Disclosure

I have no actual or potential conflict of interest in relation to this presentation.

The views expressed are my own and do not necessarily represent the official view of the California Department of Public Health or the Centers for Disease Control and Prevention.
Learning Objectives

For Technicians:

1. Outline the 2010 cost of medical treatment of heart disease, arthritis, cancer, diabetes, depression, and asthma as compared to the cost of all health care expenditures in California.

2. Describe the opportunities for collaboration between community and health system pharmacists to provide seamless transitions between hospital and ambulatory care settings in partnership with public health and health system leaders in California.
Learning Objectives

For Pharmacists:

3. Review current CMM pilots and opportunities for expansion, including sources of payment / reimbursement.

4. Describe the best situations for proposing CMM and types of resources available for implementation.
Pharmacists in California

PUBLIC HEALTH CORE FUNCTION: ASSESSMENT
CA Pharmacists by Age Group, by Gender

31,766 (89.15%)
US Graduates

3,760 (10.85%)
Foreign Graduates

20,772
Female

14,754
Male

35,526 licensed/reside in CA*

*Does not include:
113 licensed in CA/reside out of country
5,947 licensed in CA, reside out of state
Total with CA license: 41,586
2016 Survey of California Pharmacists

- Pharmacists’ Use of Team Based Care for Hypertension, Diabetes, or Prediabetes

- CDPH developed online Survey accessed by 155 pharmacists
  - 28 different counties in California (48 Los Angeles, 16 Orange, 13 San Bernardino and 9 San Diego)
  - Independent, community based (40.8%), Chain-based (23%), Other (19.1%), hospital-based (13.2%), clinic-based (12.5%)
  - Majority provide medication management patient consultation services (81.6%)
## Lifestyle Behavioral Education Services (n=152)

<table>
<thead>
<tr>
<th>Type of Patient Consultative Service, if appropriate</th>
<th>Percentage of Pharmacists</th>
</tr>
</thead>
<tbody>
<tr>
<td>Recommend physical activity</td>
<td>69.1%</td>
</tr>
<tr>
<td>Provide immunizations (e.g., influenza, pneumonia, shingles)</td>
<td>51.3%</td>
</tr>
<tr>
<td>Ask patients about tobacco use and offer education and cessation resources</td>
<td>51.3%</td>
</tr>
<tr>
<td>Provide general nutrition information</td>
<td>50.7%</td>
</tr>
<tr>
<td>Screen patients for high blood pressure and/or diabetes</td>
<td>42.1%</td>
</tr>
<tr>
<td>Make referrals to dietitian for nutrition counseling</td>
<td>38.2%</td>
</tr>
<tr>
<td>Provide diabetic educational services (if pharmacist is a Certified Diabetes Educator)</td>
<td>30.3%</td>
</tr>
<tr>
<td>Refer patients with pre-diabetes to National Diabetes Prevention Program</td>
<td>20.4%</td>
</tr>
<tr>
<td>Refer patients to accredited diabetes self-management education program</td>
<td>26.3%</td>
</tr>
<tr>
<td>Conduct insulin pump instruction</td>
<td>11.2%</td>
</tr>
</tbody>
</table>
Communications between Pharmacists and Primary Care Providers (n=54) who have collaborative agreements

<table>
<thead>
<tr>
<th>Mechanisms (all that apply)</th>
<th>Frequency</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fax</td>
<td>31</td>
<td>57.4%</td>
</tr>
<tr>
<td>Phone</td>
<td>30</td>
<td>55.6%</td>
</tr>
<tr>
<td>Shared Electronic Medical Records</td>
<td>29</td>
<td>53.7%</td>
</tr>
<tr>
<td>Email</td>
<td>16</td>
<td>29.6%</td>
</tr>
<tr>
<td>Other</td>
<td>14</td>
<td>25.9%</td>
</tr>
</tbody>
</table>
## Developing Collaborative Agreements (n=79)

<table>
<thead>
<tr>
<th>Challenges</th>
<th>Frequency</th>
<th>Distribution</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lack of payment structure</td>
<td>48</td>
<td>60.8%</td>
</tr>
<tr>
<td>Not discussed with providers</td>
<td>37</td>
<td>46.8%</td>
</tr>
<tr>
<td>Pharmacists have inadequate time</td>
<td>31</td>
<td>39.2%</td>
</tr>
<tr>
<td>Providers not interested or decline</td>
<td>29</td>
<td>36.7%</td>
</tr>
<tr>
<td>Other</td>
<td>56</td>
<td>70.9%</td>
</tr>
</tbody>
</table>
Challenges

PUBLIC HEALTH CORE FUNCTION: ASSESSMENT
Question

What were the top five leading causes of death in California in 2014?
Top Five Leading Causes of Death
California, 2014

- Cancer: 58,272
- Heart Diseases: 57,907
- Stroke: 13,666
- Chronic Lung Diseases: 12,747
- Alzheimer's Disease: 12,632

Number of Deaths (Source: CA Death Statistical Master File)
Question

What was the cost of medical treatment for heart disease, arthritis, cancer, diabetes, depression, and asthma as compared to the cost of all health care expenditures in California in 2010?
## Estimated health care costs in CA¹

[http://cbcd.ucmerced.edu/Health/](http://cbcd.ucmerced.edu/Health/)

<table>
<thead>
<tr>
<th>Chronic Condition</th>
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<td><strong>42.4%</strong></td>
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2. Based on statewide prevalence data & CDC Chronic Disease Cost Calculator Version
3. Based on 2009 U.S. Centers for Medicare & Medicaid Services data.
Health Spending Growth in United States*

By 2025,

- the health spending share of the United States of America economy is projected to reach 20.1 percent – up from 17.5 percent in 2014
- the percentage of the U.S. population that is uninsured is expected to be 8 percent – down from 11 percent in 2014

Life expectancy increases continuously with income
  ◦ At the age of 40 years, the gap in life expectancy between individuals in the top and bottom 1% of the income distribution is 15 years for men and 10 years for women

Adjusting for race and ethnicity, life expectancy for individuals with low incomes is highest in California, New York and Vermont.

Life expectancy did not change for individuals in the bottom 5% of the income distribution, whereas it increased by about 3 years for men and women in the top 5% of income distribution.

Most of the variation in life expectancy across areas was related to differences in health behaviors, including rates of smoking, obesity and exercise.
  ◦ Individuals in the lowest income quartile have more healthful behaviors and live longer in areas with more immigrants, higher home prices and more college graduates.

Opportunities

PUBLIC HEALTH CORE FUNCTION: POLICY DEVELOPMENT
Question

What is the state health assessment and state health improvement plan for California?
Let’s Get Healthy California Taskforce

Governor’s Executive Order B-19-12: Develop 10 year plan to improve the health of CA, control costs, improve quality of health care, promote personal responsibility for health & advance health equity

Secretary Dooley: What will it take for CA to be the healthiest state in the nation by 2022?
Let’s Get Healthy
California Task Force Framework

The Triple Aim:
Better Health • Better Care • Lower Costs

http://www.chhs.ca.gov/pages/LGHCTF.aspx
http://letsgethealthy.ca.gov

http://www.chhs.ca.gov/pages/LGHCTF.aspx
California Wellness Plan

- CA’s Chronic Disease Prevention & Health Promotion Plan – Roadmap for chronic disease prevention via collective impact
- Let’s Get Healthy CA Task Force Priorities & Performance Measures
- 9 year timeframe; numerous Programs
- Objectives with baseline, benchmark & target outcomes; Population health focus
- Healthy Community Indicators
California Wellness Plan Goals

Equity in Health and Wellness

1. Healthy Communities
2. Optimal Health Systems Linked with Community Prevention
3. Accessible and Usable Health Information
4. Prevention Sustainability and Capacity

Plan posted online February 28, 2014

http://www.cdph.ca.gov/programs/cdcb/Pages/CAWellnessPlan.aspx
CDPH Commitment
Goal 2 Optimal Health Systems Linked with Community Prevention

Statewide Workgroup to promote
- National Diabetes Prevention Program
- **Comprehensive Medication Management**
- Home visiting: Children with Asthma & High Risk Mothers
- Breast Feeding Friendly Hospital Policy
- Colorectal Cancer Screening (FIT)
- Tobacco Cessation Benefit Standardization
Comprehensive Medication Management

PUBLIC HEALTH CORE FUNCTION: ASSURANCE
CWP G2: Comprehensive Medication Management Work Group

CMM Programs: Description, Impacts, and Status in Southern California, 2015
  ◦ current landscape, including the delivery, use, outcome, benefits, and challenges
  ◦ status of CMM (“case studies”) in Southern California as of May 2015
CMM

evidence-based
physician approved
pharmacist-led
preventive clinical service
  ◦ ensuring optimal use of medications that is effective at improving health outcomes for high-risk patients while decreasing health care costs
Patient Centered, Team-based

“listening to our patients, understanding their needs, understanding the art and science of medicine, applying our best effort for each patient’s circumstances, acknowledging uncertainty, and above all, having the humility to share our limitations.”

Thomas W. Ormiston, MD, Sierra Sacramento Valley Medical Society President’s Message on his values in treating patients (SSVMS Magazine May/June 2016)
CMR vs. dsMTM vs. CMM

Medication Therapy Management Comprehensive Medication Review (CMR)

Disease State Medication Therapy Management (dsMTM)

Comprehensive Medication Management (CMM)
Conduct a comprehensive medication therapy review to identify all medications currently being taken

Generate a personal medication record, a complete record of all medications (prescription and nonprescription), herbal products, nutraceuticals, etc.
Only CMR

Eligibility is determined by anticipated annual drug spend minimum of $3138 (2015) & a minimum number of drugs & conditions. No clinical data is necessary. Absent clinical data, drug therapy problems are found only related to potential drug-drug interactions, duplicative therapy, opportunities for less expensive alternatives, & suggested inappropriate medications based on age (Beers criteria).

A standardized CMR format of information is given to the patient and may be faxed/transmitted to a provider; no follow-up is required to see if recommendations were followed.
dsMTM & CMM

Evaluate patient to clarify or confirm medication-related problems including basic assessment, point-of-care testing, ordering medication-related tests, etc.

Develop an individualized medication care plan to resolve medication-related problems and ensure successful attainment of treatment goals.

Add, substitute, discontinue, or modify medications/doses as needed or recommend changes, depending on state-specific scope of practice laws and in collaboration with health care team.
Document care delivered, including progress towards treatment goals, and communicate details to primary care provider and other relevant healthcare team members in a timely manner.

Ensure that care is coordinated with all other team members within the broad range of services being provided to the patient.

Provide follow-up care, according to individual patient needs, to determine actual outcomes from medication therapy and ensure that treatment-related goals are being achieved.
CMM – Best Solution

Assessment of clinical status for ALL medications and medical conditions problems as opposed to select medications or conditions

Requires formal collaborative practice agreement between pharmacist and physician
CMM Pilots
Successfully implemented in six health care systems in Southern CA

Improvements seen in clinical, fiscal and quality measures.
Challenges include lack of: reimbursement mechanisms, alignment of financial incentives, robust health information exchange, tracking systems for CMM impacts & adequate staff and space.
CWP G2 Work Group
Evaluation Subcommittee
Retreat – October 21, 2016 hosted by CSHP in Sacramento, CA

CMM Core measures discussion:
- Minimum Data Set (universal, standardized)
- Site specific Data Points (hospital, ambulatory care clinic, FQHC)
- Business Models (financial configuration for reimbursement – hospital, commercial pharmacy, clinics)
- Collaborative Practice Agreement Templates – Core Elements
- Connectivity/Communications for Data Flow across Partners (secured electronic data flow preferable)
- Training Standards and Training Options – for Pharmacy
Expanding Role of Pharmacists
AB 1114 – Signed by CA Governor

Rate of reimbursement for pharmacist services (as authorized in Section 4052 of the CA Business and Professions Code) shall be at 85 percent of the fee schedule for physician services under the Medi-Cal program as soon as federal approvals are obtained and shall be implemented only to the extent that federal financial participation is available:

(A) Furnishing travel medications
(B) Furnishing naloxone hydrochloride
(C) Furnishing self-administered hormonal contraception
(D) Initiating and administering immunizations
(E) Providing tobacco cessation counseling and furnishing nicotine replacement therapy
Opioid Epidemic in CA

10.07 prescription opioid related overdoses per 100,000 ED visits (2014)
10.71 prescription opioid related overdoses per 100,000 hospitalizations (2014)
3.52 prescription opioid related deaths per 100,000 deaths (2014)

5.98 heroin related overdoses per 100,000 ED visits (2014)
1.34 heroin related overdoses per 100,000 hospitalizations (2014)
1.38 heroin related deaths per 100,000 deaths (2014)

Sources: Emergency Department Data and Hospital Patient Discharge Data, CA Office of Office of Statewide Health Planning and Development; Vital Statistics, Death Statistical Master Files, CDPH
Almost half of women weighed too much at conception

13.9% binge drinking during 3 months prior to pregnancy

11.9% smoking during 3 months prior to pregnancy

CDPH, Maternal, Child and Adolescent Health Program, Maternal and Infant Health Assessment. Data are weighted to reflect the population of women delivering a live birth in the survey year.

Flojaune G. Cofer, PhD, MPH, Preconception Health Coordinator MCAH Division
Preventive Services for Women

Unintended Pregnancies – California 2012 – Almost 1/3 of live births in CA (30.9%) result from mistimed or unwanted pregnancies

Percent of mothers in California with a recent live birth by race/ethnicity, 2012 (Data Source: Maternal and Infant Health Assessment Survey) Flojaune G. Cofer, PhD, MPH

The Affordable Care and Patient Protection Act 2010

- More than 4 in 10 women ages 15 – 44 use some form of contraception
- Law requires full coverage of FDA-approved birth control at no cost to women.
- Law requires coverage at no cost for services to help individuals quit smoking.

New regulations: Pharmacists required to report immunizations to the California Immunization Registry (CAIR)

- The California State Board of Pharmacy recently announced new regulations (CCR, section 1746.4) effective August 25, 2016, pharmacists are required to report the administration of any vaccine to an immunization registry **within 14 days**.
- CDPH website (http://cairweb.org/pharmacies-and-cair/) specifically for pharmacists seeking information on how to submit vaccination information to CAIR.
- Regulation specifies requirements for training and education, notification of health care providers, including prenatal care providers (if known) about the immunizations, and document retention for pharmacists who administer vaccines.

Authority for pharmacists to initiate or administer vaccines independently was established in 2013 by Senate Bill 493 (Hernandez), Bus Prof Code, Section 4052.8.
Adult immunizations covered by Medi-Cal

Medi-Cal fee-for-service (FFS) contract drug list (CDL) has been updated to include ACIP-recommended adult immunizations as a pharmacy benefit. An August 31, 2016, Medi-Cal managed care All Plan Letter clarified that Medi-Cal managed care plans must also provide these adult immunizations on their pharmacy formulary.

Currently, a number of the Medi-Cal managed care health plans already cover adult immunizations as a pharmacy benefit.

Please check with your local Medi-Cal managed care plan to see if pharmacy administered adult immunizations are currently covered.

Pharmacists & Tobacco Cessation

California Smokers’ Helpline at 1-800-NO-BUTTS (www.nobutts.org)

- Please make an e-referral or recommend patients call the Helpline for sustained follow up counseling sessions. Counseling with the Helpline can double a person’s changes of successfully quitting!
- Free materials to promote the Helpline can be ordered on the Helpline website, and they also offer free continuing education training for health providers on tobacco cessation.

Quit Tobacco: How Pharmacists Can Help

Talk to Your Pharmacist About Quitting Tobacco

Pharmacy CE Courses free at Purdue - https://ce.pharmacy.purdue.edu/courses/login/index.php
Medicaid, Covered CA, HMO/PPO

If patient receives denial of prevention services or is over charged, patient must file formal grievance with health plan (as described in denial letter from insurance company HMO/PPO).

If Health Insurance still denies prevention services, patient can call 1 888 466-2219 (CA Department of Managed Health Care) to receive technical assistance over the phone. Patient must then fill out online independent medical review/complaint form. DMHC will follow up with confirmation by mail. Within 30 days, determination letter will be mailed to patient.

www.healthhelp.ca.gov
Thank you!

Questions?
Jessica Núñez de Ybarra, MD, MPH, FACPM
California Wellness Plan Implementation
916.552.9877
Jnunez2@cdph.ca.gov
Test Answers
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State Health Assessment
and
State Health Improvement Plan

http://www.chhs.ca.gov/pages/LGHCTF.aspx

http://letsgethealthy.ca.gov

http://letsgethealthy.ca.gov
Session Code:

1. Write down the course code. Space has been provided in the daily program-at-a-glance sections of your program book.

2. To claim credit: Go to www.cshp.org/cpe before December 1, 2016.