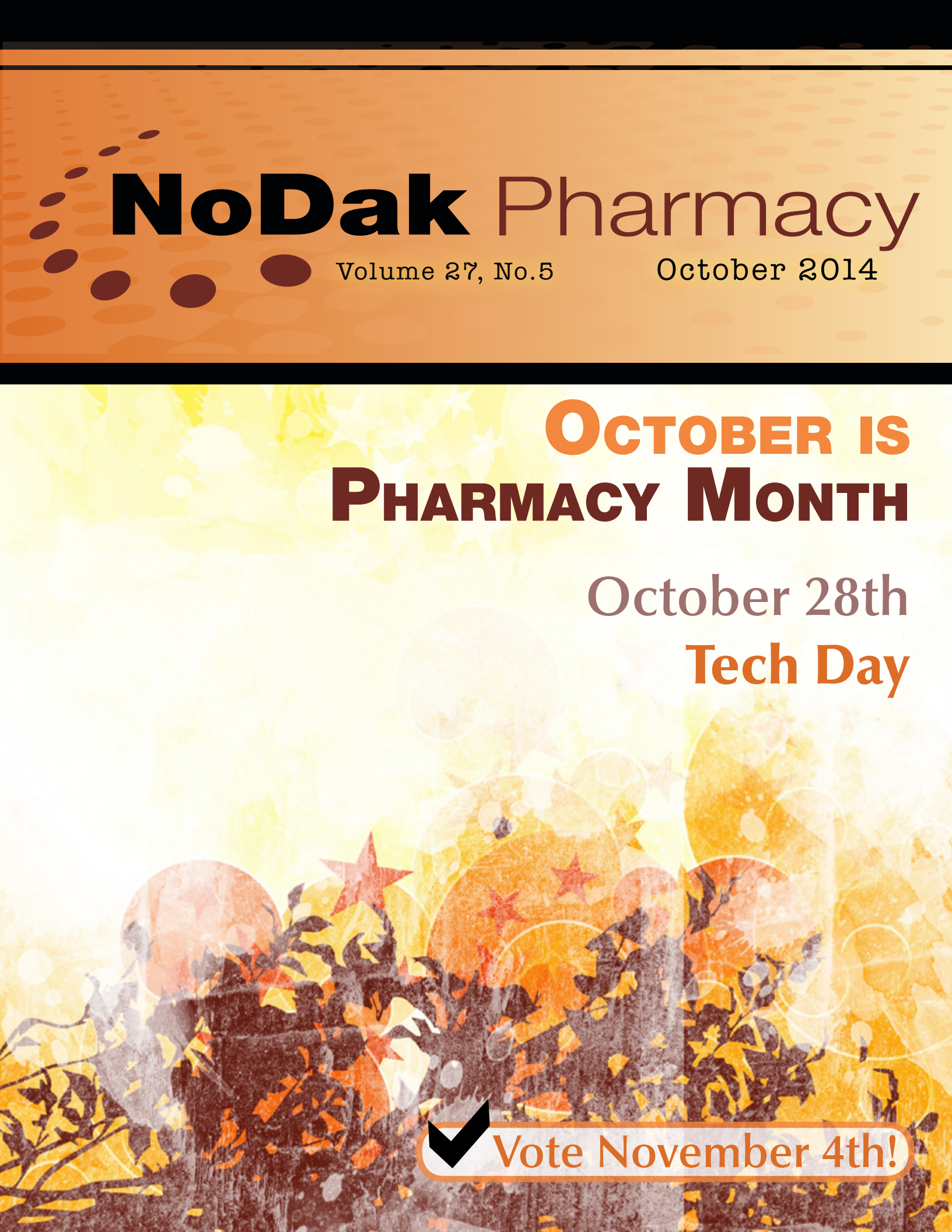
NoDak Pharmacy

Volume 27, No.5 October 2014

October is Pharmacy Month

October 28th

Tech Day



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Message from the NDPhA President

I hope everyone had a great summer and has had some time to enjoy the fall weather. It seems like every year we get busier and busier and this year is no exception. There are lots of things going on in the practice of pharmacy. Provider status, star ratings, preferred networks and access to pharmacy services, medication therapy management are just a few. There seems to be a common thread through all of these issues. Pharmacy and pharmacists proving that we are valued health care professionals.

I have thought a lot about this issue and wonder if this has become such a fight because of the loss of control of our own profession. I have been practicing pharmacy for 23 years and have seen a lot of changes in that time frame. It appears to me that many of these changes have been for the good but we have also had a fair amount of struggles. In my opinion, one of the biggest issues is letting people who do not practice the profession make decisions for how our job should be done. Some of the prime examples of this are, insurance companies deciding how and what our profession should be, drug manufacturers dictating how medications should be distributed, and corporate control of the practice of pharmacy by businesses that are not primarily in the pharmacy business.

I am well aware that measure 7 is on the ballot in November and that there are very strong feelings about pharmacy ownership in this state. This same question has popped up in many other countries with similar ownership laws. While the ownership law is unique in the United States, it is very common in a lot of the world. The International Pharmacy Federation has titled a reference document – Pharmacist Ethics and Professional Autonomy: Imperatives for Keeping Pharmacy Aligned with the Public Interest. This is a very well written document that elaborates on the issues related to pharmacy and who should dictate the practice of the profession. In its conclusion its states: "Pharmacy cannot achieve its full potential, and patients will not benefit from that potential, unless pharmacists are committed to the highest standards of professional conduct and have sufficient autonomy to serve patients' best interests".

I think that even if you do not support the current law in ND as I do, all would agree that the profession should be in charge of how it operates. If you look at the issues facing the profession today, it appears that we are fighting for the value we provide to people that do not work or understand our industry. Why are pharmacists not considered providers? Why are we having to fight to get paid a fair amount for MTM services? Is it because the people who decide what the practice is are not pharmacists themselves? Do they not understand the value of the time and services that you provide to the patient?

No matter how you vote this November, I hope everyone considers how their job is managed. Who is in control of what you do and what are the motives behind the decisions that are made? What is in the best interests of the patient and the practice? There is a saying that if you are not at the table then you are on the menu. Be active in what you do. Consider being more involved in the association. Make your voice heard.

Sincerely,

Steve Boehning R.Ph

President NDPhA

NATIONAL
PHARMACY TECHNICIAN DAY

is

TUESDAY,

OCTOBER 28, 2014

The Theme for National Pharmacy Technician Day 2014 is:

PHARMACY TECHNICIANS:
BUILDING BRIDGES to SUCCESS

The first National Pharmacy Technician Day was 1991. The Congressional Record of July 16, 1991 contains a note about Technician Day, and the theme in 1991 was "Technician Recognition." This year we are celebrating the 24th annual Pharmacy Technician Day.

Along with Pharmacy Technician Day being recognized on the National level, many technicians have gotten their State legislators to recognize National Pharmacy Technician Day. We encourage you to do the same.

American Association of Pharmacy Technicians
877-368-4771
www.pharmacytechnician.com

Pharmacy Technician Educators Council
202-567-7832
http://www.pharmacytecheducators.com

The Society for the Education of Pharmacy Technicians
www.thesepht.org

NPTA uses the same National Pharmacy Technician Day Theme every year:
"Rx Techs…Helping America Feel Better"

President's Report:

The Fall Conference is coming together nicely and many pharmacy technicians have already registered. We will be having the conference at Kelly Inn/Minerva's in Bismarck on October 17-18.

Thank you to Diane Halvorson for volunteering to head up the speakers and working with NDSU College of Pharmacy, Nursing, and Allied Sciences to make sure the CEs offered are ACPE approved.

Tamara Link has been working on having jackets and pullovers on display at the conference. They will have NAPT on the upper back or the sleeve and the NAPT logo on front. You will be able to order your clothing directly from the store and have it personalized to your liking. It is a great idea to wear our logo and advertise our organization. We want more people to know what NAPT stands for and realize once you are a Registered Pharmacy Technician, you are a member of the Northland Association of Pharmacy Technicians.

A representative with PTCB from Washington DC will be in attendance at the Fall Conference. He will be giving a short report after the last CE on Friday and will answer questions afterwards and also on Saturday.

Happy Pharmacy Technician Day on October 28th!!

Thank you for all you do for your patients and your pharmacy!

Remember, what you do isn't just a job - - - it is your Profession.

Sharon Kupper

NAPT Board of Directors

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American Association of Pharmacy Technicians Convention Report

Sharon Kupper, *NAPT President*

"Building Bridges to Success" was the theme for the 32nd AAPT Annual Convention held this past July. Pittsburgh, known as the city of bridges, with nearly 2000 bridges served as the host city. It was an informative convention providing 15 continuing education credits.

As the scope of pharmacy practice changes, technicians are moving into new roles and keep building bridges in areas such as: Medication Reconciliation, Informatics, Analysts, E-Prescribing, or MTM Coordinators.

The convention began with featured speaker, Chris Jerry, who founded the Emily Jerry Foundation. The CE was titled, The Emily Jerry Story – "From Tragedy to Triumph", the vital role of pharmacy technicians in the pharmacy practice. Chris's daughter, Emily, was diagnosed with a form of cancer at 1-1/2 years old. Chemotherapy treatment was successful and her last MRI showed the tumor had disappeared. Emily was scheduled to begin her last chemotherapy session just to be sure there were no traces of cancer. A key point in his presentation is the importance of preventing system errors. If you want to read the complete article on Emily's story, check out the website: www.emilyjerryfoundation.org.

Another aspect of the Emily Jerry Foundation is an interactive map located on the Emily Jerry Foundation home page. Take a look at the National Pharmacy Technician Initiative which includes "State Scorecards", rating pharmacy technician requirements, regulated by ASHP. North Dakota is highlighted in this article; "States like North Dakota, that are doing a tremendous job of protecting their patients through strict controls and educational requirements for pharmacy technicians, will serve as a model moving forward for states with failing grades, and most importantly for the 6 states that have absolutely zero regulations regarding pharmacy technicians."

Thank you for allowing me to represent North Dakota with this great opportunity to attend the AAPT Convention. I had the privilege to attend this convention with 4 ND pharmacy technicians and we were able to connect with other pharmacy technicians from all over the US and the Bahamas.

The Profession of a Pharmacy Technician

Where we began, where we are, and where are we going?

Diane Halvorson, *RPhTech, CPhT*

Pharmacy Technicians have always been an active and essential part of the pharmacy. In 1991 a group, through the guidance of Al Schwindt, RPh, began discussing the need for an organization that could be the voice of and represent pharmacy technicians. Through the support of Pharmacist Schwindt, other pharmacists and a core group of pharmacy technicians; the Northland Association of Pharmacy Technicians (NAPT) was created. In January 1992 the first business meeting was held to set short term/ long term goals to best serve its members. It has always been the ultimate goal of this organization to be an advocate for the Profession of the Pharmacy Technician. Many changes have been implemented on the state and national level and the NAPT Executive Board has been at the lead paving the way for its members to look outside the normal practice and reach for the multitude of roles Pharmacy Technicians can embrace to best enhance their role in the pharmacy.

Let's do a brief overview of the standards as set by the North Dakota State Board of Pharmacy. August, 1995, Pharmacy Technicians began annual registration with the North Dakota State Board of Pharmacy. With the registration process, pharmacy technicians could use the professional title of ND Registered Pharmacy Technician or RPhTech. Since that point other changes to the rules include; Certification for ND Registered Pharmacy Technicians, currently the PTCB (Pharmacy Technician Certification Board) is the approved national body. At the present, all applicants applying for registration must be a graduate of an ASHP (American Society of Health Pharmacists) program; this includes an ASHP accredited on-the-job training program. Along with the annual registration, the standardization of CE (continuing education) requirements was implemented. Presently, CE requirements include; 10 CE per year. It is important to highlight that PTCB has a standard for CE and it is acceptable to utilize your CE for both state and PTCB. Keep in mind, PTCB does require 2 law CE and 1 patient safety CE every two years.

Focusing on the profession, the opportunities available for pharmacy technicians reach beyond the day to day practice in a pharmacy. Current settings in the state that pharmacy technicians are practicing and/or are involved in include; traditional (both hospital and retail), educational, information technology, management, research and serving on the ND State Board of Pharmacy. Most likely, there are other roles that are not mentioned here. The greatest realization is very simple, with the evolution of pharmacy; there will always be opportunities for pharmacy technicians to expand their role. The most important point is that you need to pursue the role, it will not pursue you. Looking back to the core group of Pharmacy Technicians that began the NAPT, where would we be today if they sat back and waited for opportunity to knock at their door?

This leads us to the last part of the article, where are we going? With the multitude of changes made, Pharmacy Technicians are of a higher standard and continue to raise the educational bar. They are prepared and competent to aspire to greater things, as the pharmacist continue to evolve to a clinical role to best serve the patient, it is the pharmacy technician that can assume the duties to keep the pharmacy the best it can be. Who would have thought that we would be where we are today. With **YOUR** continued enthusiasm, the opportunities are just waiting for you! One example of things that could change includes; the national standardization of Pharmacy Technicians, this could be a goal of the future. With the standardization of Pharmacy Technicians currently set in North Dakota, perhaps we can be an example nationally to bring all the states to our level of excellence. Our profession is headed in whatever direction **YOU** as a pharmacy technician want to go. It is through your vision of the future that will pave the way to excellence.

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Updates from the *Board of Pharmacy*

By Mark J. Hardy, Pharm D, Executive Director

I hope that this finds you well and each of you are finding some time to enjoy family and friends during this beautiful (but too short) summer we have had this year. I thought it would be a good opportunity to take some time and just quickly highlight a few of the issues the Board is dealing with or looking forward to in the future.

Pharmacy Ownership Law

We are very likely to have the opportunity to vote on the Pharmacy Ownership Law in the fall elections in North Dakota. This will be a test of Howard Anderson's statement, that *"if the patient can't tell the difference, what difference does it make."* We trust that if you have been taking care of your patients in the manner which they expect, they will vote to keep or to change the Pharmacy Ownership Law as they perceive it is in their own best interest. I look forward to the vote. I trust that if the change fails, you will all work doubly hard to earn the trust that your patients have placed in you. If the vote succeeds and the law changes, I trust that each of those who support the change in our Pharmacy Ownership Law will work doubly hard to be sure that they take advantage of all of the opportunities that they perceived the law change might provide them. Regardless of the outcome, we all have the responsibility to care for the people of North Dakota in the manner dictated by the Oath we took when we obtained our pharmacy degree.

Prescription Drug Monitoring Program (PDMP)

In April, the PDMP changed its software vendor to PMP AWARxE through Appriss. This caused some changes to be made in the pharmacies reporting of their prescriptions to the database. I appreciate everyone doing their diligence in making the change to the new vendor. As you are all aware, change is never easy but I was impressed in how our pharmacies quickly made the changes to report to the new vendor. Things are going well and we hear many good comments on the new system. You will continue to see improvements moving forward.

The Board has recently promulgated rules to require the use of the PDMP before filling prescriptions in certain circumstances. This came as a result of many in the pharmacy community as well as our legislators looking for solutions to deal with the prescription drug abuse epidemic. The rules would be effective in October. I encourage you to read through these on our website and discuss with your fellow pharmacists and technicians to develop policies and procedures to meet the tenets of this new rule in your pharmacy. NOW is the time to sign up for direct onlineaccess to the PDMP through the Board of Pharmacy's website!

Counseling on Prescriptions

The Board has been discussing recently at depth the issue of counseling on all prescription which is required by North Dakota Law. It is clear that patient counseling and pharmacist review of the order cannot be just at our convenience. We must make the extra effort to be sure that we make pharmacists available for these services at all times. Technology gives us the tools to accomplish this if we will step forward, insist upon it, and provide the service. Nearly every complaint that we receive in our office could have been prevented with good counseling.

The Board has been discussing on how we can use our certified pharmacy technicians in this process. We intend to further discuss this issue and see what potential solutions we can develop to ensure each patient has an appropriate interaction every time they receive a prescription. I want to hear from you on what can be done to ensure the best level of care can be provided to your patients.

The ND Health Information Network (ND HIN)

The Board encourages all pharmacist to utilize the ND HIN in their practice. This is intended to be a place where medical records of patients will be able to be viewed from multiple health institutions. This will help provide to you the health information that we as pharmacists have been desiring to better assist in patient care. You may sign up for an account at http://www.ndhin.org/services/ndhin-enrollment.

Also one of the crucial pieces of information that is needed in the system is the prescription information dispensed at pharmacies. We have been discussing with the ND HIN to determine ways to accomplish this. Having the prescription information is going to assist in streamlining the process of medication reconciliation, for all health professionals, which is a very important process for patient's wellbeing.

Legislative Session and Provider Status

The 64th Legislative Assembly will be starting shortly. The Board has a few legislative issues that it would like to bring forward during the next session. One of the big issues nationally is moving the pharmacist to a provider status federally. Our state laws and rules are very progressive in what pharmacist are allowed to do and even reference pharmacists as "primary health care providers of pharmaceutical care", however we have a hard time getting paid for it on a national level and thus there is a push to be recognized by Medicare as providers. If you have suggestions on duties that you as pharmacist would like to complete but are limited by state law please bring those forward to us so the board can examine them.

I appreciate your time and efforts in everything in which you have done to make North Dakota as a leader in the profession of pharmacy. We need to continue that leadership and be at the forefront of providing the best care to our patients. As always, please give our office a call if you have any questions or concerns.

Thank Yous and *Time Casules 2014 Fourth Quarter*

We would like to thank the following for participating and contributing to the 2014 North Dakota Pharmacy Opportunities Night held September 10. This event provides an opportunity for pharmacists to reach out to NDSU Pharmacy candidates making them aware of opportunities in North Dakota.

Julie Falk
Hankinson

LeeAnn & Paul Folden
Wahpeton

Sheila Welle
Pharmacists Mutual

Joel Aukes, PharmD
Vibra Hospital – Fargo

Dave Olig, RPh
Southpointe Pharmacy – Fargo

Michael Peterson, PharmD
Trinity Health – Minot

Susan Dynneson, PharmD
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Sanford Health

Steve Boehning, RPh
Linson Pharmacy – Fargo

Lynn Swedberg, RPh
McKesson

North Dakota Pharmacy Service Corp

Pharmacy Time Capsules 2014 (Fourth Quarter)

1989

There were 74 accredited colleges of pharmacy in the United States (including Puerto Rico).

1989 graduates figures included: 5721, BS; 836 PharmD (1st professional degree); and 222 PharmD (2nd degree).

The conservative Heritage Foundation published "Assuring Affordable Health Care for All Americans," which called for a mandate to purchase health insurance.

Losec (omeprazole) was first marketed in U.S. by Astra. In 1990, FDA required name change to Prilosec to avoid confusion with Lasix.

1964

1964 graduates figures included: 2029 BS and 166 PharmD (1st professional degree)

Keflin (cephalothin sodium, Lilly) was the first cephalosporin to be marketed in the Unites States.

Average cost of prescription was $3.41

Luther L. Terry, M.D., Surgeon General of the U.S. Public Health Service, released the first report of the Surgeon General's Advisory Committee on Smoking and Health linking cigarette smoking to lung cancer and other lung problems.

1939

The first Blue Shield plan was begun as an insurance to cover physicians' fees.

1914

Cocaine, used in many patent medicines and tonics, was widely available in pharmacies and other retail establishments until banned in 1914.

By: Dennis B. Worthen, PhD, Cincinnati, OH

One of a series contributed by the American Institute of the History of Pharmacy, a unique non-profit society dedicated to assuring that the contributions of your profession endure as a part of America's history. Membership offers the satisfaction of helping continue this work on behalf of pharmacy, and brings five or more historical publications to your door each year. To learn more, check out: www.aihp.org

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Washington state implements Medicaid managed care MTM law for 2015

DIANA YAP

Although Washington state's pharmacists have had legislative provider status for years, coverage of their services was elusive until the state legislature's unanimous passage last year of Second Substitute Senate Bill 5213.

Effective January 1, 2015, the new law requires "provider reimbursement methods within medical billing processes that incentivize pharmacists and other qualified providers" to provide comprehensive medication management services in health homes for Medicaid managed care patients with multiple chronic conditions.

The law also requires evaluation and reporting on the impact of comprehensive medication management services on patient clinical outcomes and total health care costs, including reductions in emergency department use, hospitalization, and drug costs.

The Washington State Pharmacy Association (WSPA) worked closely with the Washington State Medical Association and other provider groups to include pharmacists in an expanded role. "We're hopeful that the work that we've been able to accomplish could be replicated in other states," and that the law will result in data "to share throughout the country over the coming years," WSPA CEO Jeff Rochon, PharmD, told ***Pharmacy Today***.

Rochon believes the legislation succeeded because "it was not focused on getting pharmacists paid for something. It was focused on getting coverage for patients that helped with their chronic disease state management."

Comprehensive medication management

Much of Washington state has moved to Medicaid managed care, changing the state's ideas on what services should be covered from a focus on upfront costs to total costs, Rochon said.

"We're hopeful that the work we've **been able to accomplish** could be replicated in **other states."**

SSB 5213 requires Washington state's several Medicaid managed care plans to include compensation incentives for pharmacists and primary care providers who provide comprehensive medication management services. Comprehensive medication management means using a licensed pharmacist or primary care provider to care for patients.

"Chronic care management, including comprehensive medication management services, provided by licensed pharmacists and qualified providers is a critical component of a collaborative, multidisciplinary, interprofessional approach to the treatment of chronic diseases for targeted individuals, to improve the quality of care and reduce overall cost in the treatment of such diseases," according to the law.

'Less about a turf battle, more about care'

In Washington state, pharmacists have long worked on teams with physicians under collaborative drug therapy agreements, explained Rochon. As pharmacists move into a more team-oriented approach to provision of care, he said, a history of interprofessional collaboration helps all health care providers to understand just what each team player and the entire health care team can provide.

"When it becomes less about a turf battle and more about care, it's a much easier conversation," Rochon continued. "We've been fortunate to have a good relationship [with the Washington State Medical Association] and talked with the [medical] community before this bill [landed] to just say, 'Hey, this is what we hope to do. We really want to be in a team approach here to help you better manage your patients."

From Washington state to Washington, DC

How Washington state's pharmacists and physicians together led the charge for SSB 5213 may be instructive for the pharmacy profession's push for provider status at the federal, state, and private levels.

"We advocated and lobbied quite extensively for the value of these services to patients," Rochon said. The biggest takeaway for pharmacists in other states is to focus "not on who is getting paid for what, but more on the need for this to be a covered service for patients," he added. At the end of the day, Washington state's contracts with Medicaid managed care plans soon will require "some reimbursement methods for those health care providers who provide comprehensive medication management."

Another lesson is that term "comprehensive medication management" resonated with state legislators while they were considering the bill, Rochon said. In subsequent discussions as implementation moves forward, the term "medication therapy management" has been used more frequently.

Diana Yap, Senior Assistant Editor

Kansas collaborative practice law becomes effective July 1, 2014

DIANA YAP

A new collaborative practice law in Kansas will become effective July 1, 2014. The state's Gov. Sam Brownback signed Senate Substitution for HB 2146 into law on April 10, 2014, adding Kansas to the current national count of 48 states and Washington, DC, in which pharmacists have some kind of collaborative practice authority.

The law makes several amendments to the Kansas Pharmacy Act. It adds the definitions of "collaborative drug therapy management," "collaborative practice agreement," "practice of pharmacy," and "physician" to the state pharmacy act; clarifies prescription refill restrictions; and creates the Collaborative Drug Therapy Management Advisory Committee, according to a Kansas Legislative Research Department summary of the legislation that was provided by the Kansas Pharmacists Association (KPhA).

"As health care moves away from old models of care and toward newer models that manage health and improve outcomes for patients, collaborative practice is one of the tools that will help the health care system improve patient care management," Larkin told ***Pharmacy Today***.

A ceremonial signing for Senate Substitute for HB 2146 was held April 30, 2014, with Gov. Sam Brownback of Kansas seated. L–R: Laura Taylor and Sara Neiswanger, Kansas Council of Health-System Pharmacists (KCHP) staff; Katie Oliver, University of Kansas School of Pharmacy 6P/Board of Pharmacy intern; pharmacists Lindsay Massey, Jeff Little, and Linda Radke; Kansas Sen. Vicki Schmidt and Rep. Don Hill, both pharmacists; pharmacist and KCHP President Greg Burger; Debra Billingsley, Kansas Board of Pharmacy; Mike Larkin, Kansas Pharmacists Association Executive Director; pharmacist Katie Burenheide; and Marty Singleton, Kansas Board of Pharmacy.

Starting point for bill

Collaborative practice agreements are used to create formal relationships between pharmacists and physicians or other providers that allow for expanded pharmacists' services to patients and the health care team. These agreements define certain patient care functions that a pharmacist can autonomously provide under specified situations and conditions, although they are not required for pharmacists to provide many patient care services such as medication reviews, patient education and counseling, disease screening, and referrals, according to the APhA Foundation website.

The goal of the physician–pharmacist collaborative agreement is to leverage the pharmacist's expertise and knowledge of drug therapy, treatment adherence, and cost barriers to supplement the physician's work and improve drug therapy outcomes for the patient, according to KPhA Executive Director Michael Larkin.

The legislation's starting point was the CDC tools on collaborative practice agreements and pharmacists' patient care services that were developed in partnership with the APhA Foundation and released December 13, 2013. (See page 49 of January 2014's ***Today*** for more information.) "The CDC information had a map of the United States that showed Kansas as one of four states that had limited authority (immunizations only) such that it would be difficult to provide the type of service required in a managed care plan," Larkin said.

CMS and the Kansas Medicaid managed care program both require managed care plans to include medication therapy management and collaboration between pharmacists and physicians regarding patient outcomes, and Medicare Part D plans must offer medication therapy management programs to certain patients, Larkin explained. Because the Kansas Pharmacy Act's "definition of pharmacy was outdated and silent on the use of collaborative practice," he said, the Kansas Board of Pharmacy "felt it was necessary for the public health, welfare, and safety to codify the current practices, and to clarify that pharmacists in Kansas were trained to provide medication therapy management and that pharmacy is now integrated into the health care infrastructure."

Support from state pharmacy groups

The bill was introduced in February 2014 by the Kansas Board of Pharmacy. KPhA and other state pharmacy groups supported the legislation with testimony and helped shepherd the bill through the Kansas state legislature.

"We all know pharmacists are highly trained drug experts, and more and more physicians recognize this fact," Larkin said. "Physicians appreciate the ability to partner with pharmacists in making sure patients are getting the safest, most effective drugs for patients."

Diana Yap, Senior Assistant Editor

Pharmacy Quality Measurement

Medicare Part D star ratings —a practitioner's Q & A

by Lisa Schwartz, PharmD

The Medicare Part D Star Ratings program has generated a lot of buzz in the past year, and pharmacy owners are asking questions about quality measurement, the ratings, and what effect they will have on their pharmacy. NCPA is running a series of short articles that discusses each of the measures published by the Pharmacy Quality Alliance, beginning with the five that are part of the Medicare Part D Star Ratings program. The first article appeared in the June 2014 issue; this and all subsequent articles will be available at www.americaspharmacist.net.

HOW DO I FIND OUT MY PHARMACY'S STAR RATING?
At this time, Medicare does not give individual pharmacies a star rating. Pharmacy claims data is analyzed in the aggregate to assign a star rating to a Medicare Part D Prescription Drug Plan (PDP) or Medicare Advantage Plans with prescription drug benefits (MA-PD).

HOW DO I FIND OUT IF MY PHARMACY IS HELPING OR HURTING THE PLANS' RATINGS?
The first company to market a tool for the management of pharmacy quality measure reporting is Pharmacy Quality Solutions. PQS accesses claims data to determine pharmacy performance on key areas that influence Part D Star Ratings, and creates a pharmacy-specific scorecard or dashboard to track performance.

Several wholesalers, pharmacy services administration organizations, franchises, and other groups have announced that their customers have access to PQS's EQuIPP dashboard. A list of these groups is available on the News page of www.pharmacyquality.com.

WHAT ARE THE PHARMACY QUALITY MEASURES THAT FACTOR INTO PLANS' STAR RATINGS?
They are high-risk medication use, diabetes treatment, medication adherence for oral diabetes medications, medication adherence for hypertension (in patients with diabetes), and medication adherence for cholesterol.

Technical definitions for calculating these scores is available in the technical notes for the 2013 plan year.

WHY IS THERE A SUDDEN INTEREST IN MEASURING PHARMACY PERFORMANCE?
Recent changes to health care laws have put a greater emphasis on paying for health care that creates improved patient outcomes and reducing spending that does not. Health plans want healthy members and want to avoid spending money on services, tests, and treatments that do not improve patient health outcomes. Medicare Part D plans with five stars are allowed to market the plan year-

PQA Published Measures

High Risk Medications

Pharmacy Quality Measures Explained

By Sarah Squires, MBA, PharmD

(Editor's Note: This is another in a continuing series of information articles for independent pharmacists on the Star Ratings program and pharmacy performance measurement.)

Where does this measure fit into the overall Medicare Part D Star Ratings?
This measure is classified under "Drug Pricing and Patient Safety" in the Part D Domain and specifically targets patient safety.

What does this measure analyze?
This measure compares the number of patients who received at least two prescription fills for the same high-risk medication during the measurement period with the number of people in the eligible population. The eligible population is defined by patients who are 66 years or older on the last day of the measurement year (typically 12 months), continuously enrolled, and have at least two prescription fills for any medication over the course of the measurement period.*

What impact can this have on my pharmacy?
This measure, related to the number of patients in your pharmacy that fit the eligible population criteria regarding high risk medications, can affect the star rating of plans that include your business in their network. Should your population of patients on high risk medications reduce the plan's star rating rather than improving it, your pharmacy may not be included in their network in the future.

What impact does this have on patient safety?
High risk medications in patients over 65 have everything to do with patient safety. The Beers' list, updated in 2012 by the American Geriatrics Society, is referenced for this Medicare Part D Star Rating measure. Patients who fit criteria of this measure are deemed to be at a higher risk for an adverse drug event (ADE) than they would be if they were on a medication not recognized as "high risk." If patients who fit the criteria remain on high risk medications and have an ADE due to that medication, the star rating of the plan and the patient's health and safety would suffer.

What can I do improve performance in my pharmacy?
Patients who are age 65 or older and are on at least one high risk medication that has been filled at least two times over the measurement period could be compiled into a list for reference purposes to reconcile these problems. Medication therapy management (MTM) sessions could be conducted in the pharmacy to evaluate the status of these patients' regimen. It would be beneficial to describe to patients what adverse drug events could take place with the high risk medication and for what signs or symptoms they are looking. With the consent of the patient and physician, therapy changes may be made to switch the high risk medication to an alternative not found on the Beers' list. ■

Sarah Squires, MBA, PharmD, is a 2014 graduate of the Harding University College of Pharmacy.

**Additional Resources:*
- *Use of High-Risk Medications in the Elderly (HRM): http://pqaalliance.org/images/uploads/files/HRM%20Measure%202013website.pdf*
- *Pharmacy Quality Alliance: http://pqaalliance.org/measures/cms.asp*
- *Beers' list: http://www.americangeriatrics.org/files/documents/beers/PrintableBeersPocketCard.pdf*

round and beneficiaries may make a one-time switch into a five-star plan. Plans that have lower than a three-star rating may be terminated after three years.

HOW DO I IMPROVE MY PERFORMANCE ON THE FIVE QUALITY MEASURES TRACKED BY MEDICARE?

Three of the five measures are adherence-related. There many resources and tools available to help improve patient adherence to prescription drugs. Coordinated refills and regular contact with a local pharmacy have been shown to improve adherence. Many pharmacy software systems have programs that help pharmacies identify maintenance medications due for refill, but automatic refills fall short when communication with the patient is not part of the picture. Contact NCPA for information about the Simplify My Meds® coordinated refill adherence program (www.ncpanet.org/smm).

I UNDERSTAND THAT NETWORK PHARMACIES CONTRIBUTE TO THE PLAN'S STAR RATING, BUT WHAT ELSE FIGURES INTO THE RATING?

In total, there are 18 measures for PDPs and 51 for MA-PDs. Plans are rated on customer services (such as call center hold times, timely enrollment, complaints, and members leaving the plan), pharmacy hold time at the call center, the appeals process, patient safety, and, specific to MA-PDs: health screenings, vaccination, and managing chronic conditions (such as diabetes, osteoporosis, blood pressure, and fall risk). Patient safety measures are more heavily weighted and the pharmacy measures fall into this category.

DO NON-PART D PLANS HAVE STAR RATINGS?

No and yes. The Star Ratings program belongs to the Centers for Medicare & Medicaid Services and Medicare Part D (there is also a Star Ratings program for nursing homes). That said, the pharmacy quality measures that CMS uses are published by the Pharmacy Quality Alliance (PQA) and it is likely they will be used by plans and pharmacy benefits managers to build networks if they are not already doing so. PQA has published 11 pharmacy quality measures (see box), though only five are used by CMS. For more information about PQA's published measurements and measurements under development, visit http://pqaalliance.org/measures/.

HOW SOON WILL THE STAR RATINGS PROGRAM AFFECT MY PHARMACY?

The Star Ratings Program affects your pharmacy right now. Medicare Part D plans have been given Star Ratings since the 2012 plan year, which means data as far back as 2010 was analyzed to rate the plans before open enrollment in October 2011. While the preferred networks that popped up in the 2012 plan year appear to be based on business negotiations instead of performance, CMS has released reports of claims data analysis that show preferred networks did not always lead to savings over pharmacies not in the preferred network. Legislation (H.R. 4577) has been introduced that would allow any pharmacy located in a medically underserved area to participate in all Medicare Part D Plan networks, including the plan's discounted or "preferred" network.

PQA Published Measures

1. Proportion of days covered
2. Antipsychotic use in children under 5 years old
3. Adherence to non-warfarin oral anticoagulants
4. Diabetes medication dosing
5. Diabetes: appropriate treatment of hypertension
6. Medication therapy for persons with asthma
7. Use of high-risk medications in the elderly
8. Drug-drug interactions
9. Cholesterol management in coronary artery disease
10. Completion rate for comprehensive medication review
11. Antipsychotic use in persons with dementia

WHAT HAPPENS IF I DO NOTHING?

If you are already meeting performance goals, the answer might be nothing. Keep in mind that the Star Ratings program may add additional pharmacy quality measurements or change the goals. The hope early was that high-performing pharmacies could negotiate higher reimbursement, but it's more likely that high-performing pharmacies will be allowed to stay in the network.

If you are not meeting performance goals, it is possible that the patients of your pharmacy are not meeting drug therapy goals or are taking inappropriate medications. A Medicare Part D Plan could exclude you from its network to improve its Star Ratings. By dropping underperformers, the plan can steer patients to a pharmacy that is meeting performance goals. ■

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