“ASCP Overview and Legislative Update”

NYS Upstate Meeting

10-12-17
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I have no actual or potential conflict of interest in relation to this program.
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I have no actual or potential conflict of interest in relation to this program.
Program Objectives

1. Describe opportunities for professional collaboration between pharmacy operators, consultant pharmacists and post-acute care providers

2. Examine the DEA policies on long term care pharmacy requirements with respect to provision of controlled medications for patients in this setting

3. Discuss the relationship between Medicare Conditions of Participation and the Impact Act 2014

4. List and discuss current legislations and specific regulatory changes affecting the long term care sector
Industry Drivers

• **Consumer driven health care**
  – Wellness and convenience
  – Internet and Social media - instant communication
  – Changing Demographics

• **Affordable Care Act (ACA)**
  – Changes in Payment and Ownership
  – Value-based reimbursement (VBR)
  – Regulatory environment (CMS)
Consumerism...

• Today’s “patient” is a “consumer” looking for services & information...

• What are they looking for?
  – Health Services
  – Wellness
  – Convenience

• 2021 Consumers will spend 24% of household income on health care

Source: Brian Owens, Kantar Retail Director May 2016
Role of Pharmacists in Health Care

- 2010-2020 primary care demand will increase by 14%
  - Primary care supply expected to increase 8%
- Need for interdisciplinary options
- 93% of Americans live within 5 miles of a pharmacy
- Pharmacists are delivering more than medications:
  - Immunizations
  - Wellness and prevention screening
  - Chronic condition counselling and patient education

Source: Avalere: Developing Trends and Reimbursement of Pharmacist Services Oct 2015
Experts in geriatric medication management.
Improving the lives of seniors.

U.S. BIRTHS 1905 - 2002

- **GI GENERATION**: 1905-1924, 56.6 MILLION
- **SILENT GENERATION**: 1925-1944, 52.5 MILLION
- **BABY BOOMERS**: 1945-1964, 78.2 MILLION
- **GENERATION X**: 1965-1984, 69.5 MILLION
- **GENERATION Y**: 1985-2004, 79.5 MILLION
- **GENERATION Z**: 2005-2024 = 16 MILLION (THUSFAR)
- **GENERATION BLEND**: 2025-2044! UNKNOWN

*ACC HAS CHOSEN THE MONIKER “GENERATION BLEND” BECAUSE THIS WILL BE THE MOST ETHNICALLY ASSIMILATED U.S. GENERATION EVER.*

**SOURCE**: NATIONAL CENTER FOR HEALTH STATISTICS
SNF Goal to Send Patients Home

AHCA/NCAL 2018 goals to improve nursing home quality of care:

1. Decrease nursing staff turnover by 15%
2. Reduce < 30 day rehospitalizations by 15%
3. Improve discharge back to the community by 10% or maintain a discharge rate of at least 70%
4. Reduce off-label use of antipsychotic drugs

Source: Inside Health Policy May 7, 2015
SNF/NF Discharge to Community

SNF Admissions & Discharges 2016 Q²

– 1.8 million Admissions from hospitals
– 1.2 million Discharges to Community
  • 66% go back to community

Source: CMS MDS Data, Prepared by AHCA: The Discharge to Community Measure determines the percentage of all new admissions from a hospital who are discharged back to the community and remain out of any skilled nursing center for the next 30 days. The measure is based on MDS 3.0 data. This document describes how the Discharge to Community measure is calculated and how to interpret your results.
2010 - Affordable Care Act

Based on performance based payment models:

• Value Based Purchasing (ACO)
  – CMS makes deals with hospitals or physician groups
  – Voluntary and savings can be shared

• Bundled Payment for Care Improvement (BPCI)
  – CMS makes deals with Hospitals, Physician groups or LTC providers
  – Voluntary and savings can be shared
Skilled Nursing Centers

15,655 centers 1.7 million beds

Location Breakdown:
- 21% in major cities
- 20% in the outskirts of major cities
- 11% in smaller cities
- 14% in towns
- 15% in rural areas

Individuals Served:
- 3.9 million individuals for short-stay or post-acute rehabilitation and long-term care
- 22% SHORT stays (less than 100 days)
- 44% recieve post-acute rehabilitative care
- 78% LONG stays (100 days or more)

Skilled Nursing Care Centers Prepared by: American Health Care Association June 2015
Payment and Ownership

Who Pays for Care

- **57%** paid by Medicaid
- **14%** paid by Medicare
- **29%** paid by private insurance plans, other payers, and private individuals

Who Operates SNCCs

- **70%** operated by for-profit companies
- **24%** operated by not for profit companies
- **6%** operated by government agencies
Skilled Nursing Center Growth

Trend in Certified Nursing Facilities, Beds and Residents

15,877 Fewer Beds
380 Fewer NHs

Source: Computed by AHCA Research staff using CMS Nursing Facility standard health survey data.
American Health Care Association - Research Department
Patient Care Needs

Changing Skilled Nursing patient population

The Average Medicaid Long Stay Resident...

- 80 years old
- Needs Assistance with 4 out of 5 activities of daily living
- 66% having dementia

Medicaid: Funding Long Term Services and Supports for America’s Frail, Aged Populations Jan/2017
ALF Construction Trend

Growth in Senior Living Industry Establishments and 85+ Population

Figures are indexed to 2001=100 for comparability purposes

Source: Argentum analysis from the U.S. Bureau of Labor Statistics and U.S. Census Bureau
Assisted Living Market

30,200
Assisted Living Communities
(and other residential care communities)

Sources: CDC National Center for Health Statistics, Genworth 2015 Cost of Care Survey, Bureau of Labor Statistics, National Center for Assisted Living
## Assisted Living Trend

### 10 Years of Rising Acuity in Assisted Living

<table>
<thead>
<tr>
<th></th>
<th>2001¹</th>
<th>2010²</th>
</tr>
</thead>
<tbody>
<tr>
<td>Average Age in 2001¹</td>
<td>80</td>
<td>87</td>
</tr>
<tr>
<td>Average Age in 2010²</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay 2001</td>
<td>36 Months</td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay 2010</td>
<td></td>
<td>22 Months</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th></th>
<th>2001¹</th>
<th></th>
<th>2010²</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Using a Walker</td>
<td>30%</td>
<td>45%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Heart Disease</td>
<td>28%</td>
<td>34%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>With Diabetes</td>
<td>13%</td>
<td>17%</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Using a Wheelchair</td>
<td>15%</td>
<td>23%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Source:** NCAL, National Survey of Residential Care Facilities

### Residential Care Communities Provide Increasingly Complex Services

- **89%** provide physical, occupational or speech therapy
- **89%** provide hospice care
- **76%** provide skilled nursing services
- **89%** provide disease-specific programs for residents with dementia

**Source:** 2012 Centers for Disease Control and National Center for Health Statistics study

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**Experts in geriatric medication management.**
**Improving the lives of seniors.**

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**American Society of Consultant Pharmacists (ASCOP)**
Assisted Living Reimbursement

Paying for Care

$43,200 per year

Average Yearly Cost

This is less than the average cost for homemaker services ($44,616) or a home health aide ($45,760). The majority of assisted living residents use some form of private funds to pay for care.

47% of ALs are Medicaid certified

Medicaid

A little more than 15% of residents rely on Medicaid to pay for daily services. Medicaid does not pay for room and board costs. Each state varies on whether it covers assisted living services.

Medicare

But many residents are Medicare beneficiaries, making Medicare issues (hospitalizations, medications, therapy services, etc.) important to assisted living providers.

Sources: CDC National Center for Health Statistics, Genworth 2015 Cost of Care Survey, Bureau of Labor Statistics, National Center for Assisted Living
Pharmacist Collaboration at Transitions

• Support at Three Critical Care Points
  – Admissions Medication Reconciliation During Transition from Hospital to SNF
  – Change in Condition – Potential Drug Related Adverse Event
  – Discharge Medication Reconciliation During Transition from SNF to Home
> 65 - Fastest-growing Group of Internet Users

Among all American adults, the % who use the Internet, by age.

Source: Pew Research Center surveys, 2000–2015
Is the LTC Industry Ready?

Have you installed a wireless infrastructure on your campus?

- **SINGLE-SITE ORGANIZATIONS**
  - 88.8%

- **MULTI-SITE ORGANIZATIONS**
  - 95.1%

- **OVERALL**
  - 91.2%

Source: Argentum analysis of U.S. Bureau of Labor Statistics

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State of the Industry

Our Industry is in an unprecedented period of change

– Changing characteristics of the resident
  • Older and with greater care needs
  • Shorter LOS
  • More discharges to home

– Competition
  • People staying home longer before entering a nursing facility
  • Bundled Payment Program encourages “bypassing” SNFs
  • Home and Community Based Programs
  • Assisted Living Facilities
    – Taking residents that historically went to SNFs
    – Keeping them longer

– Reimbursement Models
  • Bundled Payment for Care Improvement (BPCI) Initiative
  • CJR
  • ACOs
  • Medicare & Medicaid Managed Care
The future of our Medicaid funding faces its greatest threat in years. Congress is considering reforms that would further challenge our ability to provide quality care to our poorest residents. These proposals could dramatically reduce funding to the states and eliminate supplemental funding mechanisms.

*Nationwide Alert: Tell congress to Protect Medicaid: AHCA/NCAL 2-16-17*
State of the Industry

Additional Change Factors

- High volume of sales to Health Care REITs
  - SNFs sold at high values
  - Operators took on historical reimbursement estimates
  - Decreasing census and reimbursement makes these leases challenging

- CMS Five Star Rating System
  - Many provider concerns with process
  - In Philadelphia market 178 SNFs

Philadelphia Market
CMS 5 Star Ratings
178 Facilities

<table>
<thead>
<tr>
<th>Rating</th>
<th>Count</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>5 Stars</td>
<td>46</td>
<td>25.8%</td>
</tr>
<tr>
<td>4 Stars</td>
<td>42</td>
<td>23.5%</td>
</tr>
<tr>
<td>3 Stars</td>
<td>35</td>
<td>19.6%</td>
</tr>
<tr>
<td>2 Stars</td>
<td>31</td>
<td>17.4%</td>
</tr>
<tr>
<td>1 Star</td>
<td>23</td>
<td>12.9%</td>
</tr>
</tbody>
</table>

30%
Reimbursement Evolution

Experts in geriatric medication management.
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Part A  Part B  Part C  Medicaid

Conveners & Managed Care

PAC Facilities  Hospitals

2006 Medicare Part D  PBMs
Experts in geriatric medication management.
Improving the lives of seniors.

- OIG Report
- CMS
- AHRQ
- MEGA Rule
- ACA
- IMPACT ACT
- Quality Measures for DRR
- Med Rec
- Reimbursement Models
  - CRPh/Prescriber Documentation

The genie is out of the bottle!

OIG Report
IMPACT ACT
CMS
AHRQ
MEGA Rule
ACA
Med Rec
Reimbursement Models
CRPh/Prescriber Documentation

MCO/Insurance

OIG Report
IMPACT ACT
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MCO/Insurance
Legislative and Regulatory Activity
“Mega Rule” Background

- Medicare Conditions first published in 1989
- Set standards for health care and safety
- **First comprehensive update since 1991**
- Published July, 2015
- CMS received nearly 10,000 comments
- Final rule issued October 4, 2016
- Interpretive guidelines expected summer 2017
Implementation Timeline

• The Final Rule is effective November 28, 2016.
• Implementation is divided into 3 phases based on complexity.
  – Phase 1: implementation deadline is Nov. 28, 2016.
  – Phase 2: implementation deadline is Nov. 28, 2017.
  – Phase 3: implementation deadline is Nov. 28, 2019.
Key Pharmacy Changes

- Comprehensive person centered care
- Antibiotic Stewardship Program
- Defines medication “irregularities”
- Re-defines “psychotropic drugs”
- Documentation of DRR recommendations and prescriber response
Irregularity Reporting & Follow Up

• **The Final Rule requires:**
  – Pharmacist monthly DRR review to include the complete medical record.
  – Adds **medical director** notification **AND**
  – Requires the **attending physician** to record in the medical record the irregularity was reviewed and what, if any, action has been taken.
Focus on “Person Centered Care”

– Basic Care plan within 48 hours of admission including:
  
  • Patient/Care Giver participation
  
  • Medication Reconciliation:
    – At time of admission
    – At time of discharge
    – Including:
      
      » Pre & post discharge medications & OTC’s
“Mega Rule”
DRR – Reporting & Follow up

• Requires the facility to establish and maintain policies and procedures that address the monthly DRR including:
  – *timeframes* for the various steps in the process
  – defining policy for *immediate action* due to potential harm

• *Intended to allow facilities flexibility* to determine how monthly DRRs will be conducted.
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
Impact Act 2014

• Defines PAC providers to include
  – Home Health Agencies, LTACHs, SNFs and IRFs
• Requires PAC providers to report standardized patient assessment data by October 2018
  – (OASIS), Outcome and Assessment Information Set
  – (MDS), Minimum Data Set
  – (IRF-PAI), Inpatient Rehabilitation Facility Patient Assessment Instrument
  – (LCDS), Long Term Care Hospital Continuity Assessment and Record of Evaluation
Data Element 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 Hospitals – Continuity Assessment Record & Evaluation (CARE) Data Set (LCDS)

IRF-PAI
- Medication Reconciliation

MDS
- Medication Reconciliation

OASIS
- Medication Reconciliation

LCDS
- Medication Reconciliation
## Standard Data Collection Timeline

<table>
<thead>
<tr>
<th>Quality Domain</th>
<th>SNF Due Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Functional Status</td>
<td>October 2016</td>
</tr>
<tr>
<td>Skin Integrity</td>
<td>October 2016</td>
</tr>
<tr>
<td>Medication Reconciliation</td>
<td>October 2018</td>
</tr>
<tr>
<td>Major Falls</td>
<td>October 2016</td>
</tr>
<tr>
<td>Patient Preference</td>
<td>October 2018</td>
</tr>
</tbody>
</table>
## What will be reported to CMS?

### SECTION B  MEDICATION RECONCILIATION

<table>
<thead>
<tr>
<th>B1. Did the post-acute care provider obtain lists of current medications from more than one information source?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>8. N/A; Patient/Resident is not taking any medications [END SECTION]</td>
</tr>
<tr>
<td>9. Unknown; missing information sources or lack of documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B2. Did the prescriber include an indication for each medication on the list or multiple lists obtained from the information sources?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>9. Don’t know; missing information sources or lack of documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B3. Did the review identify any medication discrepancies?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>9. Unknown; missing information sources or lack of documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B4. Did the review identify any potential adverse drug events?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No [if no to both #B3 and #B4; END SECTION]</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>9. Unknown; missing information sources or lack of documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B5. Did any discrepancies or potential adverse drug events involve “high-risk” drugs defined as medications that are either anti-coagulants, anti-diabetics, opioids, anti-psychotics, anti-microbials, or are listed in the Beers Criteria, for example?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No [if no proceed to #B10]</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>9. Unknown; missing information sources or lack of documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B6. Did the post-acute care provider address all high-risk discrepancies or potential adverse drug events within:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>1. 24 hours after admission</td>
</tr>
<tr>
<td>2. 48 hours after admission</td>
</tr>
<tr>
<td>3. 72 hours after admission</td>
</tr>
<tr>
<td>4. Not addressed within 3 days of admission</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B7. Did the post-acute care provider address high-risk discrepancies or potential adverse drug events by involving the patient/resident or patient’s/resident’s family/formal caregiver?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No</td>
</tr>
<tr>
<td>1. Yes</td>
</tr>
<tr>
<td>9. Don’t know; missing information sources or lack of documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B8. Did the post-acute care provider contact a physician (or physician-designee) about all high-risk discrepancies and potential adverse drug events within 24 hours after identification of the first medication issue?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No, the physician was not contacted [if so, proceed to #B10]</td>
</tr>
<tr>
<td>1. No, the physician was contacted but not within 24 hours after identification of high-risk discrepancies and potential adverse drug events</td>
</tr>
<tr>
<td>2. Yes</td>
</tr>
<tr>
<td>8. N/A; The assessment is being completed less than 24 hours after identification of the first medication issue [if so, proceed to #B10]</td>
</tr>
<tr>
<td>9. Unknown; missing information sources or lack of documentation</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>B9. After the physician (or physician-designee) responded, did the post-acute care provider complete the physician (or physician-designee) prescribed/recommended actions within 24 hours in response to all high-risk discrepancies and potential adverse drug events?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Enter Code</td>
</tr>
<tr>
<td>0. No, the actions were not completed</td>
</tr>
<tr>
<td>1. No, the actions were completed but not within 24 hours after the physician responded</td>
</tr>
<tr>
<td>2. Yes</td>
</tr>
<tr>
<td>9. Unknown; missing information sources or lack of documentation</td>
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</tbody>
</table>
**Section B Medication Reconciliation**

<table>
<thead>
<tr>
<th>B1. Did the post-acute care provider obtain lists of current medications from more than one information source?</th>
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<tr>
<th>B3. Did the review identify any medication discrepancies?</th>
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</tr>
</tbody>
</table>

**Did facility obtain more than “1” list?**

**Required indication for use**

**Medication discrepancies found?**

**Adverse Drug Events?**
### Section B Medication Reconciliation

#### High risk drugs?
- anti-coag
- anti-diabetic
- opioids
- anti-psych
- antimicrobial
- Beers

#### Did the facility address High Risk Discrepancies?

<table>
<thead>
<tr>
<th>B5. Did any discrepancies or potential adverse drug events involve “high-risk” drugs defined as medications that are either anti-coagulants, anti-diabetics, opioids, anti-psychotics, antimicrobials, or are listed in the Beers Criteria, for example?</th>
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<th>B6. Did the post-acute care provider address all high-risk discrepancies or potential adverse drug events within:</th>
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<td>Enter Code</td>
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<tr>
<td></td>
</tr>
<tr>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Section B Medication Reconciliation

<table>
<thead>
<tr>
<th>Question</th>
<th>Enter Code</th>
</tr>
</thead>
</table>
| B7. Did the post-acute care provider address high-risk discrepancies or potential adverse drug events by involving the patient/resident or patient’s/resident’s family/formal caregiver? | 0. No  
1. Yes  
9. Don’t know; missing information sources or lack of documentation |
| B8. Did the post-acute care provider contact a physician (or physician-designee) about all high-risk discrepancies and potential adverse drug events within 24 hours after identification of the first medication issue? | 0. No, the physician was not contacted [if so, proceed to #B10]  
1. No, the physician was contacted but not within 24 hours after identification of high-risk discrepancies and potential adverse drug events  
2. Yes  
8. N/A; The assessment is being completed less than 24 hours after identification of the first medication issue [if so, proceed to #B10]  
9. Unknown; missing information sources or lack of documentation |
| B9. After the physician (or physician-designee) responded, did the post-acute care provider complete the physician (or physician-designee) prescribed/recommended actions within 24 hours in response to all high-risk discrepancies and potential adverse drug events? | 0. No, the actions were not completed  
1. No, the actions were completed but not within 24 hours after the physician responded  
2. Yes  
9. Unknown; missing information sources or lack of documentation |
**Section B Medication Reconciliation**

**B10. Did the post-acute care provider communicate the reconciled medication list to the patient/resident or patient’s/resident’s family/formal caregiver?**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td>No</td>
</tr>
<tr>
<td>1.</td>
<td>Yes</td>
</tr>
<tr>
<td>8.</td>
<td>N/A; The physician(s) did not respond and therefore there was no reconciled list</td>
</tr>
<tr>
<td>9.</td>
<td>Unknown; missing information sources or lack of documentation</td>
</tr>
</tbody>
</table>

**B11. Did the post-acute care provider communicate the reconciled medication list to all of the patient’s/resident’s primary care providers?**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
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</tr>
</tbody>
</table>

**B12. Did the post-acute care provider communicate the reconciled medication list to the patient’s/resident’s primary pharmacy?**

<table>
<thead>
<tr>
<th>Enter Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0.</td>
<td>No</td>
</tr>
<tr>
<td>1.</td>
<td>Yes</td>
</tr>
<tr>
<td>8.</td>
<td>N/A ; The physician(s) did not respond and therefore there was no reconciled list</td>
</tr>
<tr>
<td>9.</td>
<td>Unknown; missing information sources or lack of documentation</td>
</tr>
</tbody>
</table>
Provider Status in 115th Congress

New Congress, new bills:

- **Senate-S.109** introduced in January by Sen. Charles Grassley (R-IA) with **33 cosponsors**
  - 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 **138 cosponsors**.
  - Referred to Ways and Means and Energy and Commerce Committees
DRUG ENFORCEMENT AGENCY POLICY
NURSE AS AGENT

• DEA Task Force activity:
  – ASCP and Crowell & Moring hosted a stakeholder meeting - 2015
  – Follow up meeting with Ruth Carter, Chief DEA Office of Diversion Control – Now working with Jim Arnold
  – Follow up meeting was held on March 16, 2017
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DEA Task Force Update

Obtained written clarification from DEA:

– Electronic e-kits: use for 1st dose only do not require separate DEA registration.

Comprehensive Addiction & Recovery Act (CARA)

– DEA Clarification: CARA 30-day fill limitation does not apply to long-term care and hospice patients
  • DEA verified, partial-fills for CII prescription medications with up to 60-days to complete.
USP Chapter <800>
“Handling of Hazardous Drugs in HealthCare Settings”

• Published on February 1, 2016 in the First Supplement to USP 39–NF 34
• Official implementation date of July 1, 2018
• USP developed to further enhance clinician safety
USP Chapter <800> “Handling of Hazardous Drugs in HealthCare Settings”

• Applies to all healthcare personnel who handle hazardous drug preparations (e.g. pharmacists, pharmacy technicians, nurses, physicians, physician assistants, home healthcare workers, veterinarians, and veterinary technicians)

• AND all healthcare entities that store, prepare, transport, or administer hazardous drugs (e.g., pharmacies, hospitals, other healthcare institutions such as LTC facilities, patient treatment clinics, physicians’ practice facilities, and veterinarian offices)
USP Chapter <800>
“Handling of Hazardous Drugs in Healthcare Settings”

• If HD dosage form requires manipulation such as splitting crushing tablet or opening capsule for a single dose,
  – Require PPE (personal Protective Equipment – gloves, gown, mask, etc.) and use a plastic pouch to contain dust.

• If manipulations are made in a pharmacy, full compliance required

• HDs that do not require any manipulation, other than counting or repackaging of final dosage forms, may be dispensed without requirements for containment (unless required by manufacturer)
USP Chapter <800>
“Handling of Hazardous Drugs in HealthCare Settings”

• ASCP joined with other pharmacy associations, writing to all Boards of Pharmacy in the US, asking states to consider a **5 year delay** in enforcement and a phased in approach

• ASCP is working with other pharmacy organizations and USP staff to provide educational sessions for members – coming soon
USP Chapter <797>
“Pharmaceutical Compounding - Sterile Preparations”

• Proposed Revision published in September 2015
  – First Revision to <USP 797> since 2008

• Update needs to harmonize with new USP Chapter 800 handling of hazardous drugs by reference
USP Chapter <797>
“Pharmaceutical Compounding - Sterile Preparations”

• Collapses sterile risk categories from 3 to 2
  – Current: Low, Medium, and High Risk
  – Proposed: **Category 1** and Category 2

• Changes to BUD (Beyond Use Dating)
  – Gloved isolator cabinets w/o clean rooms BUD max 24 hours

• Employee training, testing, and retraining
  – No compounding in > 90 days requires retraining and testing
“Centrality of Pharmacy”

- Home
- HomeCare
- Primary Care Doctor
- Assisted Living Facility
- Nursing Home
- Hospital
- HomeCare
- Home

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In the Future we must reach out.
1. Certificate Program
2. Online Directory
3. Virtual Network
4. Path to BCGP
5. Focus Groups
New Opportunities for Pharmacists

New Certificate Program:
Business Skills for Private Practice

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

Find a senior care pharmacist

A consultant or senior care pharmacist is a pharmacist who provides expert advice on the use of medications to individuals and older adults, wherever they live.

Powered by the American Society of Consultant Pharmacists
www.ascp.com
Senior Care Virtual Pharmacy Network

- New ASCP Membership Category
- Includes credentialing & monitoring required by payors
- Access to SN patients eligible for MTM/CMR
- Includes billing administration by Xchangelabs, LLC
The Future

UBERIZATION...
OF CONSULTANT PHARMACISTS

UBER

SENIORx SOLUTIONS

Experts in geriatric medication management.
Improving the lives of seniors.
Credentials Offer Added Value

ASCP Path to BCGP

- Differentiate yourself
- Advanced clinical practice
- Knowledge and expertise
- Recognized as a qualifying credential by multiple state pharmacy advanced practice programs
Networking Opportunities

ASCP – Focus Groups

• Home and Community Based Consultant Pharmacists
• Nursing Home Executives
• Pharmacy Operators
• Consultant Pharmacist Owner/Operators

• In-person meetings at ASCP Annual Meeting & ASCP Forum
• Specialized education
New Solutions for Consultants

1. Certificate Program
2. Online Directory
3. Virtual Network
4. Path to BCGP
5. Focus Groups
Join us in Kissimmee Nov 2-5

SPECIAL for Senior Care 2017 attendees:

Register now through July 31st using promo code AM17FL50 and save an additional $50 on top of early bird rates!

Pre-conference activities:
- Fall Prevention Workshop
- Private Practice Business Skills Certificate Program
- Home and Community-Based Senior Care Pharmacist Focus Group
- Antimicrobial Stewardship Workshop
ASCP Overview and Legislative Update (10/12/17)
ACPE UAN: 0203-0000-17-032-L03-P * 1.25 Contact Hours
October 12, 2017 * NY Up-State Meeting & CE Day, Williamsville, NY

*Per ACPE, this live activity must be completed within 60 days of the live activity. No exceptions or extensions permitted. CPE evaluation expiration date: December 11, 2017.*

Continuing Pharmacy Education Instructions

Please ensure that your NABP ePID number and DOB are correctly entered in your ASCP Profile before completing any courses.

Go to [www.ascp.com](http://www.ascp.com).

Click on the “Learning” tab (Learning Center – Sign in).

Log in with your ASCP account to be directed to the ASCP Learning Center. If you do not have an ASCP profile, click on [Click here to create a free non-member account.](http://www.ascp.com) to create a Guest account.

Locate “ASCP Overview and Legislative Update (10/12/17)”

Select “Launch”, enter the CE Code provided at the live activity and complete the evaluation

Check your CPE Monitor in 24-48 hours to ensure it is posted. Please contact our Education Department at [education@ascp.com](mailto:education@ascp.com) with any questions or concerns.
Empowering pharmacists to promote healthy aging through the appropriate use of medications.
Learning Center Sign-In
<table>
<thead>
<tr>
<th>Title</th>
<th>Credit Hours</th>
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<tbody>
<tr>
<td>1. 2016 Annual Meeting Flex Plan Recordings - CPE &amp; BCGP</td>
<td>CPE: 1.5</td>
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<tr>
<td>Member $110, Non-Member $175, View Details: 12/15/16 - 6/30/17</td>
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<tr>
<td>2. 2016 Annual Meeting Flex Plan Recordings - CPE Only</td>
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<tr>
<td>Member $70, Non-Member $105, View Details: 12/15/16 - 12/15/17</td>
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<tr>
<td>3. A Collaborative Approach to Falls Prevention: introduction to the</td>
<td>CPE: 1.5</td>
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<tr>
<td>ASCP-NCOA Toolkit Free Webinar, View Details: Launch</td>
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</tr>
<tr>
<td>4. Advocating &amp; Lobbying 101 (On-Demand)</td>
<td>CPE: 1.6</td>
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<tr>
<td>Free Webinar, View Details: Launch</td>
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<tr>
<td>5. ASCP Legislative and Regulatory Update (6/8/17)</td>
<td>CPE: 1.5</td>
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<td>For NY Chapter Mid-State Meeting Attendees Only, View Details: Launch</td>
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<tr>
<td>6. BCGP Self-Assessment Exam</td>
<td>CPE: 1.0</td>
</tr>
<tr>
<td>$99 for 3 Months, $109 for 6 Months, View Details</td>
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Questions