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Congratulations for taking on the challenge of improving your pharmacy’s performance on key pharmacy quality measures, as well as improving the outcomes of the patients you serve! This guide is intended to support you and your pharmacy staff in improving your pharmacy’s performance to positively affect health plans’ star ratings and protect your access to insured patients.

The guide is organized by five key star ratings quality measures tracked by the Centers for Medicare and Medicaid Services (CMS) that pharmacies can impact. For each measure, the guide includes a description of the measure, the clinical relevance of the measure, a case study and suggested initial action steps that your pharmacy can take. The guide also includes examples of motivational interviewing techniques and sample fax templates that can be customized for the particular requirements in your state and the specific operations in your pharmacy.

The topics discussed in the playbook are generalized based on common pharmacy systems or program-agnostic action steps that may pertain to all pharmacies. The guide also includes third-party guidelines and resources. These links or resources are sourced directly from third parties and have not been modified, updated or verified. Accordingly, use them as a general reference but verify and tailor the information based on your practice and location. Note that the Board of Pharmacy in your state may have patient counseling, documentation or other requirements that are different from or in addition to the information and examples discussed in this guide.

Finally, although this guide is an educational resource, it is not intended to be the only resource used in establishing your quality improvement efforts. In addition to the legal requirements imposed by your state, other resources may be available and helpful.

The information provided here is for reference use only and does not constitute the rendering of legal or other professional advice by Health Mart®. Readers should consult appropriate professionals for advice and assistance prior to making important decisions regarding their business. Health Mart is not advocating any particular program or approach. Health Mart is not responsible for, nor will it bear any liability for, the content provided in this guide.
Why Performance Measures Matter to Your Pharmacy

Both of your customers — the patient and the payer — want better value for their investment through reduced total healthcare cost and improved outcomes.

This desire is being driven by the tremendous mismatch of healthcare expenditures compared to healthcare quality in the U.S. The United States spends more than any other country in the world on healthcare. In fact, 17% of the GDP, or nearly $1 out of every $5 dollars produced, is spent on healthcare. Yet according to the World Health Organization, the United States ranks in the mid-30s worldwide in healthcare quality. The huge gap between investment in healthcare and quality of outcomes is leading many experts to look for ways to improve the quality of each dollar spent and to create tangible changes in how health systems are incentivized. This impacts every aspect of the healthcare system, including your pharmacy.¹

THE MEDICARE STAR RATINGS SYSTEM

Star ratings are a 5-star quality rating system of health plans designed by CMS to help patients compare and choose Medicare plans. These ratings impact health plan reimbursement and open enrollment periods, and higher ratings are better. The ratings are used to review many aspects of plans and benefits provided to patients, ranging from customer service to patient outcomes. The quality measures most relevant to community pharmacies are the five measures related to medication use and medication adherence. Each of these quality measures directly affects patients’ quality of care and health outcomes.²

The five measures are:³

<table>
<thead>
<tr>
<th>Core measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1</td>
<td>The treatment of hypertension in diabetic patients with a renin angiotensin system (RAS) antagonist</td>
</tr>
</tbody>
</table>
| #2, 3, 4 | Medication adherence for three chronic disease states:  
- RAS antagonist adherence in the treatment of hypertension  
- Statin adherence in the treatment of hyperlipidemia  
- Oral diabetic agent adherence in the treatment of diabetes |
| #5 | The rate of high-risk medication use in the elderly |

The United States spends more than any other country in the world on healthcare. In fact, 17% of the GDP, or nearly $1 out of every $5 dollars produced, is spent on healthcare. Yet according to the World Health Organization, the United States ranks in the mid-30s worldwide in healthcare quality.
MEDICATION THERAPY MANAGEMENT
Medication therapy management, or MTM, is one tool pharmacists can use to improve upon the pharmacy quality measures. When used within this guide it refers to medication therapy management in a general sense and not any federal or state-specific program or definition. Particular references to medication therapy management within this guide are more focused on targeted interventions for a specific medication related to the pharmacy quality measures, which differ from comprehensive medication reviews. More information on MTM programs is provided in Appendix A of this guide.

For More Information
For more information on the star ratings, changes in the healthcare marketplace and a general overview of payment model changes, refer to “The Pharmacy Performance Imperative: A Guide for Independent Pharmacies” found with other resources on the Know Your Numbers and EQuIPP™ pages in the Health Mart Operations Manual. The following CE opportunities are also available on Health Mart University:

- Pharmacy Quality Measures: Know Your Numbers (prerequisite for EQuIPP access)
- Coaching at the Counter … Opportunities for Enhancing Communication with a Patient-Centered Approach
- Implementing Medication Synchronization
- Practical Steps for Integrating MTM into Your Daily Practice
- Disease state–specific education courses and more!
CORE MEASURE #1
IMPROVE DIABETES TREATMENT PERFORMANCE
CORE MEASURE #1

IMPROVE DIABETES TREATMENT PERFORMANCE

Why is CMS targeting diabetes treatment? According to the American Diabetes Association (ADA), diabetes costs us $176 billion per year in direct medical fees. Put another way, more than one in ten healthcare dollars are spent on diabetes and its complications, and more than one in five healthcare dollars go to treating people with diagnosed diabetes. It’s a disease that affects more than 25 million Americans and is the seventh leading cause of death in the U.S.

The ADA reports that two in three people with diabetes have high blood pressure or take medications to lower their blood pressure. Both diabetes and hypertension exacerbate one another’s effect on the kidneys and overall health. Therefore, appropriate treatment of diabetes and hypertension is very important to decrease the long-term effects of both diseases.

Measure Description

<table>
<thead>
<tr>
<th>2014 CMS 5-Star Goal:</th>
<th>87% (higher is better)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What:</strong></td>
<td>When people with diabetes also have high blood pressure, certain types of blood pressure medication are recommended. This measure captures the percentage of patients who received one of the blood pressure medicines that are recommended for people with diabetes.</td>
</tr>
<tr>
<td><strong>Who:</strong></td>
<td>This measure looks at the percentage of Medicare Part D beneficiaries age 18 or older who were dispensed a medication for diabetes (see Table A on page 13) and a medication for hypertension whose treatment included a renin angiotensin system (RAS) antagonist (see Table B on page 14), which are the medications recommended for patients with diabetes. RAS antagonists include angiotensin converting enzyme inhibitors (ACEI), angiotensin receptor blockers (ARB), and direct renin inhibitors.</td>
</tr>
</tbody>
</table>

Note: In the EQuIPP dashboard you may see this measure referred to as ACE-ARB in diabetes. Renin inhibitors were a recent addition to this measure.
Measure Calculation
The diabetes treatment measure is calculated based on Prescription Drug Event (PDE) data submitted to Medicare two years prior to the reporting year (e.g., data from January 1–December 31, 2012 for reporting year 2014). Data must be reported by June 30 of the year prior to the reporting year (e.g., June 30, 2013 for 2014).  

The formula:

\[
\frac{\text{# member-years of enrolled beneficiaries 18 years or older from the eligible population who received a RAS antagonist medication during the period measured}}{\text{# member-years of enrolled beneficiaries 18 years or older in the period measured who were dispensed at least one prescription for an oral hypoglycemic agent or insulin and at least one prescription for an antihypertensive agent during the measurement period}}
\]

Key Takeaway: Only a single prescription fill for a RAS antagonist during the measurement period (a year) is needed to positively impact this measure!

Clinical Relevance: Diabetes, Hypertension and ESRD
The following is intended to be a brief overview of the clinical relevance of this measure. It should not be used as a treatment guide, but rather as a reference point for correct treatment guidelines. It does not constitute legal or other professional advice by Health Mart. Each pharmacist should apply his or her own professional judgment.

**Diabetes** is the most common cause of newly diagnosed *end stage renal disease (ESRD)*, attributable to nearly 44% of all new cases. Hyperglycemia impacts the kidneys through both hemodynamic and structural changes in the kidney. Early on, hyperglycemia causes hyperfiltration and increased glomeruli pressure in the kidney, which leads to proteinuria. Over time it can cause cellular degradation and inflammation leading to less glomeruli filtration surface area. Both of these impacts lead to poor kidney function and increased proteinuria. These are long-term effects that take up to 20 years to fully manifest.

**Hypertension** is the second leading cause of ESRD. Hypertension impacts renal function through increased capillary pressure that damages blood vessels and reduces functionality in the kidneys.

**Diabetes + Hypertension:** Diabetes and hypertension exacerbate one another’s effect on the kidneys and on overall health. Therefore appropriate treatment is necessary to decrease the long-term effects of both diseases.
2014 TREATMENT GUIDELINES
A report from the panel members appointed to the Eighth Joint National Committee (JNC 8) — an update from JNC 7 — provides the 2014 evidence-based guideline for the management of high blood pressure in adults.

Key Takeaways from 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults

| Treatment of hypertension in the general diabetic population | Four medication classes that can be used individually or in combination for first line therapy:  
  • Thiazide type diuretic  
  • A calcium channel blocker (CCB)  
  • An ACEI  
  • An ARB  
  
This recommendation is based on study data and the impact the medications have on the cardiovascular impact of hypertension within the diabetic population. |
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Treatment of hypertension in the chronic kidney failure population with or without diabetes</td>
<td>Recommended first line therapy is an ACEI or ARB to improve kidney outcomes.</td>
</tr>
</tbody>
</table>

These medications reduce kidney disease progression by blocking or inhibiting the binding or production of angiotensin in the renin-angiotensin pathway. This pathway is pathologically responsible for multiple inflammatory processes that impact glomerular function and therefore filtration issues in the kidney.
CASE STUDY: Hayat Pharmacy

MEDICATION THERAPY MANAGEMENT TO BOOST DIABETES QUALITY MEASURES

Hayat Pharmacy is one of the top providers of Medicaid medication therapy management services in Wisconsin, with state and nationwide awards to prove it! The pharmacy has multiple locations in Wisconsin including five retail pharmacies, clinic locations, and an exam room in every location in which to conduct on-site MTM visits, enabling easier physician collaboration.

Challenge
Hayat Pharmacy wanted to extend their established MTM services to other patient populations, including Medicare patients with diabetes.

Solutions
• Extended in-pharmacy and at-home Medicaid MTM services to Medicare patients, particularly targeting those with diabetes
• Used standardized forms and checklists to guide conversations with patients and physicians to identify gaps in care and close the gaps
• Once MTM established with patients, applied manual medication synchronization as well (Simplify My Meds solution); plan to upgrade to automated system

Results
• 9% improvement over a six-month period at the Hayat Pharmacy location with focus on performance improvement. They are still trending in the right direction and focusing on improvement.
• Two of the newer locations, although they have a low patient count, are currently at 100% for diabetes treatment measure. They are starting things off right from the beginning.
• 200 patients on medication synchronization system, most of which also benefit from MTM services.

At a glance
Health Mart member: January 2011
Pharmacist: Hashim Ziabak and Omar Eliwa
Number of locations: 7
Quality measures focus: Diabetes treatment
Key tools: Medication therapy management, standardized checklists
Results: Closed gaps in care and avoided ER visits

November 2013 snapshot of EQuIPP dashboard for Hayat Pharmacy, showing the diabetes treatment measure.

May 2014 snapshot of EQuIPP dashboard for Hayat Pharmacy, showing the diabetes treatment measure.
How to Succeed Like Hayat Pharmacy
If you’re interested in implementing an MTM program, here are some suggested steps:

❑ Get educated
   • Take the CE course available on Health Mart University: Practical Steps for Integrating MTM into Your Daily Practice (CE)
❑ Check for and complete MTM cases daily
   • Enroll with one or more MTM vendors such as: Mirixa, Outcomes, State Medicaid, Other
   • Implement a process to check for cases on a daily basis and complete them within specified time frame
❑ Involve the whole pharmacy team
   • Consider assigning a specific pharmacy technician as the “MTM tech” to help implement and lead the program logistics (performing tasks that technicians are allowed to do under the state pharmacy laws)
   • Educate team members on the MTM program and ask for their assistance in identifying patients

DISCLAIMER This case study is for informational purposes only. The results of this case study depend on a variety of factors that are unique to this organization. There is no guarantee that your results will be similar to this case study. Each party’s results will depend on the factors of its business. The success in this case study cannot be used as an indication of future success with these programs.
DIABETES TREATMENT ACTION STEPS
FOR PHARMACIES

The following information is intended to be a general overview of some action steps a pharmacy can consider implementing to increase quality and performance in this area. It does not constitute legal or other professional advice by Health Mart. Each pharmacist should apply his or her own professional judgment.

1. IDENTIFY GAPS. Look for potential gaps in therapy — no RAS antagonist.
   - Participate in medication therapy management (MTM) programs that include targeted interventions that help identify gaps in care. These types of programs can help identify patients for you.
   - As part of your prospective drug utilization review (DUR) for patients with diabetes who are on an oral diabetes agent along with a hypertensive medication, check to see if the patient is on an ACE, ARB or renin inhibitor.
   - Similarly, when counseling diabetic patients, review the patient profile or ask open-ended questions to determine if a potential gap in therapy exists.
   - Leverage technicians and the whole pharmacy team to refer patients with diabetes to the pharmacist for counseling and the identification of potential gaps in therapy.

2. DISCUSS WITH PATIENT. If a gap is identified, discuss it with the patient at the pharmacy or by phone.
   - Ask open-ended questions to find out what the patient might have tried in the past or may know about these types of medications. Ask for permission to discuss the benefits of using these types of medications because the patient has both diabetes and hypertension. Focus on the protective benefits to the kidneys.
   - Offer to call or fax the prescriber to request a new prescription.

3. CONTACT PHYSICIAN. If applicable, contact the prescriber by phone or fax to let him/her know about the potential gap in therapy identified, as well as any pertinent information from the discussion with the patient.
   - Use physician fax templates (such as the samples in Appendix C) and customize as needed.
   - These recommendations are endorsed by the National Kidney Foundation Kidney Disease Outcomes Quality Initiative. Use evidence-based information as needed to inform your discussions.
### Table A: Diabetes Medications — Oral Hypoglycemics, Insulin, Incretin Mimetics

#### Biguanides and Biguanide Combination Products
- metformin
- pioglitazone and metformin
- rosiglitazone and metformin
- repaglinide and metformin
- sitagliptin and metformin IR and SR
- glyburide and metformin
- saxaglipitin and metformin SR
- glipizide and metformin
- alogliptin and metformin

#### Sulfonylureas and Sulfonylurea Combination Products
- acetohexamide
- chlorpropamide
- glipizide and metformin
- glimepiride
- glyburide and metformin
- glipizide
- glyburide
- rosiglitazone and glimepiride
- pioglitazone and glimepiride
- tolazamide
- tolbutamide

#### Meglitinides and Meglitinide Combination Products
- nateglinide
- repaglinide
- alogliptin and metformin

#### Alpha-Glucosidase Inhibitors
- acarbose
- miglitol

#### Thiazolidinediones and Thiazolidinedione Combination Products
- pioglitazone
- pioglitazone and glimepiride
- pioglitazone and metformin
- rosiglitazone
- rosiglitazone and glimepiride
- alogliptin and pioglitazone
- sitagliptin and metformin IR and SR
- alogliptin and metformin
- saxaglipitin and metformin SR
- alogliptin and pioglitazone
- linagliptin and metformin

#### Incretin Mimetic Agents
- exenatide
- liraglutide

#### Amylin Analogs
- pramlintide

#### DPP-IV Inhibitors and DPP-IV Inhibitor Combination Products
- sitagliptin
- linagliptin
- alogliptin
- saxaglipitin
- alogliptin and metformin
- alogliptin and pioglitazone
- linagliptin and metformin
- sitagliptin and metformin IR and SR
- saxaglipitin and metformin SR

#### Insulins
- insulin aspart
- insulin aspart Protamine and Aspart
- insulin detemir
- insulin glargine
- insulin glulisine
- insulin isophane and regular human insulin
- insulin isophane (human N)
- insulin lispro
- insulin lispro Protamine and insulin lispro
- insulin regular (human R)
- insulin zinc

#### Sodium Glucose Co-Transporter2 (SGLT2) Inhibitors
- canagliflozin

---

**Note:** The active ingredients are limited to oral and injectable formulations only (includes all dosage forms). Excludes nutritional supplement/dietary management combination products.

Excerpted from CMS Medicare 2014 Part C and D Star Rating Technical Notes

---
Table B: RAS Antagonists
Below are renin angiotensin system (RAS) antagonist medications for hypertension.

<table>
<thead>
<tr>
<th>ACE Inhibitors</th>
<th>ARBs</th>
<th>Direct Renin Inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• benazepril</td>
<td>• candesartan</td>
<td>• aliskiren</td>
</tr>
<tr>
<td>• captopril</td>
<td>• irbesartan</td>
<td></td>
</tr>
<tr>
<td>• enalapril</td>
<td>• eprosartan</td>
<td></td>
</tr>
<tr>
<td>• captopril</td>
<td>• losartan</td>
<td></td>
</tr>
<tr>
<td>• fosinipril</td>
<td>• telmisartan</td>
<td></td>
</tr>
<tr>
<td>• lisinopril</td>
<td>• valsartan</td>
<td></td>
</tr>
<tr>
<td>• perindopril</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>• quinapril</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>• ramipril</td>
<td>•</td>
<td></td>
</tr>
<tr>
<td>• trandolapril</td>
<td>•</td>
<td></td>
</tr>
</tbody>
</table>

Excerpted from CMS Medicare 2014 Part C and D Star Rating Technical Notes

Note: The active ingredients are limited to oral formulations only.
CORE MEASURES #2–4
ADHERENCE TO DRUG THERAPY FOR THREE CHRONIC DISEASE STATES
ADHERENCE TO DRUG THERAPY FOR THREE CHRONIC DISEASE STATES

Why is CMS targeting adherence? There's a lot of room for improvement. Today, only 25–30% of prescriptions are taken properly and only 15–20% are refilled as prescribed. The World Health Organization estimates that the average nonadherence rate is 50% for patients with chronic diseases. A study published in 2012 in the *Annals of Internal Medicine* estimated that nonadherence is costing the U.S. healthcare system in the range of $100 billion to $289 billion a year. In addition to higher healthcare costs, the consequences of nonadherence include worsening condition, increased comorbid diseases and death.\(^3\)

**Measure Description\(^3\)**

<table>
<thead>
<tr>
<th>2014 CMS 5-Star Goal:</th>
<th>(Higher is better)</th>
</tr>
</thead>
<tbody>
<tr>
<td>RAS Antagonists: &gt; 79%</td>
<td></td>
</tr>
<tr>
<td>Statins: &gt; 75%</td>
<td></td>
</tr>
<tr>
<td>Diabetes: &gt; 77%</td>
<td></td>
</tr>
</tbody>
</table>

**What:**

These measures look at improving adherence in three key medication groups:

(i) RAS antagonists (see Table B on page 26)

(ii) Oral diabetic agents (see Table C on page 26)

(iii) Statin medications (see Table D on page 27)

**Who:**

Adherence is measured by proportion of days covered (PDC), which assesses the percentage of patients covered by prescription claims for the same drug or another drug in the same therapeutic class within a calendar range. Specifically, these measure the percentage of plan members who have a prescription for an oral diabetes medication, a hypertension medication (RAS antagonist) or a cholesterol medication (statin) and filled their prescription often enough to cover 80% or more of the time that they are supposed to be taking the medication.\(^3\)
Measure Calculation
These adherence measures are calculated based on Prescription Drug Event (PDE) data submitted to Medicare two years prior to the reporting year (e.g., data from January 1–December 31, 2012 for reporting year 2014). Data must be reported by June 30 of the year prior to the reporting year (e.g., June 30, 2013 for 2014). This percentage is calculated separately for RAS antagonists, oral diabetic agents and statins. It is calculated as:

The formula:

\[
\frac{\text{# member-years of enrolled beneficiaries 18 years or older from the eligible population who received a RAS antagonist medication during the period measured}}{\text{# member-years of enrolled beneficiaries 18 years or older in the period measured who were dispensed at least one prescription for an oral hypoglycemic agent or insulin and at least one prescription for an antihypertensive agent during the measurement period}}
\]

Adjustment for inpatient stays: Medication fills during beneficiary stays in inpatient facilities are not included in the Prescription Drug Event claims used to calculate the adherence measures.

Patient attribution: The pharmacy that filled the most prescription claims within the target therapeutic category for a specific patient within the calendar range is assigned responsibility for the patient. All prescription claims, regardless of pharmacy, are counted toward the patient’s PDC threshold.

The EQuIPP dashboard, which is provided to Health Mart members through Pharmacy Quality Solutions (PQS), is a 6-month rolling report as opposed to the 12-month reporting cycle used by CMS.

Key Takeaway:
PDC measures look at patients’ ability to remain adherent throughout the measurement period [year]. Continued health coaching along with addressing patient-specific barriers with each prescription fill or refill is critical to long-term performance success!
Clinical Relevance: Behavioral Changes

The following is intended to be a brief overview of the clinical relevance of this measure. It should not be used as a treatment guide, but rather as a reference point for correct treatment guidelines. It does not constitute legal or other professional advice by Health Mart. Each pharmacist should apply his or her own professional judgment.

Adherence is defined as the “active, voluntary and collaborative involvement of the patient in the creation of a mutually acceptable course of behavior to produce a therapeutic result.” Adherence is a personal behavioral choice that a patient has to make. The choice begins with the patient's decision to even start medication therapy.

A recent study showed that up to 25% of patients fail to start newly prescribed medications. When therapy is initiated, adherence tends to be higher in acute symptomatic conditions and lower in chronic conditions (e.g., hyperlipidemia). Adherence decreases the most after the first six months of therapy. Medication adherence rates for patients with chronic diseases such as hypertension, hyperlipidemia and diabetes have been seen as low as 50–65%. The World Health Organization (WHO) has characterized adherence as a “worldwide problem of striking magnitude.”

Patient nonadherence has been shown to cause worsening of disease and increased hospitalization rates. This in turn has significant cost impacts on the healthcare system. The impact of medication nonadherence on the U.S. healthcare system had previously been estimated at $100 billion per year. Of that, approximately $47 billion was due to hospitalizations caused by patients not starting, not maintaining, or having a complication from medication therapy. When other indirect costs such as physician visits and nursing home admissions were added, that number climbed to $177 billion. However, in 2009, The New England Healthcare Initiative updated the total cost in today’s economy to $290 billion per year. Lack of adherence is impacting patients' health outcomes and leading to continued escalating costs in our healthcare system.

Nonadherence can be attributed to many different causes, which are summarized in Table E on page 27.
Adherence — Three Core Areas of Focus

1. RAS antagonist adherence
   The clinical relevance and mechanism of actions of RAS antagonist and tracked medications from these classes are explained in the diabetic treatment measure section of this guide.

2. Statin therapy adherence
   HMGCoA Reductase inhibitors or statins have become key therapeutics agents in the treatment of hypercholesterolemia to reduce the risk and progression of atherosclerotic cardiovascular disease (ASCVD). These medications work on the cholesterol synthesis pathway to decrease the production of endogenous LDL.

   The 2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults supports the benefits of statin use in four major groups:
   1. Patients currently with ASCVD
   2. Patients with primary elevations of LDL-C > or equal to 190 mg/dL
   3. Diabetic patients age 40 to 74 with LDL-C 70 to 189 mg/dL with clinical ASCVD
   4. Patients without ASCVD or diabetes with LDL-C 70 to 189 mg/dL and estimated 10-year ASCVD risk > or equal to 7.5%

3. Oral diabetic agent adherence
   Oral diabetic medications in this measure include (see Table C on page 28):
   - Biguanides
   - Sulfonylureas
   - Thiazolidinediones
   - DPP-IV inhibitors

   These medications improve glycemic control through various mechanisms of action including:
   - Decreasing hepatic glucose production
   - Decreasing glucose absorption
   - Increasing insulin-mediated glucose uptake
   - Increasing insulin secretion
   - Decreasing insulin resistance
   - Suppressing glucagon release

   Detailed recommendations on when to use which agent can be found in the 2013 American Association of Clinical Endocrinologists (AACE) guidelines.
CASE STUDY: Parkland Pharmacies

IMPROVING ADHERENCE EFFECTIVELY, ON A BUDGET

After attending her first McKesson ideaShare meeting in 2010, Parkland Pharmacies pharmacist Lisa Umfleet was inspired to improve her patients’ medication adherence rates, specifically taking steps to implement a medication synchronization program.

Challenge
Distances are great in the wide-open spaces of rural Missouri. Geography was proving to be a business challenge for Parkland Pharmacies, which was looking for a way to streamline operations and increase revenues. Inefficient and uncoordinated delivery of multiple medications to customers was proving too costly. Furthermore, customers on multiple medications were finding pickup inconvenient, particularly if they needed to drive to the pharmacy more than once a month. As a result, many patients were late picking up medications or never filled them at all.

Solutions
• Targeted adherence to streamline operations, save money and increase number of scripts filled, bringing in additional revenue
• Implemented medication synchronization to increase adherence and gain more control over staffing and inventory
• Piloted program with manual appointment-based model vs. new technology due to tight budget
• Focused initially on seniors; later rolled out program to long-term care patients
• In 2011, added manual compliance packaging system (Dispill); upgraded to Parata PASS to help with retail compliance packaging, long-term care and home healthcare agency business
• Synched delivery customers
• Synched drive-through customers

Results: New Store’s Adherence Measures in Top 20%
• Parkland’s new Ironton store adherence measures are trending in the top 20% of all retail pharmacies
• Parkland’s Desloge and Fredrickstown stores have at least two adherence measures that are higher than CMS 5-star goals and Health Mart average
• Medication synchronization program brought in incremental prescriptions and revenue
• Currently 133 patients enrolled in medication synchronization program

At a glance
Health Mart member: 2010
Pharmacist: Lisa Umfleet
Number of locations: 3
Quality measures focus: Adherence
Key tools: Medication synchronization
Result: New store in top 20% for adherence measures
Result: Incremental prescriptions and revenue
How to Succeed Like Parkland Pharmacies
If you’re interested in implementing a manual medication synchronization program, here are some suggested steps:

- **Get educated**
  - Take the [Implementing Medication Synchronization CE course](#) available on Health Mart University

- **Review the resources**
  - [Health Mart Operations Manual Medication Synchronization](#) page
  - Links to valuable information for implementing med sync including National Alliance of State Pharmacy Associations (NASPA) Operations Manual for implementing the appointment-based model of medication synchronization, as well as templates and more. Also a link for NCPA members to Simplify My Meds branded med sync program.

- **Set a goal and get started**
  - Consider assigning a specific pharmacy technician as the “medication sync tech” to help implement and lead the program logistics (performing tasks that technicians are allowed to do under the state pharmacy laws)
  - Involve the whole pharmacy team: educate them on the new program and ask for their assistance in recruiting patients
  - Start by enrolling your first patient and then set a goal (e.g., add one patient per week until you reach 100)

**DISCLAIMER** This case study is for informational purposes only. The results of this case study depend on a variety of factors that are unique to this organization. There is no guarantee that your results will be similar to this case study. Each party’s results will depend on the factors of its business. The success in this case study cannot be used as an indication of future success with these programs.
CASE STUDY: Central Drugs

COACH EVERY PATIENT TO IMPROVE ADHERENCE

Family-owned since 1903, Central Drugs has been serving its community for more than 111 years. The pharmacy is best known for its mission of serving underserved populations, specifically individuals living with HIV and hepatitis C. Central Drugs provides medication synchronization, adherence packaging and health coaching. For individuals living with HIV and hepatitis C, medication adherence is greater than 90%.

Challenge
In addition to focusing on adherence for people living with HIV and hepatitis C, Central Drugs wanted to scale to increase adherence rates for a broader set of patient populations, such as Medicare patients with chronic diseases. Already highly trained in specialized techniques, Central Drugs planned to transfer these skills to new target populations who would be seen in a traditional retail setting.

Solutions
• Deploy technology solutions from Prescribe Wellness to facilitate proactive, high-quality interactions with each customer (e.g., expanding “specialty” adherence solutions to the rest of the patient population)
• Transfer skills used with specialty high-risk patients, such as behavioral coaching, medication synchronization, and adherence packaging to a broader audience with a focus on Medicare Part D patients with chronic diseases
• Use long-term care–type techniques such as med sync and chart reviews in a retail setting

Results: Top Performer for All Adherence Measures
• In the top 20% of all retail stores for all adherence measures

At a glance
Health Mart member: 2009
Owner: Shelley Bailey
Number of locations: 1
Specialties: High-risk populations, long-term care, compounding
Quality measures focus: Adherence
Key tools: Behavioral coaching, medication synchronization
Results: In top 20% for all adherence measures

Snapshot of Central Drugs’ EQuIPP dashboard, showing adherence measures in the top 20%.
How to Succeed Like Central Drugs
If you’re interested in implementing a behavioral coaching program, below are some suggested steps.

- Get educated
  - Take the CE course available on Health Mart University: Coaching at the Counter... Opportunities for Enhancing Communication with a Patient-Centered Approach
- Review the resources
  - See Appendix B in this Playbook — Motivational Interviewing: Conversation Starters and Common Objections
- Involve the whole pharmacy team
  - Educate team members on the program objectives and ask for their assistance in referring patients to the pharmacist for health coaching

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ADHERENCE ACTION STEPS FOR PHARMACIES
The following information is intended to be a general overview of some action steps a pharmacy can consider implementing to increase quality and performance in this area. It does not constitute legal or other professional advice by Health Mart. Each pharmacist should apply his or her own professional judgment.

1. DO TARGETED INTERVENTIONS. Participate in targeted interventions and comprehensive medication reviews (when applicable) where patient adherence can be accessed and addressed. These programs help identify patients for you.

2. USE BEHAVIORAL COACHING. Use motivational interviewing and behavioral coaching to reinforce medication adherence with each fill and to determine potential reasons for nonadherence.

   • Remember patients typically have multiple reasons for nonadherence. Adherence is a personal behavioral choice; therefore, the first step to improving adherence is having an open conversation with the patient to determine his or her reasons for not being adherent. Based on the cause, you can then select the right tool or action.

   • A motivational interviewing quick reference guide is provided in Appendix B to help you with conversation starters and handling common objections.

   • If you would like to learn more about or refresh your knowledge on behavioral coaching, take the Coaching at the Counter … Opportunities for Enhancing Communication with a Patient-Centered Approach CE course available on Health Mart University.

3. MATCH SOLUTION TO CAUSE. Select the right tool or action based on the cause of nonadherence.

<table>
<thead>
<tr>
<th>Cause for Nonadherence</th>
<th>Solution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not know why I need to take the medication</td>
<td>Disease-state medication counseling using motivational interviewing approach</td>
</tr>
<tr>
<td>Forget to order refills</td>
<td>Use electronic refill reminders including IVR, calls, text messages, and email (e.g., Your Pharmacy Online)</td>
</tr>
<tr>
<td>Forget to take each day</td>
<td>Dose reminders, or if multiple meds, dose reminder (compliance) packaging</td>
</tr>
<tr>
<td>Inconvenience of multiple medications and multiple trips to pharmacy</td>
<td>Medication synchronization • Refer to the Health Mart Operations Manual medication synchronization page for resources on getting started with a manual method of med sync • Consider taking the Implementing Medication Synchronization CE course on Health Mart University</td>
</tr>
<tr>
<td>Intolerable side effects</td>
<td>Therapeutic interchange/prescriber collaboration</td>
</tr>
<tr>
<td>Cost</td>
<td>Therapeutic interchange, formulary review, patient assistance programs</td>
</tr>
</tbody>
</table>
### Table B: RAS Antagonists

Below are renin angiotensin system (RAS) antagonist medications for hypertension.

<table>
<thead>
<tr>
<th>ACE Inhibitors</th>
<th>ARBs</th>
<th>Direct Renin Inhibitor</th>
</tr>
</thead>
<tbody>
<tr>
<td>• benazepril</td>
<td>• candesartan</td>
<td>• aliskiren</td>
</tr>
<tr>
<td>• captopril</td>
<td>• irbesartan</td>
<td></td>
</tr>
<tr>
<td>• enalapril</td>
<td>• losartan</td>
<td></td>
</tr>
<tr>
<td>• fosinipril</td>
<td>• olmesartan</td>
<td></td>
</tr>
<tr>
<td>• lisinopril</td>
<td>• telmisartan</td>
<td></td>
</tr>
<tr>
<td>• moexipril</td>
<td>• valsartan</td>
<td></td>
</tr>
<tr>
<td>• perindopril</td>
<td>• valsartan</td>
<td></td>
</tr>
<tr>
<td>• quinapril</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• captopril</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• lisinopril</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• moexipril</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ramipril</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• trandolapril</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Excerpted from CMS Medicare 2014 Part C and D Star Rating Technical Notes

Note: The active ingredients are limited to oral and injectable formulations only (includes all dosage forms). Excludes nutritional supplement/dietary management combination products.

### Table C: Oral Diabetic Agents

Below are medications that may be prescribed for diabetes treatment.

<table>
<thead>
<tr>
<th>Biguanides and Biguanide Combination Products</th>
<th>Sulfonylureas and Sulfonylurea Combination Products</th>
<th>Thiazolidinediones and Thiazolidinedione Combination Products</th>
<th>DPP-IV Inhibitors and DPP-IV Inhibitor Combination Products</th>
</tr>
</thead>
<tbody>
<tr>
<td>• metformin</td>
<td>• candesartan</td>
<td>• pioglitazone</td>
<td>• sitagliptin</td>
</tr>
<tr>
<td>• pioglitazone and metformin</td>
<td>• irbesartan</td>
<td>• pioglitazone and metformin</td>
<td>• saxagliptin</td>
</tr>
<tr>
<td>• rosiglitazone and metformin</td>
<td>• losartan</td>
<td>• rosiglitazone and glimepiride</td>
<td>• alogliptin and pioglitazone</td>
</tr>
<tr>
<td>• linaglipitin and metformin</td>
<td>• olmesartan</td>
<td>• rosiglitazone and metformin</td>
<td>• sitagliptin and metformin IR and SR</td>
</tr>
<tr>
<td>• glyburide and metformin</td>
<td>• telmisartan</td>
<td>• alogliptin and pioglitazone</td>
<td>• saxagliptin and metformin SR</td>
</tr>
<tr>
<td>• glipizide and metformin</td>
<td></td>
<td>• alogliptin</td>
<td>• sitagliptin and simvastatin</td>
</tr>
<tr>
<td>• alogliptin and metformin</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Excerpted from CMS Medicare 2014 Part C and D Star Rating Technical Notes

Note: The active ingredients are limited to oral and injectable formulations only (includes all dosage forms). Excludes nutritional supplement/dietary management combination products.
Table D: Statin Medications
Below are statin and statin combination medications utilized in the statin adherence measure.

<table>
<thead>
<tr>
<th>Statin Medications</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>lovastatin</td>
<td>atorvastatin</td>
<td>simvastatin</td>
</tr>
<tr>
<td>rosvastatin</td>
<td>pravastatin</td>
<td></td>
</tr>
<tr>
<td>fluvastatin</td>
<td>pitavastatin</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Statin Combination Products</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>niacin and lovastatin</td>
<td>sitagliptin and simvastatin</td>
<td>aspirin-pravastatin</td>
</tr>
<tr>
<td>atorvastatin and amlodipine</td>
<td>ezetimibe and simvastatin</td>
<td></td>
</tr>
<tr>
<td>niacin and simvastatin</td>
<td>ezetimibe and atorvastatin</td>
<td></td>
</tr>
</tbody>
</table>

Excerpted from CMS Medicare 2014 Part C and D Star Rating Technical Notes
Note: The active ingredients are limited to oral formulations only.

Table E: Reasons for Medication Nonadherence

<table>
<thead>
<tr>
<th>Categories of Nonadherence</th>
<th>Examples</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient</td>
<td>Physical and cognitive impairment, age, race</td>
</tr>
<tr>
<td>Socioeconomic</td>
<td>Literacy rate, medication cost, social support</td>
</tr>
<tr>
<td>Condition</td>
<td>Asymptomatic, chronic, mental health</td>
</tr>
<tr>
<td>Therapy</td>
<td>Complexity of regimen, side effects, understanding the reason for therapy</td>
</tr>
<tr>
<td>Health System</td>
<td>Quality of patient-provider relationship, communication, access, continuity of care</td>
</tr>
</tbody>
</table>
CORE MEASURE #5
HIGH-RISK MEDICATION USE IN THE ELDERLY
CORE MEASURE #5

HIGH-RISK MEDICATION USE IN THE ELDERLY

Why is CMS focusing on high-risk medications in the elderly? Avoiding the use of certain drugs for this population is a simple and effective strategy for reducing medication-related problems. An American Geriatrics Society article about updated Beers Criteria published in 2012 highlights statistics from past studies that found that 27% of adverse drug events in primary care and 42% in long-term care were preventable. Total estimated healthcare costs related to use of potentially inappropriate medications was $7.2 billion in 2000–2001.33

Measure Description3

<table>
<thead>
<tr>
<th>2014 CMS 5-Star Goal:</th>
<th>≤ 3% (lower is better)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>What:</strong></td>
<td>This measure focuses on the percentage of plan members age 65 and older who received prescriptions for certain drugs with a high risk of side effects, when a safer drug choice may have been available.3</td>
</tr>
<tr>
<td><strong>Who:</strong></td>
<td>This metric calculates the percentage of Medicare Part D beneficiaries age 65 or older who received two or more prescription fills for the same high-risk medication (HRM) that has a high risk of serious side effects in the elderly.3</td>
</tr>
</tbody>
</table>

Key Takeaway:

Two or more fills of a HRM during the measurement period (one year) means that the patient will negatively impact measure performance. Preventing the fill is key ... identify HRM in patients over 65 before they are dispensed or refilled!

Measure Calculation

The measure is calculated based on Prescription Drug Event (PDE) data submitted to Medicare two years prior to the reporting year (e.g., data from January 1–December 31, 2012 for reporting year 2014). Data must be reported by June 30 of the year prior to the reporting year (e.g., June 30, 2013 for 2014).3*

The formula:

\[
\frac{\text{# member-years of enrolled beneficiaries 65 years or older who received two or more prescription fills for the same HRM during the period measured}}{\text{# member-years of enrolled beneficiaries 65 years and older during the period measured}}
\]

*The EQuIPP dashboard, which is provided to Health Mart members through Pharmacy Quality Solutions (PQS), is a 6-month rolling report as opposed to the 12-month reporting cycle used by CMS.
Clinical Relevance: Preventive Medication-Related Problems

The following is intended to be a brief overview of the clinical relevance of this measure. It should not be used as a treatment guide, but rather as a reference point for correct treatment guidelines. It does not constitute legal or other professional advice by Health Mart. Each pharmacist should apply his or her own professional judgment.

As patients age they become more vulnerable to adverse drug events. This is due to various reasons, including altered pharmacokinetics, diminished motor and cognitive skills, and exacerbation of multiple disease states. Adverse drug events in this population are sometimes referred to as “Potentially Inappropriate Medications” (PIMs) or High-Risk Medication (HRM) usage or medication-safety practices. PIMs are usually classified in three key categories:

i. Potentially inappropriate medications and classes to avoid in older adults;
ii. Potentially inappropriate medications and classes to avoid in older adults with certain diseases and syndromes that the drugs can exacerbate; and
iii. Medications to be used with caution in older adults.  

The most common issues seen with patients taking the medications on these lists fall into broad categories of:
• Anticholinergic side effects
• Delirium
• Gastrointestinal bleeding
• Falls and fractures

The list utilized in this measure (see Table F on page 36) is a subset of the American Geriatrics Society 2012 Beers Criteria list. See Table G on page 37 for Rationale for Avoiding Use of High-Risk Medications in the Elderly by therapeutic category. The Beers Criteria is a great reference for understanding the impact and causes of PIMs. The goal is to ensure the safety of older patients and to review the drug list to determine if a safer alternative therapy exists.
CASE STUDY: Beaver Health Mart Pharmacy, Brighton Health Mart Pharmacy and Beaver Falls Health Mart Pharmacy

REDUCING HIGH-RISK MEDICATIONS IN THE ELDERLY

Beaver Health Mart Pharmacy, Brighton Health Mart Pharmacy and Beaver Falls Health Mart Pharmacy are family-owned pharmacies located in Beaver, New Brighton, and Beaver Falls, Pennsylvania, respectively. These pharmacies range in age from less than 2 years old to a recent anniversary of 25 years old. While each store harbors its own niche service (immunizations, compounding lab, long-term care services), the daily focus is on traditional retail customer health. By implementing the high-risk medications (HRM) program in February 2014, these stores have enjoyed success in helping keep their patients safe.

Challenge
As they had done with successfully reducing ACE-ARB gaps in care for diabetes treatment, Beaver Health Mart and Beaver Falls Health Mart pharmacies wanted to improve their quality measures scores for HRM in the elderly. They realized that preventing the fill is key and that the team needed to identify HRM in patients over 65 before they were dispensed or refilled.

Solutions
• Educated and trained pharmacy team on list of high-risk medications and viable alternative treatment options
• Incorporated HRM identification into all drug utilization and chart reviews
• Identified HRM items in pharmacy-management system by character tag in item description
• Used standardized physician fax template to identify potential gaps in care to physicians
• Implementation of medication synchronization efforts afforded the time to perform the interventions

Results: At or Above 5-Star Goals for Four Out of Five Measures
• At or above 5-star goal on four out of five measures.
• Focused on ACE/ARB and in one year, reached top 20% of performers across all retail stores.
• Intangible results emerged as prescribers began to ask for recommendations and assistance in their own practices to avoid HRMs.
• They also learned that success is not static; the performance scores slide if the program is not maintained. This is not a “one and done” effort. They saw their scores drop when they lost focus.
• Their expectations are to emerge from the red by the end of summer. They are hopeful that their September scores will show not only progress, but achievement.

At a glance
Health Mart member: 2007
Pharmacist: Tim Davis
Number of locations: 3
Quality measures focus: High-risk medications in the elderly
Key tools: Staff education, integrating high-risk medications list into workflow for adherence measures
Result: At or above 5-star goals for four out of five measures
Snapshot of Beaver Pharmacy’s EQuIPP dashboard from May 2014 showing their performance at or above 5 star goals for four out of five measures.

How to Succeed Like Beaver Health Mart and Beaver Falls Health Mart

If you’re interested in implementing a high-risk medication program, here are some suggested steps:

- **Educate the team**
  - Educate the pharmacy team on list of high-risk medications in the elderly
  - Identify alternative therapy recommendations to offer prescribers when requesting a therapy intervention
  - Identify HRM items in pharmacy-management system by color or alphanumeric tag in the item description for on-the-fly intervention targeting
  - Keep fax request template handy for staff to act immediately upon realization of intervention opportunity

- **Post the high-risk medications list in the pharmacy for easy reference**
  - [HRM list](#) is available on the Health Mart Operations Manual

- **Involve the whole pharmacy team and ask for their assistance in recruiting patients**

**DISCLAIMER**

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HIGH-RISK MEDICATIONS IN THE ELDERLY ACTION STEPS FOR PHARMACIES

The following information is intended to be a general overview of some action steps a pharmacy can consider implementing to increase quality and performance in this area. It does not constitute legal or other professional advice by Health Mart. Each pharmacist should apply his or her own professional judgment.

1. IDENTIFY PATIENTS OVER AGE 65. Identify patients over age 65 who are taking drugs or classes of drugs on the high-risk medications in the elderly list.
   • Participate in medication therapy management programs that include high-risk medication–targeted interventions and/or comprehensive medication reviews (CMRs).
   • Familiarize your staff with the high-risk medications list and common classes of high-risk medications and review medications for coaching opportunities during traditional counseling interactions.
   • When performing prospective DUR, look for these high-risk medications in patients who are 65 and older.

2. DISCUSS WITH PATIENT. If a high-risk medication is identified, discuss it with the patient at the pharmacy or by phone.
   • Ask open-ended questions to find out what the patient knows about the medication. Ask for permission to discuss the potential risk(s) of taking this medication for patients 65 and older.
   • Offer to call and/or fax the prescriber to find out if discontinuing the medication or taking another medication might be recommended.
   • Use the Beers Criteria and associated risks as clinical proof when discussing potential therapeutic interchange with prescribers.

3. CONTACT PHYSICIAN. If applicable, contact physician via phone or fax to let them know about the potential high-risk medication identified, as well as any pertinent information from the discussion with the patient.
   • Use physician fax templates (such as samples outlined in Appendix C) and customize as needed.
Table F: High-Risk Medications in the Elderly

Below is the list of medications utilized in the high-risk medications in the elderly measure.

<table>
<thead>
<tr>
<th>Description</th>
<th>Prescription Products</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticholinergics (excludes TCAs)</strong></td>
<td></td>
</tr>
<tr>
<td>First-generation antihistamines (as single agent or as part of combination products) – excludes OTC products</td>
<td>- Brompheniramine&lt;br&gt; - Carbinoxamine&lt;br&gt; - Chlorpheniramine&lt;br&gt; - Clemastine&lt;br&gt; - Diphenhydramine (oral)</td>
</tr>
<tr>
<td>Antiparkinson agents</td>
<td>- Benztrapine (oral)</td>
</tr>
<tr>
<td><strong>Antithrombotics</strong></td>
<td></td>
</tr>
<tr>
<td>Antithrombotics</td>
<td>- Ticlopidine*&lt;br&gt; - Diprylamole, oral short-acting* (does not apply to the extended-release combination with aspirin)</td>
</tr>
<tr>
<td><strong>Antifective</strong></td>
<td></td>
</tr>
<tr>
<td>Anti-infective</td>
<td>Nitrofurantoin (include when cumulative day supply is &gt;90 days) (A)</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td></td>
</tr>
<tr>
<td>Alpha blockers, central</td>
<td>- Guanfacine*&lt;br&gt; - Methyldopa*&lt;br&gt; - Reserpine (&gt;0.1mg/day)* (B)</td>
</tr>
<tr>
<td>Cardiovascular, other</td>
<td>- Diisopropylam*&lt;br&gt; - Digoxin (&gt;0.125mg/day) (C)&lt;br&gt; - Nifedipine, immediate release*</td>
</tr>
<tr>
<td><strong>Central Nervous System</strong></td>
<td></td>
</tr>
<tr>
<td>Tertiary TCAs (as a single agent or as part of a combination product)</td>
<td>- Amitryptiline&lt;br&gt; - Clomipramine</td>
</tr>
<tr>
<td>Antipsychotics, first-generation (conventional)</td>
<td>- Chlorpromazine&lt;br&gt; - Thioridazine</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>- Amobarbital*&lt;br&gt; - Butabarbital*&lt;br&gt; - Butabital&lt;br&gt; - Phenobarbital&lt;br&gt; - Seconalbarbital*</td>
</tr>
<tr>
<td>Central Nervous System, other</td>
<td>- Chlormethyhydrate*&lt;br&gt; - Megrobarbamate</td>
</tr>
<tr>
<td>Nonbenzodiazepine hypnotics (include when cumulative day supply is &gt;90 days) (E)</td>
<td>- Eszopiclone&lt;br&gt; - Zolpidem&lt;br&gt; - Zaleplon</td>
</tr>
<tr>
<td>Vasodilators for dementia</td>
<td>- Ergoloid mesylates*&lt;br&gt; - Isosuprine</td>
</tr>
<tr>
<td><strong>Endocrine</strong></td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td>- Deseoated thyroid&lt;br&gt; - Estrogens** with or without progestosterone (oral and topical patch products only)</td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>- Chlorpropamide&lt;br&gt; - Glyburide</td>
</tr>
<tr>
<td><strong>Pain Medications</strong></td>
<td></td>
</tr>
<tr>
<td>Pain Medications</td>
<td>- Meperidine&lt;br&gt; - Pentazocine*</td>
</tr>
<tr>
<td>Non-COX-selective NSAIDS***</td>
<td>- Indomethacin&lt;br&gt; - Ketorolac</td>
</tr>
<tr>
<td><strong>Skeletal muscle relaxants</strong></td>
<td></td>
</tr>
<tr>
<td>Skeletal muscle relaxants (as a single agent or as part of a combination product)</td>
<td>- Carisoprodol&lt;br&gt; - Chlorzoxazone&lt;br&gt; - Cyclobenzaprine&lt;br&gt; - Metaxalone&lt;br&gt; - Methocarbamol&lt;br&gt; - Orphenadrine</td>
</tr>
</tbody>
</table>

*Infrequently used drugs. Abbreviations: TCAs, tricyclic antidepressants; OTC, over the counter.

Excerpted from CMS Medicare 2014 Part C and D Star Rating Technical Notes¹
### Table G: Rationale for Avoiding Use of High-Risk Medications in the Elderly

Below are the reasons why certain medications are considered high risk in the elderly.

<table>
<thead>
<tr>
<th><strong>Therapeutic Categories</strong></th>
<th><strong>Rationale</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anticholinergics</strong></td>
<td></td>
</tr>
<tr>
<td>First-generation antihistamines</td>
<td>Highly anticholinergic; clearance reduced with advanced age and tolerance develops when used as hypotonic; greater risk of confusion, dry mouth, constipation, and other anticholinergic effects and toxicity</td>
</tr>
<tr>
<td>Anti-Parkinson’s agents</td>
<td>Not recommended for prevention of extrapyramidal symptoms with antipsychotics; more effective agents available for treatment of Parkinson’s disease</td>
</tr>
<tr>
<td><strong>Antithrombotics</strong></td>
<td></td>
</tr>
<tr>
<td>Antithrombotics</td>
<td>Safer effective alternatives available</td>
</tr>
<tr>
<td><strong>Anti-Infecitve</strong></td>
<td></td>
</tr>
<tr>
<td>Nitrofurantoin</td>
<td>Potential for pulmonary toxicity; safer agents available</td>
</tr>
<tr>
<td><strong>Cardiovascular</strong></td>
<td></td>
</tr>
<tr>
<td>Alpha blockers</td>
<td>High risk of orthostatic hypotension; not recommended for routine treatment of hypertension; alternative agents have superior risk benefit profile</td>
</tr>
<tr>
<td>Disopyramide*</td>
<td>Potent negative inotrope and therefore may induce heart failure in older adults; strongly anticholinergic; other antiarrhythmic drugs preferred</td>
</tr>
<tr>
<td>Digoxin &gt; 0.125 mg/d</td>
<td>In heart failure, higher dosages associated with no additional benefit and may increase risk of toxicity; slow renal clearance may lead to risk of toxic effects</td>
</tr>
<tr>
<td>Nifedipine, immediate release*</td>
<td>Potential for hypotension; risk of precipitating myocardial ischemia</td>
</tr>
<tr>
<td><strong>Central Nervous System</strong></td>
<td></td>
</tr>
<tr>
<td>Tertiary TCAs (as a single agent or as part of a combination)</td>
<td>Highly anticholinergic, sedating, and cause orthostatic hypotension</td>
</tr>
<tr>
<td>Antipsychotics, first-generation (conventional)</td>
<td>Increased risk of cerebrovascular accident (stroke) and mortality in persons with dementia</td>
</tr>
<tr>
<td>Barbiturates</td>
<td>High rate of physical dependence; tolerance to sleep benefits; risk of overdose at low dosages</td>
</tr>
<tr>
<td>CNS, other</td>
<td>Chloral hydrate*: Tolerance occurs within 10 days and risks outweigh benefits in light of overdose with doses only three times the recommended dose</td>
</tr>
<tr>
<td>Meprobamate</td>
<td>High rate of physical dependence; very sedating</td>
</tr>
<tr>
<td>Nonbenzodiazepine hypnotics (include when cumulative day supply is &gt; 90 days)</td>
<td>Benzodiazepine-receptor agonists that have adverse events similar to those of benzodiazepines in older adults (e.g., delirium, falls, fractures); minimal improvement in sleep latency and duration</td>
</tr>
<tr>
<td>Vasodilators for dementia</td>
<td>Lack of efficacy</td>
</tr>
<tr>
<td><strong>Endocrine</strong></td>
<td></td>
</tr>
<tr>
<td>Endocrine</td>
<td>Desiccated thyroid: Concerns about cardiac effects; safer alternatives available</td>
</tr>
<tr>
<td>Estrogens with or without progestins (oral and topical patch products only): Evidence of carcinogenic potential (breast and endometrium); lack of cardioprotective effect and cognitive protection in older women</td>
<td></td>
</tr>
<tr>
<td>Megestrol: Minimal effect on weight; increases risk of thrombotic events and possibly death in older adults</td>
<td></td>
</tr>
<tr>
<td>Sulfonylureas, long duration</td>
<td>Chlorpropamide: Prolonged half-life in older adults; can cause prolonged hypoglycemia; causes syndrome of inappropriate antidiuretic hormone secretion</td>
</tr>
<tr>
<td>Glyburide: Greater risk of severe prolonged hypoglycemia in older adults</td>
<td></td>
</tr>
<tr>
<td><strong>Gastrointestinal</strong></td>
<td></td>
</tr>
<tr>
<td>Gastrointestinal</td>
<td>Trimethobenzamide: One of the least effective antiemetic drugs; can cause extrapyramidal adverse effects</td>
</tr>
<tr>
<td><strong>Pain Medications</strong></td>
<td></td>
</tr>
<tr>
<td>Pain medications</td>
<td>Meperidine: Not an effective oral analgesic in dosages commonly used; may cause neurotoxicity; safer alternatives available</td>
</tr>
<tr>
<td>Pentazocine*: Causes CNS adverse effects, including confusion and hallucinations, more commonly than other narcotic drugs; is also a mixed agonist and antagonist; safer alternatives available</td>
<td></td>
</tr>
<tr>
<td>Non-COX selective NSAIDs</td>
<td>Increases risk of GI bleeding and peptic ulcer disease in high-risk groups, including those aged &gt;75 or taking oral or parenteral corticosteroids, anticoagulants, or antiplatelet agents</td>
</tr>
<tr>
<td><strong>Skeletal Muscle Relaxants</strong></td>
<td></td>
</tr>
<tr>
<td>Skeletal muscle relaxants (as single agent or as part of combination)</td>
<td>Most muscle relaxants are poorly tolerated by older adults because of anticholinergic adverse effects, sedation, risk of fracture; effectiveness at dosages tolerated by older adults is questionable</td>
</tr>
</tbody>
</table>
REFERENCES


References, cont.


APPENDICES
APPENDIX A
How to Identify Target Patients

1. USE MTM. Medication therapy management (MTM) programs help target patients for you and often provide a service or activity fee for completing cases.
   • If you are not already doing MTM, consider enrolling with a vendor such as:
     – Mirixa (Call Mirixa at 866.218.6649, 8:30 a.m. to 5:30 p.m. ET Monday through Friday)
     – Outcomes (click “pharmacy” tab on top, then “getting started” link)
     – Socrates
   • Check with your state pharmacy association for any state or local MTM or pharmacy quality–related opportunities
   • If you are looking for additional training to help you or your pharmacy team integrate MTM into your pharmacy, consider taking the CE course available on Health Mart University titled “Practical Steps for Integrating MTM into Your Daily Practice”.
   • If your pharmacy is already doing both targeted and comprehensive medication reviews, it is critical to implement a process to check for new MTM cases daily (e.g., “open” cases) and complete the cases within the specified time frame

2. LEVERAGE EQuIPP DATA. For help picking a measure where impacting even one patient can make a big difference, evaluate your pharmacy’s performance using EQuIPP. See Appendix E for a quick cheat sheet of how to read your EQuIPP dashboard.
   • When reviewing your Pharmacy Performance Report on EQuIPP consider, based on current performance, approximately how many patients are needed to affect your performance for a given measure and move it to at or above the 5-star goal level.
   • For example, for Diabetes Proportion of Days Covered (PDC), if your performance was currently based on 100 patients and the gap between current performance and the 5-star goal was 1%, just one patient would be needed to move the store to the 5-star level. Look for opportunities like this, where even small changes can make a big difference.
   • Remember that while you may move one patient in the correct direction, another may become an outlier if you only rely on retrospective data of outliers. Keep your patients on track by being proactive using behavioral coaching and look to go beyond the 5-star CMS threshold goal.

3. DO REPORTING. Use your pharmacy-management tools to run reports to help you identify patients.
   • For all measures: Consider running NDC or drug-specific reports for the measure(s) you want to work on improving
   • For PDC measures: Consider running compliance or past-due refill reporting
   • Explore creating custom reports (if available in your pharmacy-management system) to help filter the list of patients to target even further (by NDC, by payer, etc.)
     o Use the “Analyze Performance” button in EQuIPP under the measure you are looking to improve to see from which payer(s) the patients who are contributing to your score are coming from. Consider targeting patients with that payer and running a report looking for patients taking those medications from the given payer.

4. CREATE FLAGGING SYSTEM. Flag patients who are identified outside of your workflow.
   • For patients who are identified outside of your workflow (e.g., through MTM cases or by running a report from your pharmacy-management system), consider a process for calling patients or placing a patient note in the pharmacy-management system to help identify those patients on their next visit.
Motivational Interviewing: Conversation Starters and Common Objections

This information on motivational interviewing (MI) approaches, conversation starters and common objections is just a starting point for increasing or refreshing your skills related to MI. Additional and ongoing CE in MI is often needed. Consider taking the session Coaching at the Counter ... Opportunities for Enhancing Communication with a Patient-Centered Approach, available for CE credit on Health Mart University.

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Medication adherence is a complex and personal issue, requiring a delicate discussion with patients. To facilitate these conversations, it’s important to use the right approach. Motivational interviewing has proven to be more effective than traditional approaches, leading to a higher success rate for more efficient and longer-lasting health behavior change. The first step in improving adherence is using a MI-based coaching session to have open conversations with patients to determine their personal reasons for not being adherent.

Four Key Motivational Interviewing Skills to Develop

- **Engaging**: Establishing a connection and working relationship.
- **Focusing**: Developing and maintaining a specific direction in the conversation about change.
- **Evolving**: Eliciting the patient’s own motivations for change. Uncovering motivation is key to changing the conversation perspective from being an “expert” to being a “partner.”
- **Planning**: Developing commitment and formulating a plan of action.

Steps in Motivational Interviewing

1. Develop rapport
   - Remember to use open-ended questions
     - What did the doctor tell you this medication is for?
     - What concerns do you have about your medication?
     - Tell me about how the past few weeks have gone with taking your medication …

2. Reflect back your understanding of the patient’s sense making
   - What I am hearing you saying is …

3. Ask permission to proceed in providing the patient with new information to promote a sense of collaboration

4. Provide new information

5. Ask the patient what he/she thinks of this new information

6. Summarize and discuss next steps
   - Reflect overall on what was discussed by patient and outline next steps
### Motivational Interviewing Conversation Starters: Examples

Examples of open-ended questions and typical types of responses are listed below. Consider using these open-ended questions to begin an MI-based coaching session with patients.

<table>
<thead>
<tr>
<th>Suggested Question</th>
<th>Suggested Responses</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Initiation of therapy conversation:</strong></td>
<td>Response choices:</td>
</tr>
</tbody>
</table>
| “What did the doctor tell you this medication is for (or what it does)? How important is that to you?” | a. Important: If the patient acknowledges importance, AFFIRM (“great”), and REFLECT back/restate) what they know and its importance.  
b. Unsure of importance: Ask permission to offer what you know about medication and importance (i.e., benefits). Then, ASK patient how information applies to them.  
c. Resistant: REFLECT what the person says without arguing. “At the moment, you are still not certain you really need this medication. It’s true, only you can decide, and I do encourage you to talk to your physician.” |
| “What do you believe are the benefits of taking your medicine?” | Response choices: |
| | a. Provides benefits: AFFIRM and add, “What other reasons would you have for taking this medicine?”  
b. Unsure of benefits: WITH PERMISSION, offer possible benefits, and add, “How might any of these benefits be important to you?” |
| “Would you mind if I mention an area where some patients run into trouble?” | EXAMPLE: “You may know that feeling ‘well’ is not what [medication name] helps with. Thus, as you start to feel better, continue to take your medication every day.” |
### Handling Common Objections Once on Therapy

<table>
<thead>
<tr>
<th>Potential Patient Objections</th>
<th>Potential Pharmacist Response: Reflection or Open-Ended Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Asymptomatic:</td>
<td>“It sounds like you are frustrated with having to take the medication every day, when you don’t feel any better or different when you take it.”</td>
</tr>
<tr>
<td>“I feel fine and I’m tired of taking it.”</td>
<td>Listen, Reflect, Ask Permission: “Would you mind if I share some information and you tell me what you think?” [Share benefits/risk reduction of taking medication]</td>
</tr>
<tr>
<td>Already implemented lifestyle changes:</td>
<td>“That is great that you are [exercising or eating healthy] regularly and there are definitely benefits to improving your blood sugar with [exercise/diet]. You’re feeling good, so you’re wondering if the [exercise/diet] has eliminated the need to take your [medication].”</td>
</tr>
<tr>
<td>“I exercise and/or eat healthy every day to stay healthy; I don’t need my medication.”</td>
<td>Listen, Reflect, Ask Permission: “You raise a good question. Would it be ok if we talk a little more about your medication, [exercise/diet], and how they can work together to manage your [condition]?”</td>
</tr>
<tr>
<td>Side effect(s):</td>
<td>“You sound worried about this side effect. It sounds like if you weren’t experiencing this side effect with the medication, that you would be more likely to take your medication.”</td>
</tr>
<tr>
<td>“I feel worse on the medication and I’ve developed this [side effect], I don’t want to take my medicine anymore.”</td>
<td>Listen, Reflect, Ask Permission: “Would you be willing to discuss options for [side effect management] and/or a different medication to help lower your blood pressure that may have fewer [side effects]?”</td>
</tr>
<tr>
<td>Cost:</td>
<td>“It sounds like you are worried about how you might be able to pay for your medications.”</td>
</tr>
<tr>
<td>“I can’t afford my medication anymore.”</td>
<td>Listen, Reflect, Ask Permission: “Would you mind if I look into [patient assistance program, co-pay card, therapeutic interchange, etc.].”</td>
</tr>
<tr>
<td>Forget to take:</td>
<td>“It sounds like it’s challenging to remember to take your medication(s) every day/every time.”</td>
</tr>
<tr>
<td>“It’s hard to remember to take my medication.”</td>
<td>Listen, Reflect, Ask Permission: “You raise a valid concern. Some of my other patients who also find it hard to remember to take their medication have benefited from [pill box, compliance packaging, reminder technology].”</td>
</tr>
<tr>
<td>Forget to refill:</td>
<td>“That is great that you were doing well remembering to take it before you ran out of pills. Would you mind if I [sign you up for refill reminders]? Some of my other patients who often forget to refill have benefited from it.”</td>
</tr>
<tr>
<td>“I was doing good taking it, but I was really busy with my grandkids and forgot to refill all my pills.”</td>
<td></td>
</tr>
</tbody>
</table>

### Additional Resources

Consider taking or encouraging your staff to take CE courses on Health Mart University including “Coaching at the Counter ... Opportunities for Enhancing Communication with a Patient-Centered Approach.”


APPENDIX C
Sample Fax Templates

Appendix C contains four sample fax templates for communicating identified gaps in therapy or adherence medication issues to the patient’s physician. Refer to the Health Mart Marketing Hub on McKesson Connect to find modifiable physician fax and letter templates that can be used to communicate with physicians and market your pharmacy services (search term = “physician”). To find other prescribers or to gather more information on prescribers, refer to the Physician Outreach Program.

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Improving Quality of Care

We partner with you to improve outcomes for both patients and providers.

The U.S. healthcare system is quickly moving from fee-for-service toward value-based purchasing, with the intent to reduce costs while improving quality of care. Payers, like CMS, are making providers like us accountable for patients’ health outcomes by tying reimbursement to performance. That’s why it’s more important than ever to work together to help our mutual patients have the best outcomes possible. Did you know that on average only 25–30% of prescriptions are taken properly and only 15–20% are refilled as prescribed?

How is your practice being measured?
Medicare Advantage plans receive financial incentives from CMS for keeping care quality high and improving outcomes. So, they’re choosing providers for PPOs and HMOs that can help them raise their Five-Star Quality Ratings — the system CMS uses to measure health plan quality. Providers are being measured on a set of “core quality measures” that focus on diabetes treatment, medication adherence and high-risk medications in the elderly. For more information, visit http://smartretailingrx.com/regulatory-public-affairs/star-ratings-explained/.

Services we provide that directly affect your Medicare Part C quality scores

Staying Healthy: Screening, Tests and Vaccines

<table>
<thead>
<tr>
<th>Services Provided at Our Pharmacy</th>
<th>Directly Help You with Medicare Part C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholesterol screening in pharmacy</td>
<td>Cardiovascular care — cholesterol screening</td>
</tr>
<tr>
<td>Cholesterol screening in pharmacy</td>
<td>Diabetes care — cholesterol screening</td>
</tr>
<tr>
<td>Vaccination program</td>
<td>Annual flu vaccine</td>
</tr>
<tr>
<td>Weight management program</td>
<td>Adult BMI assessment</td>
</tr>
</tbody>
</table>

Managing Chronic Conditions

<table>
<thead>
<tr>
<th>Services Provided at Our Pharmacy</th>
<th>Directly Impact Medicare Part D</th>
<th>Directly Help You with Medicare Part C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication therapy management (MTM) program with high comprehensive medication review (CMR) completion rate</td>
<td>Comprehensive medication review (display measure)</td>
<td>Care for older adults — medication review</td>
</tr>
<tr>
<td>MTM program with high targeted medication review (TMR) completion rate</td>
<td>Diabetes treatment (ACE/ARB)</td>
<td>Diabetes care — kidney disease monitoring</td>
</tr>
<tr>
<td>Adherence counseling, med sync, refill reminders</td>
<td>Medication adherence for diabetes</td>
<td>Diabetes care — blood sugar controlled</td>
</tr>
<tr>
<td>Adherence counseling, med sync, refill reminders</td>
<td>Medication adherence for cholesterol</td>
<td>Diabetes care — cholesterol controlled</td>
</tr>
<tr>
<td>Adherence counseling, med sync, refill reminders</td>
<td>Medication adherence for hypertension</td>
<td>Controlling blood pressure</td>
</tr>
<tr>
<td>MTM Program with high TMR completion rate</td>
<td>High-risk medication</td>
<td>Reducing the risk of falling</td>
</tr>
<tr>
<td>Medication reconciliation program</td>
<td>Medication reconciliation program</td>
<td></td>
</tr>
</tbody>
</table>

Thank you for partnering with [Insert Store Name] to improve medication adherence and patient care. Please call us with any questions at xxx.xxx.xxxx.

[Insert Pharmacist’s Name]
Insert Address Line
Phone: XXX.XXX.XXXX
Fax: XXX.XXX.XXXX
www.url.com

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Improving Diabetes Treatment Performance

We partner with you to improve quality measures to help our Medicare patients stay healthy by identifying potential gaps in therapy.

Patient Name: _____________________________________________
DOB: _____________________________________________________
Medication(s): _____________________________________________

On review of our mutual patient’s current prescription regimen, we noted that he/she is not currently prescribed an ACE or an ARB, but is taking other medications for both diabetes and hypertension. Please review this patient’s record and:

- If this patient should be prescribed an ACE, ARB or direct renin inhibitor, please check “yes” at right, complete the prescription blank and fax it back to XXX.XXX.XXXX.
- If this patient should not be prescribed an ACE, ARB or direct renin inhibitor, please check “no” at right, indicate reasons why so that we can update our records, and fax back to XXX.XXX.XXXX.

Why an ACE or ARB? Inhibitors of the renin-angiotensin system (RAS) may reduce the risk of cardiovascular disease, heart failure and kidney disease. Based on the recommendation from the National Kidney Foundation Kidney Disease Outcomes Quality Initiative, we recommend that an ACE-I, ARB or direct renin inhibitor be initiated for our mutual patient if you deem it clinically appropriate.

Thank you for partnering with [Insert Store Name] to improve diabetes treatment and patient care. Please fax this form back to us at XXX.XXX.XXXX or call us with any questions.

[Insert Pharmacist’s Name]

If you no longer want to receive faxes from [Insert name of pharmacy] and want your name and fax number removed from the distribution list, please call [insert phone number]. Alternatively, to opt out of receiving faxes, fax this document to [insert fax number], and check the box below. In order to process your opt-out request, you must provide us the fax number for which the opt-out request applies. Pursuant to applicable law, we must process your request within the shortest reasonable time, not to exceed 30 days. Your opt-out request may be revoked if you subsequently provide us with express invitation or permission, in writing or otherwise, to send advertisements to that fax number.
Improving Drug Therapy Adherence

We partner with you to improve quality measures to help our Medicare patients stay healthy and adhere to their medication regimen.

Patient Name: ________________________________________
DOB: _______________________________________________
Medication(s):________________________________________

We are working with this mutual patient to improve his/her medication adherence. Our approach is to tailor our medication adherence services to each patient. We wanted to let you know that we have been taking the following approach(es) with this patient so that you can update your patient record, as appropriate:
- Behavioral coaching and disease state education
- Refill reminders via phone, email or text
- Dose reminder packaging
- Medication therapy management (MTM) — comprehensive medication reviews
- Medication synchronization to make prescription pickups more convenient

What was discussed:
- Disease state education
- Reviewed patient-specific barriers to adherence
- Discussed patient-specific solutions
- Made a plan for regular check-ins
- Other ____________________________

Why focus on adherence? Studies estimate that 77% of patients don’t take their prescriptions as they are supposed to, and it’s estimated that as many as 2.8 million avoidable readmissions each year stem from failed drug therapy. Our goal is to encourage adherence and work with each patient and his/her physician to individualize an adherence plan.

Thank you for partnering with [Insert Store Name] to improve medication adherence and patient care.
Please call us with any questions at xxx.xxx.xxxx.

[Insert Pharmacist’s Name]
Insert Address Line
Phone: XXX.XXX.XXXX
Fax: XXX.XXX.XXXX
www.url.com

If you no longer want to receive faxes from [Insert name of pharmacy] and want your name and fax number removed from the distribution list, please call [insert phone number]. Alternatively, to opt out of receiving faxes, fax this document to [insert fax number], and check the box below. In order to process your opt-out request, you must provide us the fax number for which the opt-out request applies. Pursuant to applicable law, we must process your request within the shortest reasonable time, not to exceed 30 days. Your opt-out request may be revoked if you subsequently provide us with express invitation or permission, in writing or otherwise, to send advertisements to that fax number.

Fax Opt Out   Fax Number ____________________________

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Focused on High-Risk Medications for the Elderly

We partner with you to improve quality measures to help our Medicare patients stay healthy and help reduce medication-related problems in the elderly.

Patient Name: __________________________
DOB: __________________________
Medication: __________________________

On review of our mutual patient’s current prescription regimen, we noted that he/she is currently prescribed a medication listed in the American Geriatrics Society Beers Criteria for Potentially Inappropriate Medication Use in Older Adults. We are contacting you because this medication presents a potential risk for this patient. Please review this patient’s record and the Beers Criteria and:

- If this patient **should discontinue** this medication, please check “yes” at right, complete the prescription blank for an alternate therapy if appropriate, and fax it back to XXX.XXX.XXXX.
- If this patient **should continue** receiving this medication, please check “no” at right, indicate reasons why so that we can update our records, and fax back to XXX.XXX.XXXX.

Why a focus on high-risk medications in the elderly? Approximately 95% of adverse drug events in the elderly are predictable and about 28% are preventable, according to the American Academy of Family Physicians. That’s why we want to work closely with you to help our mutual elderly Medicare patients achieve better outcomes.

Thank you for partnering with [Insert Store Name] to review use of high-risk medications in the elderly. Please fax this form back to us at XXX.XXX.XXXX or call us with any questions.

[Insert Pharmacist’s Name]
Insert Address Line
Phone: XXX.XXX.XXXX
Fax: XXX.XXX.XXXX
www.url.com

If you no longer want to receive faxes from [Insert name of pharmacy] and want your name and fax number removed from the distribution list, please call [insert phone number]. Alternatively, to opt out of receiving faxes, fax this document to [insert fax number], and check the box below. In order to process your opt-out request, you must provide us the fax number for which the opt-out request applies. Pursuant to applicable law, we must process your request within the shortest reasonable time, not to exceed 30 days. Your opt-out request may be revoked if you subsequently provide us with express invitation or permission, in writing or otherwise, to send advertisements to that fax number.

☐ Fax Opt Out Fax Number __________________________

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APPENDIX D
Quick Reference Guide: How to Drive Improved Performance
Now that you’ve accessed your pharmacy’s specific performance data on the EQuIPP™ platform, you may be wondering what to do next. There’s no one-size-fits-all solution. You’ll need to customize your approach depending on your current performance, the pharmacy services you offer and other factors. However, The Pharmacy Quality Measures: Know Your Numbers course on Health Mart University is a good starting point for everyone to understand performance as well as an approach to evaluating and targeting improvement. After that, take a closer look at the five key medication use–related star rating measures your pharmacy can impact and evaluate what approaches you and your pharmacy team can take to most effectively affect health plans’ ratings — while also making your business more competitive and successful.

**Five key medication use–related star ratings measures**

**HOW YOUR PHARMACY CAN DRIVE IMPROVED PERFORMANCE**

**PHARMACIES SIGNIFICANTLY IMPACT HEALTH PLANS’ CORE MEASURES**

- Drug plan customer service
- Member complaints, problems getting services and improvement in drug plan’s performance
- Member experience with drug plan

3X weighted: Measures that impact clinical outcomes
- Diabetes treatment
- Adherence
- High-risk medications
This measure looks at the percentage of patients dispensed a medication for diabetes and a medication for hypertension that included angiotensin converting enzyme (ACE) inhibitors, angiotensin receptor blockers (ARBs) or a direct renin inhibitor. The goal of this measure is to try to close potential gaps in care for patients with diabetes who may not be on the type of hypertension medication that also may have renal protective effects.

**CLINICAL IMPORTANCE: DIABETES AND HYPERTENSION**

- When people with diabetes also have high blood pressure, there are certain types of blood pressure medications recommended.
- For the purpose of this measure, patients are identified as a diabetic patient if they are currently taking a diabetic medication and/or insulin.
- Renal complications are high-impact complications in diabetic patients. They increase morbidity and mortality in these patients.
- Renin antagonist agents are utilized to treat hypertension in these patients in order to reduce renal complications.
- These medications work through either blocking the production of renin or decreasing receptor binding affinity for renin.
- Renin is made and stored in the kidneys and is released in response to pressure changes. It can cause a cascade to occur that increases volume retention and vasoconstriction. This can in turn increase pressure in the kidneys and increase the risk of albuminuria, which leads to kidney disease in diabetic patients.

**SUGGESTED ACTION STEPS**

- Participate in medication therapy management (MTM) programs that include targeted interventions that help identify gaps in care.
- Perform a prospective drug utilization review (DUR) when checking oral diabetic agent prescriptions to see if patient is on an ACE, ARB or renin inhibitor.
- When counseling diabetic patients, review profiles to determine if a gap in therapy exists.
- If gap is found, discuss the benefits and offer to contact a prescriber to request a prescription. This recommendation is endorsed by the National Kidney Foundation Kidney Disease Outcomes Quality Initiative.
These measures look at improving adherence in three key medication groups, including statins, oral diabetic agents and renin-angiotensin system (RAS) antagonists. Adherence is measured by proportion of days covered (PDC), which assesses the percentage of patients covered by prescription claims for the same drug or another drug in the same therapeutic class within a calendar range. Only patients with at least two fills are included.

**CLINICAL IMPORTANCE: STATINS, ORAL DIABETIC AGENTS, RAS ANTAGONISTS**

**Statin PDC**
- Statin medications block converting enzymes in the pathway to produce endogenous LDL cholesterol. This decrease in endogenous cholesterol production offsets the influx of dietary cholesterol to reduce total cholesterol.
- Statins are recommended in patients with LDL >190 with atherosclerotic cardiovascular disease (ASCVD) or at high risk with ASCVD and comorbidities such as diabetes (2013 ACC/AHA Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults).

**Oral Diabetic Agent PDC**
- Medications include biguanides, sulfonylureas, thiazolidinediones and DPP-IV inhibitors.
- These medications improve glycemic control through various mechanisms of action, including decreasing hepatic glucose production, decreasing glucose absorption, increasing insulin-mediated glucose uptake, increasing insulin secretion, decreasing insulin resistance and suppressing glucagon release.
- Detailed recommendations on when to use which agent can be found in the 2013 American Association of Clinical Endocrinologists (AACE) guidelines.

**RAS Antagonist PDC**
- Medications include ACE inhibitors, ARBs and renin inhibitors.
- Clinical implications of these medications can be found in the previous measure detail.
- Refer to the 2014 Evidence-Based Guideline for the Management of High Blood Pressure in Adults for clinical treatment guidelines.

**SUGGESTED ACTION STEPS**
- Participate in MTM programs that offer targeted interventions and/or comprehensive medication reviews where patient adherence can be accessed and addressed.
- Adherence is a personal behavioral choice. Therefore, the first step to improving adherence is using behavioral-based coaching/interviewing to have open conversations with patients to determine their personal reasons for not being adherent.
- Based on the cause (typically patients have multiple reasons), you can then select the right tool or action:
This measure looks at patients aged 65 and older who received prescriptions for certain drugs that are considered to have a high risk of side effects in the elderly, when there are safer choices available. This is calculated as a percentage of patients who received two or more fills of a prescription for a high-risk medication on the CMS list.

**CLINICAL IMPORTANCE: HIGH-RISK MEDICATIONS FOR ELDERLY**
- Centers for Medicare and Medicaid Services (CMS) has a one-page list of high-risk medications specific to this measure.
- The medications on this list cover a wide variety of therapeutic classes such as anticholinergics, barbiturates, certain antithrombotics and calcium channel blockers, tricyclic antidepressants, estrogens without progestin, long duration sulfonylureas, NSAIDS, muscle relaxants, hypnotics and others.
- Although the medication list is a subset of the 2012 Beers Criteria, the criteria are good for referencing increased risk of side effects from using the high-risk medication which include, but are not limited to, falls, gastrointestinal bleeds, hypotension, renal impairment and others.

**SUGGESTED ACTION STEPS**
- Participate in MTM programs that include interventions targeted at high-risk medications.
- Utilizing patient targeting methods that are listed on back can be helpful to drive prospective DUR interventions for these patients.
- Familiarize your staff with the list and common classes, and review medications for coaching opportunities during traditional counseling interaction.
- Utilize Beers guidelines as clinical a reference when making therapeutic interchange recommendations to providers.

### ADHERENCE MEASURES: CAUSE AND ACTION

<table>
<thead>
<tr>
<th>CAUSE</th>
<th>TOOL/ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do not know why I need to take</td>
<td>Disease state — medication counseling</td>
</tr>
<tr>
<td>Forget to order refills</td>
<td>Electronic refill reminders (calls, IVR, text, email)</td>
</tr>
<tr>
<td>Forget to take each day</td>
<td>Dose reminders, or if multiple meds, compliance packaging</td>
</tr>
<tr>
<td>Inconvenience of multiple medications and multiple trips to pharmacy</td>
<td>Medication synchronization</td>
</tr>
<tr>
<td>Intolerable side effects</td>
<td>Therapeutic interchange/physician collaboration</td>
</tr>
<tr>
<td>Cost</td>
<td>Therapeutic interchange, formulary review, patient assistance programs</td>
</tr>
</tbody>
</table>
HOW TO IDENTIFY WHICH PATIENTS COULD BENEFIT

REPORTING
Utilize your pharmacy-management system to run reports to help you identify patients.

- For all measures: Consider running NDC or drug-specific reports for the measure(s) you want to work on improving
- For PDC measures: Consider running compliance or past-due refill reporting
- Explore creating custom reports (if available in your pharmacy-management system) to help filter the list of patients to target even further (by NDC, by payer, etc.)
- EQuIPP tip: On your Pharmacy Performance Report under each measure, if you click Analyze Performance button, you will be able to see which plan(s) the patients impacting your performance are coming from. This can help you customize reporting and patient targeting efforts.

FLAGGING SYSTEM
For patients who are identified outside of workflow (e.g., through MTM cases or by running reporting from your pharmacy-management system), consider a process for calling patients and/or placing a patient note in the pharmacy-management system to help identify those patients on their next visit.

MTM PROGRAMS
These help target patients for you and often provide a service fee for completing cases.

- If your pharmacy is already doing MTM, consider implementing a process to check for new cases daily and complete the cases within the specified time frame.
- If you are not already doing MTM, consider enrolling with a vendor including, but not limited to:
  - Mirixa® (Call 866.218.6649, 8:30 a.m. to 5:30 p.m. EST Monday–Friday)
  - Outcomes™ (Click Pharmacy tab on top, then Getting Started link)
  - Socrates®
- Check with your state pharmacy association for any state or local MTM or pharmacy quality–related opportunities.
HOW WILL YOU DRIVE IMPROVED PERFORMANCE?

For questions, contact your retail sales manager or HealthMartOperations@mckesson.com.

REVIEWS BY

Pharmacy Quality Solutions (PQS)

REFERENCES:


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APPENDIX E
EQuIPP: How to Read Your Dashboard

**PHARMACY PERFORMANCE REPORTS: HOW TO READ YOUR EQuIPP™ DASHBOARD**

Here’s an example of what you’ll see when you log into your EQuIPP dashboard and what it means.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Trend</th>
<th>Pharmacy</th>
<th>Versus Goal</th>
<th>Versus Others</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PDC</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**PDC = Proportion of days covered.** PDC calculations look at percentage of patients covered by prescription refill records for the length of therapy for the intervention drug.

**Measurement period shown.** Although CMS uses a 12-month measurement period, EQuIPP uses a six-month measurement period for the calculations in the dashboard to allow you to more quickly see the impact of improvement efforts. Data is updated monthly on a mid-month cycle (by the 16th of the month) and there is a 45-day lag. Six-month rates are highly correlated with 12-month rates when trended over time.

**Data source.** EQuIPP data is pulled from payers’ claims-level data. EQuIPP currently has approximately 40% of plans and lives included in its calculations and is in active discussions with other plans to add their data to the dashboard.

**FOR MORE INFORMATION**
Take the Pharmacy Professional tutorial on equipp.org under the FAQ tab. For tips on how to use EQuIPP data to your advantage, visit the Know Your Numbers page in the Health Mart Operations Manual. Or, email HealthMartOperations@mckesson.com with questions.
### APPENDIX F
Quality Measures Goals Cheat Sheet

<table>
<thead>
<tr>
<th>Measure</th>
<th>Goal Direction</th>
<th>5-Star Goal %*</th>
<th>Top 20%**</th>
</tr>
</thead>
<tbody>
<tr>
<td>ACE-ARB in Diabetes</td>
<td>▲</td>
<td>≥ 87%</td>
<td>88%</td>
</tr>
<tr>
<td>PDC: RAS Antagonists</td>
<td>▲</td>
<td>≥ 79%</td>
<td>89%</td>
</tr>
<tr>
<td>PDC: Statins</td>
<td>▲</td>
<td>≥ 75%</td>
<td>88%</td>
</tr>
<tr>
<td>PDC: Diabetes</td>
<td>▲</td>
<td>≥ 77%</td>
<td>90%</td>
</tr>
<tr>
<td>High-Risk Medications in the Elderly</td>
<td>▼</td>
<td>≤ 3%</td>
<td>3%</td>
</tr>
</tbody>
</table>

- Based on 2014 CMS 5-Star Goals, subject to change with each plan year and in addition individual payers may set their own goals relative to specific initiatives
- **Top 20% of retail pharmacies as reflected in EQuIPP (Data range: October 2013–March 2014)
Reviewed by:

PHARMACY QUALITY SOLUTIONS