Brandon Jones (00:00:00):

For those dialing in or just dialing in, welcome to our May Pharmacy Access Office Hours, excited to have you all on and I know it's been a couple months we've not had one. Conferences, trainings happening in between so we're pleased to have you all there, and we're excited about our coming presentation. All right, folks are still chiming in but in an effort to stay on time, I am going to go ahead and get started. It's 2:00 now. Our session is recording, and welcome to those who are just dialing in, and we'll let everyone else continue to chime in. Thank you to our panelists for dialing in, and I don't see their names so I'm assuming some of them are possibly our policy team, so we'll get to you all shortly in our presentation.

All right. Welcome everyone again if you're just dialing in to our Pharmacy Access Office Hours for our May session. Hopefully you saw our emails a couple weeks ago, we're excited about more or less a series of topics expanding on the clinical pharmacy or advanced practice services in a community health center. We are so excited about partnering with our El Rio Health and Holyoke Health Centers, and so that they can present the work that they're doing in their respective organizations. All right, give me one second so we can ... okay.

You all know our mission, I'm not going to read through all of this. For NACHC, you all are familiar our NACHC mission. Again, just some webinar logistics. Of course, you can ... Thankfully it's working now, so feel free to ask questions, post questions, throw some comments in the chat box while we're doing the presentation. Tim and/or I can facilitate getting responses to you. Certainly if you have any technical issues, just let us know in the chat box. Again those slides and recordings will be published to our NACHC 340B Archives webpage, and we'll provide all those links to you after the session, and certainly as soon as the recording is available, and of course on the Noddlepod page's 340B Access, our advocacy page as well as the pharmacy access office hours group. On Noddlepod, reach out to me and/or Tim to get access to that. Again, this is federally funded. All of our activities are federally funded, and Office Hours is no different. In particular, we are prohibited from discussing anything related to advocacy in this in forum, just ... You all are familiar with that disclaimer.

Today's agenda we're going to again like we always do, offer some 340B developments and updates, kind of let you know where we are in that landscape there. Certainly, we're going to provide a program alert. There's a new technical assistance document that we are in the final stages of refining, and that will be out for publication next month in June, so just to give you a heads up. Tim will talk a little more about that later on. Today, our focus topic presentation's part one of this series focus, looking at Clinical Pharmacy or Advanced Practice Services in a Community Health Center. And of course Q&A at the end, but you can always post your questions during the presentation, and we'll try to get to those as soon as possible.

What we're going to get to next, I just want to double check Vacheria and/or Jeremy or Matt, are you guys on? I just want to make sure.

Jeremy Crandall (00:03:44):

Jeremy's here.

Brandon Jones (00:03:45):

Hey, Jeremy.

Jeremy Crandall (00:03:46):

I think Vacheria's working to get in. Matt is off this week, so it's just Vacheria.

Brandon Jones (00:03:55):
Got you. All right. Let's see here. Move on to her slide, and hopefully Vacheria can jump on.

Jeremy Crandall (00:04:10):
Hey Brandon, I was going to offer maybe if you want to have me go first. I don't know-

Brandon Jones (00:04:15):
Please.

Jeremy Crandall (00:04:16):
Yeah, hold on. All right. Yeah, can you go to ... I think I've got a slide in here.

Brandon Jones (00:04:27):
She just gave me that one.

Jeremy Crandall (00:04:31):
No, I think there should be ... Did you not get mine? I'm sorry.

Brandon Jones (00:04:36):
I did not, I did not.

Jeremy Crandall (00:04:38):
Shoot, okay. All right, bear with me a moment everybody, I will just pull it up right ... Can I share my screen, is that okay?

Brandon Jones (00:04:44):
You sure can. There you go-

Jeremy Crandall (00:04:45):
All right.

Brandon Jones (00:04:46):
... hold on one second. The beauty of technology, right?

Jeremy Crandall (00:04:51):
Amen. Bear with me, everybody.

Brandon Jones (00:04:57):
[inaudible 00:04:57] there.

Jeremy Crandall (00:05:03):
What am I doing here? Hold on, what am I doing> All right, share ... There we go. All right, can everybody see this slide okay?

Brandon Jones (00:05:13):

We can.

Jeremy Crandall (00:05:15):

All right. Now I'm going to go to full screen, great. Does that make it full screen for everybody?

Brandon Jones (00:05:21):

You may want to change it to the presentation display, to the display settings up there. There we go.

Jeremy Crandall (00:05:29):

Where am I going? Nope.

Brandon Jones (00:05:31):

Display settings and swap it, top up there.

Jeremy Crandall (00:05:35):

Good?

Brandon Jones (00:05:35):

I'm not sure what's going on, but we'll work with what you got there for now.

Jeremy Crandall (00:05:40):

How about ... What do you see now? Do you see the slide?

Brandon Jones (00:05:44):

It's just showing in your ... The notes type of presentation.

Jeremy Crandall (00:05:48):

All right. [crosstalk 00:05:49]

Brandon Jones (00:05:48):

It's fine.

Jeremy Crandall (00:05:51):

All right. Well good afternoon everybody, and I know I've presented to you all before. But just a reminder about myself, Jeremy Crandall. I'm the director of what is now, it's not official yet but will be the Federal and State Policy Team. But we still have a Federal Affairs Team and Vacheria as well, we're just going to more oversee the policy development side of both the state and federal issues. Really, the name's just more to reflect the work that we do because we also do some federal work. I just wanted to bring folks up to speed a little bit on what's happening at the state level, and I will tell you that the map on the left is already out of date because there's been some action in a number of states in the last couple of weeks. But long story short, here is the deal.

As many of you already know, there is a ton of activity right now at the state level on prescription drug issues and prescription drug reform. Much of that activity centers around pharmacy benefit managers, how their rebates are handled, how they're overseen by state governments, insurance commissioners and such. One of the specific areas where there's been a lot of activity related to us and 340B covered entities is related to the anti-pick-pocketing measures. Those anti-discrimination and anti-pick-pocketing measures have been folded into larger pharmacy benefit manager reforms, or have been their own standalone bills as well. But there's really two messages I want to convey to you all. The first one is that the ... paying close attention to the larger ... Hold on, Brandon. Am I still having issues with the slide here? I just saw somebody ...

Brandon Jones (00:07:42):

Yeah, hit your slideshow and see if it will ... I'm not sure why it's not.

Jeremy Crandall (00:07:50):

Hold on. Does that solve the problem at all?

Brandon Jones (00:07:52):

Yeah, it comes up and it goes to your ... I'm not sure why it's doing that. But sorry, guys. We'll get those slides to you all [crosstalk 00:07:59]

Jeremy Crandall (00:08:01):

I'm trying everything I can. How about now? Did that do it?

Brandon Jones (00:08:06):

There it is, there it is. Stay there.

Jeremy Crandall (00:08:10):

All right. I'm not touching anything. I'm trying, folks. All right. What I wanted to emphasize is this number one. There is I'm sure in all of the states that you all work in, active prescription drug reform efforts whether it's related to PBMs. Another big effort is to establish prescription drug transparency measures whether it's for pharmaceutical companies, insurers or PBMs or all of the above. Cost review commissions, there's absolutely a lot of activity on coupons and cost sharing. Really what I want to keep emphasizing to all of you is that with all of those vehicles there is absolutely an opportunity for offensive measures on 340B, but also defensive as well. So the main piece number one is that, just be paying attention to these bills as they're coming up.

One of the pieces of advice that I've been giving, if it's not directly related to 340B, think about whether there needs to be something in there about 340B that's going to protect what we're trying to do there. Because there is so much activity just in the last six months that it is clear as this field continues to evolve, 340B is going to be on the menu for positive or for negative. So we really want to be paying attention to it. We are also through the rest of this year and then into 2022, going to be engaging with a number of state based, national state based groups, the National Academy for State Health Policy, the National Council for State Legislatures, NCOIL, that's insurance legislators, the NAIC is insurance commissioners. Here is why those groups matter, and I know that a lot of you may not be super familiar with them, but here's why they matter. These groups meet regularly when states, especially when states are out of your legislative sessions, and I will get to the map in a second.

Here's why those states matter, is because those groups meet regularly to plan and learn more about policies that are to be coming down the road at the state level. The insurance commissioners is a great example of where they hear policies, and then ultimately they go back to their states to adopt what they're hearing. So what we are trying to do throughout the rest of this year is go talk to many of these groups about 340B because prescription drugs is at the top of the list for all of these groups, and it's really important that they know what's going on there. Next, current 340B action. I talked a little bit about all the state level activity on anti-pick-pocketing, anti-discrimination. Really at a core level what many of these bills are designed to do is prevent pharmacy benefit managers especially, from discriminating or otherwise treating 340B covered entities in a different way, or in a discriminating way compared to non-340B covered entities, whether that's applying additional fees or just generally treating the program differently than they would other essentially partners that collaborate with pharmacy benefit managers.

The question about the map on the left. What this map is, and a hat tip to the Kansas Primary Care Association, this map shows all the states that have seen recent 340B anti-pick-pocketing action. This is not up to date. I really want to emphasize if you're in a state that is not colored in but you had recent action, it's because this map is a couple of weeks out of date. But the reason the colors are what they are is because the red is showing states that are either a combination of governor and/or most likely their state legislatures as well, being Republican controlled. Blue is obviously the opposite, Democratic controlled, and it's really trying to convey that a lot of the action on 340B at the state level is in red states. So prescription drug reform does not know a political side.

I will tell you some of the state legislators that are most engaged on reforming PBM practices are Republican state legislators, and so I just wanted to bring that to your attention. But just generally what we are continuing to do is track what's happening at the state level on 340B. We are here to help. I know that we're not going to talk about the advocacy piece and letters of support, but just generally we're going to continue to provide technical and policy assistance. A big hat tip to Tim Mallett who's on here. He really has been doing the lion's share of that grunt work supporting all of you. But here's the last message I want to convey before we go to the regulatory side. It is so important to let us know what is happening in your states. I can tell you that some of the other folks in this field whether it's on the national PBM front, the national drug manufacturer front, they are absolutely coordinating across states to try to get the same ... Excuse me, health insurers as well, to get the same language that benefits them introduced in as many states as possible. And so it is really, really, really critical that we all be coordinating.

Obviously each state is going to do what it needs to do, but the more we can coordinate and the more we can make sure that the best language possible is getting in in as many states as possible, the better off we're all going to be. We are especially looking forward to 2022 because this map as you can see is not even halfway filled in, and we really want to try to build towards even more action for the rest of the year and into 2022. So Brandon, I'm going to stop there. Vacheria actually popped in my office because I think she couldn't get it going on her computer. I presume you want to sit here. But do you want me to pause, or do we keep going and then take questions, however you'd like to-

Brandon Jones (00:13:41):

Let's pause in an effort to stay on time [inaudible 00:13:44] too. Sorry about that. I'm going to pop my screen back up so we can see Vacheria's slide, and we'll let you go from there, Vacheria.

Jeremy Crandall (00:13:54):

So no, keep going, not questions.

Brandon Jones (00:13:56):

No. Yeah, no questions for now. We'll let Vacheria go.

Vacheria Tutson (00:14:00):

Praise the Lord for the vaccine and Jeremy being in the office today.

Brandon Jones (00:14:00):

Thanks, Vacheria.

Vacheria Tutson (00:14:03):

Why does it not want me on here today? Hey, everybody. Thanks for joining us. I just have two updates in the 340B space that really have happened in the last two weeks, and there's even been more action today. On May 10, HRSA submitted a propose rule to the White House Office of Management and Budget which is the office that's over regulations in general, to rescind the Implementation of Executive Order on Access to Affordable Life Saving Medications. This is also known as the EpiPen/Insulin Executive Order that happened under the Trump administration. This is a great step because it shows that number one, this executive order and this final rule that has been on pause, so when the Biden administration took office he delayed this rule for implementation until July 20. So NACHC has been monitoring to see what the agency was going to do, so this is a great step just to know that HRSA has this on their radar. The only thing I will want to caution folks on is just that even if HRSA rescinds the final rule which was implementing the Executive Order, the administration, only Biden from what I really understand, only the White House can rescind the underlying executive order.

So as long as the Trump executive order exists, HRSA will still have to do something with this regulation in some form. The one that was put forward was the one that said low income is defined as up to 350% of the federal poverty level, which was clearly a departure from other definitions of low income based on other federal programs. So we're hoping that even if HRSA does have to move forward with another regulation, that it at least will align more with the health center program, and not be based on the misinformation of saying that health centers are charging patients all this money for insulin and EpiPen, when we know that's not the health center mission, nor how health centers operate. So I want to put this on your radar as NACHC did meet with the Office of Management and Budget on Monday to strongly encourage them to rescind the rule, but also stressing the importance of the underlying executive order needing to be rescinded too. So we hope that the White House will take additional action in between now and May 20 or when we see this proposed rule, to rescind the final rule, we hope that the White House will take the additional steps to completely make this problem go away. So we will definitely keep you all posted as we haven't seen the proposed rule yet, it's still sitting. It has not been published.

The second thing I want to flag is that last week, or was this last week or was this this week? That was this week on May 17, on Monday, HRSA's acting administrator sent six letters to pharmaceutical manufacturers acknowledging that after they reviewed their policies and the actions that they've taken over the last eight or nine months, that they have been in violation of the 340B statute. This was a great step for HRSA as in taking additional actions to say that covered entities include contract pharmacies, and demanding that the manufacturers start shipping drugs immediately. So the manufacturers also have up until June 1 to let the government know how they plan to move forward, how they plan to work with covered entities, and also remedy or give refunds to the covered entities that they have overcharged. So it is a good step knowing that HRSA has been sitting, it has not acted on

the complaints that have been filed over the last eight or nine months. So we are happy to see HRSA taking action, however it's still the jury's out on how the manufacturers will engage and will respond to HRSA.

I saw already today because there are three lawsuits against the administration from three manufactures, Sanofi, Astrazeneca, and Eli Lilly. Today Astrazeneca presented in court asking that they needed a stay in their litigation because of the letter that HRSA just sent out telling them they have been violating the 340B statute. So that's something we expected. Knowing that there's active litigation about this especially about the contract pharmacy issue, we figured that the manufacturers would use this litigation route to slow it down, or to say they don't have to respond to the government by June 1 because they're in active litigation. So the court set a deadline where we should know by tomorrow where the court stands, if they're going to require the manufacturers to move forward regardless of this demand letter, or how they view this. This is actively happening and playing out now, but I think the crux of the arguments on both sides is about contract pharmacies.

At the end of the day I think the result of all of this, of the communications from HRSA, the six letters and also the litigation is, there should be a bright line on contract pharmacies are covered entities. We know that's where the government stands, and that's definitely where NACHC with our health centers. We will keep you guys posted on how this evolves, but it's just good to see HRSA taking actions in the 340B space as we are waiting for other things, and waiting to see how they will enforce the civil monetary penalties if the manufacturers do not comply.

Brandon Jones (00:19:21):

Great. Thank you so much, Vacheria. In the interest of time, I'm going to continue and move on. Guys, if you have questions please feel free to post those in the chat. Also with the chat, I'm sharing my screen so I can't really see what you all see, but I'm hoping that you all can click on that chat bubble, and it pops up with an option to type something in that chat. Because while Vacheria was updating, I did check our credentials to make sure everyone had access, so you all should be able to chat. So if that's still an issue, just let us know. Again thank you Jeremy, and thank you Vacheria, for those updates. And again, post questions if you have any.

I'm going to make this really, really quick. Tim, if you can just do a minute update on this and we'll move on. Okay, thank you.

Tim Mallett (00:20:07):

What we did, we took the toolkit that we had for how to work with the fact the manufacturers weren't shipping. We have put it together in a really nice document. NACHC's done a wonderful job. We've also put some updated language about the fact that the letters were sent out. This will be a nice tool. It's the same tool, but it should be more attractive and easier to use as far as how to deal with the facts manufacturers aren't shipping. So look for it in June, something Brandon and I have worked on and I think you're really going to like. So that will be available. I did want you all to know the chatroom unfortunately folks, you can ask questions to us but not to everyone, and we will continue to work on that and try to have that fixed for next month. Thanks, Brandon.

Brandon Jones (00:20:59):

Great. We'll figure it out, guys. All right. The highlight of today's session here is the focus topic, session one on Clinical Pharmacy or Advanced Practice Cervices in a Health Center. I'm going to go ahead and stop sharing and hand over to our presenter Marisa Rowan, who's Associate Pharmacy Director at El Rio

Health. So let me stop sharing, and I'm going to hand it over to you, Marisa. Okay. Whenever you're ready, Marisa.

Marisa Rowan (00:21:34):

Okay. Can you hear me?

Brandon Jones (00:21:37):

I can, and we see your slides.

Marisa Rowan (00:21:39):

Okay, great. Well thank you so much, we're so excited and I want to make sure that the audience knows that there's actually three of us today that are presenting, and we're very honored to have this opportunity. Very quickly just so you know who we are and a little bit about our background, the three of us includes Alyssa Puia, she's a PharmD and registered pharmacist who was a 2019 graduate of the University of Rhode Island College of Pharmacy. Upon graduation she accepted a post graduate year one, PGY1 residency position at Holyoke Health Center in Holyoke, Massachusetts. As part of her residency, she participated in a grant program sponsored by NACHC to address vaccine hesitancy, and that's actually how we got to know each other was through that opportunity. Now as a clinical pharmacist at Holyoke Health Center, Alyssa provides medication therapy management and other clinical pharmacy services to Holyoke Health Center patient population, is one of two bilingual pharmacists on staff. She is also involved in the precepting of pharmacy students in their final year of training at Holyoke Health Center, as well as three PGY1 residents. Alyssa's interests include vaccine hesitancy, cultural competence, and Type II diabetes management.

Also joining us from Holyoke is Alexis Dellogono. She's also a registered pharmacist, PharmD and a graduate of University of Rhode Island College of Pharmacy in 2018, and completed her PGY1 residency at Holyoke Health Center in 2019. After her residency, Alexis was hired on as a clinical pharmacist at Holyoke Health Center's sister health center site known as Chicopee Health Center. That's where she was able to expand clinical pharmacy services to match Holyoke Health Center's model, which was included but not limited to hospital discharge follow up visits, medication and therapy management, vaccines, and a collaborative drug therapy management in hypertension. Alexis is also a preceptor for students and residents at Holyoke Health Center, and her interests include diabetes and hypertension management, as well as transitions of care.

I'm Marisa Rowan. I am a registered pharmacist, PharmD and certified diabetes educator. I work for El Rio Health Center, I've been here for 18 1/2 years. Ten of the 18 1/2 years were on the Pascua Yaqui Reservation, where I worked at an El Rio satellite clinic providing intensive pharmacist based diabetes management through a collaborative practice model that does include prescriptive authority. Most recently I've served in the capacity of Associate Pharmacy Director for Advanced Practice Services at El Rio. I received my PharmD from the University of New Mexico in 1999, where there was a strong emphasis on rural health initiatives and integration of the pharmacist into the healthcare team. My residency training was here in Tucson at the Southern VA Healthcare system, and that opportunity provided an experience that further strengthened my desire and ability to provide direct patient care services in an advanced practice model. Prior to coming to El Rio, I worked as a clinical staff pharmacist for Banner University's Health Center here in Tucson with cardiology and cardiothoracic surgery teams. I also serve as volunteer clinical faculty for the University of Arizona College of Pharmacy, as well as A.T. Still University School of Osteopathic Medicine.

So that's us and again, thank you for this opportunity. This is session one of three, and we will all be speaking and addressing our participants in the next few sessions. Jumping into it, so what should you expect as a participant? Please, we encourage you to stay until the end. But today we're going to really focus on the time that we have together, staffing considerations as well as practice models to help answer that question about what do I really have, and what is possible with our current team. In June we're going to talk about the role of data in advancing your clinical services and measuring clinical outcomes, and also some very specific detailed service considerations. And that will be with the overarching goal of that early implementation and then the operational considerations that many times seems overwhelming. We'll try to give you some real life examples about how to overcome those.

Finally in July, what we will do is with the overarching theme of how do we manage and maintain this momentum, we'll provide very specific details about payment and funding that we've explored and been successful with, as well as speak to the opportunity of growth as well as sustainability, and the whole concept of layered learning within your health center and organization. Now I'm going to hand over to Alyssa.

Alyssa Puia (00:26:34):

Hi, guys. First we just wanted to touch a little bit about our health centers at a glance. As Marisa said, she's out of Arizona at El Rio, and we're here on the East Coast in Massachusetts, so we're geographically two diverse health centers. The El Rio patient population is certainly larger than Holyoke, as you can see. It encompasses more clinical sites, as well as more in-house pharmacy sites. Both in-house pharmacy teams though, do fill a large prescription volume each year and have a large number of pharmacy staff. We hope that this goes to show that regardless of your health center size or the number of clinical sites, these services can be implemented in a variety of location.

Alexis Dellogono (00:27:21):

Then you wanted to talk about what are clinical pharmacists. So when you see that meaning, what does that exactly mean? And sometimes there are other names for it such as advanced practitioners.

Brandon Jones (00:27:35):

We can't really hear Alexis very well.

Marisa Rowan (00:27:58):

I think we lost audio with Holyoke.

Alyssa Puia (00:28:04):

Is that any better, Brandon?

Brandon Jones (00:28:06):

Do it one more time, give me one more. I don't think I heard anything.

Alyssa Puia (00:28:12):

This is Alyssa, but I'm not sure that you can hear Lexi well.

Brandon Jones (00:28:15):

Yeah, I can't hear Alexis.

Alexis Dellogono (00:28:17):

Can you hear me now?

Brandon Jones (00:28:20):

Just very muted, it's very muffled.

Alexis Dellogono (00:28:24):

How does this open?

Marisa Rowan (00:28:37):

I know you mentioned that you're in the same room. Alexis, would you be able to swap seats with Alyssa?

Alexis Dellogono (00:28:43):

Yeah.

Brandon Jones (00:28:44):

Yeah, hang tight everyone. Thank you, guys.

Alexis Dellogono (00:28:51):

There we go.

Brandon Jones (00:28:53):

There we go.

Alexis Dellogono (00:28:57):

All right, then. Sorry about that.

Brandon Jones (00:28:58):

No worries. Thanks [inaudible 00:29:00]

Alexis Dellogono (00:28:59):

So clinical pharmacy services, we wanted to make sure that everybody knew what we were talking about in this presentation. Sometimes it goes by a couple different names such as advanced practice services or even ambulatory care. I have a definition here by the American Pharmacist Association, I won't get into it. But really what we're doing is providing direct patient care through medication management with our patients. A lot of this involves patient education, teaching them how to care for themselves, self management, working with the patients on chronic disease state management like hypertension, diabetes, high cholesterol. These things that we can provide are provided in a couple different practice models which we have on the next slide. Today we're going to talk about four main practice models. One would be the outpatient pharmacy, so that can be in-house or a contract pharmacy like CVS or Walgreens. You can also provide clinical pharmacy services through direct patient

care, so in your heath centers directly in those clinic sites. There's also an option to be like a hybrid pharmacist that kind of goes in between outpatient pharmacy and clinical pharmacy services which we'll explain further. Then teaching and academia, so partnering with your local college or pharmacy so that you can provide those services through that. Next slide.

I think we're going to talk a little bit more about what outpatient pharmacy exactly is. I mentioned contract pharmacy which would be your Walgreens, your CVS, your Rite Aid. Then in-house would be a pharmacy inside your health center. So here at Holyoke Health Center we also have an in-house pharmacy, but we didn't always start that way. We did start as a contract pharmacy through a local pharmacy, Louis & Clark. So if you have a contract pharmacy through your health center, what that can help you do is provide revenue through 340B savings. This through these pharmacies, it's not as much as you can get through an in-house pharmacy, so if you had one in your own health center, but it does provide some savings that can help you start or promote clinical services. If you do have an in-house pharmacy like we do here, you can get more revenue through these 340B savings. You can also provide outcomes which is the MTM or medication therapy management platform. You can do CMRs or comprehensive medication reviews, targeted intervention plans or tips, and those things can help you connect with those patients and get that direct patient care right in that pharmacy, and this also helps your Medicare star ratings.

You also can do medication adherence packaging in your in-house pharmacy. Not every in-house pharmacy may have this, but that's something that you do have here that helps increase your script volume and increase your patient's adherence and overall health. We also do provide vaccines via standing order in our in-house pharmacy. Contract pharmacies can also do this, but in this way that we're able to improve the quality of care right in our health center. You want to add anything, Alyssa?

Alyssa Puia (00:32:19):

I was just going to add that outpatient pharmacy is often seen as a way to get some revenue and use that revenue to then promote your other services. So as a pharmacy starting out or as a health center starting out, it can be a big undertaking to start an in-house pharmacy, which is often why the contract pharmacy is a good avenue to take. It's a little bit less of an undertaking to get that up and running, but it can generate some revenue that you can put into your other services, versus if in-house is always something you want to do and you're ready to take that step, it comes with more revenue from 340B savings, and thus more opportunity to invest that funding, as well as the opportunity to have touch points with your patients, offer the adherence packaging like Lexi said, and really start some clinical or advanced services on the outcomes as an early version of that, as well as vaccines or standing orders.

In addition to vaccine standing order prescriptions in our pharmacy, we also have standing orders to write for emergency contraception and Narcan, so pharmacists based on that agreement can write the prescription and we do all the patient counseling. I think we're ready for the next slide, Marisa.

Marisa Rowan (00:33:26):

One of the things that I'll add as we transition into this next slide is one of the really important things about what Alexis and Alyssa just mentioned. I know not everybody on the call is a pharmacist so we're going to over-message some of these things probably for the pharmacist participants, and it may be new information for non-pharmacists. But being creative in those funding sources and why we're talking about things like 340B is really important when you're talking about this next section, because there are not currently abundant ways that pharmacists can engage in order to receive direct revenue. So unlike physicians, nurse practitioners, physician assistants where there's very clear and defined revenue sources, our profession as a whole continues to struggle with that. So that's why some of these things

that we're going to talk about on this slide as well as what was just presented on the last slide, really are the jumpstart ways that many of the programs like ours are able to start and sustain these clinical lines or advanced practice services.

In this slide I love the way that ... And all credit to Alexis and Alyssa for this, I love the way they put it together. What you'll see in blue is services that are provided are unique to our model here at El Rio, orange would be what's unique to Holyoke, and green would be the things that we both have felt work well for our two different organizations. I'll talk very briefly about El Rio and then transition over to the Holyoke team to talk about that, and then we'll compare and contrast the green. With the Medicare Annual Wellness Visits, Medicare and Medicare Advantage patients are eligible as a benefit, and it's truly defined as a benefit, for what is called wellness encounters. The first one would be the first year of enrollment which is known as the welcome to Medicare year, and then after 365 days of enrollment you shift into this Annual Wellness Visit model. Although there's different regulatory issues from state to state, or when you're in a FQHC versus outside, or you're considered an educator and how does your organization choose to define educator, there are some technicalities around this model, but it can be quite effective.

In the context of an annual wellness visit, the pharmacist's role would be for example in our model, to interact in a tandem model with the primary care team, which could be the physician or nurse practitioner themselves or their defined care team, to offer this benefit service to the patients where you're looking at things like home safety evaluation, fall risk, but also a huge focus on being able to interact with a patient that has Medicare and Medicare Advantage, and focusing on the medication regimen. So is it safe, is there anything that should be overcome like cost, are they at risk for entering the donut hole and could we make a more affordable regimen, and/or are there things that could be on the [inaudible 00:36:45] list for example, that could be contributing to safety concerns, specifically falls, confusion, memory loss at home because their medication regimen isn't necessarily the most appropriate for them. Then of course it's always on our radar as pharmacists to consider de-prescribing. So overall the goal and the role of the pharmacist in these visit types would be to address medication adherence as well as safety, accuracy and appropriateness of current regimens, and then build in those other elements that are important for overall health of the patient as they age.

Chronic care management is something that we also do here at El Rio. We were talking, the Holyoke team and myself about the similarities and why one of us went MTM and the other has gone CCM. But chronic care management also known as CCM again, it's for Medicare and Medicare Advantage patients. But it looks at high risk individuals who have two or more chronic conditions that are expected to last at least 12 months or until the death of the patient that could, if not appropriately managed result in significant death, exacerbation of their underlying disease state, or decline in function. So through this model, the goal is to spend a minimum of 20 minutes per month which is a billing opportunity and speaks to that sustainable model, but really it's to develop comprehensive care plans for these high risk individuals and continually review, revise and monitor the patient's progress when focusing on the management of their various disease states. I'm going to hand it over to Holyoke to talk about their two specialties before we start to compare and contrast our similarities.

Alyssa Puia (00:38:39):

Immunizations and the vaccine program that we offer in the pharmacy is one of the things that's unique to Holyoke. Although we met the El Rio team on that [inaudible 00:38:49] looking at vaccine hesitancy, we had two very different models for how to go about getting our patients vaccinated. In Holyoke we found that the pharmacists were spending a great deal of time with patients through our other visit types identifying vaccines that they were in need of. We wanted to be able to give them those vaccines

in the moment when they were agreeable to them, so we started a program via standing order where the pharmacist will write the prescription for that vaccine and administer it, all in accordance with the CDC adult immunization schedule. In that way we're able to get our patients vaccinated, and that was the workflow that worked best for Holyoke. Lexi, do you want to talk about MTM?

Alexis Dellogono (00:39:25):

Sure. MTM as Marisa said, we have similarities between our CCM and our MTM programs, where MTM is more of like the comprehensive medication review. We sit down with the patients, we go through each medication one by one, how are you taking this, when are you taking this, and make sure that they're taking the right drug at the right time for the right reason, and make sure there is an indication for every medication. A lot of is it patient education where patients don't even know what these medications are for, so it's a huge learning experience for these patients to learn what exactly their medication is for and how it's going to help them, so that they can increase their adherence and keep them out of the hospital. That's what our MTM services are for. Usually we do them initially, and then we'll follow up with them in another month, and then maybe three to six months or a year after depending on if the patient has understood everything that we've gone over. Or if they need more disease state management along the line, we'll see them more frequently.

We also use our medication adherence packaging that I talked about before to help get these patients that are doing the MTM on that adherence packaging and increase their adherence, which helps to keep them out of the hospital. So we do a lot more MTM than the CCM. Then we both do transitions of care and CDTM. I don't know if Marisa you want to start, and we can go back and forth?

Marisa Rowan (00:40:50):

Sure. With transitions of care, again you can have a very formal structured program, or you can do a more on demand type of approach, and that's what I like about our two systems is we've dabbled in both. Transitions of care, any time that a patient is transitioning from more of an acute care setting into their chronic care management with their PCP teams, we all know that there's opportunities where things don't go as planned. So the whole transition of care model utilizes pharmacists as part of an interdisciplinary team to really try to keep people from going back into those acute care facilities. With the pharmacist being involved in these, again the medication focus really helps to address things that have already been brought out as we spoke about, annual wellness visits, chronic care management, MTM, really using our role as the drug expert to use that lens, and to make a more safe transition for that individual.

In the El Rio model we've done it both formally, where we have people who are staffed and would be collocated with our physicians that were completing those hospital discharge visits. But over the years we learned that really, the best way to service our patients is to be on demand. So now what we do is when we have someone who's coming specifically for the visit type of hospital discharge follow up, the team that will be seeing that patient calls over and will ask to see if one of our staff can come over and do a quick med rec with the patient. So it's not uncommon, and I don't think I'll surprise anybody on the call by saying that many times a single point of contact with a pharmacist that could last anywhere from five to 15 minutes can identify anywhere from one to 20 med related errors that could have potentially resulted in harm and/or re-hospitalization of the patient. So again it depends on how complex your patient is, but that's not unrealistic to find that many opportunities to intervene.

Now we're going to start a new model here for El Rio where we're still going to engage in transitions of care, but we're going to try to target people in the home using telehealth. The main driver for that really, is that there are opportunities to really better understand what is going on and what are

the challenges facing the patients when they're in their own setting. So many times when we were doing those on call type of consults when a patient showed up for their hospital discharge follow up, they didn't have their medication vials, they didn't have their blood pressure cuff, they may not have had their glucometer. I mean, who would expect them to? They just got out of the hospital. So it's challenging. There's challenges we need to overcome. So by having the patient comfortable in their own home, it's easy enough to say it's okay that you don't have your bottles, your medication vials in front of you. I'll wait, and while you're up getting those bottles, collect any herbs or over the counter medicines that you may have. Why don't you also grab your blood pressure cuff if you have it? So the power of having really useful information and essentially setting up those next team members that may interact with them face to face is something that we're really excited about.

More to learn because this is our newest form of how we're going to handle transitions of care, but just to give you a very quick example of how we've even tried to restructure how we do this model. Then for the collaborative drug therapy management also known as collaborative practice agreements, this is really an exciting area but again, you really need to know your state opportunities as well as barriers that might exist. But collaborative drug therapy management can be a whole range of opportunities for your pharmacists on your team and in your organization. It could be things like Alexis and Alyssa mentioned whether it's Narcan prescribing, emergency contraception, vaccinations, those technically are forms of collaborative drug therapy management or of collaborative practice agreements. You can also in various states go into disease state management, and we both are fortunate in our respective organizations to have things that allow us to work directly in the clinic with patients and manage things like diabetes, hypertension, dyslipidemia. Many times you hear about anticoagulation clinics, congestive heart failure, COPD. I mean it's endless, honestly.

Then there's also the next level where some states will afford the pharmacists the opportunity to prescribe within those collaborative drug therapy management programs. So again, it's very different as you go across from East Coast to West Coast, North to South. But I would encourage everyone on this call if you aren't intimately familiar with those opportunities for your pharmacists, it would be a great place to start. Is there anything that you would like to add Holyoke, before we go to the next slide?

Alyssa Puia (00:46:07):

I think we were talking about Marisa, with the change in the way that you structured your TOC visits is a good point for us as well. Because while we started doing those visits in person immediately prior to the provider's visit, and then we were able to give them a handoff and kind of prep them on some issues we had identified, as a result of the pandemic and kind of a silver lining for us in the pandemic is we started to do those visits over the phone a day in advance of the provider's visit. It allows us to reach the patient while they're at home like you said with their bottles of medication, with their glucometers, with their blood pressure machine, which they often wouldn't remember to bring in. But it also allows us to draft our note and put it in the EHR, send it to the provider that's going to see the patient the next day, and it gives them some advance time to review that note and the issues we've identified, and I think it helps to bridge the gaps on those issues and those patient needs a little bit better. So the change for us was received favorably by our patients but also by our providers, and it's something we're going to continue to do even as we move out of this pandemic life.

Our CDTM agreements like Marisa said, we have a couple different disease states that we're able to prescribe in. Lexi's involved in prescribing for hypertension, and we're expanding it to diabetes and then hopefully within the next year or so, asthma as well. These are disease states that we can do monitoring for, write the prescriptions for, and directly impact the patient's care.

Marisa Rowan (00:47:36):

We didn't include testimonials in our presentation today, but honestly if you were to go and ask any of the clinicians that work directly with our various teams, it's a high level of satisfaction for those primary care providers. Because we all know everything they're facing and all the different challenges that they have to address when a patient comes to them, and so having highly skilled and competent team members by your side that you know, you feel confident you can bridge them to these different services is such an amazing opportunity for your health center.

The hybrid. Both of us, it's funny again we met through vaccines but as we've gotten to know each other, this is one of the other areas where we really share this belief that you can have two different types of components that are essentially performing the same function, but it's in different service areas. For us, the commonality is that we have pharmacists who are trained and motivated and engaged, and want to provide direct patient care services in two distinct practice settings, while maintaining that they're always, that concept of always working at the top of your license. So many times these different opportunities will allow you to bill, and there's that opportunity for reimbursement of those services like we mentioned in that other slide. But the other thing is that we really want to make sure that we're increasing interventions that are going to elevate the level of service that the health center provides with the goal of improving patient outcomes and care, and then also improve the satisfaction and the relationships that the pharmacy department have with their different team members in the health centers. How we both arrived at this whole hybrid concept is honestly rooted in, how do you change your current practice or your current culture. So knowing who your staff are, and who maybe is best suited for these different things is an easy way to understand why we took this on.

With honoring your long timers, it is not uncommon here at El Rio to have people with 20 plus years at the health center. They have a very important role. We would never want to get rid of them, right? They are the people we are all learning from on a daily basis. We have people who were here from the very first time the doors opened and just retired within the last five years. So there's so much, and it's not just about the job at hand, it's about the culture, it's about the story, it's about the mission and vision of the whole community health center movement that they bring and they constantly instill in all of us. It excites us to stay in this work environment. It's not by chance I've been here 18 1/2 years. Things like that really, really get you far. So how do we honor those long timers, but also recognize that when they went to pharmacy school it was much different than the curriculum that's required these days?

So really talking out loud to your staff about what do they see their role being in this model, how can they help support it, will they be the prescribers, will they be the person in the clinic sitting down conducting the visit? Maybe not, but what can they do where they're comfortable to always again, focus on working at the top of your license to advance these kind of models and to provide the service whether it's in the pharmacy or elsewhere, that will make us a stronger department and play a more integral role in the health center and outcomes of the patients. Don't think that these things aren't possible because you have a staff that's been here quite a long time, maybe there's a mismatch between new grads and people who are more seasoned. There's always that opportunity to do that. Things like the hybrid model also make it less scary for those who are saying oh, I put my foot out there but I can't jump all the way in the pool, I just want to dip my toe in. That's fine, dip your toe in. Before long your foot and your leg are in there. Maybe eventually you're going to be all the way in the water.

But this is really a great opportunity to think outside the box about bridging those gaps. So don't feel like you have to go out and seek out only residency trained pharmacists, or that they have to be

board certified in ambulatory care. There are unique ways that you can honor all people so that all of your department staff are working together and that alignment exists.

Alyssa Puia (00:52:31):

One of the last models that we wanted to talk a little bit about is teaching our academia. Both at El Rio and at Holyoke we've seen this model come to fruition in our health centers. These are pharmacists who are also professors at a local university or college of pharmacy. At Holyoke, we started with a resident who then moved on to a professorship and continues to work on at Holyoke with that being one of her clinical practice sites, and that brings some unique opportunities for us. A lot of our research opportunities at the health center come from that pharmacist and her position at the university. It also brings a lot of student involvement, which is a great piece of being a pharmacist and teaching the next generation of pharmacists to offer the services that we offer here, so I know both health centers have a teaching academia model embedded in their services.

I think what we wanted to end this session with was just a little bit of an overview of how we got started. There's a lot of information to cover, a lot of services that you can consider offering, and different people you can consider having in those positions. But it doesn't have to be all at once, there doesn't have to be all or nothing. At Holyoke at least, we started as a contract pharmacy in 2001, and it wasn't until later in the 2000s, 2007 and 2009 when we opened the in-house pharmacies. We started with just a little bit of clinical services doing set outcomes, and then expanded our residency program. When that first resident like I said went on to be a professor, that brought new opportunities to have students here learning with us on expanding our residency, and we've been lucky enough to have our residents stay on. I've been one, Lexi is one, to keep the clinical services going and also to expand them into new opportunities. It just takes one change in one thing to start one layer of services, and then expand it to the rest.

Marisa Rowan (00:54:33):

For El Rio, we opened the community health center in the early '70s, and in 1971 we had our first in-house pharmacy. It wasn't until 2000 that we really had our first break, and it was the stars aligned. So HRSA had a demonstration project that they had messaged to the Office of Pharmacy Affairs that was specifically looking at the role of pharmacist when added to the primary healthcare team or traditional standard team, and how could that pharmacist improve health outcomes. At the same time the state of Arizona had adopted collaborative practice agreements that did include prescriptive authority. So we're super fortunate that that happened, and that Sandra Leal at the time was working here in town and got things going for us. In 2003 that's where I entered the picture and again, just speaking to that unique opportunity and to not think that it always has to be the traditional models of care or the traditional funding sources.

We do have a partnership with the Pascua Yaqui tribe. So what happened is these patients were receiving services through our collaborative practice model and saying hey, what's going on? Our tribal members are doing so much better, we see less absenteeism at work, we see less healthcare spend. What's going on? So the tribe themselves approached El Rio and said, "We want this model. We want it on the reservation." So they fully funded for a medical assistant and a pharmacist to replicate the services on the reservation. Again, unique opportunity. Bank of America said, "What are you doing at El Rio? What's going on? We hear about this program." Our foundation was really instrumental in getting the work that we are doing out there, and formally publishing and speaking about the outcomes that we are seeing due to the pharmacist's role when added to the primary healthcare team. Bank of America said, "Hey, we want to pay for a pharmacist." Just this whole spirit of collaboration and messaging and

we want to do the right thing really served us as El Rio very well. Then in 2018 similar to Holyoke, we had the opportunity to partner for a faculty position and that then led to a residency opportunity, and the rest is history.

So that's why we are very fortunate as our two independent health centers to talk about opportunity and being able to say yes, and willing to say yes. It is that self reflection of what makes sense for us and what's realistic for us that's gotten us to where we are, but in the future sessions we hope to be able to give you more of the nitty gritty. Today was really that view from a helicopter. The next two sessions we want to get down in the Jeep and start talking about the specifics of how we did what we did. Hopefully, we gave you a little bit of a teaser that makes you come back for sessions two and three. But I'm going to stop talking. I know we only have three minutes left, and we want to be able to answer any questions that might be out there.

Brandon Jones (00:57:43):

Thank you Marisa and Alexis and Alyssa, for the great presentation to get us started off. We actually do have several questions, and I mentioned in the chat that we'll try to get you guys to respond to those and get the responses into Noddlepod, and certainly we can have an email list of those questions. But I will just circle around to just one of the questions, maybe of the earlier questions that you guys can answer, and then we'll try to close out our session so we don't hold folks over. But there was one ... There are several questions, but let me see here. Stand by, stand by, stand by. For example from Rita [inaudible 00:58:25] how do the clinical pharmacists promote and engage the patient? That's a question. Same thing, kind of with PCP or a separate encounter subsequent to a visit with PCP? This could be tough per state due to who is the eligibility provider.

Alyssa Puia (00:58:45):

The way that our services work at Holyoke, we are able to bill same day as a provider. So when we were doing those transitions of care visits immediately prior to the provider's visit, we went into it knowing that that wasn't a billable encounter. But it helped bridge the gaps for the patient, and it also helped the provider who didn't have very much time with the patient, to focus more on the physical assessment and that and less on making sure the meds were all set. Our MTM visits, since they're on a different day we are able to bill for, and now that our TOC visits are on a separate day, that's also something that we're looking into. Marisa, I don't know if you want to add something?

Marisa Rowan (00:59:19):

One of the other things that I will speak out in our other sessions as well, but I'll just say it out loud now, is that it's also really important for health centers who are considering models like this to not completely go into it with the mindset of the pharmacist needs to bill to pay for themselves. That is not going to work, and it's not realistic. But really think about your value based contracts, and what do we have to gain. So the med adherence dollars, the things related to A1C less than nine, anything related to vaccines, anything that you have around diabetic retinopathy screening. Also, pharmacists can talk about a lot of things. So if you need them to help you to increase your mammogram rates or your colon cancer screening rates, those are all things we can easily and effectively incorporate into our disease management conversations, and are very happy to do.

You asked also the question about how do you sell it, or how do you engage the patient. When the teams see the value of having the pharmacist on their team and how it's elevating the level of care for their patient population, and also helping to offset their own workload, it's an easy sell. So when the provider says I want you to see my pharmacist for the following reasons, the patients already are set up

to be open to us. Then those warm handoffs are absolutely critical, us walking in and saying hi, I'm Marisa, I'm going to see you for your diabetes management visit. I'm going to see you for your MTM visit, whatever it may be. It makes it so much more smooth and easy and successful.

Brandon Jones (01:01:01):

Great. All right. Again, thank you ladies for this great kickoff to the next two series that we're going to have. Hopefully again, I'll give these questions to our presenters so they can get their responses in, and Tim and I will make sure they get on Noddlepod and you also get an email out with those responses post haste. Also, continuing [inaudible 01:01:23] next sessions we'll be able to piggyback on some of these for next month and the following month's sessions. So again, thank you presenters, and we're looking forward to the next two sessions.

Before ... Hopefully for you guys who are still on, I just want to give you a quick update on some additional resources that we have at NACHC. Within my operations portfolio, some of you probably are very familiar with the regional operations trainings that we host every early spring to summer. We're hosting our very last one in the series of three, it's called Elevating Health Center Operations or EHCO. That's going to be on June 15 and 16, two half days, so 12:00 to noon on each day. It's all virtual. Registration is open, deadline is the first for the early birds. Feel free to take a look at that whenever you get a moment. What I'll do is in the email that I send out I'll make sure that link is there. You can also just Google NACHC Elevating Health Center Operations Training and you will find that registration link very easily.

All right. Thanks again everyone for your participation today. I've had quite a bit of folks here and we know that there are some tech issues. I was messaging my colleague during the session so that we can get those rectified for next month's session, so we should have that cleared up by then. We appreciate your patience. I did put in the chat the evaluation link, so if you could take a moment to click on that, it's a quick little survey. I see what they're saying, it's not working. We'll get you the link out so you guys can complete that evaluation quickly. All right. Thanks again everyone for your participation, and again, we'll see you next month on the third, Thursday from 2:00 to 3:00 for our next portion of the series of three sessions on clinical pharmacists in the care model. All right, thank you all.