Community Care
OF NORTH CAROLINA

Pharmacy Administration Efforts

Prospective and Ongoing Facilitation and Management of Pharmacy Benefits

NCCCN works with Medicaid and other payors to help facilitate pharmacy benefit management. The goal of NCCCN is not to set policy, but rather inform policy making and facilitate policy transitions once policy is approved. We believe that patients that need medication should get it and that attrition from therapy is not an appropriate outcome of policy implementation. There are three primary goals of NCCCN's pharmacy benefits management and facilitation programs:

Goals: 1) Ensure Patients have Access to Medication/Supplies at the Pharmacy
2) Minimize Prescriber Disruption Resulting from Coverage Changes
3) Minimize Pharmacy Disruption Resulting from Coverage Changes

Using tools like MDEZ forms to indentify in advance of policy those affected and strong efforts in provider and pharmacy training have proven to be effective in mitigating any unintended consequences of pharmacy benefits policy.

Focus of Effort: 1) Education of Policy and Process
2) Pre-emption of Drug Coverage Problems Prior to Patient Rejection at the Pharmacy
3) On-Call Troubleshooting and Case Manager Support
4) Creating and Implementing Programs to Assist in Efficient and Effective Implementation of Drug Benefits Management

Specific Interventions: 1) Practice and Pharmacy Site-Visits for PAL/DOC List and Policy Education
2) Practice and Pharmacy On-Call Support
3) Practice and Pharmacy Fax and Email Policy Updates
4) Creation and Implementation of Instant Approval Programs
5) Creation, Generation and Distribution of MD-EZ Forms
6) Pharmacy Home Reports
7) Point-Of-Sale Messaging to the Pharmacy
8) Pre-printed Prescriptions
9) Medical Management Meeting Pharmacy Updates

Results: 1) 7.9 % increase in generic prescription use from Jan 2009-Jan 2010

2) 73.4% of Prescribers and 77.8% of Pharmacists prefer Instant Approval to traditional method of drug coverage management

3) 98.2% Prescriber and 96.6% Pharmacist satisfaction rate with MDEZ Forms

4) 124,769 MDEZ forms prepared and distributed in 2009 alone

5) A greater than *five-fold decrease in gaps in therapy* caused by coverage changes from MDEZ and Instant Approval efforts for regular users of medication

6) 74 Distinct Practice-Based Efforts and Materials Created and Distributed in 2009 alone

7) 13 Distinct Pharmacy-Based Efforts and Materials Created and Distributed in 2009 alone

References:

1) A physician-friendly alternative to prior authorization for prescription drugs. Wegner SE, Trygstad TK, Dobson LA Jr, Lawrence WW Jr, Steiner BD. Am J Manag Care. 2009 Dec 1;15(12):e115-22.

http://www.ajmc.com/media/pdf/AJMC_decWegnerWbX_e115finl.pdf

2) Pharmacist and physician satisfaction and rates of switching to preferred medications associated with an instant prior authorization program for proton pump inhibitors in the North Carolina Medicaid program. Jacobson Vann JC, Christofferson S, Humble CG, Wegner SE, Feaganes JR, Trygstad TK. J Manag Care Pharm. 2010 May;16(4):250-63.

http://www.amcp.org/data/jmcp/250-263.pdf

3) Evaluation of product switching after a state Medicaid program began covering loratadine OTC 1 year after market availability. Trygstad TK, Hansen RA, Wegner SE. J Manag Care Pharm. 2006 Mar;12(2):108-20.

http://www.amcp.org/data/jmcp/research_108-120.pdf

The Electronic-Prescribing Adoption Program

CCNC created and deployed an electronic prescribing adoption and support program in July of 2008 in partnership with Blue Cross and Blue Shield of North Carolina. The program is now sustained by CCNC. The focus of the effort is to provide customized, practice-specific support regardless of the type of practice or where along the continuum of adoption they currently reside. The program is vendor agnostic and supports practices (and hospitals on occasion) regardless of participation in one of the CCNC networks.

Electronic-Prescribing

Goals: 1) Increase the rate of electronic-prescribing in North Carolina
2) Increase the number of practices prepared to participate in HITECH programs.

Focus of Effort: 1) Promotion, Education and Support provided by e-prescribing facilitators having pharmacy and clinic work experience and training.
2) Support the Regional Extension Center (REC) through education and support of both staff and subject practices for the electronic prescribing component of the HITECH requirements.

Specific Interventions: 1) Education of HIT/eRx

2) System Selection
3) Vendor Appraisal
4) Practice workflow
5) Staff Training
6) System Tuning
7) Troubleshooting
8) On-Call Support
9) Physical support
10) On-going monitoring of industry changes

Results: 1) 15% increase in electronic prescribing from July 2008 through December 2009, a four-fold increase from 5% to 20% in the final month of 2009

2) 4,277 new active e-prescribers, an increase from 2,189 in July of 2009 to 6,466 in December of 2009

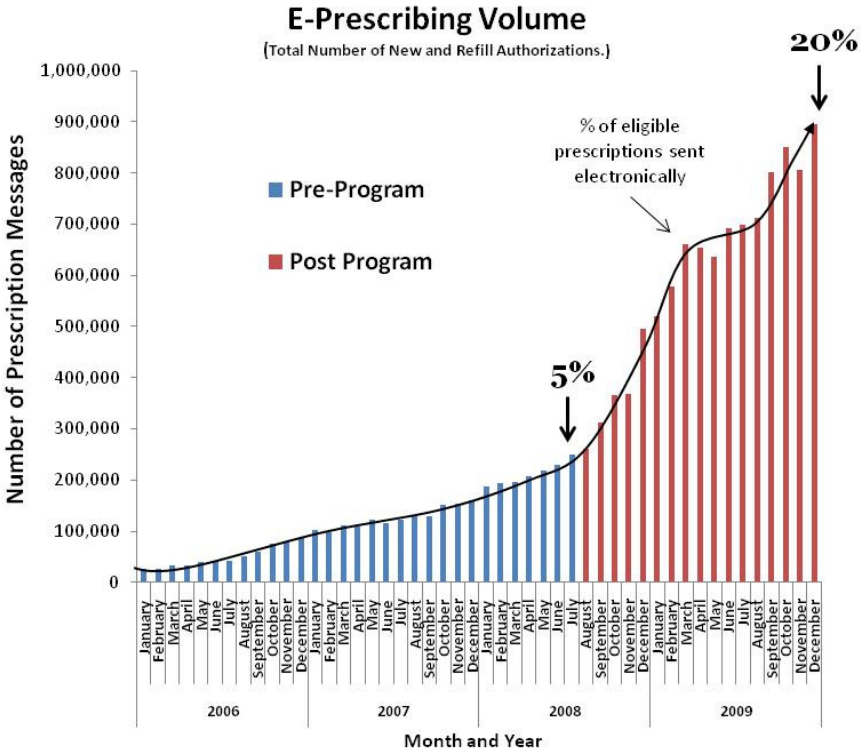
3) 2,899 Interactions with prescribers or their representatives

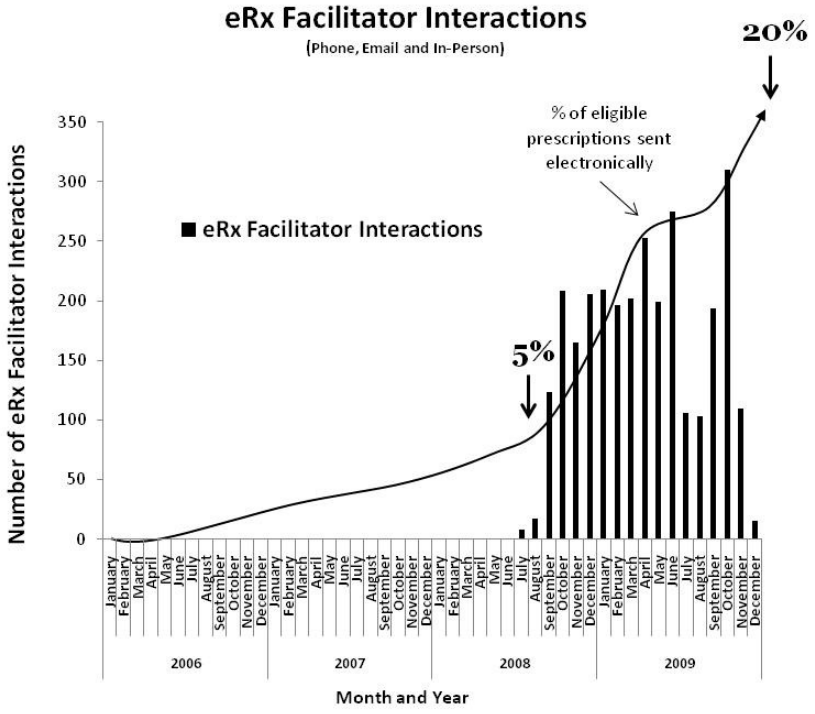
- 1,149 in-person on-site or in-training/education sessions
- 1,053 through email support (referral or request)
- 756 through phone support (referral or request)
- 34 “other” either in meetings or other means

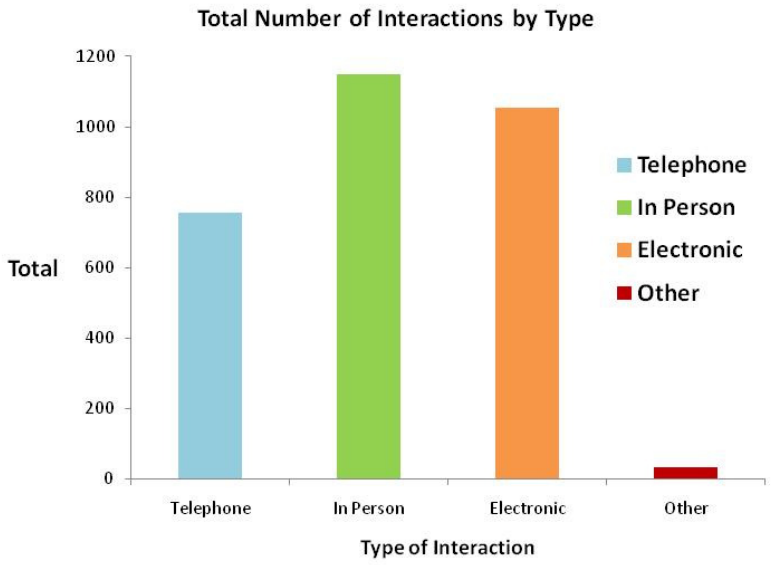
4) 53% of all e-prescriptions in NC come from CCNC Practices

5) 40% of CCNC Practices have at least 1 active e-prescriber

6) CCNC named a “key driver of e-prescribing adoption and utilization in the Surescripts National Progress Report in both 2008 and 2009


E-Prescribing Volume
(Total Number of New and Refill Authorizations.)
Number of Prescription Messages
1,000,000
900,000
800,000
700,000
600,000
500,000
400,000
300,000
200,000
100,000
0
Pre-Program
Post Program
% of eligible prescriptions sent electronically
5%
20%
2006
2007
2008
2009
Month and Year


eRx Facilitator Interactions
(Phone, Email and In-Person)
Number of eRx Facilitator Interactions
350
300
250
200
150
100
50
0
eRx Facilitator Interactions
% of eligible prescriptions sent electronically
5%
20%
2006
2007
2008
2009
Month and Year



Clinical Pharmacy Efforts

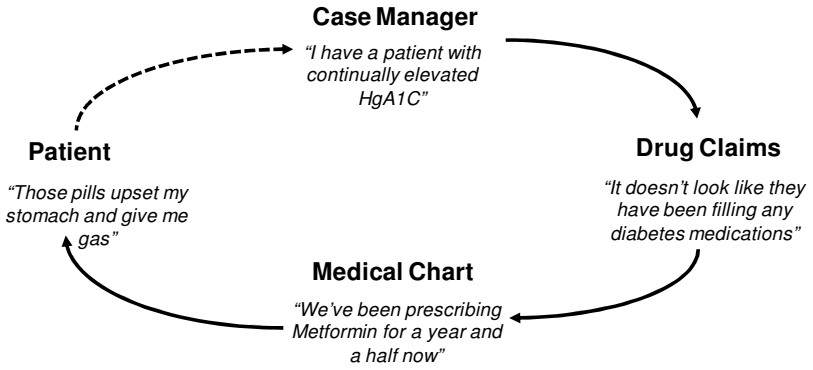
The Pharmacy Home Project

In 2007, CCNC initiated The Pharmacy Home Project within the statewide Medicaid population on the premise that both contribution of, as well as access to *medication lists* and *drug use summaries* from multiple provider types in multiple settings could greatly improve and inform care delivery, particularly for those at greatest risk who lack the ability to self-manage with any level of proficiency. Through secure, web based user portals, the Pharmacy Home application provides a shared platform for viewing claims-derived prescription fill history alongside adherence alerts and care gaps. This Pharmacy Home application also allows for user imputation of drug use information contributed by care managers and clinical pharmacists with the goal of creating, documenting and communicating potential drug therapy problems and discrepancies through the use of "drug use storytelling". The goal of creating a *drug use story* is to convey actionable, patient-centric information to other health care providers involved in the care of the patient.

*(Medical Chart, Claims, Patient, Home Visit, Pharmacist and Case Manager)

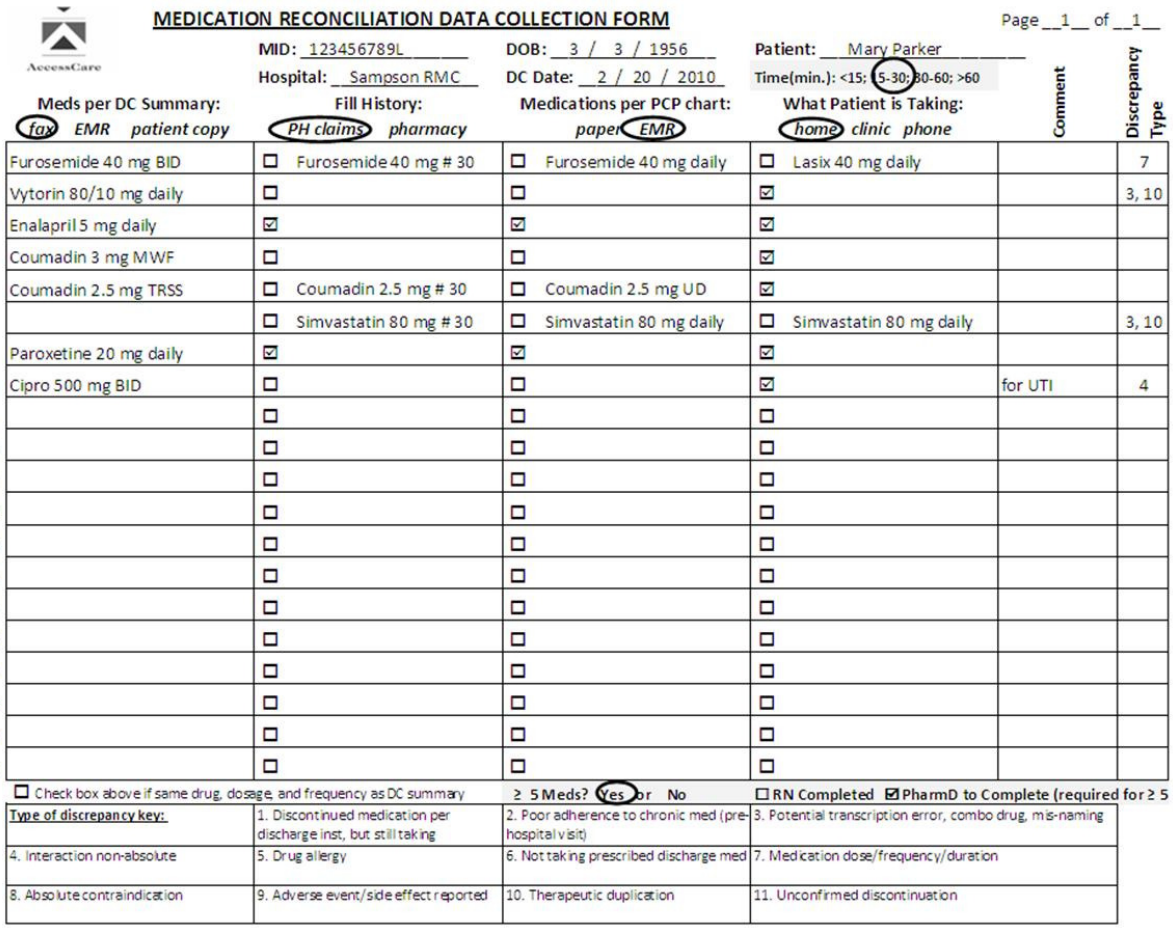
Currently, nearly 40 pharmacists and over 600 care managers can retrieve, modify and add to lists of medications and drug use stories using the Pharmacy Home. In addition, CCNC's 1,200 practices and partnering hospitals, health departments, behavioral health entities, home health agencies and other health system touch points are allowed access to the Pharmacy Home via the Provider Portal, released in August of 2010. Provider and extender access to prescription fill history, care gaps and adherence indicators with annotations of relevant and actionable information allows the healthcare system to work in unison to create a 1)well-coordinated 2) continually re-enforced 3)drug *use* plan to meet patient-centric treatment goals.

Example Drug Use Story with Actionable Information



One of the primary utilities of the Pharmacy Home is in the aid and coordination of transitions of care from Hospital to Home. Transitions are well known to cause ill-coordinated and discrepancy laden drug regimens that often have no semblance to actual patient use. Currently, CCNC requires medication reconciliation *PLUS* for targeted enrollees at-risk of recurrent hospitalizations. The *PLUS* refers to the level of depth and breadth of the activity. First and foremost, reconciliation is expected to involve the prescription fill history prior to admission as well as a post discharge assessment of patient taking behavior as well as a view of the outpatient provider's medical chart. The resulting medication "matrix" can be complex, but quite informative and illustrative of medication discrepancies and potential drug therapy problems.

Example Medication Matrix



MEDICATION RECONCILIATION DATA COLLECTION FORM

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AccessCare

MID: 123456789L DOB: 3 / 3 / 1956 Patient: Mary Parker

Hospital: Sampson RMC DC Date: 2 / 20 / 2010 Time(min.): <15; 15-30; 30-60; >60

	Meds per DC Summary: (fax) EMR patient copy	Fill History: (PH claims) pharmacy	Medications per PCP chart: paper (EMR)	What Patient is Taking: (home) clinic phone	Comment	Discrepancy Type
1	Furosemide 40 mg BID	☐ Furosemide 40 mg # 30	☐ Furosemide 40 mg daily	☐ Lasix 40 mg daily		7
2	Vytorin 80/10 mg daily	☐	☐	☑		3, 10
3	Enalapril 5 mg daily	☑	☑	☑		
4	Coumadin 3 mg MWF	☐	☐	☑		
5	Coumadin 2.5 mg TRSS	☐ Coumadin 2.5 mg # 30	☐ Coumadin 2.5 mg UD	☑		
6		☐ Simvastatin 80 mg # 30	☐ Simvastatin 80 mg daily	☐ Simvastatin 80 mg daily		3, 10
7	Paroxetine 20 mg daily	☑	☑	☑		
8	Cipro 500 mg BID	☐	☐	☑	for UTI	4
9		☐	☐	☐		
10		☐	☐	☐		
11		☐	☐	☐		
12		☐	☐	☐		
13		☐	☐	☐		
14		☐	☐	☐		
15		☐	☐	☐		
16		☐	☐	☐		
17		☐	☐	☐		
18		☐	☐	☐		
19		☐	☐	☐		
20		☐	☐	☐		

☐ Check box above if same drug, dosage, and frequency as DC summary ≥ 5 Meds? (Yes) or No ☐ RN Completed ☑ PharmD to Complete (required for ≥ 5

Type of discrepancy key:	1. Discontinued medication per discharge inst, but still taking	2. Poor adherence to chronic med (pre-hospital visit)	3. Potential transcription error, combo drug, mis-naming
4. Interaction non-absolute	5. Drug allergy	6. Not taking prescribed discharge med	7. Medication dose/frequency/duration
8. Absolute contraindication	9. Adverse event/side effect reported	10. Therapeutic duplication	11. Unconfirmed discontinuation

The second unique feature of CCNC's Medication Reconciliation PLUS program is the depth with which the reconciliation in performed. Importantly for both patient and provider, the review includes the drug use story, which entertains care note inclusions ranging from the reason(s) a prescriber may have desired to stop a medication to determining the root cause of a discrepancy to identification of side effects that the patient is experiencing. Much like the ambulatory drug use story described earlier, the transitions drug use story is meant to convey actionable, patient centric information along to the next provider of care that patient encounters in the health care system. In the absence of this common view and medication management platform, each touch point in the healthcare system is relegated to working in isolation, attempting to re-create the drug use story from scratch, typically using the patient as the gold standard source of information, which is a information gathering activity that rarely produces either reliable or intended result. Indeed, as HIT and HIE mature, patient interviews will evolve from its current status as an endeavor to document prescriber intention to an endeavor to document patient intention and understanding.

Example of Pharmacy Home Use in Transitions of Care