

Pharmacy Oversight Group Meeting Friday, January 8, 2010

Meeting Summary

Participants

Jay Currie, University of Iowa College of Pharmacy
Stacey Cyphert, University of Iowa Hospitals and Clinics
Steven Donnelly, Iowa Prescription Drug Corporation
Bery Engebretsen, Primary Health Care, Inc.
Josh Feldmann, Iowa Pharmacy Association
David Fries, Iowa Prescription Drug Corporation
Kate Gainer, Iowa Pharmacy Association

Jennifer Prymek, Iowa Prescription Drug Corporation
Susan Shields, Iowa Department of Corrections
Bernard Sorofman, University of Iowa College of Pharmacy

Staff

Ted Boesen, IA/NEPCA
Kate Burgener, IA/NEPCA
Sarah Dixon Gale, IA/NEPCA
Rebecca Williams, IA/NEPCA

Welcome and Introductions

Sarah Dixon Gale welcomed the group and began the meeting by reviewing the purpose of the Oversight Group. It was originally formed to set pharmacy-related priorities for the Network based on the needs of the safety net clinics and patients. As a result, the Network has some high quality programs. Staff is proposing the Oversight Group broaden its areas of focus to include the following: 1. Continue to provide guidance, recommendations, and oversight of Network-supported programs offered through the Iowa Prescription Drug Corporation (IPDC); 2. Discuss and make recommendations and information available about other pharmacy-related issues impacting the safety net; and, 3. Support Network staff in taking action on important issues, such as connecting the IPDC programs with the correction system. The group agreed these areas of focus made sense.

Iowa Medication Voucher Program Update

David Fries of the IPDC provided information about the Iowa Medication Voucher Program. The funding came from the Attorney General's Office pharmacy benefit manager settlement. Counties across the state received vouchers to provide 90-day prescriptions from a limited formulary to under/uninsured patients. There is a three dollar co-pay required of the patient and with the funding allocated, it is estimated that 50,000 doses can be provided. The IPDC also pays the pharmacy that filled the prescription an additional seven dollars. There is a hardship case option where the three dollar co-pay can be waived at the pharmacy or the patient can mail prescription to the IPDC where the prescription will be filled. So far, only 12 prescriptions have been filled at the IPDC office. Most of the hardship cases will be filled at the participating pharmacies. September 1, 2009 was the statewide kickoff with 95 of the 99 counties in the state participating. Vouchers have been provided to 87 counties to date and in the remaining counties, IPDC is trying to identify a county point of contact. The vouchers are available at Community Health Centers and the county points of contact typically are local boards of health, county relief offices, or pharmacies. At the end of November, 29 counties had filled 441 scripts through 18 different pharmacies. Hy-Vee pharmacies make up a majority of participating pharmacies throughout the state and every type of medication on the formulary has been dispensed. One concern is whether pharmacies are reporting correctly and in a timely manner. Finally, the program has been linked with the repository program, which is a nice connection and has helped us to expand to other clinic sites.

Questions and comments included:

- Ted Boesen – Is there anything this group could do to market/promote the program?
 - Suggestions included doing another ICN session through the IDPH, promoting the program through the Iowa Pharmacy Association, considering development of a public service announcement, and providing more education to the points of contact at the county level. The hardest group to reach is patients who would benefit from the program.
- Kate Gainer – At the current rate, how long will the program be available?
 - Fries – The program has started slowly, but it should grow in 2010. Some of the pharmacies that have dispensed medications have not reported in a timely manner, which will increase the numbers once the pharmacies are again educated about the reporting process.

HRSA Patient Safety and Pharmaceutical Collaborative (PSPC)

Dixon Gale provided a brief overview of the Collaborative. It was spearheaded by the Health Resource Services Administration (HRSA) which has headed a number of different collaboratives in the past. The purpose of this Collaborative is to help providers and pharmacy staff work together to provide evidence-based, high quality care that can improve patient safety. Three of the teams in Iowa are in Community Health Centers (CHC) – River Hills in Ottumwa, Siouxland in Sioux City, and Community Health Care in Davenport. The program in Dubuque works with Crescent Community Health Center, but is led by Josh Feldmann, a pharmacist at Mercy Pharmacy.

Josh Feldmann provided details about the PSPC based on his experience with the program. There are six specific outcome measures that are being evaluated. The national group hopes to reconvene in February, 2010 and more data and outcomes are being generated each month. An example from the Dubuque program focused on managing patients with out-of-control diabetes. After the intervention, there was a 20-30% decrease in the number of patients who had hbA1c levels that were uncontrolled. The patients served are challenging and hard to reach on a consistent basis. This intervention increased patient safety and improved clinical outcomes. The Dubuque project plans to add hypertensive patients in the near future.

As the four sites in Iowa collect and report data for a longer period of time, it would be nice to share some of those results and best practices with other safety net providers. National data will also be available for comparison. Feldmann agreed to share a PowerPoint presentation he recently gave at the national level as a way of sharing information about the Collaborative.

Iowa Pharmacy Association Corrections Evaluation Update

Gainer provided an overview of the Iowa Pharmacy Association (IPA) Corrections Evaluation, which has as a goal to identify cost savings measures and efficiencies. The funding for this was also from the pharmacy benefit manager settlement. The evaluation team has had four or five meetings to date. Nearly 10 million dollars were spent on drugs within the Department of Corrections (DOC) last year. The final report has not been completed, but the IPA hopes to issue it in the first half of calendar year 2010.

The evaluation team includes:

- Bernard Sorofman, University of Iowa College of Pharmacy
- Susan Shields, Iowa Department of Corrections
- Tom Temple and Kate Gainer, Iowa Pharmacy Association
- Paul Abramowitz and Steve Nelson, University of Iowa Hospitals and Clinics
- Jim Miller and Josh Feldmann, Mercy Pharmacy
- Brian Wegman, Nucara Pharmacy
- CoraLynn Trewet, University of Iowa College of Pharmacy and Broadlawns

The main areas of the evaluation include purchasing, distribution, and clinical services provided to offenders. Part of the report will include information focused on:

- A review of the current system and how the facilities receive pharmaceuticals (9 facilities total in the Iowa system; 4 facilities received medications from a distributor in Pennsylvania)
- The DOC will open a central pharmacy to service the four that received medications from the distributor in Pennsylvania and as services grow, additional facilities might be added
- Staffing concerns
- Health systems concerns
- Current purchasing methods
- Current medication management techniques

There are no concrete recommendations at the time, but the final report will be available in the next few months. Nevertheless, recommendations for all of the above areas will focus on:

- Purchasing changes
- Distribution/Clinical quality/formulary changes
- Department of Human Services shared facilities
- The possibility of federal 340B program status
- Proposed rules changes for pharmacy corrections chapter in Board of Pharmacy rules

Questions and comments included:

- Susan Shields noted that many of the issues that have been brought up for this study have arisen due to budget constraints. The issues are not new and emphasis is being placed on review of the formulary, developing a central pharmacy, and other recommended changes have been in the works for a period of time prior to when the study group started.
- Bernard Sorofman stated that facilities are not eligible for the 340B program because the DOC has their own health care system. Some states use CHCs for care delivery, while others use University systems.
 - Boesen – What would be the monetary impact if corrections could obtain 340B pricing?
 - Sorofman – The estimates in the states that use 340B is that costs are about 30% lower than Medicaid. It is a pretty big impact considering a \$10 million dollar budget. But, it is a difficult status to obtain.
 - Sorofman – There was a trial program in Florida that expanded 340B pricing in correctional facilities for certain diagnoses. The trial should have ended in December but no one has been able to find information about the results of the program.
 - Sorofman – This is a difficult proposal politically, but state governments would like to obtain 340B for budgetary reasons.

Connecting the IPDC Programs with the Corrections System

Dixon Gale asked if there was any other way to connect the IPDC programs with the DOC. Reentry programs were discussed during the last meeting, for example. Has anyone taken a look at the repository program?

Questions and comments included:

- Shields – It is not something that can be done while the person is incarcerated, but once the prisoner is released, these programs are much more useable. When a person is released, s/he is only provided 30 days of medications. Many of these people face barriers to receiving care in the community and need assistance finding resources.
- Gainer – Outreach and education could be provided to parole officers and others in the community to make them more aware of the IPDC programs that could be utilized by ex-offenders.

- Shields – The challenge with parole officers is they do not have as much contact with the ex-offenders. Someone on work release or who is ‘in custody’ but in the community is much easier to track.
- Fries – The voucher program would be an option and vouchers could be provided to parole officers to give to their parolees. The repository program would not work because a parole officer is not allowed to dispense medications.
- Boesen – We could also provide information about the Community Health Centers and other safety net clinics in the area for ex-offenders that are released.
- Shields – The issue is that patients need both a provider and a prescription. If there is no provider, there is no prescription. Sometimes, because of this issue, the only place for people to go is the emergency department.
- Dixon Gale noted that since all correctional facilities have a reentry program, staff should meet with them to discuss some of these ideas.
 - Shields noted that she would take information to the DOC medical director and hopefully have the reentry staff on the next call or involved in some way.
- Sorofman noted that many of the prisoners have mental health diagnoses which often leads to noncompliance when released and/or higher rates of recidivism.
- Shields noted that ex-offenders often face additional barriers to care – outstanding bills with community providers, long wait periods to see a provider and therefore no access to needed medications, etc.
- Boesen – Are ex-offenders eligible for Medicaid?
 - Shields – If they are no longer considered to be in the correctional system then yes, they are Medicaid eligible. If they are still in the system, for example on work release, then they are not eligible because s/he is still receiving health care from the DOC system.
- Sorofman – Is IPDC working with community mental health centers (CMHC)?
 - Fries indicated that some CMHCs are the county point of contact for the voucher program. If there is a prescriber working there, the centers could also participate in the repository program.
 - Shields – It can be difficult to get into a community mental health center.
- Dixon Gale will follow up with Shields and IPDC about how best to connect the IPDC programs to the DOC ex-offenders.

Other Topics

E-Prescribing Follow Up

Dixon Gale reminded the group that during the last meeting this issue was discussed. Additionally, this is a larger issue at the national level in terms of improving e-prescribing systems. Dixon Gale inquired whether staff should develop an issue brief about e-prescribing to help educate providers.

Questions and comments included:

- Gainer noted that the IPA has done a lot of work with this issue. Nevertheless, the more education provided the better. Everyone is at an early point on a steep learning curve with this issue.
- Dixon Gale stated staff could look at what has already been developed, but want to make sure that information is available to providers of the underserved.

Utilization of Generics as First Line Therapies

Dixon Gale suggested staff could develop a brief on this topic as well. The IPDC has data on how much more expensive name brands are compared to generics. Free Clinics have the most difficulty with this issue because they get so many samples. But in general, this is something to promote throughout the safety net.

Questions and comments included:

- Jay Currie noted that the Network should provide information to providers about when to use medications versus when it is not therapeutically necessary. For example, 60% of the antibiotics used in the country are unnecessary. If people do not need a drug then do not put them on it.
- Fries stated that on a regular basis IPDC gets calls from patients for assistance. There seems to be some misunderstanding about generic drugs. Also, some providers just do not think of prescribing the generic but the IPDC has found that once they are reminded, they will prescribe the generic instead.
- Boesen noted that Wellmark will start charging penalties for using brand name drugs, at least with some of their health insurance products.
- Boesen – Is this an issue for the IPDC with the repository?
 - Fries stated that it depends. Four dollar generics have helped this in sites that have the programs available. There is more awareness about generic drugs now, which is at both the provider and patient level. IPDC likes to get generics in and encourage providers to have patients take them because many of the drugs that are donated are generic and it is easier to keep underserved patients on less expensive medications.

Expanding Clinical Pharmacy Services

Dixon Gale sent out a link from Kyle Peters with a collection of resources for clinical pharmacy services that was developed by the IPA. Staff can work on developing a strategy for getting this information out to safety net providers, particularly for sites with pharmacies within their clinic. Additional information could focus on how safety net providers could partner with community pharmacies in order to improve patient outcomes.

Questions and comments included:

- Gainer – If reimbursement for these activities improved, then likely more pharmacy services could be provided by pharmacists in clinics and similar settings.
- Dixon Gale – Perhaps this issue will be of greater importance with the medical home model that is currently an area of focus.
- Currie – What about Medicare Part D? There is some reimbursement for MTM under this.
 - Gainer – There is some reimbursement, but Medicare does not seem to be enforcing plans to provide MTM services.

Other Topics

Currie mentioned that there is a need to establish consistent criteria for safety net clinics participating in the pharmacy internship program. Dixon Gale will follow up with Currie about this issue.

Next Meeting Date & Adjourn

Dixon Gale thanked everyone for participating. A summary of the meeting will be provided in the upcoming weeks and contact will be made to schedule the next meeting.