

LHHS Interim Committee presentation – November 14, 2016:

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Handouts are marked as attachments.

1. Pharmacies have been part of the solution in cost containment over the past 25+ years. NM Medicaid data shows the overall pharmacy generic substitution rate is 85% from data provided by Medicaid Director Nancy Leslie-Smith.

The average cost of prescriptions calculated from data on the Kaiser Family Foundation “State Health facts” website shows that New Mexico has the lowest cost for prescriptions for the past 12 years except for 2007 when NM was 50th. See attachment 1. Attachment 1 also shows the average cost of all states (including Washington, D.C.).

- a. Increased generic dispensing rate to about 85% for Medicaid in NM-information from Medicaid data provided by Nancy Leslie-Smith.
2. Cost containment should not focus on pressure on pharmacies, which has been the historical method of containing prescription drug costs. Rural pharmacies continue to close because of reimbursement pressure. Pharmacists can, and do, help manage costs through clinical services they can provide. See attachment 2, New Mexico information sheet.
3. The National Governors Association recommended integration of pharmacists into team based care. Full paper posted as a handout attachment 3.
 - a. From National Governors Association publication in 2015:

Conclusion: The integration of pharmacists into team-based models of care could potentially lead to improved health outcomes. To realize that prospect, states should consider engaging in coordinated efforts to address the greatest challenges pharmacists face: restrictions in CPAs, recognition of pharmacists as health care providers to ensure compensation for direct patient care services, and access to health IT systems. Examining state-specific challenges and promising practices from other states will allow

states to develop policies that permit pharmacists to practice within the full scope of their professional training across the health care continuum.

4. History of pharmacist clinical services and impact on providing patient care:
 - a. New Mexico has led the country in development of clinical pharmacy practice, starting with legislation to establish the Pharmacist Clinician (PhC) collaborative practice model in 1993. Below are a few of the almost 200 PhC's practicing in NM and their practice specialties.
 - i. Cardiology-Joe Anderson, PhC, at UNMH
 - ii. Geriatric-Melanie Dodd, PhC, at UNMH and Greg D'Amour, PhC, at VA Medical Center in T or C.
 - iii. Pain Management-Ernie Dole, PhC, at UNMH
 - iv. Diabetes care-Gretchen Ray, PhC, at UNMH and Kathy Wade, PhC, at Presbyterian Medical Group. Attachment 5 is an article from a major national pharmacy publication regarding personal diabetes care by a PhC.
 - v. Anti-coagulation-provided by almost 30 PhC's at Presbyterian Medical Group.
 - b. Pharmacist prescribing protocols were passed in statute in 2001. All our prescribing programs involve working with the NM Department of Health and other NM state agencies such as IBAC (for immunizations). There are currently five approve pharmacist prescribing protocols:
 - i. Immunization impact – DOH & NM Immunization Coalition - **1,923 certified.**
 - ii. Tobacco cessation impact – three major national publications from our successful program with NM DOH and TUPAC. The program ended with budget changes regarding the tobacco settlement program. **1,020 certified.**
 - iii. Emergency contraception –NM DOH through the Emergency Contraception Workgroup. **852 certified.**

- iv. TB testing – A poster was prepared and used in national presentations by Dianna Fortune with the NM Department of Health TB program to present the impact on New Mexico.

236 certified.

- v. Naloxone – recent history and impact of broader pharmacist provision of products. NM Department of Health and Dr. Landen, passed legislation sponsored by Senator Richard C. Martinez and Representative Terry McMillan, to create standing orders to improve access to naloxone.

221 certified.

- 1. Future plans: hormonal contraception, in pharmacy patient tests (strep, etc)
- 5. Comprehensive Disease State Management (CDSM) – diabetes, asthma, etc. Disease management is a part of pharmacist training at the UNM College of Pharmacy with continuing updated information through required continuing pharmacy education programs.
- 6. MTM – required by Medicare Part D programs. Information from Minnesota Medicaid program is in the National Governors Association handout, attachment 3.

There is an opportunity for the New Mexico Legislature to recognize the significant contributions to patient health and to cost containment pharmacists provide to health care in New Mexico. Proposed pharmacist clinical services reimbursement legislation is Attachment 7.

I have included for website handout an article about how collaborative practice has impacted New Mexico and North Carolina. Attachment 6.

The article concludes with:

Pharmacists with advanced-practice designations are providing clinical services in various settings under collaborative practice arrangements that include prescribing privileges. Despite growing patient and physician acceptance, reimbursement challenges continue to be a barrier to wider use of CDTM programs.

The Expanding Role of Pharmacists in a Transformed Health Care System

Executive Summary

Pharmacists practice in a variety of health care settings. Although they are most often associated with dispensing medications in retail pharmacies, their role is evolving to include providing direct care to patients as members of integrated health care provider teams.¹

The critical role that medication management plays in treating chronic diseases suggests that the integration of pharmacists into chronic-care delivery teams has the potential to improve health outcomes.

Studies of pharmacists providing medication therapy management (MTM) services to improve therapeutic outcomes indicate that such services can improve outcomes and reduce costs. Pharmacists typically provide those services in interdisciplinary teams through collaborative practice agreements (CPAs). Such agreements with other health care providers allow a licensed provider to refer patients to a pharmacist and delegate the delivery of clinical services under supervision. Several key challenges and barriers, however, prevent the full integration of pharmacists into health care delivery teams: restrictive laws and regulations governing CPAs, lack of provider recognition in federal and state law governing compensation of pharmacists who provide direct patient-care services, and limitations on pharmacists' ability to access health information systems.

States seeking to integrate pharmacists more fully into the health care delivery system can examine state laws and regulations governing the profession to address the challenges to pharmacists practicing to the full scope of their professional training.

Introduction

The health care system is undergoing a significant transformation in both the finance and delivery of health care services. States, in particular, are examining their health care systems to define policies that create efficient models of care focused on improved quality and health outcomes as well as reduced costs. Integrating pharmacists, who represent the third-largest health profession, into such systems is important for achieving intended goals.² Pharmacists have the professional expertise to address key challenges facing the health care system, including the prevalence of people who have multiple chronic conditions and the increased use of more complex medications to manage those diseases.

Pharmacists' Clinical Training and Expertise

Pharmacists undergo rigorous education focused on the composition, interaction, and use of medications. Pre-pharmacy students must complete at least two years of college to be eligible to enter pharmacy school, though most obtain a bachelor's degree. To apply to most graduate pharmacy programs, pre-pharmacy students are required to take the Pharmacy College Admissions Test, which measures general and pharmacy-specific academic knowledge.³

The level of education required to practice as a pharmacist has risen significantly over the past few decades, shifting from a bachelor of science (B.S.) degree to a doctor of pharmacy (PharmD) degree.

Current Scope of Practice

Pharmacists' scope of practice consists of a legal component set by state laws and board regulations and guidelines set by employers or administrators for specific practice settings. In the early 1990s, an examination of pharmacists' scope of practice identified four primary domains in which pharmacists were permitted to provide care: ensuring appropriate medication therapy and outcomes, dispensing medications and devices, engaging in health promotion and disease prevention, and engaging in health systems management.¹²

Alternative Approach Through Advanced Practice Designations

California, Montana, New Mexico, and North Carolina have created the advanced practice pharmacy (APP) designation to expand pharmacists' scope of practice through CPAs. That designation allows pharmacists to provide direct patient care, including primary care. The characteristics of an APP, however, including educational requirements, provider status, service offerings, prescribing authority, and compensation, vary across those states.¹⁴

New Mexico's Pharmacist Prescriptive Authority Act, enacted in 1993, recognized pharmacists as midlevel practitioners who can manage primary care patients independently in written collaboration with a physician. Under that designation, pharmacists are allowed to prescribe and dispense medications in accordance with state law.

The Evolving Role of Pharmacists: Integration into Chronic Care Delivery Teams

Health care experts increasingly agree that including pharmacists on chronic care delivery teams can improve care and reduce the costs of treating chronic illnesses.²⁰ The prevalence of adults who have multiple chronic diseases, such as heart disease, stroke, cancer, arthritis, hepatitis, and asthma, is increasing in the United States, and almost half of U.S. adults—approximately 117 million people—have at least one chronic disease.²¹ Most people living with more than one chronic disease take multiple medications to manage their conditions and related co-morbidities but commonly receive uncoordinated and fragmented care with little follow-up.²²

Conclusion

The integration of pharmacists into team-based models of care could potentially lead to improved health outcomes. To realize that prospect, states should consider engaging in coordinated efforts to address the greatest challenges pharmacists face: restrictions in CPAs, recognition of pharmacists as health care providers to ensure compensation for direct patient care services, and access to health IT systems. Examining state-specific challenges and promising practices from other states will allow states to develop policies that permit pharmacists to practice within the full scope of their professional training across the health care continuum.