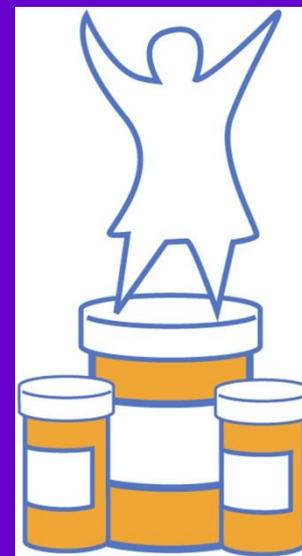


Pharmacy CARE Older Adults

Gina Upchurch, RPh, MPH

NC Institute of Medicine: Safety Net Workgroup

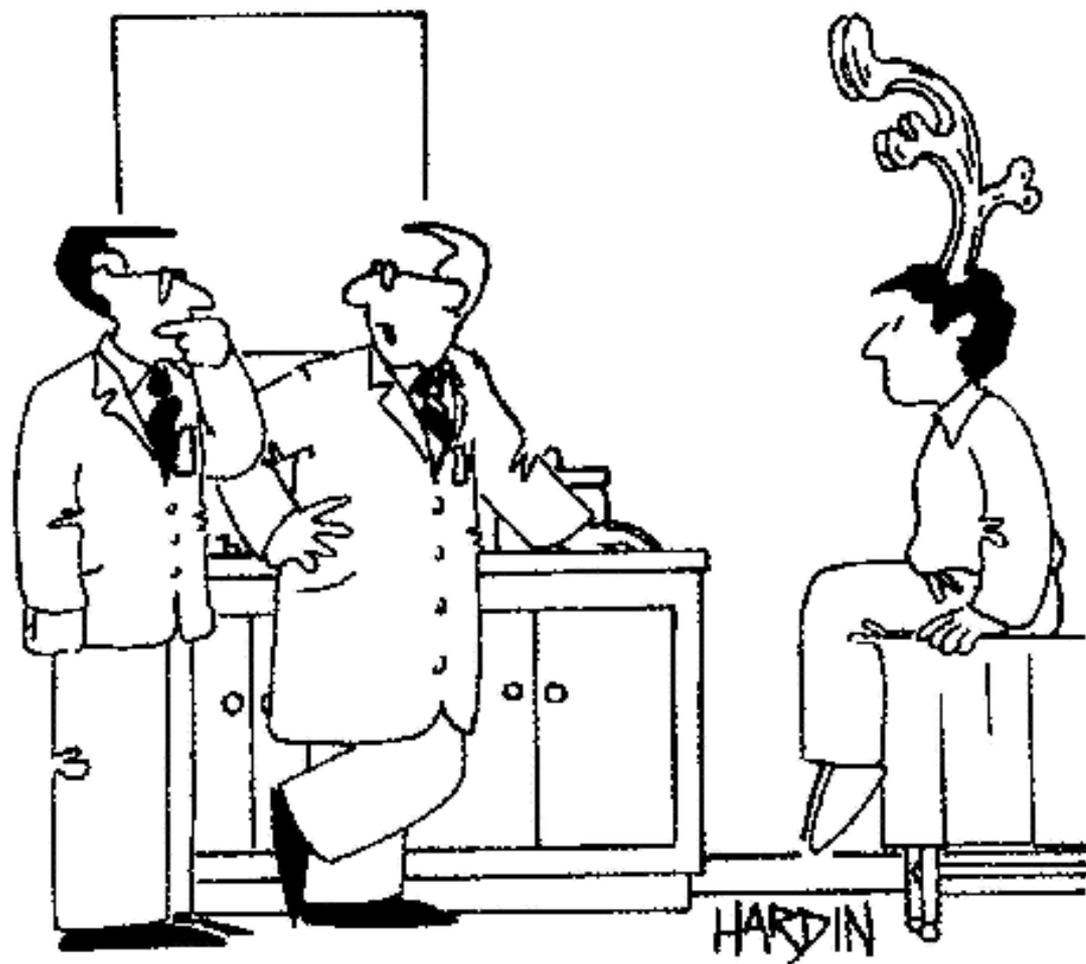
23 May 2011



Major Public Health Concerns: Associated with Medication Use

- ✓ Medicines don't work in people who don't take them.
- ✓ Sometimes the best medicine is no medicine at all.

PAIN RELIEVERS



"In the computer model the only side effect was a dry mouth."

Major Public Health Concerns: Associated with Medication Use

- Underuse:

- cost
- under-treatment or “sub-therapeutic”
- non-adherence

- Overuse or inappropriate use:

- polypharmacy -multiple, *sometimes* unnecessary drug use
- lack of attention to geriatric medicine and prevention options
- uncoordinated care - including multiple providers, poor communication & harried environments

- Health Literacy

Drug Therapy Problems

Indication

- Unnecessary Drug Therapy
- Needs Additional Drug Therapy

Effectiveness

- Needs Different Drug Product
- Dosage Too Low

Safety

- Adverse Drug Reaction
- Dosage Too High

Compliance/Adherence

- Nonadherence

Drug Therapy Problems

- Hanlon and Schmader (Medication Appropriateness Index)
 - Indication for drug
 - Medication effective
 - Dosage correct
 - Directions correct and practical
 - Drug-drug or drug-disease interactions
 - Unnecessary therapeutic duplication
 - Duration of therapy acceptable
 - Parameters monitored to assess therapeutic end points
 - Appropriately administered or taken
 - Medication cost-effective

Goal of Medication Therapy

- Maximize Benefits
- Minimize Risks
- ✓ To improve health outcomes...in the most cost-effective manner possible

Medication-related problems

- ***Good News:*** Estimated that 2/3 of the deaths and injuries from medicines can be prevented
- ***Bad News:*** Every \$1 spent on medicines is matched by \$1.36 dealing with a MRP (medication-related problem)

Pharmaceutical Care

We make assumptions:

- medications prescribed correctly
- medications dispensed correctly
- medications administered correctly
- medications monitored routinely

Medication Consumption

- Drug Interactions
 - Drug – drug
 - Drug – disease
 - Drug – nutrient
- Not all drug interactions are bad
- Clinical trials and “post-marketing surveillance”

Adherence Considerations

- Adherence as an “end” or a means to an end?
- Seniors are no more or less adherent than other age groups if matched for complexity of drug regimen
- When older adults are non-adherent, 90% of the time they underuse the medication
- 73% of the underuse is **INTENTIONAL**

Source: Cooper JK, et al. JAGS, 30(5)1982.

National Surveillance of ED Visits for Outpatient ADEs (JAMA. 2006;296:1858-1866)

- To enhance the surveillance of outpatient drug safety, the CDC, the US Consumer Product Safety Commission (CPSC) and the US FDA developed the National Electronic Injury Surveillance System-Cooperative Adverse Drug Event Surveillance project (NEISS-CADES).
- This is data from the first two years to estimate and describe the national burden of ADEs that led to ED visits.

National Surveillance of ED Visits for Outpatient ADEs (JAMA. 2006;296:1858-1866)

- 63 hospitals voluntarily participated (excluded psychiatric and penal hospitals)
- Based on 21,298 ADE cases reported, they estimated that 701,547 US patients were treated annually for ADEs in EDs in 2004 and 2005.
- Patients 65+ accounted for 48.9% of estimated ADE visits requiring hospitalization
- Individuals 65+ were more than twice as likely to be treated in EDs for an ADE and nearly 7 times as likely to require hospitalization as individuals younger than 65.

National Surveillance of ED Visits for Outpatient ADEs (JAMA. 2006;296:1858-1866)

- The 5 most common drug classes implicated in ADEs were insulins, opioid containing analgesics, anticoagulants, amoxicillin containing agents, and antihistamines/cold remedies.
- Insulins or warfarin were implicated in 1 in 7 estimated ADEs treated in the ED and 1/4 of all estimated hospitalizations
- 65+ - 3 drugs (insulin, warfarin and digoxin) were implicated in 1 in every 3 estimated ADEs treated in the ED and 41.5% of estimated hospitalizations.

Senior PharmAssist Elements

- Medication therapy management
 - Monitor
 - Educate
 - Interdisciplinary Approach
- Payment (supplement to Medicare or sole source)
- Tailored referral (medical and social)
- Medicare insurance counseling - SHIP
- Participant activation – medication records, geriatric formulary

Senior PharmAssist's Direct Financial Assistance

- ✓ If 60 or older and Durham resident - offer supplemental coverage to Medicare D or if the person has no Rx coverage, we offer primary coverage to individuals with incomes up to 200% of the federal poverty level
 - ✓ Single = \$1,815/month or \$21,780/year
 - ✓ Couple = \$ 2,452/month or \$29,420/year
- ✓ Participants pay no more than \$2/generic or \$5/brand-name - on our geriatric formulary
- ✓ Eligible for one-on-one medication therapy management and tailored community referral
 - ✓ Transport or home visit

Financial Assistance with Meds

- ✓ We help anyone apply for the federal low income subsidy via SSA to lower their premiums, co-payments, and eliminate the coverage gap or “donut hole.”
- ✓ We help seniors apply for NCRx – the statewide program that helps people 65 and older with limited incomes pay up to \$29/month on their Part D premiums



Safe and Effective Medication Use

Participants

- Medication Therapy Management (MTM)
 - ChecKmeds NC
- Medication record
- Link pharmacy profiles
 - PBM – Catalyst Rx
- Geriatric formulary

Prescribers and Pharmacists

- Medication record
- Geriatric formulary
- Direct feedback

Senior PharmAssist: What Else?

- Durham seniors 60 & older, at/under 200% FPL not eligible for our card program because of Full LIS, MQB, Medicaid or retiree coverage ARE ELIGIBLE for a free medication review every 6 months.
- We help younger people without Rx coverage – assess eligibility for drug manufacturer patient assistance programs, & look for other ways to bring costs down.
- We help ANY Medicare beneficiary in Durham sort through Medicare-approved drug plans.
 - ✓ Any age, any income.

Federal Medical Programs

Medicare

- administered federally
- persons 65+ or disabled, ESRD, ALS
- Rx medications – mostly not included until 2006
- Part A – hospital care and what follows
- Part B – outpatient benefits, including physician visits – covers 80% of “allowable”

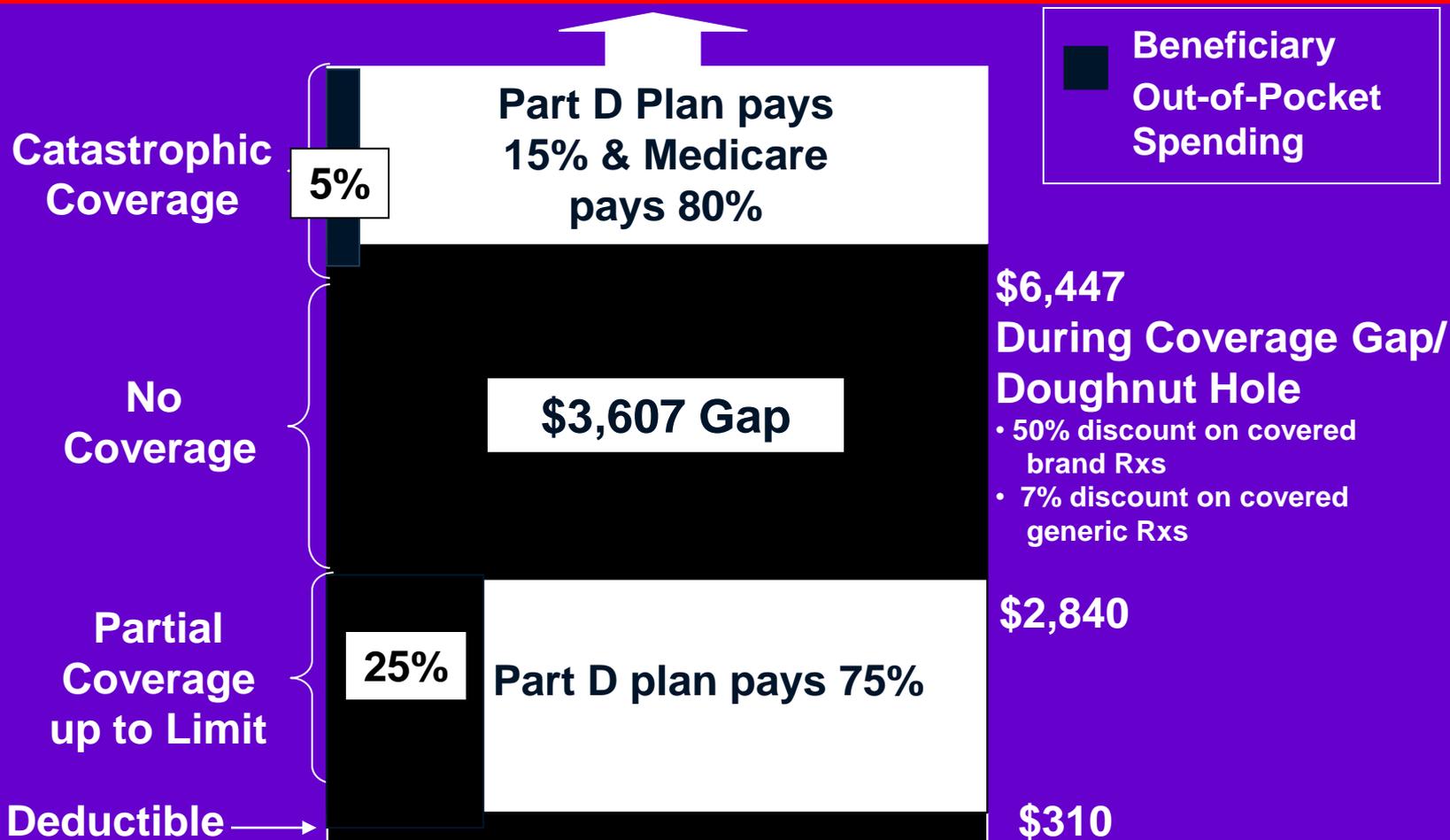
Medicaid

- administered by states; with federal matching funds
- for the medically impoverished who are deemed “categorically” eligible
- Rx medications—included – with “duals” now receiving benefit via Medicare-approved plans

Administration

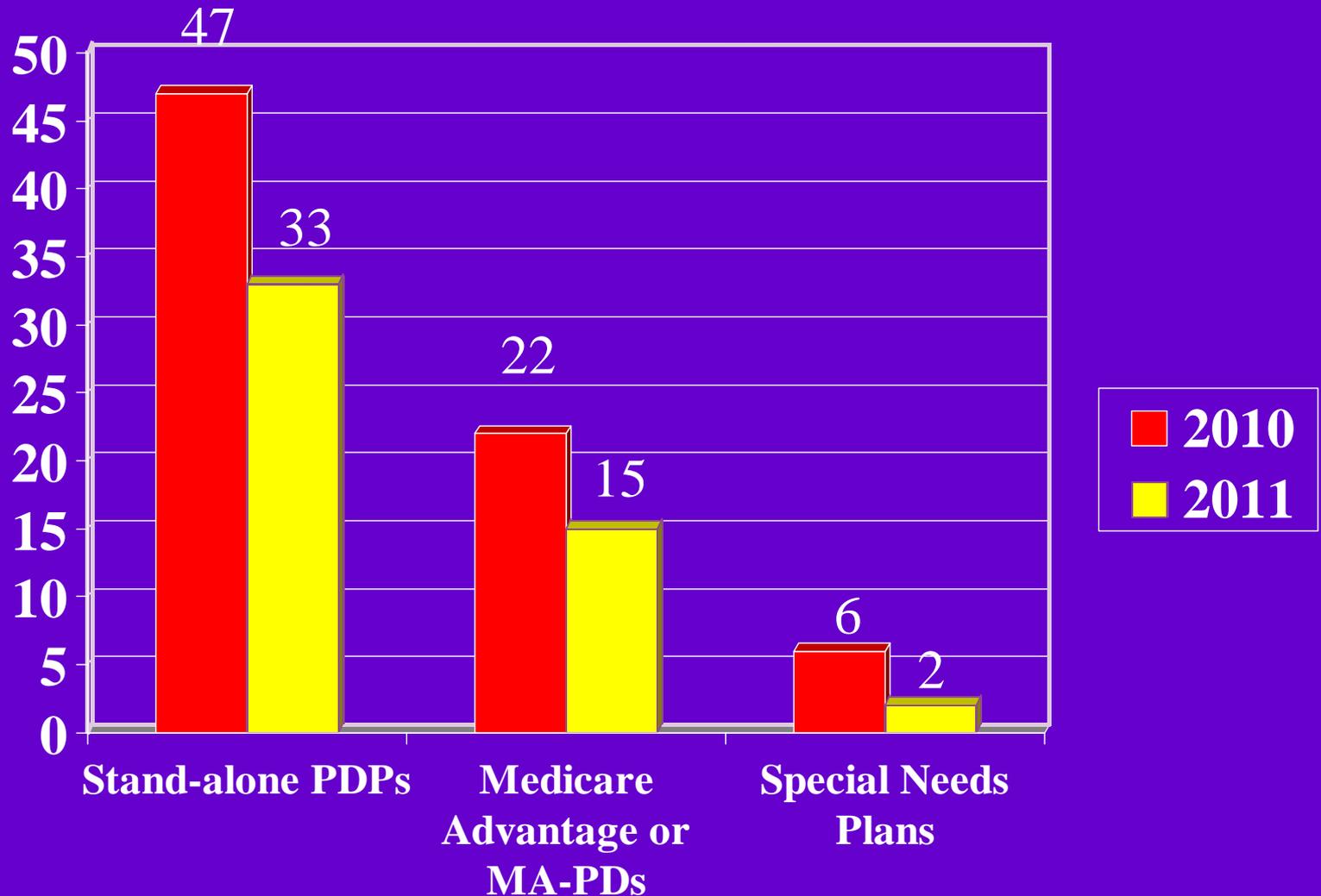
- Most Medicare beneficiaries have:
 - traditional Medicare Part A and B
 - have a secondary medical coverage or buy a supplement and
 - choose a “stand alone” **Part D** drug benefit.
- Some Medicare beneficiaries trade all of this for a “**Medicare Advantage**” plan (**Medicare Part C**), which include HMOs, PPOs, and PFFS plans, and some plans specifically for special needs populations (e.g. nursing home patients). They *can* include Rx benefits (MA-PD), but are not required to.

Medicare Beneficiaries' Out-of-Pocket Drug Spending Under Medicare Rx Benefit, 2011



Medicare Drug Benefit

Medicare Rx Benefit Options: 2010 & 2011



Warning in Durham County !!!

- While Medicare Advantage plans include A and B benefits (and sometimes “extras”) – may not be accepted by all providers in Durham.
- DUHS limited plans accepted “in network:”
 - BCBS – Blue Medicare (Partners HMOs and PPOs)
 - Sterling (PFFS and PPO’s)
 - Coventry/Advantra (PPO’s)
- Out of network – Humana, AARP/United/Secure Horizon’s, America’s 1st Choice, Universal American – Today’s Options

Medicare Beneficiaries Without Prescription Drug Insurance or “Creditable” Coverage

- **Will likely want to join a plan:**
 - Pay a monthly premium in addition to a percentage of total drug costs (via deductibles and co-payments or co-insurance).
 - **IT PAYS TO COMPARE PLANS** because plans cover different drugs at different prices, which **change EVERY YEAR.**
 - Penalty clock for not having “creditable coverage” began June 2006 - (Penalty of \$17.73/mo. more in premium if living under a rock since June 06)

PDP Plans: “Considerable Discretion”

- Formularies; TrOOP – “true” out-of-pocket
 - Medicare beneficiaries who need a drug that is not covered will pay the entire cost of the drug, without a limit on expenditures, unless they can successfully **appeal** to have it covered
- Utilization Management policies (i.e. prior authorization, step therapy, quantity limits, tiered cost sharing)
- Exceptions and appeals processes
- Transition fill policy

Medication Therapy Management Definition

“MTM is a distinct service or group of services that optimize therapeutic outcomes for individual patients. MTM services are independent of, but can occur in conjunction with, the provision of a medication product.”

Approved July 27, 2004 by AMCP, AACP, ACA, ACCP, ASCP, APhA, ASHP, NABP, NACDS,
NCPA, and the NCSPA.E.

CMS

- MTM services must evolve and become the cornerstone of the Medicare Prescription Drug benefit.

2010 Medicare MTM Requirements

- Plans must have an MTMS program that may be provided by a pharmacist; opt-out vs. opt-in
- Targeted beneficiaries:
 - Multiple chronic conditions (cannot require a minimum above 3 and 7 core chronic disease states) AND
 - Multiple medications (cannot require more than 8) AND
 - High drug costs (>\$3,000)
- Interventions for beneficiaries and prescribers

2010 Medicare MTM Requirements

- Interventions must be comprised of interactive component as well as continued monitoring and f/u
- Minimum interventions
 - Comprehensive medication review (CMR)
 - Targeted medication review
 - Interventions targeted towards prescribers
- May include passive or “low touch” interventions
- <http://www.slideshare.net/roycondell/2010-mtm-guidelines-for-medicare-part-d-sponsors-final-ms-5>

MTM Core Components

- Medication Therapy Review (MTR)
- Personal Medication Record (PMR)
- Medication Action Plan (MAP)
- Intervention and/or Referral
- Documentation and Follow-up

MTM services

- Distinct from dispensing
- Applicable to all patients in need of MTM services
- Patient-centered – self-management
- In collaboration with physicians and other HCPs
- Facilitate continuity of care
- Able to be delivered by large numbers of pharmacists

MTM services

- Delivery
 - Usually appointment based
 - Face-to-face
 - Private area
 - Documentation

Medication Therapy Review

- With patient and/or caregiver
- In-person, face-to-face preferred
- MTR Process:
 - Comprehensive intake— Rx, OTC, herbals
 - Medication Assessment: appropriateness, safety, effectiveness
 - Plan: works with patient's providers

Core Components Continued

- **Medication Action Plan:**
 - Includes:
 - Medication related issues identified
 - Actions, responsibility, and expected results
- **Intervention and Referral:**
 - Pharmacist provides consultative services
 - Intervenes to address medication related problems
 - Refers to other health providers when necessary

Documentation and Follow-up

- Documentation is consistent & at a minimum includes:
 - Patient demographics
 - Known allergies, disease states, conditions
 - Record of ALL medications (incl. OTC, herbal)
 - Assessment/Plan for all medication therapy problems
 - Interventions/referrals made
 - Education received
 - Schedule for follow-up
 - Amount of time spent with patient
 - Feedback to providers/caregivers

Medication Reconciliation

Source: Institute for Healthcare Improvement

- A formal process of obtaining a complete and accurate list of each patient's current home medications — including name, dosage, frequency and route — and comparing admission, transfer, and/or discharge medication orders to that list. Discrepancies are brought to the attention of the prescriber and, if appropriate, changes are made to the orders. Any resulting changes in orders are documented.

Medication Reconciliation

Source: Institute for Healthcare Improvement

- The process involves three steps:
 - **Verification** (collection of medication history)
 - **Clarification** (ensuring that the medications and doses are appropriate)
 - **Documentation** (changes to orders or reason for differences)

- Critical in transitions in care



-
- ✓ Medication therapy management program in NC for Medicare beneficiaries 65 and older who have Medicare-approved drug benefits
 - ✓ Supported by the NC Health and Wellness Trust Fund for 30-months – ends in June?
 - ✓ Uses 3rd party – Outcomes Pharmaceutical care to track pharmacists interventions