Moving beyond Filling Prescriptions at a Moment in Time, to **Caring for Patients** over Time

Change Package

March 2020

Community Pharmacy Foundation

www.flipthepharmacy.com

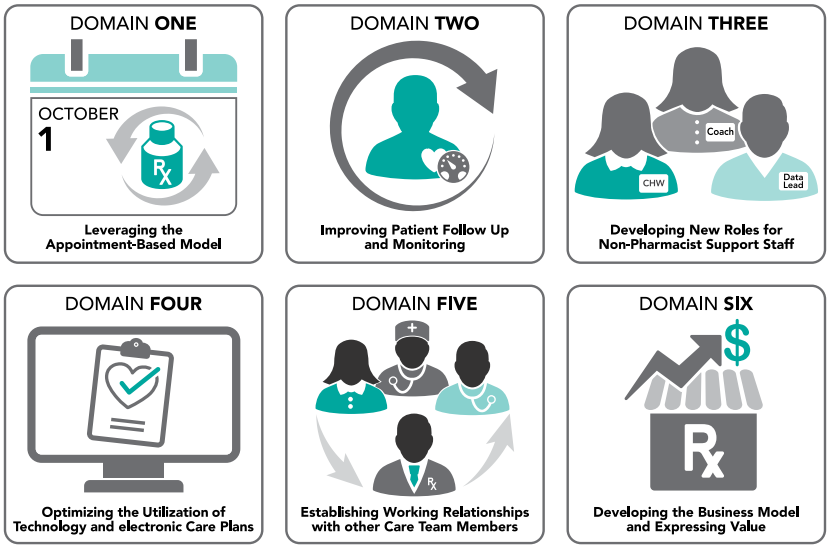
CPESN

Welcome to the **Flip the Pharmacy** Change Package

Pharmacy practice transformation requires big changes. This **Change Package** is your guide for practice transformation. This **Change Package** is designed to offer you a stepwise approach to help you transform 3 key areas of your pharmacy:

1. Your Workflow
2. Your Patient Care Processes
3. How you lead your Business

The **Change Package** will provide you focused practice transformation activities to develop each of the 6 Domains.



Each month, the **Change Package** will prescribe specific steps to help your team implement workflow innovations designed to assist your pharmacy with implementing patient care processes.

Here's how to make it work:

- **Each month:**
  - Review and lead team through the **Change Package**
  - Keep your entire team engaged in the Domain focus of the month
  - Complete your **Change Package** monthly requirements, if you are part of the Flip the Pharmacy cohort
- **As needed:**
  - Check in with your coach for near-real time feedback, if you are part of the Flip the Pharmacy cohort

DOMAIN **SIX**

Developing the Business Model and Expressing Value

Domain 6: ***Developing the Business Model and Expressing Value*** – What is the return on investment to the pharmacy for moving towards longitudinal, patient level health care services delivery.

Domain 6: *Developing the Business Model and Expressing Value*
Progression 1: *Hypertension Focus*

One of the goals of Domain 6 is to help you **better understand how community-based pharmacy fits in to measures that impact prescribers**. Knowing this information will help you accomplish the ultimate goal of this Domain, which is to better understand your patient data within the pharmacy in a way that you may not have thought about before. In turn, the data and additional materials within the change package will **help prescribers understand your value** as you do so much more for patients that only dispensing their medications.

Continue These Workflow Innovations from Previous Months

1. **Keep checking blood pressures** for your antihypertensive patients. Grow the number of patients on antihypertensives for whom you have checked their blood pressure. Do this by **training your staff to look for a documented blood pressure each time they fill an antihypertensive medication**.
2. **Continue to add patients to your med sync program** if they take multiple chronic medications, with a focus on getting as many patients taking antihypertensive medications into your sync program as possible.
3. **Continue to document or update eCare Plans** for patients you are following.

Start These **New Workflow Innovations** this Month

1. **Begin looking at data** to show how your pharmacy is doing with regard to adherence and blood pressure control among your patients taking antihypertensives
2. **Prepare for a follow up visit** with the prescriber/practice with whom you met last month
3. **Educate your staff** on how to respond to prescriptions for enhanced pharmacy services and/or requests for adherence reports

This Month's Deliverables

Education Check List

- ☐ **Understand the importance** of HEDIS, CMS Star Measures for Adherence, and the role of the Hypertension Management and Education Service Set Standard.
- ☐ **Review the talking points** for sharing the value that your community-based pharmacy brings to your mutual patients with a prescriber.

Workflow Innovation Goals/Check List

- ☐ If you have not done so yet, **complete one prescriber-pharmacy introduction**
- ☐ **Know your data**
  - Create a global **Flip the Pharmacy Performance Dashboard** for your pharmacy (see page 8)
  - Create a **Prescriber Visit Data – Mutual Patient** sheet for your mutually shared patients with hypertension (see page 10)
- ☐ Present the data from the **Prescriber Visit Data – Mutual Patient** sheet and share the value that you can provide.
- ☐ **Refine your eCare Plan strategy** and Document at least 25 eCare Plans
  - **Identify Medication Related Problems** (MRPs) and Interventions that you want to focus on during March
  - **Utilize your learnings** from the past 5 months

How is Hypertension Care Measured?
Clinical *Outcomes – HEDIS*

HEDIS *(pronounced 'hee-dis')* is the **acronym for the Heathcare Effectiveness Data and Information Set**. HEDIS is a widely used set of ***90+*** **healthcare performance measures** that are used to report various aspects of healthcare quality for 191 million Americans.

HEDIS measures are commonly used to assess both the performance of health plans and providers within the plan's network. HEDIS measures are wide-ranging – they assess everything from effectiveness of care, to access to care, to utilization. More detailed information about HEDIS measures can be found at *https://www.ncqa.org/hedis/measures/*.

Within the HEDIS measure set are measures related to blood pressure control. The **Controlling High Blood Pressure measure** assesses adults 18–85 years of age who had a diagnosis of hypertension and whose blood pressure was adequately controlled (<140/90 mm Hg). For the most recent year of national data available (2018), **less than 2/3** of patients within commercial and Medicaid populations have their blood pressure controlled, and for Medicare, it is just over 2/3. That leaves a lot of opportunity to **improve hypertension management among adults in the United States**, regardless of insurance coverage. Blood pressure control is also included within the **HEDIS Comprehensive Diabetes Care measure set**.

Primary care providers in particular are very likely to have their performance measured (and perhaps even financially rewarded or penalized using value based payment programs) using HEDIS blood pressure measures, and this is true across their insured patient population, regardless of whether the coverage is through Medicare, Medicaid, or commercial plans. As a result, providers and/or practice managers are probably very familiar with how their practice is performing on these and other HEDIS measures, or they have the data close at hand. **If you are able to demonstrate how your pharmacy could help the practice with blood pressure management**, particularly for monitoring and improving control within their patients who are currently non-controlled, **you would likely catch the provider or practice's attention and create an ideal opportunity to prove your value**.

Medication Adherence – CMS Star Measures

Chances are, you are already familiar with the **CMS Star Measures** that are focused on medication adherence. In case you are not, here is a quick primer.

All Medicare plans (be it Medicare Advantage, Prescription Drug Plans (PDPs), or a combination) **are measured and rated on their ability to perform well on a set of measures called Star measures**. The number of Star measures that apply to them depend on the type of plan(s) they offer within the Medicare space.

The **HEDIS hypertension measure** described above is included as a Star measure in the 2020 plan year, but only for non-PDP Medicare plans.

Also within the Star measures is an adherence measure focused on achieving at least an 80% proportion of days covered for RASA antihypertensive agents. This measure was originally developed by the Pharmacy Quality Alliance and is relevant for all Medicare plans for the 2020 year.

Some additional information about how the measure is calculated is listed below. Importantly, this **Medication Adherence for Hypertension measure** is *triple-weighted* within the Star measures, meaning that plans focus a disproportionate share of interest and effort on this (and other) triple-weighted measures because of both the quality and financial impact that they have on the plan if performance is poor.

Description Percent of plan members with a prescription for a blood pressure medication who fill their prescription often enough to cover 80% or more of the time they are supposed to be taking the medication. **One of the most important ways people with high blood pressure can manage their health is by taking medication as directed. The plan, the doctor, and the member can work together to do this.** (Blood pressure medication means an ACE (angiotensin converting enzyme) inhibitor, an ARB (angiotensin receptor blocker), or a direct renin inhibitor drug.

Numerator Number of member-years of enrolled beneficiaries 18 years and older with a proportion of days covered (PDC) at 80% or higher for RAS antagonist medications during the measurement period.

Denominator Number of member-years of enrolled beneficiaries 18 years and older with at least 2 blood pressure medications fills on unique dates of service during the measurement period.

Which Measures Affect Physician Practices?

For primary care physician practices that care for Medicare beneficiaries, they are likely being held accountable for their performance on at least one if not both the HEDIS hypertension measure and the **Medication Adherence for Hypertension measure**. Depending on the type of Medicare model they participate in, there is a strong chance that the practice is financially incentivized to achieve strong results on these and other quality measures used by CMS. Pharmacies with a patient care workflow in place for hypertension patients, like the one developed during **Flip the Pharmacy progression 1**, are in a good position to be able to demonstrate their ability to be capable and trustworthy collaborators to physician practices.

CPESN® USA Hypertension Management and Education Service Set Standard

If you have been following along with the **Progression 1 Change Packages** focused on Hypertension and implemented the associated learnings within your pharmacy, **CONGRATULATIONS!** You have met the minimum requirements for the **Hypertension Management and Education Service Set Standard**. The FtP Coordinating Center recommends going to your **CPESN Pharmacy collaboration site profile** and selecting that you offer the service set standard by clicking the check box. By continuing to offer the services that you have begun with hypertension, you will continue to make a major impact on your patients' lives and the quality of care that you offer your patients.

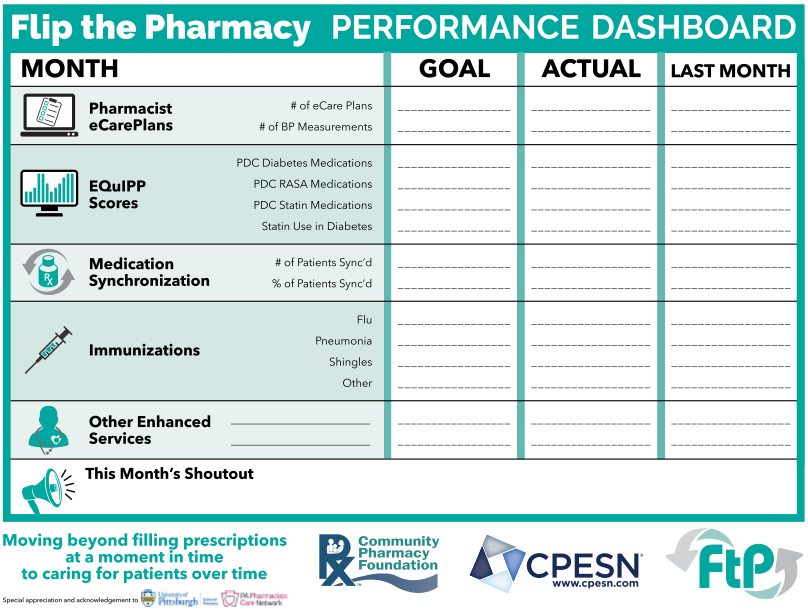
ACCESS STANDARD HERE

Workflow Innovation:
Preparing for the Practice Visit

Flip the Pharmacy Performance Dashboard

ACCESS DASHBOARD HERE

- Performance dashboards are designed to keep score of performance measures that reflect quality and help drive your profitability.
- A performance dashboard was created with support by a PA Department of Health and PA Pharmacists Association grant, and shared with all *40* FtP PA pharmacies at the PA Pharmacists Association mid-year meeting *(see sample of the new FtP Performance Dashboard below)*.
  - In case you're interested in **ordering a whiteboard of this scoreboard for your pharmacy**, the customized whiteboards were ordered from ***https://mywhiteboards.com*** and they were 36" wide x 24" tall. This may be a great way to keep track of your pharmacy's goals in place of printing multiple PDF versions to update overtime.



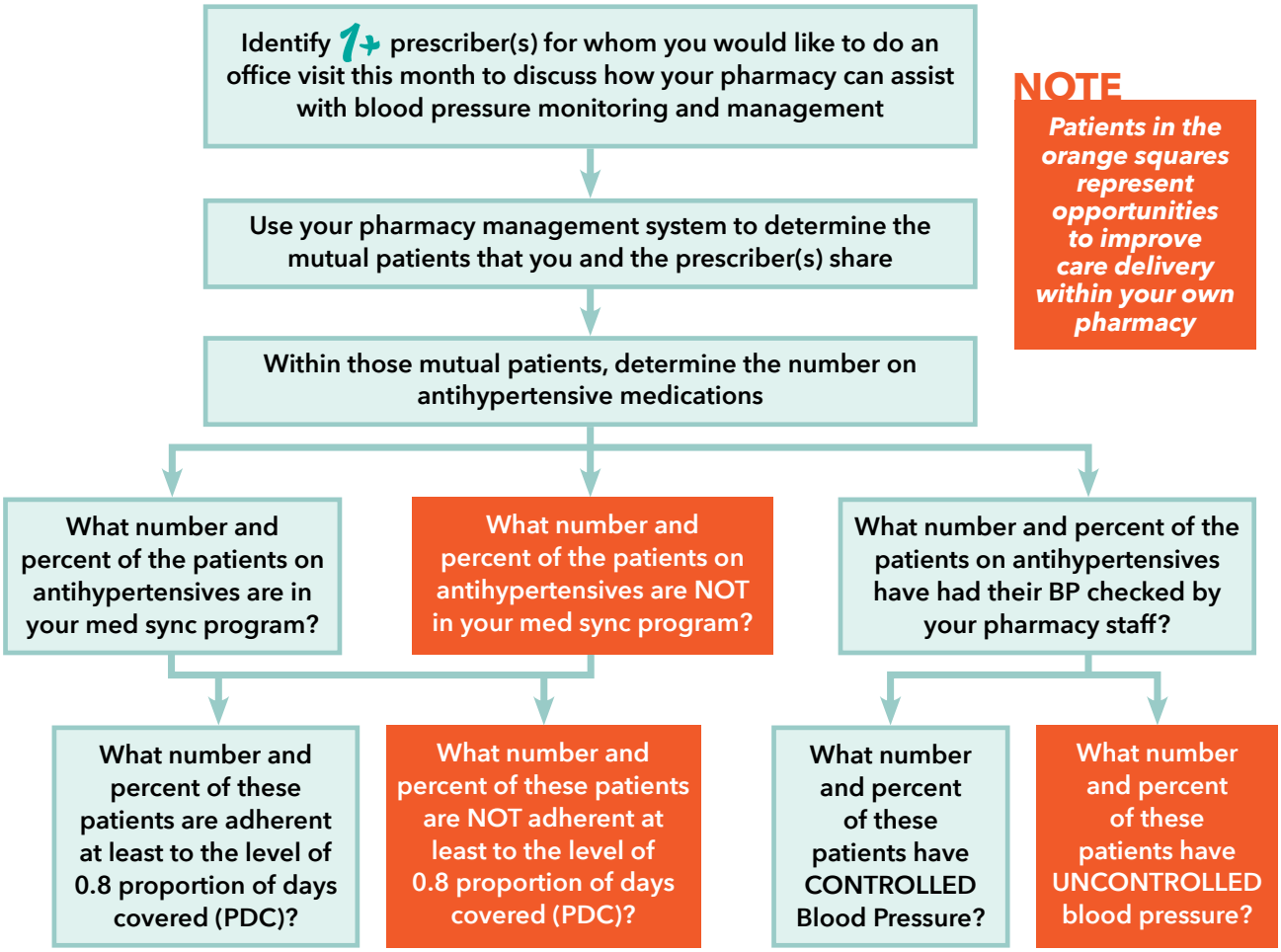
- We encourage you to have a **dashboard** in a location so it is visible to pharmacy staff. The goal is to get ***all staff on board*** with knowing and owning the goals!

> **TIP → The first month you use this tool, determine the actual numbers at baseline and share with your FtP Coach to goal set for the following month.**

- **FtP Coaches are here to help!** Reach out to your coach and share progress each month. You can incorporate this performance dashboard into your monthly coach visits for ideas and feedback.

Know Your Data Before the Practice Visit

Before you approach your local prescribers with whom you share a lot of common patients about how you can work together, it is best to make sure you know your own data – and specifically how your pharmacy is performing on all measures related to blood pressure care, since that is your current focus.



Prescriber Visit Data – Mutual Patients Template

Once you gather your data utilizing the above chart, and if you're comfortable with the data, complete the **Prescriber Visit Data – Mutual Patients template** by clicking button below. The document is editable so that you can type in your findings.

ACCESS DATA TEMPLATE HERE

TIP → You can also use this template within your pharmacy as a score board to keep track of your growth and for your improvement.

A sample of a completed sheet can be seen on the next page.

Hillcrest Pharmacy

PRESCRIBER VISIT DATA – MUTUAL PATIENTS

We are participating in a national program called Flip the Pharmacy, where the goal is to transform our services and workflow to focus on the broader needs of patient care, rather than prescription processing alone. Over the past 6 months, we made a number of improvements related to medication adherence, monitoring, and patient education for hypertension. Below are some data points that describe how our pharmacy is working to improve care for our mutual patients with hypertension.

Number of mutual patients we share:	**105**
Number of mutual patients in med sync:	**75**
Number of mutual patients with medications for hypertension:	**68**

MEDICATION ADHERENCE

Number of patients on our pharmacy's med sync process to improve adherence:	**52**
Percent of patients on our pharmacy's med sync process with a *Proportion of Days Covered > 0.8:	**98%**

BLOOD PRESSURE CONTROL

Number of patients with blood pressure taken at the pharmacy in past 3 months:	**45**
Percent of patients with controlled blood pressure, based upon most recent measurement:	**76%**

**Medication adherence as measured by CMS Star measures*

Pharmacy Point of Contact:

Jill Jones
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(919) 555-5555

Visit the Prescriber's Office

To prepare for your practice visit, we recommend that you compile a few key materials to take along with you. Below are the materials and a description of how each can be useful during your discussion with the practice.

- Hypertension Management and Education Service Set Standard (see page 7)
- Personalized Enhanced Services Prescription (see bottom of page for link)
- Your pharmacy's data *(if applicable)* (see page 9)
- Examples of Adherence Report Card *(optional) (see page 12)*

Consider the following for use on your practice visit:

TALKING POINTS

- Most pharmacies are focused on filling prescriptions. Part of the reason for our visit today is to make sure you know that our pharmacy goes beyond prescriptions – we are part of a network of pharmacies that we describe as an accountable pharmacy organization. Similar to a physician ACO, we provide services and care that is focused on improving a patient's health outcomes.
- In order to assure quality and consistency of care delivery across our network's pharmacies, we have documents called service sets that guide implementation, akin to a care pathway a physician might use.
  - **Share the Hypertension Management and Education Service Set Standard**
- In addition to the service sets, for the last 6 months, we've been participating in a national initiative called Flip the Pharmacy where the goal is to transform pharmacy workflow from one focused on prescription processing to one focused on patient care. We started this program with a focus on hypertension.
- We wanted to take a look at how we are doing managing our patients who take antihypertensive medications, and how these new services might allow us to assist your practice. [Explain the mutual patients that you share, and highlight the data showing how med sync helps to maintain high levels of medication adherence. Then show how your recent initiation of blood pressure monitoring has slowly started to incorporate patients at the practice.]
  - **Share your Prescriber Visit Data – Mutual Patients**
- We'd like to incorporate more of our mutual patients with hypertension into our blood pressure monitoring program, and even consider doing this for other patients of yours that are not currently using our pharmacy. This is an enhanced services prescription pad that you can use to communicate the need for pharmacy services to us. It can be used for existing patients that we share, or for new patients who are willing to fill their prescriptions at our pharmacy in addition to having us monitor their blood pressure and provide education about optimal self-management.
  - **Share the Enhanced Services Prescription Pad**

ACCESS PRESCRIPTION PAD HERE

TIP → Inform the prescriber's practice that they can have the patient bring it to the pharmacy, or it may be better for the practice to fax it to the pharmacy so that pharmacy staff will not have to depend on the patient to bring it to the pharmacy.

- **OPTIONAL:** Some of our network's pharmacies have started producing these adherence report cards and providing them to the patient's primary care physician, and the feedback they have gotten is that physicians find this adherence data very helpful, because it is not otherwise readily available to them. Is this something that would be useful to you? If so, how can we coordinate the timing of the information relative to the patient's appointment with you?
    - **Share adherence report cards for 1-2 of your mutual patients**

ACCESS REPORT CARDS HERE

TIP → If you feel that your hypertension specific data is not as valuable as it should be, continue working toward improvement prior to the prescriber visit. If at the time of the practice visit, your hypertension specific data is not up to your standards, continue on with your meeting. Discussing the Hypertension Management and Education Service Set Standard, the Enhanced Services Prescription, the Adherence Report Cards, and Blood Pressure Logs are helpful to show the value that you provide as a community-based pharmacy.

QUESTIONS FOR THE PRACTICE

- If we were going to share blood pressure values with your practice, what is the best way for us to share them with you?
- If our blood pressure monitoring shows that a patient's medication dose or regimen might need to be changed, what is the best way for us to send that to you?
- How is your practice currently doing with the hypertension performance measures? Is there a way our pharmacy could help using the services I've described?

Workflow Considerations

From Subject Matter Experts

Tripp Logan, Deborah Bowers and Randy McDonough shared responses to a couple questions that may be helpful about how they've implemented a hypertension monitoring service within their pharmacies.

ACCESS SME RESPONSES HERE

If you missed it during last month's change package, click the button to access a document with Jeff Olson's Practical-Clinical Process for hypertension. This is a Blood Pressure Measurement tool helps you to follow a process for monitoring a patient's blood pressure management.

ACCESS BP MEASUREMENT TOOL HERE

Strategies for eCare Plan Documentation

UPDATE: ***eCare Plans need to be submitted no later than the 5th day of the next month*** to be included in your monthly report. (e.g., any eCare Plan that you want counted to your goal for February, must have an encounter date for February and submitted no later than March 5)

There are 2 strategies outlined below for eCare Plan Documentation

- **Track 1:** For pharmacies that have been unable to meet the 25 eCare Plans per month
- **Track 2:** For pharmacies that have met or exceeded the 25 eCare Plans per month. Also, don't forget about Track 1 – there's opportunity within your pharmacy to excel.

IDEA → Submit 25 eCare Plans for Track 2 and try to submit more eCare Plans for Track 1

TRACK ONE: Beginner Level

STEP ONE: Identify a single prescriber and/or patients with anti-hypertensive medications (think Domain 1 – Leveraging the Appointment-based Model), determine which patients are in med sync vs not in med sync

STEP TWO: Patients who are not in med sync, target patients with at least 3 or more chronic medications.

STEP THREE: Discuss with and enroll patients in med sync

TIP → Have a champion in the pharmacy to lead this initiative.

STEP FOUR: For each patient who is enrolled into med sync, document an eCare Plan

- Use the **Patient Encounter Documentation Form** to document a patient needing an eCare Plan. Select the most appropriate Medication-Related Problem (MRP)
  - Place these at the appropriate workstations to be completed at the time of med sync enrollment or during the day.

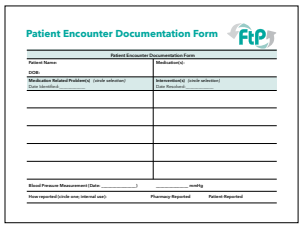
ACCESS ENCOUNTER FORM HERE

- Items to document for each patient:
  - Medication-Related Problem(s)
    - **Noncompliance with medication regimen:** document this as the MRP if patients are noncompliant/nonadherent to their medications
    - **Polypharmacy:** document this as the MRP if patients are compliant/adherent to their medications, but just take multiple medications and could benefit from med sync
  - Intervention
    - **Synchronization of repeat medications**
- **NOTE:** If you have patients enrolled into med sync who have not received an eCare Plan yet, document polypharmacy as the MRP and the intervention as synchronization

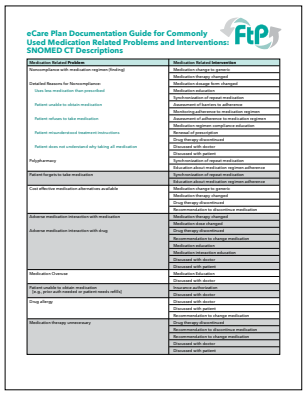
TRACK TWO: Intermediate-Advanced Level

STEP ONE: Identify a single prescriber or continue with the prescriber that you previously identified. Additionally, identify patients irregardless of med sync status, who have anti-hypertensive medication(s)

STEP TWO: Create your Pharmacy's **Personalized Patient Encounter Documentation Form** by utilizing the **SNOMED CT Descriptions Document**


Patient Encounter Documentation Form

ACCESS ENCOUNTER FORM HERE


eCare Plan Documentation Guide for Commonly Used Medication Related Problems and Interventions: SNOMED CT Descriptions

ACCESS DESCRIPTIONS HERE

- These are commonly used MRPs and Interventions that community-based pharmacies use, even though the list is not comprehensive
- Each white or gray highlighted section correlates with a likely MRP or Intervention
- Pharmacy Champions should work with their team members to determine what are some of the top MRPs and/or interventions that the pharmacy provides and which ones they would like to focus on during the month of March

TIP → Start with MRP or interventions as the "anchor." From there, determine which associated MRP or intervention is most likely.

ACCESS SAMPLE ENCOUNTER FORM HERE

- You can also just complete one or the other and print a copy of the SNOMED CT Descriptions Guide and have it readily available by pharmacy team members who are responsible

TIP → Start with MRP or interventions as the "anchor." From there, determine which associated MRP or intervention is most likely.

STEP THREE: Continue documenting eCare Plans for patients

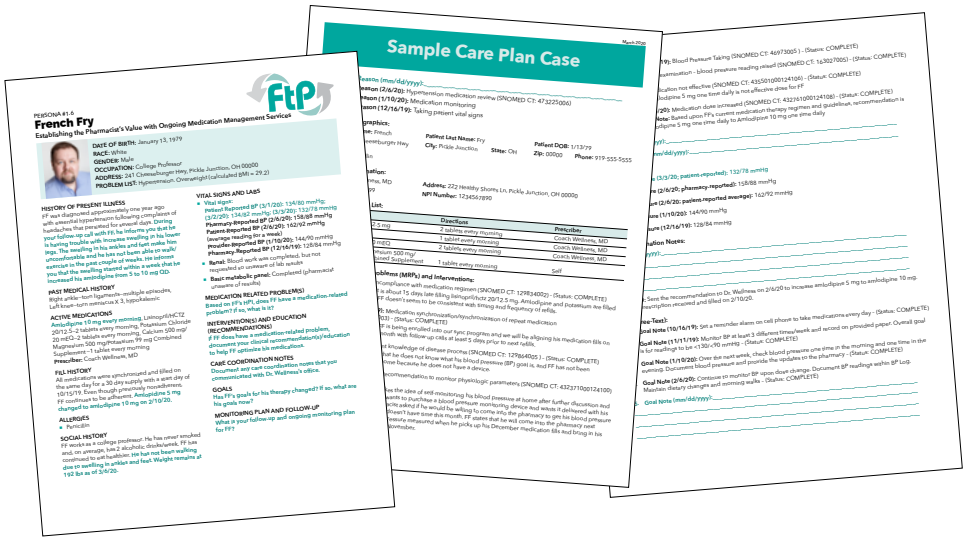
TIP → Have a champion in the pharmacy to lead this initiative

CASE INSTRUCTIONS: Let's Practice!

Patient Case Materials

Step 1: Review the Persona and Sample Case

- This is now Month 6 that we have been following French Fry (FF). As you read through the documents, note the History of Present Illness in the Persona.
- The Sample Case is left open-ended so that pharmacy staff members can complete the case based on what they would do for FF utilizing their clinical expertise and eCare Plan documentation skills. This is building upon the past 5 months of learnings and applying it to FF.



ACCESS BP PERSONA & CASE HERE

Step 2: Complete the Sample Case and Document the Encounter for French Fry

Please document the sample patient case before moving on to documenting real patients

- After you have determined the medication-related problems and interventions for French Fry, document within your platform for eCare Plans. Consider adding the Vital Signs, Care Coordination Notes and Goals.