Update on the Mega Rule
What is it looking like already?

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Learning Objectives

• Compare and contrast the regulatory language of the Mega Rule and the guidance for surveyors.
• Produce a timeline for the consultant pharmacist which meets the regulations as they pertain to reviews.
• Educate a fellow health care professional or administrator about psychotropics as outlined in the guidance to surveyors and what constitutes continued need for PRN psychotropics.
• List and discuss current legislation and specific regulatory changes affecting the long term care sector.

“Mega Rule” Background

• Medicare Conditions first published in 1989
• Set standards for health care and safety
• First comprehensive update since 1991
• Proposed rule published July, 2015
• CMS received nearly 10,000 comments
• Final rule published October 4, 2016
• Phased Implementation
  – Phase 1 – 11/28/2016
  – Phase 2 – 11/28/2017 (see moratorium notes)
  – Phase 3 – 11/28/2019

CMS Memo November 24, 2017
Ref: S&C 18-04-NH

• Temporary (18-mo) moratorium on specific Phase 2 requirements:
  – F758 Psychotropic Medications related to PRN limitations §483.45(e)(3)-(e)(5)
  – F881 Antibiotic Stewardship Program §483.80(a)(3)
  – F865 QAPI Program and Plan related to the development of the QAPI Plan §483.75(a)(2)

• CMS will hold constant the current health inspection star ratings on the Nursing Home Compare (NHC) website for any surveys occurring between November 28, 2017 and November 27, 2018. Surveys under the new LTC survey process will be published on the NHC but will not be incorporated into the calculations for the Five-Star Quality Rating System for 12 months.
• In early 2018, NHC health inspection star ratings will be based on the two most recent cycles of findings for standard health inspection surveys and the two most recent years of complaint inspections.

Disclosure / Contact Information

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  • Nothing to disclose at this time

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  • Jennifer Hardesty, Chief Clinical Officer and Corporate Compliance Officer, Remedi SeniorCare
  • William Vaughan, VP Education and Clinical Affairs, Remedi SeniorCare

CMS Memo November 24, 2017

• Nothing to disclose at this time
Why the Mega Rule?

- Two different survey processes existed to review for the Requirements of Participation (Traditional and QIS).
- Surveyors identified opportunities to improve the efficiency and effectiveness of both survey processes.
- The two processes appeared to identify slightly different quality of care/quality of life issues.
- CMS set out to build on the best of both the Traditional and QIS processes to establish a single nationwide survey process.

Regulation vs. Guidance

- F 756 (Drug Regimen Review)
  - Regulation: 245 words
  - Guidance: 4,055 words
  - "...Surveyors must base all cited deficiencies on a violation of statutory and/or regulatory requirements, rather than sections of the interpretive guidelines. The deficiency citation must be written to explain how the entity fails to comply with the regulatory requirements, not how the facility fails to comply with the guidelines for the interpretation of those requirements."

Bottom Line

- "Must" versus "should"
  - Abnormal or toxic serum concentrations must be evaluated for dosage adjustments. (F 757: Unnecessary Drugs)
  - The facility should have a procedure for how to resolve situations where the attending physician does not concur with or take action on identified irregularities and the attending physician is also the medical director. (F 756: Drug Regimen Review)
- Strict compliance with guidance not required, not easy to accomplish, but will likely immunize against deficiencies.
Important Definitions: Pharmaceutical Services

- The process (including documentation, as applicable) of receiving and interpreting prescriber’s orders; acquiring, receiving, storing, controlling, reconciling, compounding (e.g., intravenous antibiotics), dispensing, packaging, labeling, distributing, administering, monitoring responses to, using and/or disposing of all medications, biologicals, chemicals (e.g., povidone iodine, hydrogen peroxide);
- The provision of medication-related information to health care professionals and residents;
- The process of identifying, evaluating and addressing medication-related issues including the prevention and reporting of medication errors; and
- The provision, monitoring and/or the use of medication-related devices  

- Guidance at F 755: Pharmacy Services

Notable Guidance

F 755: Pharmacy Services

- Liquid controlled medications are often dispensed in multi-dose containers which indicate approximate volume. The containers may also be opaque to protect the medication from light. It should be noted that absolute accuracy in tracking volume and use of liquid controlled medications may not be possible. The actual volume in these containers may be slightly over or under the manufacturer’s stated volume depending on the shape and material of the container and the formulation of the medication such as thick liquid suspensions. The opaque container, measurement markings, manufacturer fill volume variation, and method for recording usage all make detection of diversion for liquid controlled medications more difficult.

Notable Guidance

F 755: Pharmacy Services

- The general standard of practice for documenting usage of liquid controlled medications is to record the starting volume from the label, record each dose administered, subtract the dose administered from the previously recorded volume, and record the remaining amount. Any observed discrepancy between the recorded amount and what appears to be remaining in the container should be reported according to facility policy.

Notable Guidance

F 755: Pharmacy Services

- Manufacturer’s instructions may list the estimated volume variance (e.g., 30 mL plus or minus 2.5 mL). For liquid controlled medications, signs of diversion may include: an observable discrepancy between the written balances of remaining medication compared to the remaining amount in the bottle upon visual inspection; changes in the viscosity or color of the medication; reports of spills; and, as with other controlled medications, statements from a resident that the medication is not working.

Quiz true/false

- Medications can never be combined for crushing prior to po administration.
- Medications can never be combined for crushing prior to feeding tube administration.
- Facilities should use a person-centered, individualized approach to administering all medications.

Significant (F760) vs. Non-significant Error

Based on:

- Resident condition
- Drug category (narrow therapeutic index drugs)
- Frequency of error
Experts in geriatric medication management.
Improving the lives of seniors.

Notable Guidance

F 759: Med Errors
F 760: Significant Med Errors

• The standard of practice is that crushed medications should not be combined and given all at once, either orally (e.g., in pudding or other similar food) or via feeding tube. Crushing and combining medications may result in physical and chemical incompatibilities leading to an altered therapeutic response, or cause feeding tube occlusions when the medications are administered via feeding tube.

Update on Crushing Meds

ASCP Answer from CMS, December 6, 2017 – not yet clarified in SOM

• CMS will be revising the interpretive guidance to convey that best practice would be to separately crush and administer each medication with food to address concerns with physical and chemical incompatibility of crushed medications and ensure complete dosing of each medication.
• However, separating crushed medications may not be appropriate for all residents and should not be counted as a medication error unless there are instructions not to crush the medication(s).
• Facilities should use a person-centered, individualized approach to administering all medications.
• Interpretive guidance related to crushed medications administered via feeding tube will remain unchanged.”

Quiz

• MRR irregularities must be reported to:
  a. Attending physician
  b. Medical Director
  c. Director of Nursing
  d. All of the above

Phase 1

PHASE 1: STARTED 11/28/2016

Irregularities → Medical director

F 501:
• The medical director is responsible for—
  (i) implementation of resident care policies; and
  (ii) The coordination of medical care in the facility.
• Guidance:
• The medical director helps the facility identify, evaluate, and address/resolve medical and clinical concerns and issues that:
  • Affect resident care, medical care or quality of life; or
  • Are related to the provision of services by physicians and other licensed health care practitioners.
Important Definitions: Irregularity

• “... use of medication that is inconsistent with accepted standards of practice for providing pharmaceutical services, not supported by medical evidence, and/or that impedes or interferes with achieving the intended outcomes of pharmaceutical services. An irregularity also includes, but is not limited to, use of medications without adequate indication, without adequate monitoring, in excessive doses, and/or in the presence of adverse consequences, as well as the identification of conditions that may warrant initiation of medication therapy.”

- Guidance at F 756: Drug Regimen Review

Quiz

• Medication Regimen Review (MRR) must be done:
  – A. Every 30 days
  – B. Monthly
  – C. When resident is at the facility less than 30 days
  – D. B and C

F756 §483.45(c)(5)

• “The pharmacist must review each resident’s medication regimen at least once a month in order to identify irregularities and to identify clinically significant risks and/or actual or potential adverse consequences which may result from or be associated with medications.”

Timeline for CRPh Review

• Monthly MRR
• Short Stays – When residents discharged prior to CRPh’s next routine visit
• Change in Condition – falls, weight loss, mental status change, etc.

F756 §483.45(c)(5)

• Facilities must develop policies and procedures to address the MRR. The policies and procedures must specifically address:
  – The appropriate time frames for the different steps in the MRR process
  – The steps a pharmacist must follow when he or she identifies an irregularity that requires immediate action to protect the resident and prevent the occurrence of an adverse drug event.
F756 §483.45(c)(5) Policies and Procedures

- MRR policies and procedures should also address, but not be limited to:
  - MRRs for residents who are anticipated to stay less than 30 days;
  - MRRs for residents who experience an acute change of condition and for whom an immediate MRR is requested after appropriate staff have notified the resident’s physician, the medical director, and the director of nursing about the acute change.

Policy and Procedure

**MEDICATION REGIMEN REVIEW (MRR) WORKSHEET FOR SHORT TERM STAY RESIDENTS**

- **Purpose:** A medication regimen review (MRR) must be completed on all patients who have an anticipated stay of less than 30 days.
- **Procedure:**
  1. Upon admission or readmission, an allocated staff member (i.e., social worker, charge nurse, etc.) who has determined the stay of the resident will be less than 30 days, will fax to the designated phone number the completed MRR request form (see attached), the discharge summary, most recent labs and current medication list.
  2. A Consultant pharmacist will obtain the faxes on a weekly basis unless the admitting physician or attending physician (if applicable, labs, nursing notes, etc) have requested or denied a pharmacy medication regimen review.
  3. The consultant pharmacist will email, phone or fax the completed review to the facility. The report will indicate either a recommendation or no recommendation. If recommendations are requested at this time, if the review is completed by phone a written report will follow.
  4. Upon receipt of the pharmacist’s recommendation the facility will notify the appropriate medical staff.

MRR Remotely??

- "While conducting the MRR in the facility is not required for compliance, important information about indications for use, actual or potential medication irregularities or adverse consequences may be attainable only by talking to the staff, reviewing the medical record, and observing and speaking with the resident, the resident’s family and/or representative."

**MEDICATION REGIMEN REVIEW (MRR) FOR RESIDENTS WITH A SIGNIFICANT CHANGE**

- **Purpose:** A medication regimen review (MRR) must be completed on all patients who have experienced a significant change in status that may be medication related. If the attending physician determines that a medication regimen review (MRR) is necessary the facility will then contact the consultant pharmacist directly to request an immediate review. The facility will indicate either a recommendation or a review that states No Irregularities at this time or no recommendations at this time. If a MRR is recommended the staff will fax to the designated phone number the completed MRR request form (see attached), the discharge summary, most recent labs and current medication list.
  1. The nursing staff or the physician shall document in the clinical record a statement that confirms the physician has either requested or denied a pharmacy medication regimen review.
  2. The consultant pharmacist will obtain the faxes on a weekly basis unless the admitting physician or attending physician (if applicable, labs, nursing notes, etc) have requested or denied a pharmacy medication regimen review.
  3. The consultant pharmacist will email, phone or fax the completed review to the facility. The report will indicate either a recommendation or a review that states No Irregularities at this time or No recommendations at this time.
  4. If a MRR is recommended the pharmacist will contact the patient’s physician directly to request an immediate review.

MRR Findings

- CRPh must document no irregularity or nature of irregularity
- Timeliness of notification depends on factors including the potential for serious adverse consequences
- No need to document a continuing irregularity in the report each month if the attending physician has documented valid rationale
- Findings should be housed in a consistent location
- It is not acceptable for an attending physician to simply disagree – must be clinical basis
- Facility should have a procedure for resolving situations when the attending physician does not take action and/or the attending physician is also the medical director
F 758: Psychotropic Drugs

• §483.45(c)(3) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:
  • (i) Anti-psychotic;
  • (ii) Anti-depressant;
  • (iii) Anti-anxiety; and
  • (iv) Hypnotic

Indications for Antipsychotics

• Behavioral symptoms present danger to the resident or others
• Expressions or indications of distress that cause significant distress to the resident
• If not clinically contraindicated, multiple non-pharmacological approaches have been attempted, but did not relieve the symptoms which are presented a significant distress and/or
• GDR was attempted, but clinical symptoms returned

GDR Timetable

• Within the 1st year in which a resident is admitted on a psychotropic or after a psychotropic is initiated
  – Must attempt GDR in 2 separate quarters with at least 1 month between attempts, unless clinically contraindicated
  – After the 1st year, a GDR must be attempted annually, unless clinically contraindicated

“Clinically Contraindicated”

• Target symptoms returned or worsened after the most recent attempt at GDR
• The physician has documented the clinical rationale for why an additional attempted GDR at that time would be likely to impair the resident’s function or increase distressed behavior
• Treatment of disorder other than distress related to dementia
F 758: Psychotropic Drugs

• §483.45(e)(4) **PRN orders for psychotropic drugs are limited to 14 days.** Except as provided in §483.45(e)(5), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident’s medical record and indicate the duration for the PRN order.

Further Guidance

• Use of psychotropic medications, other than antipsychotics, should not increase when efforts to decrease antipsychotic medications are being implemented, unless the other types of psychotropic medications are clinically indicated.

• OTC natural or herbal products must also only be given with a documented clinical indication.

Further Guidance “Enduring Conditions”

• The facility must ensure that the resident’s expressions or indications of distress are:
  – Not due to medical condition
  – Not due to environmental stressors alone
  – Not due to psychological stressors alone
  – Persistent

Quiz True/False

• Melatonin requires a consent for administration.

• An initial prn order for a psychotropic requires direct examination and assessment of the resident.

• Under certain conditions, prn psychotropic medications can be ordered indefinitely.
F 881: Infection Prevention & Control Program

- Guidance – Antibiotic Stewardship
  - Improve resident outcomes and reduce antibiotic resistance
  - CDC / AHRQ protocols referenced but not mandated
    - The facility must develop an antibiotic stewardship program which includes the development of protocols and a system to monitor antibiotic use. This development should include leadership support and accountability via the participation of the medical director, consulting pharmacist, nursing and administrative leadership, and individual with designated responsibility for the infection control program if different.
    - The term "drug expertize" does not appear in appendix PP.
    - The facility must have leadership support and accountability that includes the development of protocols and a system to monitor antibiotic use. This development should include leadership support and accountability via the participation of the medical director, consulting pharmacist, nursing and administrative leadership, and individual with designated responsibility for the infection control program if different.
  - The facility does not mandant that drug records are maintained in order to ensure that an account of all controlled drugs is maintained.

Influenza and Pneumococcal Vaccinations

F883 §483.80(d) Influenza and pneumococcal immunizations

Guidance to Surveyors:

- Review facility policies regarding the provision of vaccines in order to determine if the policies reflect current standards of practice. Refer to §483.21(b)(3)(i) of the services provided or arranged by the facility must meet professional standards of quality (F466). Also, refer to F883 for concerns with infection prevention and control.

- As of the date of publication of this guidance, ACIP recommends that "both 23-valent pneumococcal polysaccharide vaccine (PPSV23) and 13-valent pneumococcal conjugate vaccine (PCV13) vaccines should be administered routinely in series to all adults aged 65 years.”

Antibiotic Stewardship Tools

- Antibiotic Reports
  - Drug class
  - Drug Route
  - Days of therapy
    - Orders > 14 days
    - Orders with no stop dates
  - Possible IV to PO conversion
  - Orders by prescribers

- Antimicrobial Stewardship Toolkit
  - A quick primer can be found at: https://www.youtube.com/watch?v=O1DEF48EQKw&feature=youtu.be
  - ASCP-SIDP Long-Term Care Antimicrobial Stewardship Certificate Program
  - Practice-based certificate program focused on the role that pharmacists play in the appropriate use of antimicrobial agents

Controlled Substances

F755 §483.45 Pharmacy Services

- §483.45(d) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who—
  - §483.45(d)(1) provides consultation on all aspects of the practice of pharmacy services in the facility.
  - §483.45(d)(2) establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable or accurate reconciliation and
  - §483.45(d)(3) determines that drug records are in order that an account of all controlled drugs is maintained.

Guidance to Surveyors:

- The facility must employ or obtain the services of a licensed pharmacist who—
  - Provides consultation on all aspects of the practice of pharmacy services in the facility.
  - Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and
  - Determines that drug records are in order and that an account of all controlled drugs is maintained.

- The facility must employ or obtain the services of a licensed pharmacist who—
  - Provides consultation on all aspects of the practice of pharmacy services in the facility.
  - Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable accurate reconciliation and
  - Determines that drug records are in order and that an account of all controlled drugs is maintained.

Herbal and alternative products are considered to be dietary supplements. They are not regulated by the Food and Drug Administration (e.g., they are not reviewed for safety and effectiveness like medications) and their composition is not standardized (e.g., the composition varies among manufacturers). If a dietary supplement is given to a resident between meals and has a vitamin(s) as one or more of its ingredients, it should be documented and evaluated as a dietary supplement, rather than a medication. For clinical purposes, it is important to document a resident’s intake of such substances elsewhere in the clinical record and to monitor their potential effects, as they can interact with other medications. NOTE: Because nutritional and dietary supplements are not considered to be medications for purposes of the medication administration observation, noncompliance with the administration of these products should not be included in the calculation of the facility’s medication error rate. The exception to this would be vitamins and minerals which are generally considered a category of dietary supplements. Medication errors involving vitamins and/or minerals should be documented at FT59 and counted towards the error rate calculation. Medication errors involving vitamins and minerals would not be considered to be a significant medication error unless the criteria at F750 were met.

It is expected that the facility staff, along with the prescriber and consulting pharmacist, are aware of, review for, and document any potential adverse consequences between medications, nutritional supplements, and dietary supplements that a resident is receiving.
F 552: Planning and Implementing Care

The resident has the right to be informed of, and participate in, his or her treatment, including:

- The right to be fully informed in language that he or she can understand of his or her total health status, including but not limited to, his or her medical condition.
- The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.
- The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of any proposed care, of treatment alternative or treatment options and to choose the alternative or option he or she prefers.

Person-Centered Med Pass

Guidance:

- Residents have the right to choose health care schedules consistent with their interests and preferences, and the nursing home should gather this information in order to be proactive in assisting residents to fulfill their choices. The adjustment of medication administration times, to meet the individual needs and preferences of residents, must be considered by the nursing home. However, medication administration scheduling must still consider physician prescription, manufacturer’s guidelines, and the types of medication, including time-critical medications.

Current Legislative and Regulatory Focus

- Provider Status
- CMS — Mega Rule, Transitions of Care, IMPACT Act, DRR Pilot, MTM Pilot, CMMI: Innovations Center, Bundled Payment & other Risk Sharing Models
- FDA — Proposed Rules on Compounding & Repackaging
- EPA — Proposed Rule on Pharmaceutical Waste
- ONC — Interoperability EHR, Pharmacy HIT Collaborative, LTPAC HIT Collaborative
- USP — Chapter <800> Hazardous Drug Compounding, Proposed Chapter <797> Sterile Compounding
- DEA — access to CDS for patients while preventing diversion

Resident Rights versus Facility Responsibility

Guidance:

- “Treatment” refers to medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms.

Federal Legislative Advocacy

- “Provider Status for Pharmacists” - The Patient Access to Pharmacist’ Care Coalition’s (PAPCC) mission is to develop and help enact a federal policy proposal that would enable patient access to, and payment for, Medicare Part B services by state-licensed pharmacists in medically underserved communities. Our primary goal is to expand medically-underserved patients’ access to pharmacist services consistent with state scope of practice law.
- PAPCC – organizations representing patients, pharmacists, pharmacies & interested stakeholders (around 40 groups)
Provider Status in 115th Congress

- **Senate-S.109** introduced in January by Sen. Charles Grassley (R-IA) with **51 co-sponsors**
- Referred to the Senate Finance Committee
- **House-H.R.592** (same bill number as 114th Congress, but totally new bill) introduced by Brett Guthrie (R-KY) with **241 co-sponsors**.
  - Vote depends on the official cost estimate from the Congressional Budget Office, which has not yet been released.
  - (Updated 1/18/18)

Plus - AMDA 2018 House of Delegates supports provision of CMS Provider Status for the CRPh to LTC facilities – submit to AMA for an item of business at the 2018 Annual Meeting.

### Impact Act 2014

"Improving Medicare Post-Acute Care Transformation Act"

- Bipartisan bill passed on September 18, 2014 and signed into law by on October 6, 2014

  Requires standardized patient assessment data across Post-Acute Care (PAC) settings to enable:
  - Improvements in quality of care and outcomes
  - Comparisons of quality across PAC settings
  - Information exchange across PAC settings
  - Enhanced care transitions and coordinated care
  - Person-centered and goals-driven care planning and discharge planning

Standardized patient assessment data across all four PAC settings – Quality Measures Defined by CMS

### Impact Act Standardization

- Inpatient Rehabilitation Facilities - Patient Assessment Instrument (IRF-PAI)
- Skilled Nursing Facilities Minimum Data Set (MDS)
- Home Health Agencies - Outcome & Assessment Information Set (OASIS)
- Long-Term Care Hospital - Continuity Assessment Record & Evaluation (LCDS)

### CMS Quality Strategy Goals

**Six Priorities**

- Making Care Safer
- Strengthen person and family engagement
- Promote effective communication and coordination with care
- Make care affordable
- Work with communities to promote best practices of healthy living
- Promote effective prevention and treatment

### ASCP and the DEA

- ASCP established its DEA Task Force in 1998 to address ambiguities within the CSA (Controlled Substances Act)
  - Hospital vs. Community vs. LTC Pharmacy
  - CSA and the practice standards of LTCs represented a potential "regulatory compliance risk"
  - DEA Task Force - mission of working with the DEA to resolve issues and challenges - Balance patient care vs. regulatory compliance
  - Changes for LTC: 7 day allowance for signature vs. 72hr and faxing as original in LTC & hospice

- **2004-2005**: ASCP worked with the National Association of Boards of Pharmacy (NABP) on a joint task force to identify model language addressing legal access to controlled medications for LTC patients
- Model language focused on recognizing chart orders as legal prescriptions for ordering controlled substances
- ASCP made multiple presentations to Boards of Pharmacy across the country and encouraged them to update their regulations to include LTC specific rules
ASCP and the DEA

- In 2010, the DEA suggested that NABP convene a second national task force to go through the entire CSA and identify areas that needed modernization
  - ASCP participated with NABP and identified items related to LTC pharmacy practice
- October 6, 2010 DEA issues Policy Statement that addressed the nurse as an agent of the prescriber
  - Changed the way that controlled substance prescriptions are handled in LTC
  - Nurses in a facility today remain the agent of the prescriber for non-controlled medications

Current Nurse Agent Overview

- Agents are employed by the authorized prescriber and may be:
  - A nurse located in the prescriber’s office
  - A non-licensed receptionist
  - Hospital employees (because hospitals are DEA registrants)
  - NOT LTCF Nurses
- LTCF employees may become agents but only through a very prescriptive and detailed process that documents such delegation
- Authority of Agent (under current guidance)
  - Prepare CII prescription for practitioner to sign
  - Transmit CII prescription that is signed by practitioner to pharmacy via fax
  - Take a verbal CIII prescription from the physician and communicate that prescription via telephone to the pharmacy

ASCP DEA Task Force Pathway to Resolution – A Policy Approach

- Task Force – working directly with DEA staff since 2015 on list of issues, focused on Nurse Agent issue.
- Recommend that DEA issue a revised Nurse Agent Policy which specifically addresses an alternative approach for the LTC setting
  - Benefits:
    - No legislative or regulatory action needed
    - Shortened timeframe to drive change
- ASCP understands that any changes have to be carefully crafted so they do not create unintended consequences or affect other practice areas

ASCP- DEA Task Force Update

Obtained written clarification from DEA:
- Electronic e-kits: use for 1st dose only do not require separate DEA registration (11/30/16).

Comprehensive Addiction & Recovery Act (CARA)
- DEA Clarification: CARA 30-day fill limitation does not apply to long-term care and hospice patients (1/13/17)
  - DEA verified, partial-fills for CII prescription medications with up to 60-days to complete.

ASCP - NABP Model Rules TF – Updated/Revised LTC Rules and presented to NABP at meeting in August 2017

Collaboration is the Key to Effective Advocacy

ASCP has representation on over 30 coalitions and collaborative groups

ASCP- DEA Task Force Update

Collaboration is the Key to Effective Advocacy

Access and collaboration with other post-acute care groups and associations
The vision of the American Society of Consultant Pharmacists is optimal medication management and improved health outcomes for all older persons.

Mission - The American Society of Consultant Pharmacists empowers Pharmacists to enhance quality of care for all older persons through the appropriate use of medication and the promotion of healthy aging.

Advocacy For Senior Care Pharmacists

1. Certificate Program
2. Online Directory
3. Virtual Network
4. Path to BCGP
5. Focus Groups

New Certificate Program: Business Skills for Private Practice

- Entrepreneur overview
- Business planning
- Financial management
- Sales & marketing
Senior Care Pharmacist Directory

- Get listed
- Someone finds you

Senior Care Virtual Pharmacy Network

- New ASCP Membership Category
- Includes credentialing & monitoring required by payors
- Access to patients eligible for MTM/CMR
- Includes billing administration by Xchangelabs, LLC
- Contact Carol Sirianni at csirianni@ascp.com
- 412-491-9888

Thank you! Questions?

American Society of Consultant Pharmacists & Legislative Fly-In

May 3, 2017: Hill Prep at Crowell & Moring, Over 100 members and over 300 congressional office visits, Fund-raising event in the evening followed by opening of the Forum with Congressman Buddy Carter’s Keynote: Perspectives from Congress’ Only Pharmacist