Interoperability in Practice: Pharmacist eCare Plan

Session 296, March 9, 2018
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Conflict of Interest

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Has no real or apparent conflicts of interest to report.
Agenda

• Payment models for pharmacists providing patient care services
• Electronic capture of pharmacist-provided medication-related data
• Interoperable standards to capture pharmacists’ patient care services
• How Pharmacist eCare Plan implementation is changing chronic care management payment models
• Next steps
Learning Objectives

• Describe the value-based and alternative payment models for pharmacist.

• Describe the importance of electronically capturing clinical services such as electronic care plans for chronic care management.

• Discuss the NCPDP/HL7 Pharmacist eCare Plan using HL7 eCare Plan standards.

• Discuss the importance of attaching clinical documentation for future billing models.

• Describe examples of eCare Plans exchange for chronic care management.
Pre-test Questions

• HHS has set a goal to have 30 percent of Medicare payments in alternative payment models (categories 3 and 4) by the end of 2016 and 50 percent in categories 3 and 4 by the end of 2018?

• CMS pays for chronic care management and recommends using certified EHR systems to electronically capture and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers?

• HL7 Clinical Document Architecture (CDA) Clinical Notes R2.1Care Plan standard is the basis for the NCPDP Pharmacist eCare Plan guidance document?
Payment Models
Claims Transactions to Value Capture

- Pharmacy claims - mainly based on prescription dispensing
  - Value is medication adherence or formulary management
  - Movement to merge pharmacy with medical claims
- Pharmacists’ service payment
  - Pharmacist not recognized by Social Security Act as provider
  - MTM payment (PBM/Health plan driven) and EMTM
  - Value is difficult to measure
  - Movement to eCQM to support team-based care
HHS Payment Categories

- Health care payment framework categories how providers receive payment
  - category 1—fee-for-service with no link of payment to quality
  - category 2—fee-for-service with a link of payment to quality
  - category 3—alternative payment models built on fee-for-service architecture
  - category 4—population-based payment

Target percentage of Medicare FFS payments linked to quality and alternative payment models in 2016 and 2018

- **All Medicare FFS (Categories 1-4)**
- **FFS linked to quality (Categories 2-4)**
- **Alternative payment models (Categories 3-4)**

**2016**
- 85%
- 30%

**2018**
- 90%
- 50%

Chronic Care Management

- Process to manage high risk patients
- Care coordination
- Case management
- Follows patient longitudinally through multiple care settings
Chronic Care Management Services Changes for 2017

- What is CCM?
  Chronic Care Management (CCM) services by a physician or non-physician practitioner (Physician Assistant [PA], Nurse Practitioner [NP], Clinical Nurse Specialist [CNS], Certified Nurse-Midwife [CNM]) and their clinical staff, per calendar month, for patients with multiple (two or more) chronic conditions expected to last at least 12 months or until the death of the patient, and that place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline. Only 1 practitioner can bill CCM per service period (month).

The included services are:
- Use of a Certified Electronic Health Record (EHR)
- Continuity of Care with Designated Care Team Member
- Comprehensive Care Management and Care Planning
- Transitional Care Management
- Coordination with Home- and Community-Based Clinical Service Providers
- 24/7 Access to Address Urgent Needs
- Enhanced Communication (for example, email)
- Advance Consent

Please note: The information in this publication applies only to the Medicare Fee-For-Service Program (also known as Original Medicare).

Capturing Medication-Related Data
Workflow - Pharmacists’ Patient Care Process

Joint Commission Pharmacy Practitioners (JCPP)

• COLLECT
• ACCESS
• PLAN
• IMPLEMENT
• FOLLOW-UP MONITOR and EVALUATE

Previous Landscape

• Data stored in many software systems that don’t talk to each other
  – Clinical Data – EHRs
  – Medication Data – pharmacy software
  – Labs/Genomic Data – lab software, EHRs

• Communication standards exist, but **no standard data** set to facilitate interoperability and reporting
Changing Landscape

• Pharmacy Systems
  – Clinical Data captured following Pharmacists’ Patient Care Process workflow
  – SNOMED CT
  – Labs/Genomic Data – collection through C-CDA or HIE

• Standard data sets – search under “PharmacyHIT” value sets in NLM Value Set Authority Center (VASAC)
  – >500 clinical terms identified
  – >100 PharmacyHIT value sets
Value Sets

Reporting
- Quality Measures
- Value-Based Payment

Value Sets

Interoperability
- Health Info Exchange
- Care Coordination
Sharing and Reporting Medication-Related Data with Interoperable Standards
Reporting

Pharmacy

Proprietary Data Set

Payer

Software A

Value Set

Software B

Proprietary Data Set
Enhanced MTM Model

CMS Innovation Grant

Pharmacy

Software A

Software B

Value Set

Payer
Standardization Using Accredited Standards

• Standard Terminology (SNOMED CT)
  – PHIT efforts and resources
  – JCPP standard definitions
• Other standard terminology (RxNorm, LOINC)
• Standard Electric Structure Documents (C-CDA)
  – CCD
  – Discharge and Patient Care Summaries
Other Accredited Standards

• ePrescribing SCRIPT, NCPDP D.0 claims, X12 837 (CMS 1500) medical claim

• CCD to Pharmacist eCare Plan
  – FHIR
  – ONC Interoperability Proving Ground
    https://www.healthit.gov/techlab/iptg/node/4/submission/1376
Pharmacist eCare Plan

Description
This is a joint project between NCPDP and HL7. The goal of this project is to develop an eCare Plan with enhanced medication management content based on the templates in the HL7 Implementation Guide for C-CDA Release 2: Consolidated CDA for Clinical Notes. This care plan called "Pharmacist eCare Plan" will serve as a standardized, interoperable document for exchange of consensus-driven prioritized medication-related activities, plans and goals for an individual needing care. Pharmacist work in multiple environments. The Pharmacist eCare Plan will be a dynamic plan that contains information on the patient, pharmacist and care team's concerns and goals related to medication optimization. The care plan may also contain information related to individual health and social risks that may impact care, planned interventions, expected outcomes, and referrals to other providers or for additional services e.g., nutrition consultation or diagnostic laboratory studies. Fourteen (14) organizations have agreed to implement the Pharmacist eCare Plan. Community Care of NC (CCNC), Community Pharmacy Enhanced Service Network (CPESN), Indian Health Services (IHS), QS1, PioneerRX, Rx30, Computer-RX, Creative Pharmacist, VIP Pharmacy Systems, AssureCare, BestRx, McKesson, PDX-NHIN-Rx.com, Pharmetika PrescribeWellness, AZOVA, DocsInc, DocStation, FDS, Fuse, MicroMerchant Systems, Omnicell, Innovative Pharmacy Solutions, Smartlink Health Solutions and Speed Script. The IG will be The FHIR resources will be used for this project.

- http://www.hl7.org/Special/committees/structure/projects.cfm?action=edit&ProjectNumber=1232

Start Date 12/21/2015  Projected End Date 09/30/2020
Pharmacist eCare Plan Adoption

- CCNC to CPESN USA (https://www.cpesn.com/)
- 23 pharmacy system and case management vendors adoption
- Proof of interoperable exchange
  - CCNC as of Oct 2017 >3800 completed Pharmacist eCare Plans from >100 different pharmacies
  - Vendors used Pharmacist eCare Plan FHIR IG to create the shared eCare Plan
Next Steps

- Pharmacist eCare Plan & FHIR Standards for Trial Use
- Link PHIT Value Sets to the standard
- Share Pharmacist eCare Plan nationally with providers and payers
- Expand use of eCare Plan standard for chronic care management
  - Supporting provider/payer payment models
  - Use discrete codified non-claims based data
  - Outcomes based eCQMs
Assessment Question 1

1. What are the 4 HHS payment taxonomy framework categories?
   a. Fee for service – no link to quality
   b. Fee for service – link to quality
   c. Alternative payment models built on fee for service architecture
   d. Population based payment
   e. All of the above
Assessment Question 2

2. True or False - HHS has set a goal to have 30 percent of Medicare payments in alternative payment models (categories 3 and 4) by the end of 2016 and 50 percent in categories 3 and 4 by the end of 2018?
Assessment Question 3

3. True or False - CMS pays for chronic care management and recommends using certified EHR systems to electronically capture and share care plan information electronically (other than by fax) as appropriate with other practitioners and providers?
Assessment Question 4

4. True or False - HL7 Clinical Document Architecture (CDA) Clinical Notes R2.1Care Plan standard is the basis for the NCPDP Pharmacist eCare Plan guidance document and the HL7 Pharmacist Care Plan draft standard?
Assessment Question 5

5. HL7 eCare Plans can be attached as an attachment to the following standards?
   a. NCPDP D.0
   b. X12 837P
   c. None of the above
   d. All of the above
Answers

• Key (1)e; (2)T; (3)T; (4)T; (5)b
Questions

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