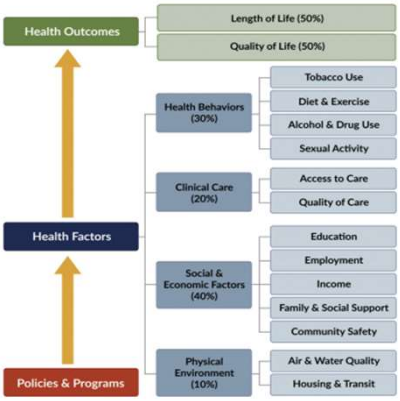
Objectives

- At the completion of this program, pharmacists will be able to
  - Define population health and detail forecasts, trends, and pharmacy-specific strategies of population health management.
  - Describe the role of health and well-being in large employers' workforce strategy as well as barriers to executing that strategy.
  - List pharmacist-led, value-based care initiatives and interventions that led to positive clinical outcomes aligned with large employers' health and well-being workforce strategy.

Defining Population Health

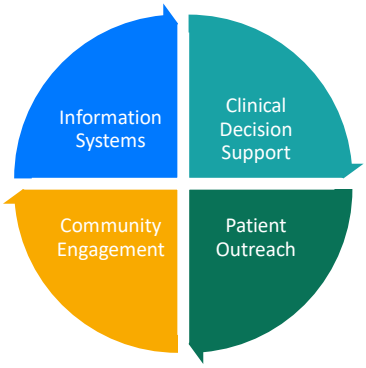
- Multiple stakeholders
- Multiple levels of action
- Targets fundamental determinants of health
- Connects clinical practice to policy
- Addresses health AND health equity
- Achieves large-scale health and disease improvements



Silberberg M, Martinez-Bianchi V, Lyn M. What Is Population Health? Prim Care Clin Office Pract.2019;46:475-484.doi:10.1016/j.pop.2019.07.001
Mays GP. *Organizing and Financing Population Health: Systems, Policies & Incentives*. University of Kentucky; Aug 28, 2017. Accessed March 16, 2023. https://works.bepress.com/glen_mays/307/

Population Health for Health Systems

System Requirements



Facilitating Factors

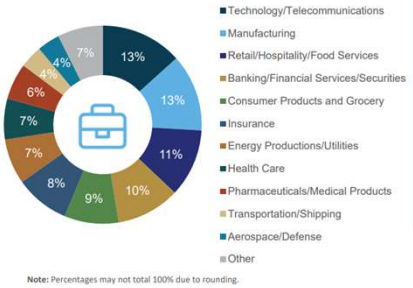
Internal Factors	External Factors
Leadership/Team Skills	Health Care Financing
Critical Thinking	Data Sharing
QI Techniques	Support for Practice Change
Advocacy Skills	
Community Engagement	Political Will

Silberberg M, Martinez-Bianchi V, Lyn M. What Is Population Health? Prim Care Clin Office Pract.2019;46:475-484. doi:10.1016/j.pop.2019.07.001
Swarthout M. *Population Health Management Design: Optimizing the Outcomes for Special Populations* [PowerPoint presentation]. 21st Annual ASHP Conference for Pharmacy Leaders. https://www.ashpmedia.org/leader16/docs/handouts/512-L04%20(Breakout%20D)%20Slides%20-%201%20per%20page.pdf?_ga=2.27220980.87748532.1668528360-166493443.1655323131

Population Health: The US Workforce

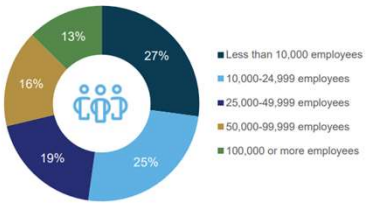
- Definition: Individuals who currently have a job in the US

Industry Breakdown



Note: Percentages may not total 100% due to rounding.

Employer Size (in the U.S)

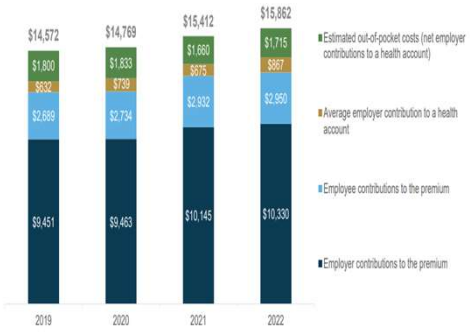


73% have more than 10,000 employees
77% are multinational employers

Business Group on Health. 2023 Large Employers' Health Care Strategy and Plan Design Survey. Business Group on Health; 2022. Accessed March 16, 2023. Updated 2016. Accessed March 16, 2023.

Why the Workforce Population?

Help to Control the Continuous Rise in US Health Care Costs



Public Health Authorities Recognize the Workforce as a Focus Population

Healthy People 2030

- GOAL: Strengthen the workforce by promoting health and well-being
- Central to the strength of the economy

Business Group on Health. 2023 Large Employers' Health Care Strategy and Plan Design Survey. Business Group on Health; 2022. Accessed March 16, 2023. Updated 2016. Accessed March 16, 2023.
Office of Disease Prevention and Health Promotion. *Healthy People 2030*. US Department of Health and Human Services; Aug 18, 2020. Accessed March 16, 2023. https://health.gov/healthypeople/objectives-and-data/browse-objectives/workforce

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Why Traditional Healthcare Doesn't Work for the US Workforce

Barriers to Access | Disconnected Experience | Variable Cost and Quality

PQA 23 ANNUAL MEETING

Why Traditional Healthcare Doesn't Work for Employers

Disengaged Members | Fragmented Solutions | Misaligned Incentives

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Employer Needs: Quality & Affordability

Quality of Care

- Integration of virtual care delivery and in-person care
- Improved transparency of cost and quality
- Navigation to higher-quality sites-of-care/providers
- Coordination of integrated care teams
- Ability to select providers based on specific expertise or demographics
- Movement away from fee-for service towards value-based and alternative payments
- Data interoperability/electronic health record improvements

Affordability of Care

- Top 3 SDOH Focus Areas for large employers
  - Health care
  - Finances/income
  - Childcare
- Market-based reform for a competitive prescription drug market
- Specialty pharmacy/high-cost therapy management
  - Cancer
  - Musculoskeletal
  - Cardiovascular
  - Diabetes
  - High-Risk Maternity/NICU

Business Group on Health. 2023 Large Employers' Health Care Strategy and Plan Design Survey. Business Group on Health; 2022. Accessed March 16, 2023. Updated 2016. Accessed March 16, 2023.

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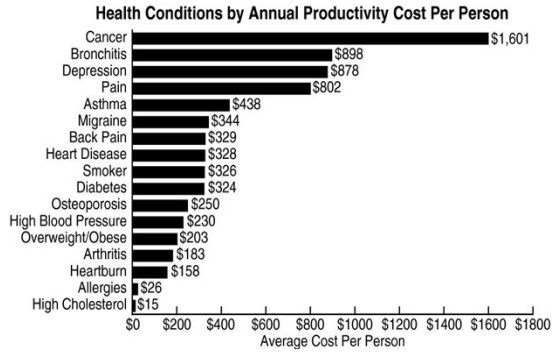
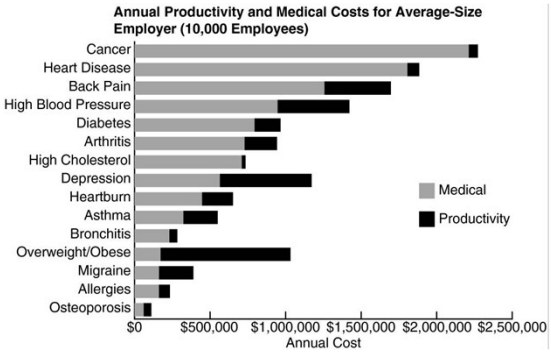
Cost of Productivity Loss

Health Conditions by Annual Productivity Cost Per Person



Annual Productivity and Medical Costs for Average-Size Employer



Mitchell RJ, Bates P. Measuring Health-Related Productivity Loss. Pop Hlth Mgmt.2011;14(2):93-98. doi:10.1089/pop.2010.0014

Workforce Specific Care Gaps: Measures for Evaluation

Worker Productivity
- Absenteeism
- Greater Work Output*
- Reduced Overtime
- Costs to Train Replacement Employees

Healthcare Costs
- Number/Type of Health Insurance Claims
- Health Care Utilization
- Quality of Care Indicators
- Direct Medical Costs

Health Outcomes
- Targets for Optimal Levels of Health Status
- Acceptable Levels of Disease/Injury/Disability
- Prevalence of Risk Factors
- Targets for Effectiveness of Care

Health Culture
- Documented Changes in Employee Morale
- Reduction in Employee Turnover Rates
- Employee Engagement/Outcomes from Health Events

Workplace Health Model. Centers for Disease Control and Prevention. Updated May 13, 2016. Accessed March 16, 2023.
https://www.cdc.gov/workplacehealthpromotion/model/index.html

Primary Care Providers and Pharmacists on the Same Care Team

Physicians, pharmacists, and industry players recognize the value of a coordinated approach

Stronger Clinical Collaboration

90% of physicians noted that adding a pharmacists to their team improved medication management, and 93% considered pharmacists' recommendations clinically meaningful[1]

Better Health Outcomes

Integration of a non-dispensing pharmacist in a primary care setting has shown improved outcomes in 70% of cases compared to 55% of members who do not have pharmacist involvement in non-dispensing capacity[2]

Deeper Investment in Retail Clinics

To diversify revenues, CVS announced a $1 billion dollar plan to convert existing sites to a primary care clinic, and Walgreens made a $5.2 billion investment in their primary care partner, Village MD[3]

- 1 Pharmacy Times | 2 Science Direct | 3 eMarketer

Premise Health: Sets the Bar for Direct Healthcare

Our Vision

To be the premier direct healthcare company in the world

Dedicated – Proactive – Primary
Comprehensive – Aligned

Our Mission

To help people get, stay and be well

Our Values

Providing high-quality, tech-enabled, personal care that is focused on health improvement and an exceptional member and client experience

Courageous – Engaged – Innovative
Accountable – Quality-Focused –
Respectful – Ethical

Together We

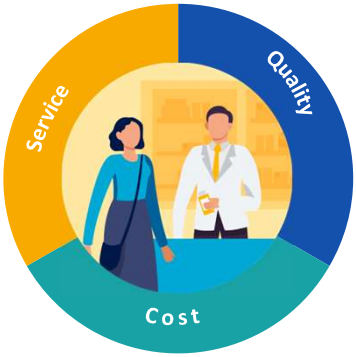
11M+ eligible members
800+ wellness centers
45 states and Guam

Our Approach

Builds trusted relationships

Employees make smarter healthcare choices

Personal connections increase member satisfaction



Improves healthcare outcomes

Avoid adverse health events and reduce overall costs

Members become the owner of their health journey

Reduces healthcare spend

Medication adherence impacts downstream medical costs and avoidable health incidences

Opportunity to maximize prescription benefits and formulary savings

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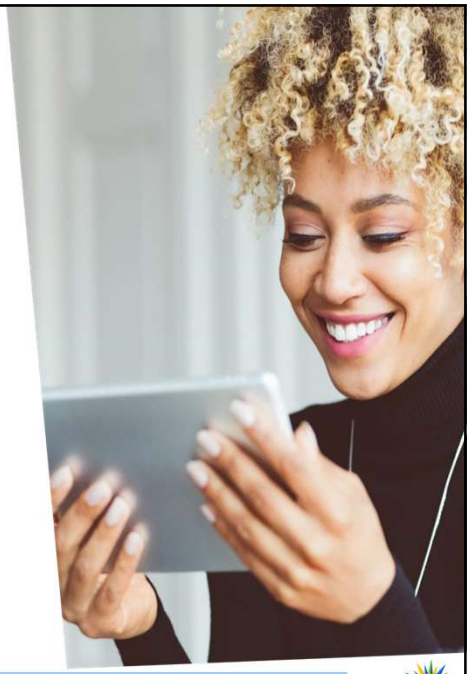
Premise Health Pharmacy Care: Applicable Lines of Service

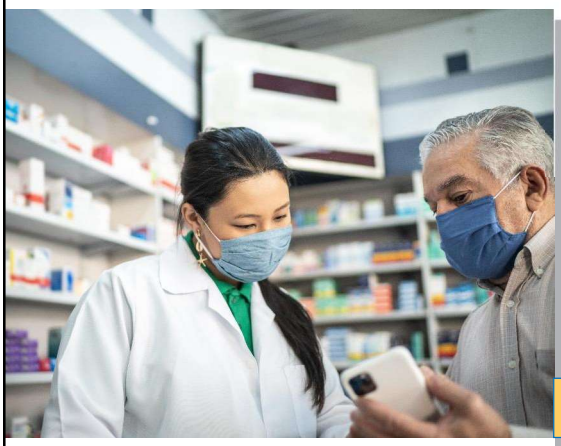
- Onsite/Nearsite (Community-Based)
- Ambulatory Clinical Services
- Virtual Care



PQA 23 ANNUAL MEETING

Pharmacy Overview

Our pharmacists go beyond simply dispensing medication by playing an essential role on the care team, coaching members through behavior change for better health



Solutions that offer more convenience and a deeper level of care:

- Medication dispensing and monitoring
- Over-the-counter medications
- Member counseling, coaching, and guidance
- Disease-specific education
- Variable copay assistance program
- Immunizations
- Workers' compensation medication
- Formulary review and management
- Medication therapy optimization
- Prescription delivery

Access: Onsite / Nearsite / Virtual / Event / Connected Devices

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Ambulatory Clinical Services

Our dedicated pharmacists lead condition management, education, and lifestyle coaching to help members with high-cost medication regimens save money and feel better

Treatment is tailored to each member and can address a range of chronic conditions:

- Asthma
- Chronic obstructive pulmonary disease (COPD)
- Congestive heart failure (CHF)
- Coronary artery disease (CAD)
- Diabetes and pre-diabetes
- Dyslipidemia
- Gastroesophageal reflux disease (GERD)
- Hypertension and pre-hypertension
- Metabolic syndrome
- Migraine headaches

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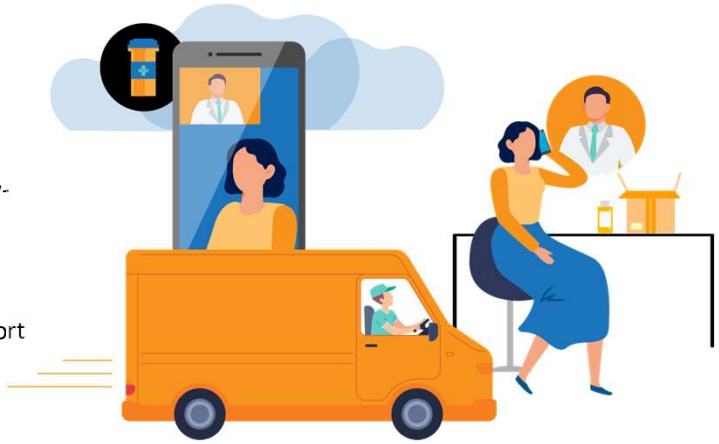
Virtual Pharmacy Services

Taking a consultative approach that goes beyond simply dispensing medication, pharmacists play an essential role on the care team and proactively build relationships with members

Capabilities include:

- Prescription delivery and refills
- Treatment monitoring and follow-up
- Behavior change coaching
- Disease-specific education
- Medication adherence and support
- Variable copay program



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Prescription Delivery

Direct to home deliveries that promote medication adherence, provides a deeper level of care, and facilitates cost savings and personalized treatment plans

Member prescriptions shipped right to the door

- Personalized consultations
- Prescription consolidation
- At-home delivery
- Reduced co-pays
- Discounted over-the-counter medications
- 90-day fills

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Delivering Value Through Multiple Channels

Premise Health pharmacy solutions offer more convenience and a deeper level of care

Ingredient Cost Savings

- Scale and buying power with pass-through savings and transparency
- Significant over-the-counter product discounts

Benefit Plan and Preference List

- Generic dispensing
- Therapeutic interchange and formulary support
- Variable copay and customized plan design
- Specialty medication management

Adherence and Clinical Outcomes

- Proactive approach via Care Complete
- EHR integrated with other solutions
- Coaching and behavior change
- Follow-up to ensure success

Member Experience and Trust

- Consultative approach and relationship building
- Turning transactions into interactions
- Caring for overall member health and wellbeing

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Serving **organizations**

and their **people**

with value-based **healthcare**

across the **nation**

PQA 23 ANNUAL MEETING

Case Studies

Putting Strategies into Action

Case Study 1

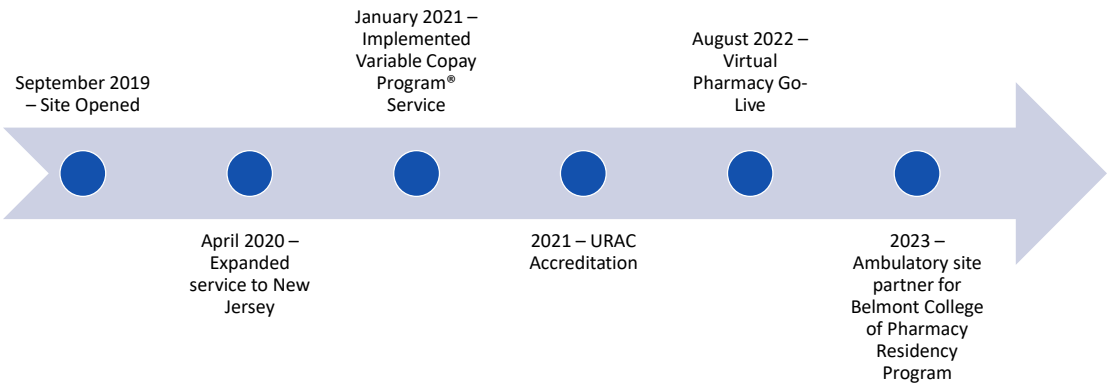
Worker Productivity

Site Background

Industry Type	Health Care
Geographic Region	Nationwide
Number of Sites	One
PCMH Attached	• Yes • MD, MA, HC Manager, Nurse

Staffing	Hours of Operation
1 Full Time Pharmacist	Mon-Fri: 8am-5pm
1 Full Time Technician	Closed Weekends

Timeline of Services



Closing the Gap To Access

Problem:

- Immediate barrier to access and care
- Gap in medication adherence

Solution:

- Virtual Pharmacy

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Prescription Delivery Available Nationwide

Home deliveries that promote medication adherence, provides a deeper level of care, and facilitates cost savings and personalized treatment plans

Today, virtual pharmacy is live in 47 states and Washington, D.C.

This solution is not available in Alaska, California, and Vermont as of August 2022

Capabilities include:

- Home prescription delivery
- Scheduled video or phone consultations
- Secure messaging
- 90-day refills
- Hassle-free prescription transfer
- Treatment monitoring and follow-up
- Behavior change coaching
- Disease-specific education
- Medication adherence and support

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Benefits of Virtual Pharmacy

Tech-enabled pharmacy services that are personalized and support care delivered by a member's provider

- Removes the barrier of access through convenient home prescription delivery
- Personalized pharmacy care and convenient home prescription delivery
- Ability to build a relationship with a pharmacist
- Concierge support and access to chronic condition support, coaching, and education

Quality Care in Action

Inquiry via app messaging

Cost Burden Layered On To Devastating Diagnosis

Sourced and adjudicated in 1 day

Shocked & Grateful

Tackle Hug Promise

$988 out of pocket savings

Case Study 2

Healthcare Costs

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Site Background

- **Industry Type:** Aerospace/Defense
- **Geographic Region:** Northeastern US
- **Number of Sites:** Two
- **PCMH Attached:**
  - One Attached
  - One Standalone

	Site 1	Site 2
Hours of Operation	• Mon, Fri: 6:30am-5:30pm • Tues, Thurs: 7am-7pm • Weds: 7am-6pm • Sat: 8am-1pm • Closed Sunday	• Mon, Fri: 6:30am-5:30pm • Tues, Thurs: 9am-7pm • Weds: 9am-5pm • Sat: 8am-1pm • Closed Sunday
Pharmacy Staffing	• 4 Full Time Pharmacists • 1 Clinical Pharmacist • 7 Technicians	• 2 Full Time Pharmacists • 1 Clinical Pharmacist • 2 Technicians
PCMH Staffing	• 1 MD, 2 PA, 2.5 NPs • 1 Condition Management RN • 1 Physical Therapist	

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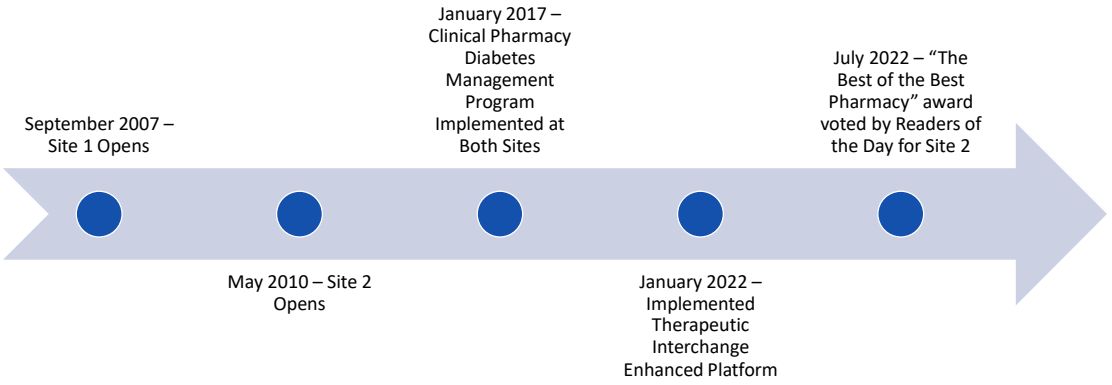
Timeline of Services



Pharmacist Led Therapeutic Interchange

Estimated Interchange Savings

	Site 1	Site 2	Total
Q1 2022	$16,270.00	$284,178.76	$300,448.76
Q2 2022	$21,806.00	$465,582.26	$487,388.26
Q3 2022	$295,676.35	$134,236.56	$429,912.91
Q4 2022	$143,061.00	$358,008.66	$501,069.66
Total 2022	$476,813.35	$1,242,006.24	$1,718,819.59
Biosimilar Totals	$420,628.35	$263,499.75	$684,128.10

Top Interchanges

- **Skipped Step Approach**
  - Xiidra → OTC Systane
  - Edarbi 80mg → Losartan 100mg
  - Dexilant 60mg → Pantoprazole 40mg
- **High-Dollar "Me-Too" Drugs**
  - Trexall 5mg → Methotrexate 2.5mg
  - Ortikos 9mg ER → Budesonide 3mg DR
  - Soaanz 60mg → Torsemide 20mg
- **Biosimilar Conversions**
  - Lantus Solostar → Insulin Glargine-yfgn Soln Pen
  - Humalog Kwikpen → Insulin Lispro 100u/mL Pen
- **Drug Class Alternatives**
  - Jublia 10% Soln → Ciclopirox 8% Soln
  - Zerviate 0.24% Opth → Ketotifen 0.025% Opth
- **Dosage Form/Strength Alternatives**
  - Metformin 1000mg ER (mod) → Metformin 500mg ER
  - Levothyroxine caps → Levothyroxine tabs
  - Plexion 9.8/4.8% → Sulfacet Sod/Sulfur Cleanser 10/5%

Quality of Care Cost Avoidance Savings

Medical Cost Avoidance *			
Onsite Adherence Rates vs. Benchmark			
	Diabetes	Dyslipidemia	Hypertension
Benchmark: Quarterly Average Medical Savings at 80% Adherence	$939.00	$314.50	$977.00
Site % At Optimal Adherence - 2021 Q2	85.40 %	84.40 %	87.49 %
State Average % Employers (CVS 2013)	69.00 %	72.40 %	78.00 %
Number of Patients With Disease State	692	1744	2423
Number of Onsite Patient at Optimal Adherence	591	1,472	2,120
Number of State Average Adherent Patients	477	1,263	1,891
Difference (number of additional Adherent Patients at onsite)	114	209	279
SAVINGS	$106,596	$65,835	$272,114

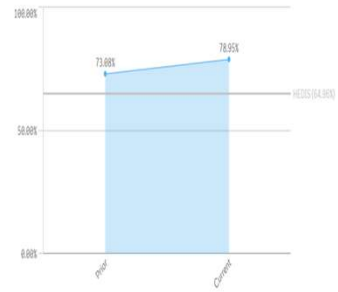
Q2 2021 Savings	$444,548
Q2 2020 Savings	$564,534
2021 YTD Savings	**$903,609**
2020 YTD Savings	**$1,017,089**

* Reference CVS Caremark 2013 State of the State Adherence Report http://www.cvshealth.com/sites/default/files/SOS-Adherence-Report-2013_Final_2.pdf
Roebuck M C et al. Health Aff 2011;30:91 -99

DM: HbA1c Control < 8%

Previous Period	Current Period
Q1 2020 - Q4 2020 (n = 104)	Q1 2021 - Q4 2021 (n = 152)
▲ 73.08%	▲ 78.95%
HEDIS 62.77% (+10.31%)	HEDIS 64.96% (+13.99%)

DM: HbA1c Control Trend



Quality Care in Action

Able to afford his meds

Low carb diet and daily exercise

Completely changed his lifestyle

Lowered A1C 5.6%

Lost over 30 pounds

Case Study 3

Health Outcomes

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Site Background

Industry Type	Manufacturing - Auto
Geographic Region	Southeastern US
Number of Sites	One
PCMH Attached	• Yes • Primary Care, Optical, Dental, PT, Occ Health

Staffing	Hours of Operation
• 3 Full Time Pharmacists • 1 Part Time Pharmacist	Mon-Fri: 6am-8pm
• 1 Full Time Clinical Pharmacist • 1 Part Time Clinical Pharmacist	Sat: 7am-12pm
• 1 PGY1 Resident • 1 PGY2 Resident	Closed Sunday
• 9 Full Time Technicians • 4 Part Time Technicians	

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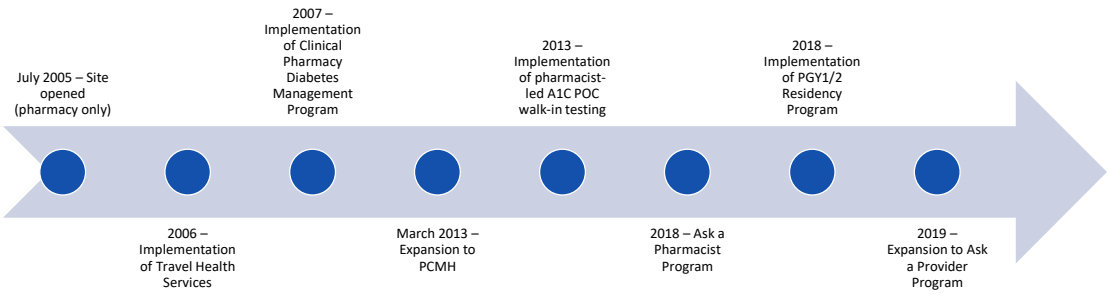
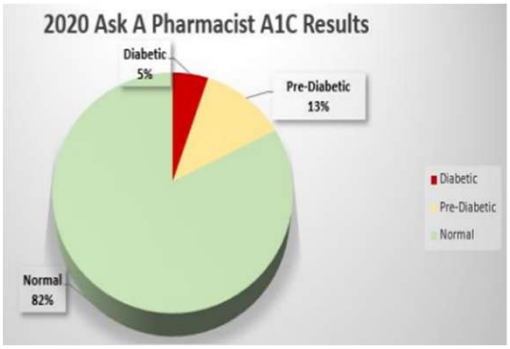
Timeline of Services



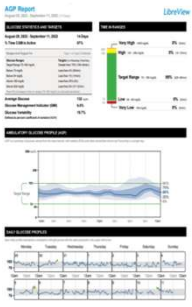
Patient Care Outside the "Box"

Ask a Pharmacist Series

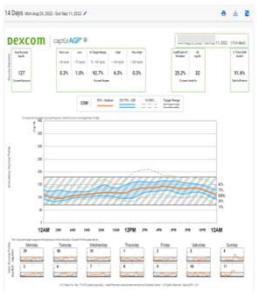


Connected Devices

Freestyle Libre - LibreView



Dexcom – Dexcom Clarity



Collaborative Care Services for Diabetes Management

Primary Care Provider

- Identifies eligible patients
- Refers to triage nurse for appropriate placement

Triage: Condition Management RN

Determines appropriate line(s) of service based on pre-determined risk criteria

Condition Management RN

- Prediabetes
- Uncomplicated T2DM

Dietician

- All patients

Clinical Pharmacist

- T2DM with > 6 (total) meds
- Uncontrolled T2DM
- All insulin dependent diabetics

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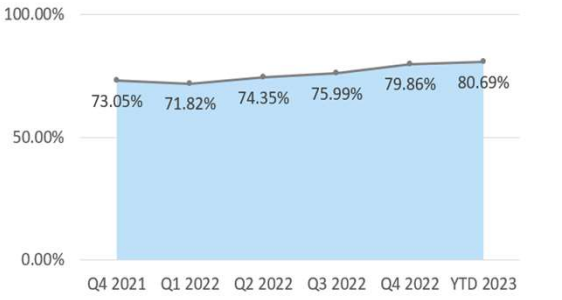
Clinical Quality Outcomes

Clin Rx: Diabetes Control < 8%

Previous Period	Current Period
Q1 2021 - Q4 2021 (n = XXX)	Q1 2022 - Q4 2022 (n = XXX)
73.05%	▲ 79.86%

Clin Rx: Diabetes Control Trend



PQA23 ANNUAL MEETING

Quality Care in Action

Years long relationship

Life-threatening DKA

Safely restart meds

Remotely monitor progress

Empowered and motivated

Reduced A1C 6.4%

Case Study 4

Health Culture

Site Background

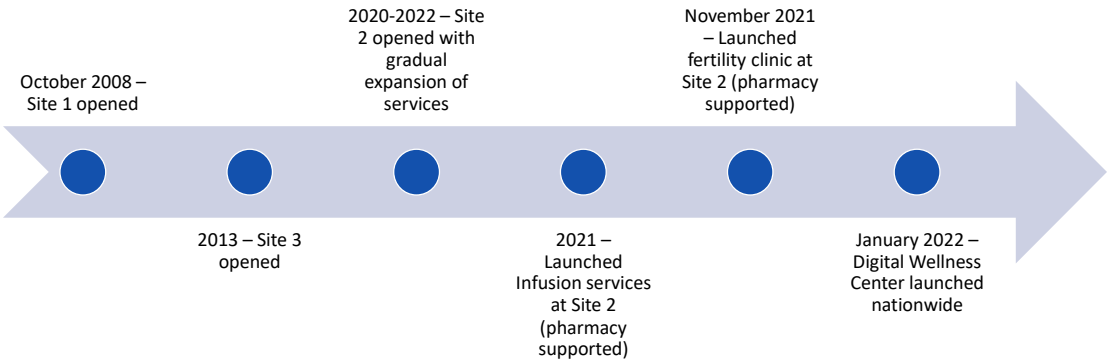
Industry Type	Retail/Hospitality
Geographic Region	Multiple Regions
Number of Sites	Three
PCMH Attached	• Two Attached • One Standalone

- PCMH Lines of Service
  - Primary Care
  - Ambulatory Care Pharmacy
  - Radiology
  - Optical
  - Medical Fitness
  - Behavioral Health
  - Nutrition
  - Women's Health
  - Infusion
  - Virtual Primary Care
  - Virtual Behavioral Health
  - Care Navigation

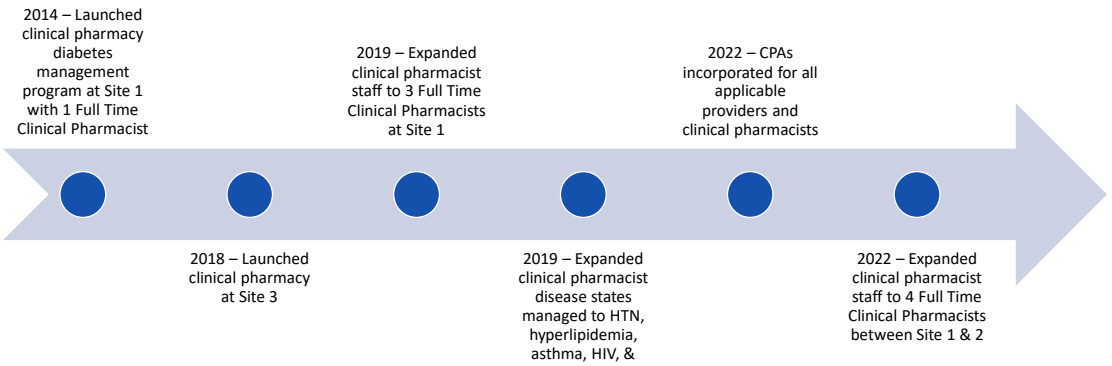
Multi-Site Background

	Site 1	Site 2	Site 3
Hours of Operation	• Operates 365 days per year • Mon-Fri: 7am-7pm • Sat-Sun, Holidays: 8am-6pm	• Operates 365 days per year • Mon-Fri: 7am-7pm • Sat-Sun, Holidays: 8am-6pm	• Mon-Tues, Thurs-Sat: 9am-5pm • Weds: 6am-5pm • Closed Sundays & Holidays
Pharmacist Staffing	• 6 Full Time Pharmacists • 1 Part Time Pharmacist • 2 Ambulatory Care Pharmacists	• 4 Full Time Pharmacists • 1 Part Time Pharmacist • 2 Ambulatory Care Pharmacists	• 1 Full Time Pharmacist • 1 Part Time Pharmacist • 1 Clinical Pharmacist
Technician Staffing	• 13 Technicians	• 6 Technicians	• 1 Full Time Technician • 1 Part Time Technician
PCMH Staff	• 5 MDs, 5 PAs/NPs • 10 MAs • 1 Psychologist • 1.5 Wellness Coaches • 0.5 Registered Dietician • 2 RNs • 2.5 Radiology Techs	• 5 MDs, 5 PAs/NPs • 10 MAs • 1 Psychologist • 1.5 Wellness Coaches • 0.5 Registered Dietician • 2 RNs, 1 Infusion Cert • 2 Optometrists • 2 Exercise Physiologists • Women's Health: 3 MDs, 1 PhD, 2 RNs, 3 MAs	

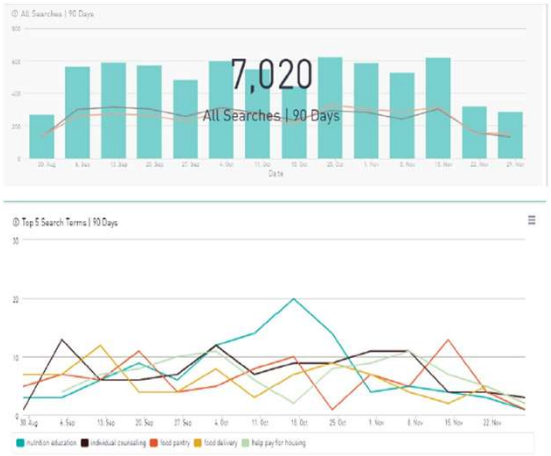
Timeline of Services

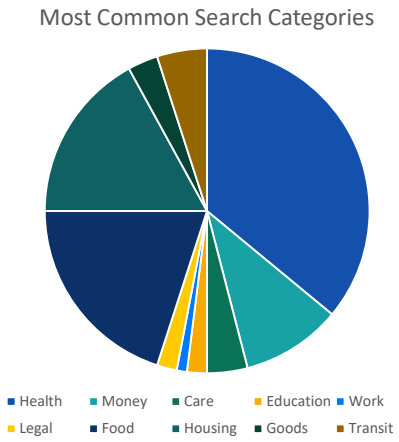


Timeline of Services – Clinical Pharmacy



Addressing SDOH:
Find Help Tool





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Promoting Health Culture

Diversity & Inclusion at the Team Level

Weekly update 77
7.5.22
Cricket is considered the most popular sport in Pakistan ever since it's partition and has now moved to be its national sport.
Matches are most looked forward to when against India to the extent that it is considered a national holiday throughout the country so family and friends can enjoy the nail-biting competition. Up until now Pakistan has won one World Cup and the next one is scheduled for November 2023. (Thank you XXX for promoting inclusion in the XXX Pharmacy).

Reinforce Inclusive Language

- **Situation:** No method for documenting patients' chosen name and/or personal pronouns
- **Solution:** Set a standard expectation for all pharmacy team members that a patient's chosen name & personal pronouns be documented, and patient is addressed using their chosen name and personal pronouns
  - Developed policy & corresponding procedures
- **Example Elements**
  - When to document
  - Define responsible parties
    - Documentation
    - Addressing patients
  - Workflows
    - Handling insurance adjudication barriers
    - Discrete identifiers

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Quality of Care in Action

Understand & experience patients' culture

Language is not the only barrier to care

Rationing Insulin & Skipping Meals

Instant sense of relief

Following through on health promises

Saved his life

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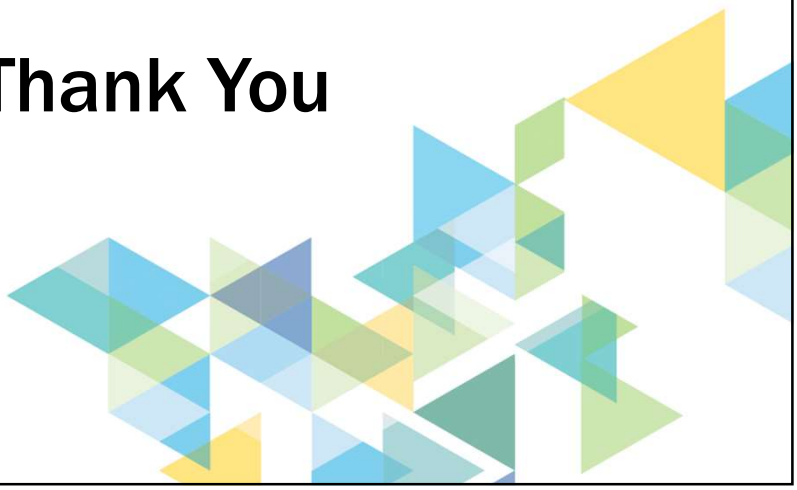
Thank You



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Show Me the Data: Collect and Analyze Health Equity Data

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Objectives

- At the completion of this program, pharmacists will be able to
  - Recognize the gaps in medication use due to health disparities and the role health plans can play in bridging the gaps.
  - Identify opportunities and challenges health plan members face when collecting race, ethnicity, language, SOGI, disabilities, geography, and SDOH data.
  - Review case examples on methods to collect health equity data and explore how data can be used to improve medication use quality.

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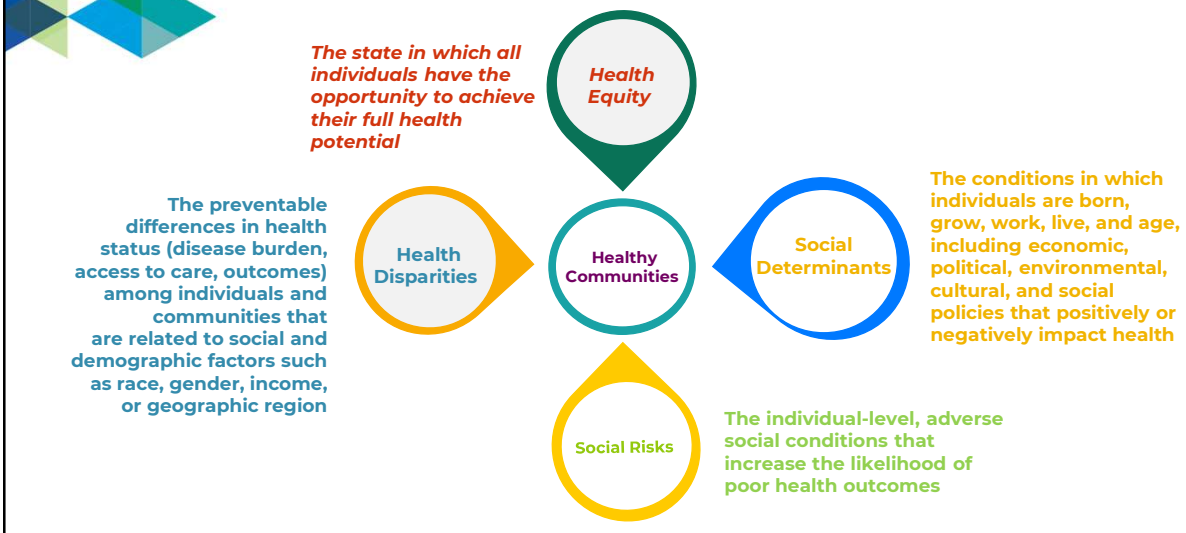
What is Health Equity?



Academy of Managed Care Pharmacy Health Disparities Advisory Group discussions from March to May 2022.

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Role of health plan

Data
- Diversity in clinical trails
- Augmentation of available data
- Use of algorithms and artificial intelligence

Formulary Process
- Data diversity in drug monographs
- Education specific to P&T Committee
- Considerations to P&T Committee

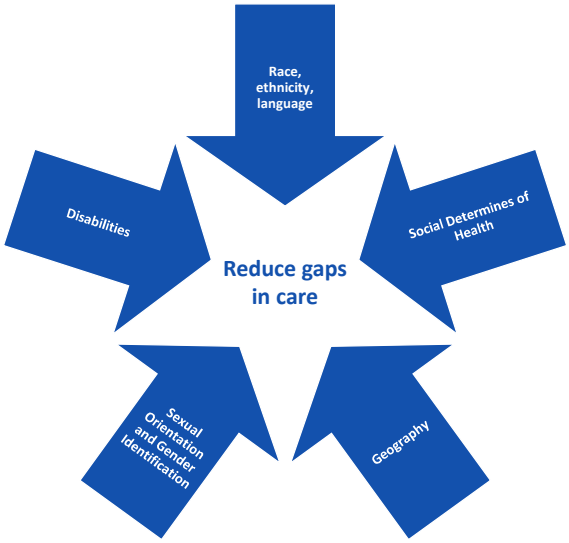
Benefit Design
- Consider health equity in process
- Adjust cost-sharing models based on income or disease states

Patient Access
- Utilize automated tools
- Enhance care coordination
- Patient outreach programs

Where does the data come from?

- Direct Data
  - Information **collected directly** from the patient
  - "Gold Standard" for health equity data
  - Best use for focused interventions
- Indirect Data
  - Information **inferred** from other sources
  - Examples of sources:
    - Zip code
    - Census data
  - Best use for population level analysis

Types of Data collected



Race, Ethnicity, and Language

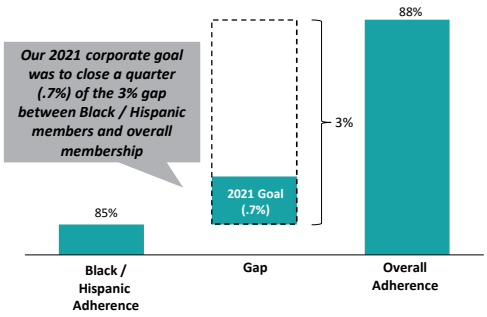
How SCAN's Health Equity Journey Began…

CMS Star Ratings: measures the quality of Medicare Advantage health plans and Prescription Drug Plans (PDPs/Part D plans)

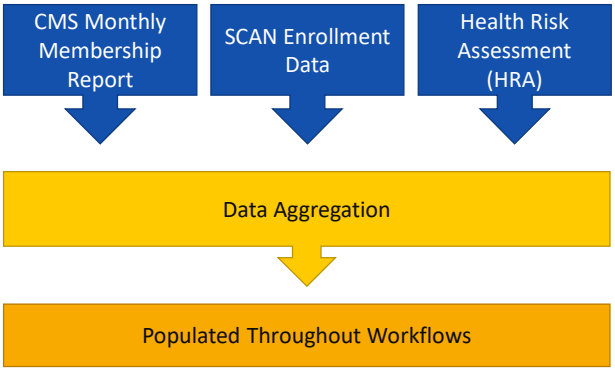
When looking at SCAN's Star Ratings **by race**, the lowest scores overall were seen among members who were Black

- In medication adherence measures, lowest scores were seen among Black and Hispanic members
- In survey measures overall, lowest scores were seen among Asian and Black members

SCAN made it an organizational priority to reduce racial disparities in medication adherence



How Does SCAN Obtain Race, Ethnicity, and Language Data?

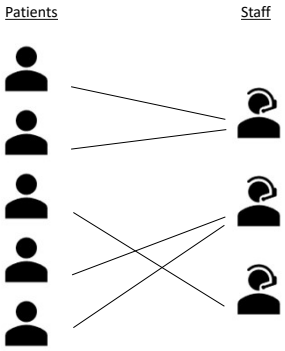


Challenges:

- Achieving full representative and unobtrusive collection
- Ensuring appropriate data governance
- Consistency in how data is utilized

SCAN uses REL Data to Drive Culturally-Sensitive and Linguistically-matched Pharmacy Interventions.

- Core staff has English-, Spanish-, and Korean-speaking capabilities
- We actively pair our staff culturally and linguistically with our members
- Learnings:
  - Patients appreciate a clinical pharmacist explaining their medications and chronic conditions
  - Cultural competency and in-language conversations helps build trust with patients to uncover potential barriers to medication adherence



We Use Technology to Guide REL-Matching and Task Prioritization

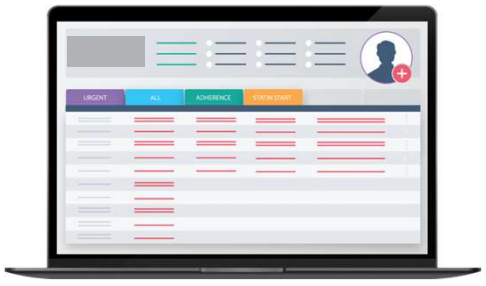


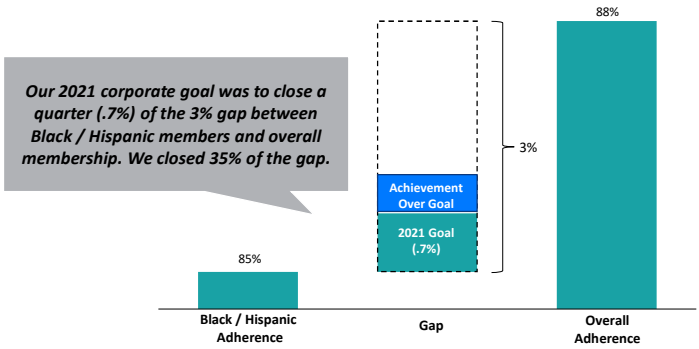
Image courtesy of Arine, Inc

- REL + SDOH data pulled into data pipelines
- Language and ethnicity information appear on task page
- Tasks auto-assigned by task and provider type
- Tasks prioritized based on next refill date and risk of nonadherence

We Deploy Additional Interventions Beyond REL-Matching

- Require all staff to undergo Cultural Competence/Cultural Humility Training
- Offer culturally-sensitive and in-language resources/health literacy tools regarding medication management
- Supply medical group providers with REL data + additional resources to enable culturally appropriate care

Overall Outcomes: We Exceeded Our Goal and Reduced the Medication Adherence Disparity by 35%



Sexual Orientation and Gender Identification

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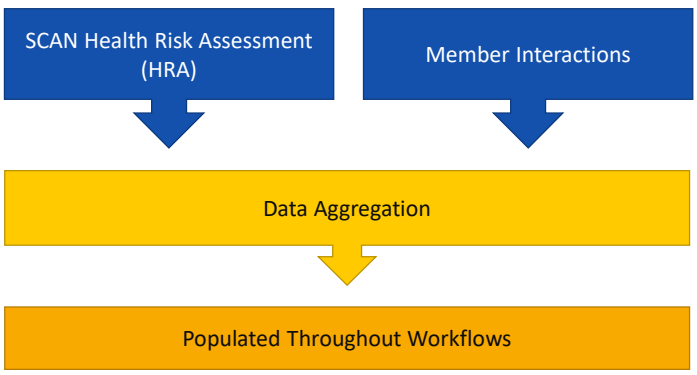
How Does SCAN Obtain Sexual Orientation and Gender Identity (SOGI) Data?



Challenges:

- SOGI data is still relatively new and thus, not widely utilized (across organizations, patients, and providers)
- Potential discomfort among patients in sharing very private information
- Ensuring appropriate data governance
- Consistency in how data is utilized

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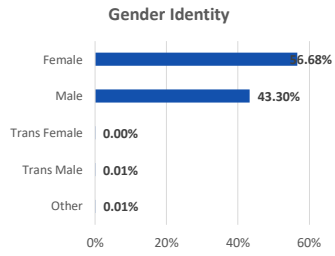
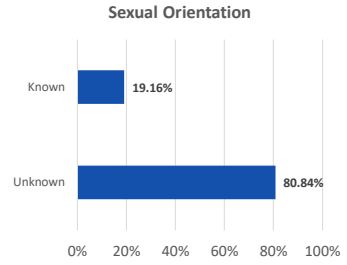
A Snapshot of SOGI Data Among SCAN's Population

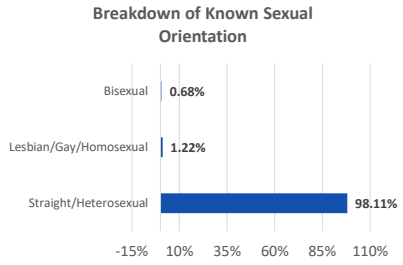
Based on a population of ~285,000:



~61 members identify as a gender ***other*** than male or female



We know the sexual orientation for **~54,000 of our members**



Of the ~54,000 we know the sexual orientation, **~1,000 identify as LGBTQ+**

SOGI Data Has Guided SCAN in Developing Products Specific to the LGBTQ+ Population

SCAN "Affirm" Plan:

- Virtual behavioral health offering via LGBTQ+ affirming providers
- Companion care services to address isolation and exclusion
- Legal services reimbursement (e.g., durable power of attorney, living will, etc.)
- Lower Rx copays on specialty tier drugs (HIV drugs, removing UM edits from HRT, etc.)
- Care navigation services including lifestyle support, peer groups, community resources and advocacy

Social Determinants of Health

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SDOH are the non-medical factors that influence health outcomes[1]

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Geography also impacts health disparities

Food Availability

Demography

Air and Water Quality

Access to Public Transportation

Physical Access to Health Care

Racialized Segregation

Cultural Practices

Attitudes

Socioeconomic Resources

Lifestyle Factors

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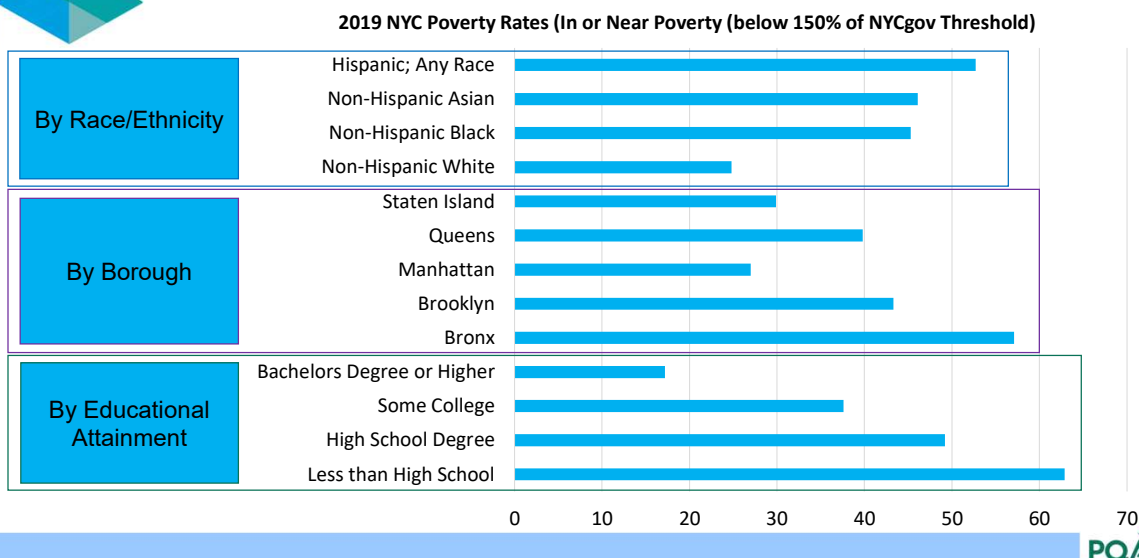
Poverty in NYC is not evenly distributed



The NYC Government Poverty Data Tool. NYC Opportunity. https://www.nyc.gov/site/opportunity/poverty-in-nyc/data-tool.page. Accessed 02/17/2023.

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Robust data allows for impactful action

- Universal Assessment
- Hot Spotting
- Predictive Analytics
- Group-Based Risk Identification

Social Determinants of Health: Resource Guide. NCQA. https://www.ncqa.org/public-policy/white-papers/social-determinants-of-health-resource-guide/ Accessed 02/16/2023.

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Robust data allows for impactful action

- Universal Assessment
- Hot Spotting
- Predictive Analytics
- Group-Based Risk Identification

Community Partnerships to Tackle Food Insecurity

- Zip Code Focused
- Localized Support
- Community Building

https://advance.healthfirst.org/case-studies/healthfirst-partnerships-increase-food-access-during-covid-19-pandemic

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Robust data allows for impactful action

- Universal Assessment
- Hot Spotting
- Predictive Analytics
- Group-Based Risk Identification

Medicare Advantage Value-Based Insurance Design Model

- Affordable Prescriptions!
- Food Security!
- Additional SDOH Targeted Support!

VBID. CMS. https://innovation.cms.gov/innovation-models/vbid Accessed 02/16/2023.

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SDOH and geographic data come from many sources

Enrollment	Z Codes	Publicly Available Data
Member Interactions	HCPCS Codes	Purchasable Data
ACO Member Screenings	Provider-reported Data	

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Disabilities

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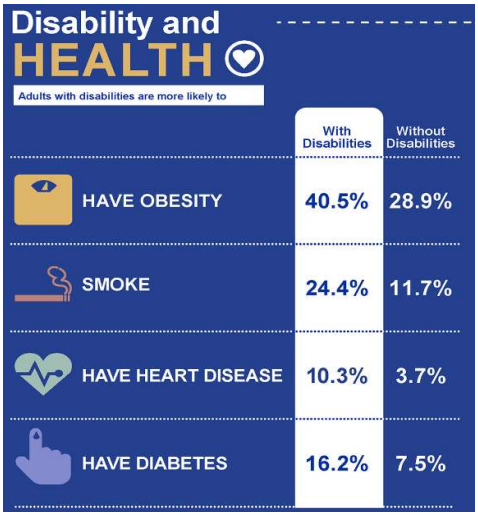
The CDC estimates 1 in 4 adults have a disability



CDC. Disability Impacts All of Us. Available at: https://www.cdc.gov/ncbddd/disabilityandhealth/infographic-disability-impacts-all.html

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Health & Human Services (HHS)[1] & American Community Survey (ACS)[2] recommend data standards for disability status

1) *Are you deaf or do you have serious difficulty hearing?*
2) *Are you blind or do you have serious difficulty seeing even when wearing glasses?*
3) *Because of a physical, mental, or emotional condition, do you have serious difficulty concentrating, remembering, or making decisions? (≥5 years old)*
4) *Do you have serious difficulty walking or climbing stairs? (≥5 years old)*
5) *Do you have difficulty dressing or bathing? (≥5 years old)*
6) *Because of a physical, mental, or emotional condition, do you have difficulty doing errands alone such as visiting a doctor's office or shopping? (≥15 years old)*

1) U.S. Department of Health and Human Services. HHS Implementation Guidance on Data Collection Standards for Race, Ethnicity, Sex, Primary Language, and Disability Status. Available at: https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//43681/index.pdf
2) U.S. Census Bureau. American Community Survey Data. Available at: https://www.census.gov/programs-surveys/acs/data.html

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Challenges and Opportunities

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SDOH, geographic, and disability data collection present challenges

Lack of Standardization
- Data reporting
- Collection requirements/formats

Lack of Provider Participation

Member/Patient Trust

Stigmatism

Internal Readiness

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Overcoming challenges takes teamwork

Leverage all points of member contact

Establish robust data governance

Educate and incentivize provider partners

Train appropriately for sensitive data collection

Reinforce importance of understanding and addressing inequity

Lean on published resource guides

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Take Aways

Identify Data Gaps

Recognize Limitations

Appreciate Sensitivity and Stigma

Foster Member Trust

Get Started!

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Thank You

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Using Technology to Drive Patient Care

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Faculty

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Objectives

- At the completion of this program, pharmacists will be able to
  - List challenges in specialty pharmacy medication management that could lead to increased risk of poor outcomes for patients.
  - Discuss the data available to Health System Specialty Pharmacists that could help identify patients who could benefit from additional support.
  - Describe targeted support that could be provided to patients to lessen their risk for poor outcomes.

Patient Clinical Care Challenges

- Complex dosing regimens
- Monitoring requirements
- Adherence and side effects
- Disease exacerbations
- High risk factors
- Follow up care challenges
- Coordination of care between medical and pharmacy services

IBD Laboratory Monitoring Dashboard

Sort Test | Lab Results Sorted by PA Expir... | Lab Results Sorted by Refills R... | Lab Results sorted by Delivery ...

Lab Results Sorted by Delivery Date

MRN	Last Delivery Date	Medication	PA Expiration Date	refillsleft	Lab Name	Result_Val..	Month, Day, Year of Labs_Results
112233445AB	10/08/2020	Stelara 90 MG/ML SOSY x1...	12/31/2021	0	QUANT TB1(-)NIL	0.00	November 01, 2019
116677889XY	10/07/2020	Humira Pen 40 MG/0.4ML PNKT x1.000 EA	06/30/2021	0	SEDIMENTATION RATE	4	February 28, 2020
					WHITE BLOOD CELLS	5.8	February 28, 2020
					C-REACTIVE PROTEIN	3.1	February 28, 2020
					QUANT TB1(-)NIL	0.00	August 08, 2019

- Identifies patients 4-weeks in advance of next Rx fill date with:
  - 0 refills remaining on Rx
  - TB test ≥ 11 months ago
  - Labs (CBC, CMP, ESR, CRP) ≥ 5 months ago

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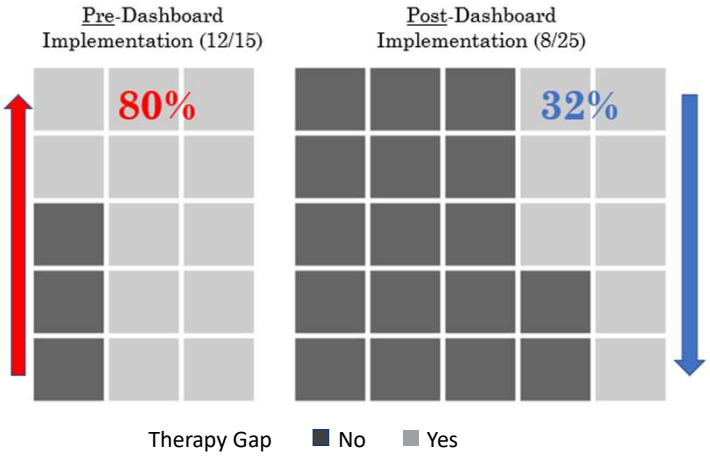
Decreased Treatment Gaps Observed



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Complex Dosing Regimens

- Infusion (IV) to Injection (SQ) medications
- Goal: create a simple tracking method to coordinate and monitor IV to SQ medications within the EHR

Medication	
Provider	
Referral date	
Medication counseling date	
Infusion information	
Infusion Status Update	
Infusion counseling date	
Therapy plan entered date	
Infusion approval date	
Number of infusions	
Infusion center 1	
Infusion 1 scheduled date	
Infusion 1 administered date	
Infusion center 2	
Infusion 2 scheduled date	
Infusion 2 administered date	
Infusion center 3	
Infusion 3 scheduled date	
Infusion 3 administered date	
Injection information	
Specialty pharmacy for injection	
Injection PA approval date	
Injection PA expiration date	
Injection RX sent date	
Due date of first injection	
Injection RX fill date	
Injection RX copy card obtained	
Medication samples	
Medication discontinued	

Preventing Gaps in Care

BestPractice

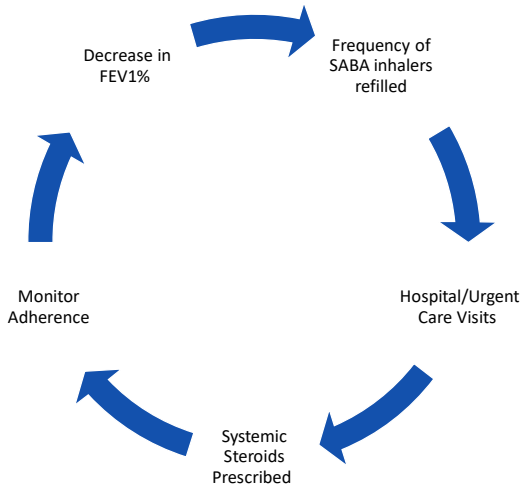
- Best Practice Alerts triggered when:
  - IV is administered --> start SQ authorization
  - IV is administered --> send SQ Rx
  - No SQ Rx sent 2 weeks prior to injection due date

✔ Complete BPA

- These alerts rely on the advance capabilities of the EHR and flowsheet system:
  - Help coordinate between the different teams handling medical and pharmacy authorizations
  - Getting medication doses on time

Asthma Clinical Monitoring Dashboard

Goal: Proactively identify patients at risk for uncontrolled disease by monitoring various factors associated with poor outcomes



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Oral Steroids

Oral Steroids in past 30 Days

PAT_MRN_ID	dispense_date	GENERIC_NAME
119122xxx	1/20/2023	predniSONE 20 mg tablet
119710xxx	10/26/2022	predniSONE 20 mg tablet
129455xxx	12/27/2022	predniSONE 10 mg tablet
	1/5/2023	predniSONE 10 mg tablet
		predniSONE 10 mg tablet
139597xxx	12/14/2022	predniSONE 20 mg tablet
118932xxx	11/16/2022	predniSONE 20 mg tablet
119444xxx	12/4/2022	methylPREDNISolone 4 mg tablets in a dose pack
	2/25/2023	methylPREDNISolone 4 mg tablets in a dose pack
179944xxx	9/13/2022	predniSONE 10 mg tablet
	11/15/2022	predniSONE 10 mg tablet
110135xxx	1/16/2023	predniSONE 50 mg tablet
110372xxx	11/22/2022	predniSONE 10 mg tablet
121411xxx	10/2/2022	predniSONE 20 mg tablet
	10/14/2022	predniSONE 20 mg tablet
	1/27/2023	predniSONE 20 mg tablet
	2/23/2023	predniSONE 10 mg tablet
112406xxx	9/20/2022	methylPREDNISolone 4 mg tablets in a dose pack

Identify Patients at risk for Poor Clinical Outcomes

Dashboard will email clinical alerts for patients that fall into metrics identified as potential risk factors

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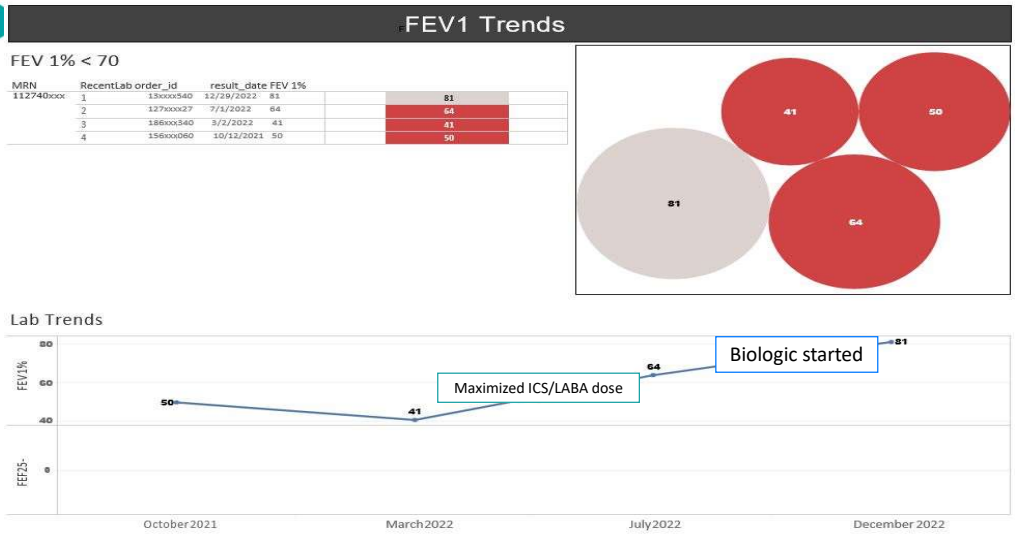
Utilization of Dashboard to Monitor Response to Therapy



Hepatitis C Patient Monitoring Dashboard

Patient Care Challenges

1. Multiple patient types and practice settings with differing workflows and needs
   - Adults
   - Children
   - Advanced/complex disease and mild disease

2. One Size Fits All Approach
   - Overstretching available healthcare resource personnel
   - Under and/or over-serving certain patient populations

Hepatitis C Patient Monitoring Dashboard

Targeted Solutions

1. Complex care needs
   - The few amongst the many
   - Individualized Care balanced with available resources and patient costs

2. Lost to Follow-Up
   - May not be a one size fits all problem or solution
   - Find and narrow contributing factors of affected patients to develop solutions to improve this outcome

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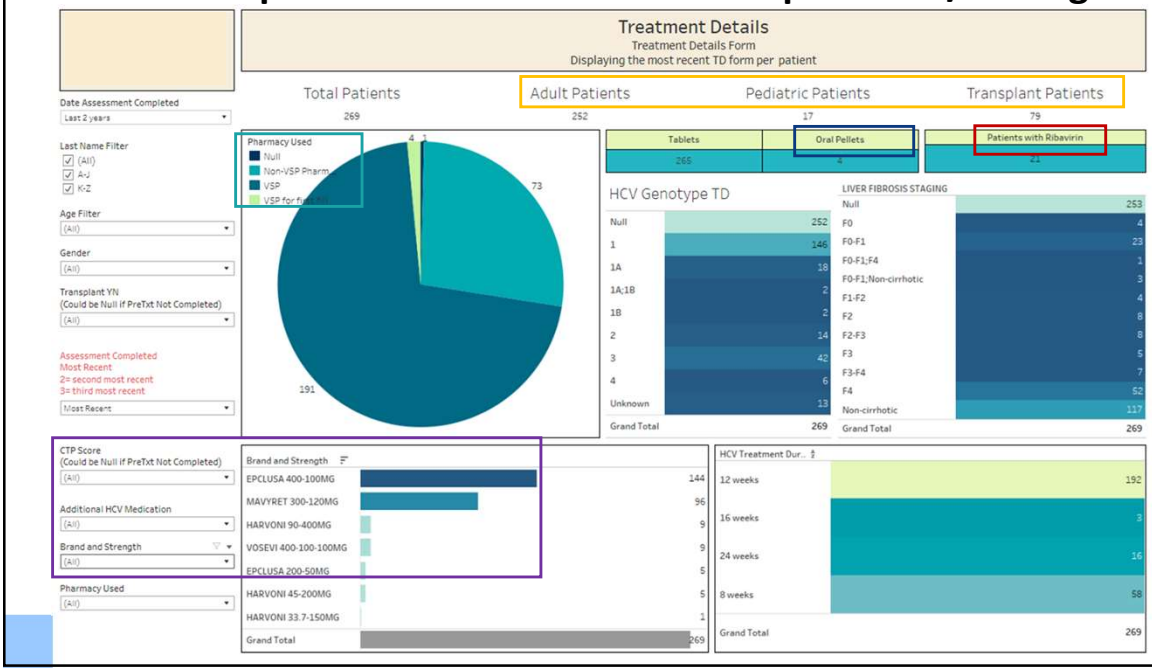
Complex Care Needs in Diverse Populations/Settings



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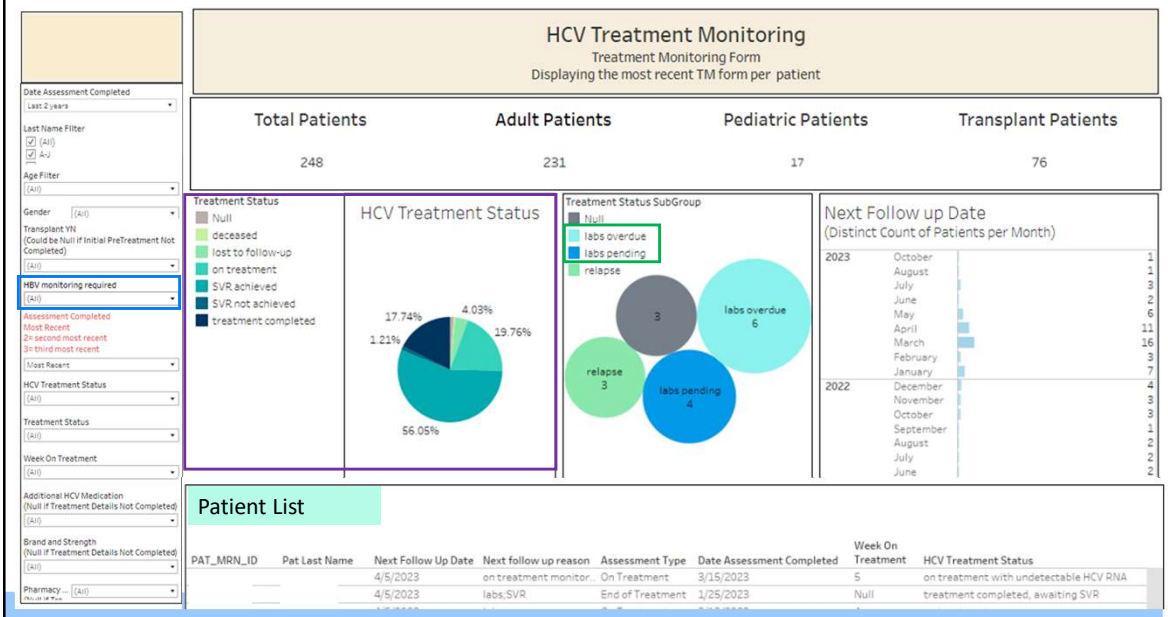
Therapy Outcomes/Follow Up



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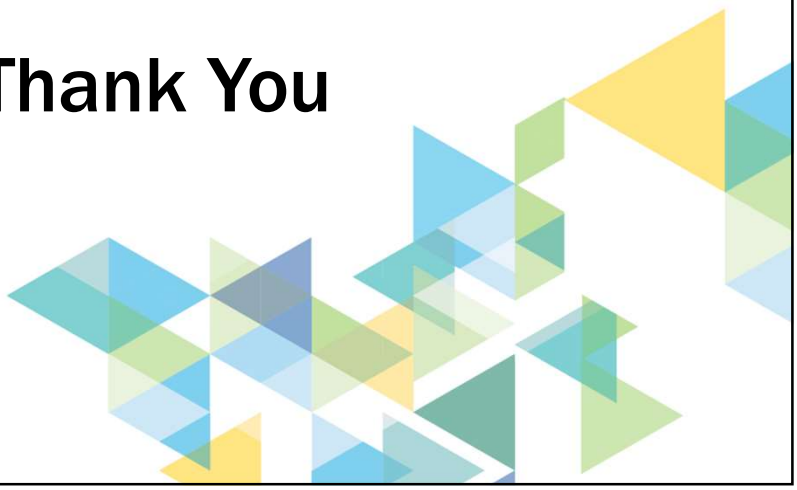
Thank You



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