

Prescription Medication Preparedness Initiative - II

MARCH 11, 2016 COLLABORATIVE MEETING PROCEEDINGS

**OFFICE OF THE ASSISTANT SECRETARY FOR PREPAREDNESS AND RESPONSE
U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES**

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MEETING OBJECTIVE

The workshop was conducted in the spirit of “letting every voice be heard.” The meeting outcomes reflect of the diversity of opinion across the attendees and are not meant to suggest consensus recommendations but rather to identify the challenges in our current system for dispensing emergency prescription medications, opportunities for collaboration, and innovative ideas for the way forward.

MODERATORS

CDR Bruce Dell, US Public Health Service, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

Dr. Cynthia Hansen, Senior Advisor, Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services

OPENING REMARKS

Dr. Gregg Margolis, Director, Division of Health Systems Policy , Office of the Assistant Secretary for Preparedness and Response, U.S. Department of Health and Human Services.

PARTICIPANTS

1. Jeffrey Kelman, Centers for Medicare and Medicaid Services
2. Jason Ausili, National Association of Chain Drug Stores
 - a. Kyle Mcgrath, National Association of Chain Drug Stores
 - b. Michelle Robinson, National Association of Chain Drug Stores
 - c. Jacqueline Scheid, National Association of Chain Drug Stores
3. Bellinda Schoof, American Academy of Family Physicians
4. Mitchel C. Rothholz, American Pharmacists Association
5. Lisa Schwartz, National Community Pharmacists Association
6. Krystalyn Weaver, National Alliance of State Pharmacy Associations
7. Jason Money, Amerisource Bergen
8. Lisa Peterson, ASTHO
9. Emily St. Martin Lord, Healthcare Ready
10. Everett Sedgwick, FEMA/ODIC
11. Pamela Allweiss, Centers for Disease Control and Prevention
12. Michael Pollard, Pharmaceutical Care Management Association
13. Michele Davidson, Walgreens
14. Charlie Oltman, Target Pharmacy

PRESENTATIONS

CDR Bruce Dell: What Have We Learned?

- PMPI is evolving, and we have many of the requisite groups here to move the agenda forward
 - Not building consensus today, collaborating to advance the agenda
- Have been having small meetings in parallel to this one: legislative, pharmacy, etc
- Last meeting we identified the barriers to getting medications to patients
 - Realized we cannot do waivers, so what else can we do?

Dr. Gregg Margolis: CVS Outreach during Hurricane Joaquin

- Gregg presents on behalf of CVS, who could not be here today
 - ASPR had been communicating with CVS throughout PMPI and had developed an informal relationship with them
 - They contacted us prior to the storm and asked what they could do;
 - We provided them with zip codes of areas projected to be affected in VA and NC;
 - They used existing communication networks to send messaging in advance of the storm;
 - Could have used HHS/ASPR in the messaging but opted not to;
 - One meeting attendee mentions that pre-cleared messaging from HHS would be useful as we roll this effort out to other venues
 - It is pointed out that we want to have consistent messaging from pharmacy to pharmacy, this group can help with that
 - The pharmacies did talk about this and said that perhaps a trigger coming from HHS would help with creating the uniformity
 - In this meeting we want to link everyone together so that we are all on the same page, not just the pharmacies, but also with state and local officials and public health and emergency management
 - One of the CVS reasons and desires to use HHS name was so that they didn't look like they were marketing and trying to get patients into the store, however they opted to not use HHS name in the end, and the overwhelming response was positive
 - CVS is also running metrics to see differences between stores that got messages and those that didn't
 - Question – can we message through the emergency alert system rather than the drug stores?
 - We don't actually control those system and they are tightly regulated; but it is worth investigating

- However, this may be an example of something that the private sector is more appropriately suited for due to their existing relationship with patients
 - Amber alerts are not targeted, this would be
- CDC efforts looking at similar things, so opportunity to align; they are really concerned about the slippery slope of urging people to buy things from the private sector, first meds, then gas, then groceries, etc.
- Also, we don't want to start message fatigue by sending too many things to people, especially to those that it may not be applicable for
 - Question – with the calls, can we also do pre-scripted PSAs? Can use captioning and sign language interpreter, etc.
 - Can also work with Facebook, who already does something similar with their disaster area OK button

Dr. Cynthia Hansen: Where Are We Now?

- What are the technology platforms like ICERx that are out there that can be used?
- I think a PSA would be useful, perhaps convene a panel to determine when/if to use this messaging in alerts.
 - We should also think about what happens if the grid goes down and we can't use text or email?
- I'm thinking about instances in which there is no electricity for days. If you're in that situation, meds may not be top of mind. Need to look at the community and understand where people normally get their meds and have those providers discuss with them the needs for family plans; this is also true for caregivers. How do we engage community partners around this messaging? At the last meeting we talked about Sandy and NYC, and we know the challenges associated with going door-to-door so we need to work at the community level and also individual level so more people are educated and self-sufficient.
- What is being done elsewhere? For example in communication in neighborhoods so we can build from those systems. We need to integrate pharmacy and PH, for example.
- NCPA program called "simplify my meds" (<http://www.ncpanet.org/solutions/adherence-simplify-my-meds/simplify-my-meds/preview-of-simplify-my-meds->) which is meant to be more hands on than a call or a text. Synchronizes all refills, for example. Pharmacists know who is due to run out, so it would be easy to plant the seed of preparedness in this program and educate patients about it.

- NCPA Foundation also did a response/recovery program last summer with Farmer's Mutual Insurance. Can also discuss this there to add to pharmacy COOP the patient piece. Easier to recover if all patients are not knocking down your door.
- I have been thinking about pharmacy scope-of-practice, and there are situations in which patients may come to the pharmacy without refills left on the Rx. Maybe need to give pharmacist more leeway to refill in a disaster, and maybe not only then so that they are practiced in a disaster. These are state-by-state now, and not widely supported, so maybe advocacy would assist.
- Big issue here is really medication adherence in general.
- Also, are there tax breaks for the costs associated with messaging? What do we do during extended disasters?
- Have to make sure that the state health departments are included in whatever efforts we put forth.
- Support scope-of-practice change; challenge is that it is provider-to pharmacy, and patients don't know what the pharmacist can do. In Idaho, state health department can make agreement with all pharmacies and make the determination during an event to allow expanded scope. It's great to be thinking about pharmacies, but we also need to think about other providers that communicate with the patient (primary care, dialysis, etc.). If it works here, could translate well there too. Can also think about what the major distributors can do (3 major ones cover 90%) and we need to make sure the right amount of meds are in the pharmacy or pre-positioned. This analysis can be done – what do we normally need in certain disaster types. Empower map is great tool that wasn't live last year. Need to let the private sector know some of this data, even if it is just at the county level.
- Emergency go-kits still need more uptake, and they don't always include medications and medical equipment. What happens if, like during 911, you couldn't enter certain areas unless you could prove you lived there? Need to make sure the medications and the caregivers are able to enter, and getting to know EM before something happens so they know better what they can help with. Better local integration with EM is needed.
- Providers should be talking to their patients. Can put it on the checklist of quality measures for primary care and included in the materials for chronic care management education. Consumers need this information from multiple sources. Knowing the burden of disease in the county is important; we have this information. How can we also leverage the data on medication use (for example, med companies know areas that are high insulin users)?
- What are the legal and regulatory impediments?

- As Walgreens, we need to be concerned about whether people at corporate know who to contact to ensure a centralized response; also need to ensure the stores are prepared; also have responsibility for the employees and to ensure their safety and wellbeing. Also need to coordinate better with organizations about communicating the disasters; have gotten away from that and need to get back to it. Medicaid is also a barrier, since it is state-to-state.
- Can look at simplifying and communicating the refill override process. Relook at EPAP process and make sure it is live and working. Can we redevelop ICERx and make it come live within hours? Also, how does e-prescribing and its messaging capability need to be updated? How can we work with healthcare ready to give more frequent updates? What about credentialing faster when patients move across state lines? How to consolidate all the information into a one-pager so associations can help send to individual pharmacies to help remind them of what they are able to do in an emergency?

Dr. Cynthia Hansen: Assessment Exercise & Small Group Discussions

On a scale of 1 to 10 (worst to best), where are we?

- About 3 say 6
- About 5 say 5
- About 2 say 4
- About 4 say 3

Cost/Payment Group

- Refill-too-soon causes override issues because payors use different methods
 - Also it is not allowed until a disaster is declared
 - Will payors even talk about covering it before a declaration?
 - Perhaps we can allow a 7 day supply and not a 30 day supply to reduce costs for the payors
 - Leaders for the NACP task force
- Talked about copay, coinsurance barriers
 - Today some pharmacies absorb that cost, but is that their responsibility?
 - In perfect world, HHS would use EPAP to cover those costs
 - How do we start the conversation to expand EPAP?
 - Can OIG give community pharmacy a waiver in the case of inducements?
- We should encourage more medications to be refilled concurrently
- Engage CMS in a call letter for Medicare and Medicaid override processes, so it is mandatory and standard in the government programs

- In 90 day refills, many are no longer allowed for maintenance meds so can we reverse that and make it less likely for patients to run out of meds
- What is the business case for this? How big of a problem is it really? Where is there data on this?
 - The data is important to the payors, example of Humana interested
- NCP code can be used after a trigger, so we need public health to help with an advance trigger to activate a 7-day allowance
- Level of effort – what is easier?
 - More difficult piece is the rule change and the early trigger to waive copays or allow refill before a disaster declaration. What is the use case of working with plans on a regular basis before a disaster (since we know the advantages of after)?
 - What if disaster can't declare a waiver?
 - Also what if we send people in for early refills and they cannot afford it? Are there vouchers available? What are other means to pay for an emergency refill? This is part of patient education before a disaster.
 - Perhaps we need a chart of what can be done before versus after the declaration.
 - If CMS (who influences coverage) gave a directive through Medicare and Medicaid to have a plan to address pre and post event emergencies it would force the discussion.
 - Need guidance about who is responsible for paying and what the law is around this
 - Regarding CMS, if it is part D it is a rule, if it is Medicaid then it is a guidance and up to the states
- Have we talked about the VA for early refill? They could be used as a case example.

Education and Outreach Group

- Leveraging existing systems to get the word out would be a plus – use community mobilizing orgs that came out of ACA
 - Need to synchronize messaging
- Use health demographic data to assist us in an emergency, for example the empower map
- Community and public health systems need to be more integrated, many entities don't talk the same language
- Need to bridge emergency management and emergency planners in the communities
- Key leaders in education should be insurance companies (what is the business case), providers (as a trusted information source), families, medical societies, state health

departments, federal government; faith based groups; chronic disease advocacy groups (diabetes, asthma, cancer, etc.); can also “think outside the box” (for example, postal workers in rural areas)

- Coordination of patients across multiple physicians is another reason for consistent messages; how do we coordinate care across the physicians and across the pharmacies if they use more than one?
 - Also, some patients may not want to be on a list so our messages won’t reach them
- Think about messaging for special needs patients (deaf, no television at home, etc.)
- Education and outreach needs to be a main focus because if people don’t know what is available they cannot use it

Legal and Regulatory Group

- Provisions shouldn’t be triggered only in an emergency, because won’t be prepared to do it if they haven’t practiced
- Pharmacists need autonomy for refill extensions – most can do 3 days, but there are different processes for this; also 3 days is probably not enough in a disaster
- Effort level would be high to change the state laws, but low hanging fruit may be statement of support that can be used for those lobbying at the state level
- Also talked about using pharmacists to extend Rx for displaced patients or for patients that you don’t have a hard copy of what they are taking; can talk to the patient to figure out what they are on and what they may need and then issue a temporary Rx when they can’t get to primary care
 - Most states are too restrictive to do this, can be done in about 11 states
 - Could use a statewide authority for this like Oregon and Idaho have, again a statement of support would help
- Adjudication assurances for when systems are down would help
 - What if we have to fill a brand name because the generic is out? Insurers may not cover this, so how do we avoid the pharmacy taking the cost?
- Leaders would include state boards of pharmacy, state legislatures, state medical societies, pharmacy, nursing, etc.
 - Key group for the letter of support would be those in this room

Communications and Messaging Group

- Need a process with consistent messaging that can be customized to the area and the audience
 - May need to start at the local level, who can communicate with the feds the need and then the feds could create it and push it down

- Concerns are if pharmacists are dispensing early refills because of the texts and they get a lot of extra patients, do we have an alarmist states, do we have the supply, do we have staff, do we need security? Have we identified all the at risk populations?
- How can we use mobile pharmacies?
- We need a streamlined process out of HHS that provides the data (what areas are affected, etc.) to pharmacies, major stakeholders, state EOCs, and patient advocacy groups that can talk to the patients.
 - Also need to think about using different languages and reaching people who aren't in the mainstream communications or linked to a particular pharmacy
- Patient advocacy groups are notably absent and need to be engaged with us
- Data that the federal government has is good but limited – we don't have ground pharmacy data and it may not be appropriate for feds to have it. There are privacy concerns here and it should be done at local and state level.
 - Can help set up relationships, but cannot run the data collection
 - CMS data would be really helpful for the pharmacies, and we need to work together on using this
 - We also don't have the weather trajectory data from the SOC, so that would be useful
 - Also need to align with the EOC locally and what information they have

Dr. Cynthia Hansen: What Is Surprising or Concerning?

- There's a lot out there, but it isn't working together
- It's all about the money
- Patients are the underlying factor, we are concerned about them but what are their thoughts and barriers? If we implement a system, will it work and how will it affect them?
- How can we get a national stockpile of some of the core needed meds and ensure we can get them to the areas that need them?
 - Some states have that already and some distributors are able to move things when they are needed
- Transportation also needs to be considered so that the meds can come in when needed – Emergency management needs to be notified and aware
 - Can we use drones?
- Department of State and Local Readiness (DSLRL) at CDC was looking at stockpiles but the stockpile people were very specific about the types of medications that they control (countermeasures rather than chronic), but what they could do is employ some of their connections. They also recommended looking at the formulas to know what meds are needed and so you're not looking for 8 different types of insulin.

- Again, can we get data regarding what are the most essential meds in that area so that we can make sure the pharmacies have them
- Some believe that information is already available and that this is being done and can be turned around quickly

Dr. Cynthia Hansen: What is “Just One Thing” That You Can Do Now?

- Reinitiate the NCPDP task group
- Improve the NCPDP emergency preparedness plan to allow for refills
- Reintroduce PMPI to CDC/OPHPR
- Bring back to leadership and staff at FEMA and see how we can work together
- Will continue to bring it back to state level public health and coalitions
 - Getting the RECs involved would help
- Represent the state and territorial health dept., look at the state MOUs with the health departments for opportunities for alignment
- Work with internal pharmacy to see if we’ve done an assessment on emergency prep and customer communications
- Creating statement of support for PMPI/pharm scope of practice
- Talk to director of Simplify my Meds to reinforce that emergency should be part of the plan
- Bring report to team and review the disaster preparedness toolkit for physicians, look at patient education materials
- Bring back to association and get a pulse from the pharmacy members to see what they say about policy, operations, and care
- Active workgroup participant on cost/payment under Charlie’s lead to look at 90 day refills
- Continue the dialogue with the whole group to ensure a concerted effort, continue the momentum; help plug everyone in with emergency management
- Gregg: we will look at what, when we share information with all of you; our ability to reach the public depends on you all; need to get our arms around the triggers, etc. Also, will continue to support this effort and bring it up to leadership (who is already committed).

Donna Boston: Critical Infrastructure Protection (CIP)

- CIP has an extended team that works with government and private entities of national infrastructure protection program, you’re invited to join us in our meetings and I am also happy to bring information back
 - Emily Lord launched pharmacy subgroup and would love for people to join – pharmacy, lab, blood are the focus

- CIP also does risk analyses and funds small projects with contractors to do surveys to find vulnerabilities in the critical assets
- Can email her at the cip@hhs.gov box