Navy Pharmacy Breakout

October 22, 2018
# Navy Pharmacy Breakout Sessions Agenda

<table>
<thead>
<tr>
<th>Time Period</th>
<th>Session Title</th>
<th>Presenter(s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1400-1445 EST</td>
<td>1) Pharmacy Updates – Where We Are and Where We Are Going</td>
<td>CAPT Brandon Hardin</td>
</tr>
<tr>
<td></td>
<td>2) Opioid Stewardship</td>
<td>CDR Janel Rossetto, LCDR Reina Gomez</td>
</tr>
<tr>
<td>1445-1530 EST</td>
<td>3) Clinical Pharmacy Update • Virtual Health • Auricular Acupuncture</td>
<td>Dr. Alexandra Vance</td>
</tr>
<tr>
<td>1530-1600 EST</td>
<td>4) MTF Transition to DHA</td>
<td>CDR Janel Rossetto</td>
</tr>
<tr>
<td>1600-1630 EST</td>
<td>5) Pharmacy Technician Roles – Pharmacy Enlisted Technical Leader</td>
<td>HMC (SW) Jennifer Muldrew, LT Sebastian Garcia</td>
</tr>
<tr>
<td>1630-1700 EST</td>
<td>6) USNH Guantanamo Bay and Its Unique Mission</td>
<td>LCDR Jone’ Tillman</td>
</tr>
</tbody>
</table>
CPE Information

- Target Audience: Pharmacists and Pharmacist Technicians
- ACPE#: 0202-0000-18-240-L04-P/T
- Activity Type: Knowledge-based
Learning Objectives

- Describe enterprise-wide initiatives guiding administrative and clinical decisions within Navy Pharmacy.
- Identify national standards and applicable regulations that can be applied to improve patient/medication safety and operational efficiencies.
- Identify industry, professional, and Service-specific best practices to make sound fiscal decisions.
Pharmacy Updates: Where We Are and Where We Are Going

CAPT Brandon W. Hardin, PharmD
CAPT, MSC, USN
Pharmacy Consultant & Specialty Leader
Bureau of Medicine and Surgery
CAPT Hardin declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

The American Pharmacist Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Self-Assessment Questions

1) Navy Pharmacy’s annual expenditures have been steady the last 4 years.
   a) TRUE
   b) FALSE

2) Pharmacists impact which of the following areas:
   a) Formulary management
   b) Drug shortages
   c) Controlled substances management
   d) All of the Above
   e) None of the Above
3) The FY17, FY18 and FY19 National Defense Authorization Acts (NDAA) have no impact on Navy Pharmacy Community.

   a) TRUE
   b) FALSE
Pharmacy: The view from 30,000 feet…

**Navy Pharmacy**
- Number of FTEs AD/CIV/CTR Pharmacists at MTFs: ~300
- Number of FTEs AD/CIV/CTR Pharmacy Techs at MTFs: ~900
- Navy MTF spending in FY18:
  - FY17 - $446M
  - FY16 - $400M
  - FY15 - $485M
- Navy Prescriptions processed at 100+ MTFs in FY18:
  - FY17 - 10.7M
  - FY16 - 10.8M
  - FY15 - 11.1M

**DoD Pharmacy Points-of-Service**

<table>
<thead>
<tr>
<th>Point of Service</th>
<th>Actual # of Rx</th>
<th>Total 30-day eq Rx</th>
<th># of utilizers*</th>
<th>Total Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>MTF</td>
<td>45,580,116</td>
<td>78,828,329</td>
<td>3,787,651 (40%)</td>
<td>$2.174B</td>
</tr>
<tr>
<td>Retail</td>
<td>44,098,030</td>
<td>42,974,778</td>
<td>4,399,413 (47%)</td>
<td>$2.181B</td>
</tr>
<tr>
<td>TMOP</td>
<td>30,348,656</td>
<td>85,751,701</td>
<td>1,702,150 (18%)</td>
<td>$3.313B</td>
</tr>
</tbody>
</table>
The Navy Pharmacy Advisory Board (NPAB) services as the chief advisory group the Navy Pharmacy Consultant and optimizes the delivery of pharmacy care by representing the Navy Pharmacy Community.

- **Policy Development**: The NPAB helps in developing and updating Navy Pharmacy policy and processes in support of the Navy Surgeon General's Strategic Goals and Enabling Objectives
- **Standardization and Modernization**: The NPAB supports efforts across the entire pharmacy enterprise, from standardization to modernization, all to ensure the delivery of clinically effective, safe and cost efficient care to our patients

**Membership**
- The board is chosen from the community with representatives from NME and NMW each having a seat
- Other members are selected from the Navy Pharmacy community and include MTF Pharmacists, JOs, civilians, and enlisted personnel (pharmacy technicians)

**Roles**
- The NPAB’s role includes:
  - **Reviewing** all Navy Pharmacy SOP changes
  - **Providing** oversight for the program to ensure compliance with IG, Joint Commission, IOM, and other standards required of Navy Pharmacy
NPAB Accomplishments and Current Initiatives

**NPAB Accomplishments**

**Standard Operating Procedure (SOP) v5.0:** NPAB reviewed and incorporated 150+ SOP change requests into SOP v5.0 deriving from the Navy Pharmacy community, Institute for Safe Medication Practices (ISMP) guidance, United State Pharmacopeia (USP) 797 and 800, and The Joint Commission guidelines, with the goal of providing safe care, high-quality patient experience, and a consistent experience for pharmacy staff; SOP v5.0 released in summer 2018

**2018 NPAB Onsite Meeting:** NPAB members met for a one week summit to tackle key pharmacy topics. Key accomplishments included:
- **Identified** $14.3M in fiscal adjustments resulting in $11.5M proposed pharmacy cost reductions
- **Identified** 15 initiatives to be prioritized in FY19 to serve and enhance the Navy Pharmacy Community
- **Determined** and finalized standardized best practices for United States Pharmacopeia (USP) 800, Navy Pharmacy Staff Credentialing and Privileging programs
- **Developed** 14 Navy Pharmacy Technician Personnel Qualification Standards (PQS) and identified additional necessary PQS to be developed.

**Standardization Initiatives:** NPAB completed several standardization initiatives that aim to create improvements in patient care. Initiatives included creating a Hazardous Drug Exposure and Waste Flowsheet Guide.

**Current Initiatives**

- Deployment Readiness Training and Readiness
- USP 800 Site Preparation
- Communication Strategy and milSuite Revamp
- Drug Shortage Plan
- Unit Does Packaging Standardization
- Monthly Cleaning Log Standardization
- Pharmacy Technician / Pharmacist Personnel Qualification Standards (PQS)
Major Contributions to the Mission

**DEPLOYMENT SUPPORT**
- Continuing Promise
- Pacific Partnership
- NATO Role III Kandahar
- Humanitarian Assistance – South America

**COMMUNITY ACCOMPLISHMENTS**
- Inventory Optimization Platform – cost-savings/avoidance of $65M in FY16, $31M in FY17, $11M FY18
- Drug Take Back Program – Since NOV16: 12,000 pounds collected (JUN18)
- NORA – 43% of DEA numbers registered (lead other services)
- Pharmacy Data Standardization – 42% of drug files reviewed
- USP 800 | TJC | GSL Pilot | Auto-sub Pilot

**MHS GENESIS**
- Implementation – NH Bremerton & NHC Oak Harbor
- LEADERSHIP: BUMED Implementation Lead – CAPT Dave Hardy; DHA OCHIO Pharmacy Solution Owner – CDR Angie Klinski

**Executive Medicine**
- CAPT Kim Lefebvre – Commanding Officer, Naval Submarine Medical Research Laboratory
- CAPT Jody Dreyer – Executive Officer, USNS Comfort
- CAPT Chad McKenzie – Executive Officer, NHC Patuxent River
Reserve Component Major Contributions

1. 39 Reserve Pharmacists (36 Billets): 108% Manned (down from 44 Pharmacist FY17)
   - 78% Billet Fill (28/36)
   - 9 Pharmacists filling billets other than a Pharmacist Billet (8) or VTU (1)

2. Mobilization - BUMED (EMF OSO): 1 Pharmacy officer
   NMCP backfill support: Pending

3. Expeditionary Medicine (Global Medic): 72 days of Annual Training (AT)
   Expeditionary Medicine (IRT): 28 days of Annual Training (AT)
   DHA Pharmacy: 352 days of Annual Training (AT)

4. RC and AC Manpower Collaboration Project: Proactive communication with MTF
   Pharmacy Department Heads and Operational Support Offices
   Matching RC and MTF by geography and skill set
August 2018 Enterprise Performance Metrics

$7.15M

Or approximately 3% of total expenditures, identified as cost avoidance across the 30 sites that have implemented the Supply Optimization Solution

54 MTFs

Have successfully implemented the Standard RxMAP Patient Information Centers and Performance Management Dashboards

150+

SOP change requests processed and v.5.0 released on 23 July 2018

Navy Pharmacy staff trained and 5 webinars conducted to support SOP launch

99

staff trained during 6 webinars on the Pharmacy Controlled Substances “Career Saver” go-by and The Joint Commission Audit Preparation

80%

*Patient-reported satisfaction for the month across the 17 PE sites as of April 2018
Future of MHS and Navy Pharmacy
### Military Health System (MHS)

#### FY17 NDAA
- **Section 702** | Services / DHA Structure
- **Section 743** | Drug Cost Parity Pilot
- **Section 744** | Urgent Care & Pharmacy Wait Times Pilot

#### FY18 NDAA
- **Section 702** | Prescription Copay Changes
- **Section 735** | Study on Safe Opioid Prescribing Practices

#### FY19 NDAA
- **Section 711** | Services / DHA Structure
- **Section 715** | Establishes MHS PDMP
- **Section 716** | Opioid Management Pilot

---

**DEFINITIONS**

- **DHA** | Defense Health Agency
- **NDAA** | National Defense Authorization Act
- **PDMP** | Prescription Drug Monitoring Program
MHS continued

**Standardizing Clinical Business Practices**
- **DHA-PI** (Procedural Instruction)
  - DHA- PM (Procedures Manual)
    - DHA-TM (Technical Manual)
- **DHA-IPM** (Interim Procedures Memorandum)

**Publications Impacting Pharmacy**
- **DHA-PI 6025.25** – MHS Drug Take Back (DTB) Program
- **DHA-PI 6025.04** – Pain Management and Opioid Safety in the MHS
- **DHA-PI 6025.07** – Naloxone in the MTFs
- **DHA-PI 6025.08** – Pharmacy Enterprise Activity
- [upcoming] **DHA-PI 6025.XX** MTF Pharmacy Operations

**Enterprise Activity Approach**
- **Identify** critical policy variations
- **Facilitate** Pharmacy Work Group (PWG) and sub-groups collaboration to standardize processes
- **Develop** and **publish** PIs and PMs
- **Implement** standardized policies and procedures using Service, DHA, and transitional oversight
Leaders in the MHS Pharmacy

Leaders in the MTF Pharmacy

Leaders in Readiness (Ready Medical Force and Medically Ready Force)

- “Combat Pharmacist” > Residency trained, board certified pharmacotherapy specialists; ACLS/critical care
- “Pier-side Pharmacist” > Comprehensive MTM; support HRO principles for seagoing pharmacies; experts in pharmacy logistics

Where will Navy Pharmacists be in 5 years, 10 years, 20 years?
Key Points

- Navy Pharmacy’s extensive experience in enterprise standardization positions us for leadership in the MHS.

- Many specifics on the MHS transition must still be defined, but patients will still get the medications they need.

- BUMED’s increased focus on readiness brings opportunities for Navy Pharmacy.
1) Navy Pharmacy’s annual expenditures have been steady the last 4 years.
   a) TRUE
   b) FALSE

2) Pharmacists impact which of the following areas:
   a) Formulary management
   b) Drug shortages
   c) Controlled substances management
   d) All of the Above
   e) None of the Above
3) The FY17, FY18 and FY19 National Defense Authorization Acts (NDAA) have no impact on Navy Pharmacy Community.

   a) TRUE

   b) FALSE
Closing Remarks

CAPT Brandon W. Hardin, PharmD
CAPT, MSC, USN
Pharmacy Consultant & Specialty Leader
Bureau of Medicine and Surgery
Opioid Stewardship

CDR Janel Rossetto/LCDR Reina Gomez
NH Jacksonville/NMC Portsmouth
CDR Janel Rossetto and LCDR Reina Gomez declare no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.
Self-Assessment Questions

1. PDMS is a sub-committee of:
   a) Medical Executive Board
   b) Command Executive Board
   c) Long Term Opioid Therapy Safety
   d) Pharmacy and Therapeutics

2. DHA-PI 6025.07 Naloxone Prescribing and Dispensing by a Pharmacist pre-implementation begins ____ days from signature.
   a) 30
   b) 90
   c) 60
   d) 120
Self-Assessment Questions

3. TRUE/FALSE: If pharmacist doesn’t have access to a computer or the Patient Look Up Tool in CarePoint, pharmacist should use the Naloxone Evaluation and Prescription Form.

4. The following patient would fall within the criteria for a LOTS patient:
   a) 30yo received first Rx for 7 day supply of Percocet post/op,
   b) 70yo on Norco getting 30 tablets every 3-4 months,
   c) 25yo on tramadol getting #60 each month for the last 6 months.

5. The DHA-PI for Pain Management indicates for uncomplicated, opioid-naïve patients, opioid prescriptions should be limited to no more than a _____ day supply of short-acting opioids for acute pain episodes, including postoperative pain from minor outpatient procedures.

6. The Joint Commission 2018 standards include three chapters involving pain: Provision of Care, Treatment and Services; Performance Improvement; and ______.
From 1999 to 2016, more than 630,000 people have died from a drug overdose.

Around 66% of the more than 63,600 drug overdose deaths in 2016 involved an opioid.

In 2016, the number of overdose deaths involving opioids (including prescription opioids and illegal opioids like heroin and illicitly manufactured fentanyl) was 5 times higher than in 1999.

On average, 115 Americans die every day from an opioid overdose.¹

**Prescription Drug Misuse Sub-Committee (PDMS) Overview**

<table>
<thead>
<tr>
<th>Background</th>
<th>PDMS Sub-Committee was established by the Pharmacy and Therapeutics Committee</th>
</tr>
</thead>
<tbody>
<tr>
<td>Purpose</td>
<td>To establish protocols for the review of potential misuse of controlled substance prescriptions</td>
</tr>
<tr>
<td>Members</td>
<td>At least one representative from each department/discipline is recommended:</td>
</tr>
<tr>
<td></td>
<td>Internal Medicine                  Pharmacy</td>
</tr>
<tr>
<td></td>
<td>Primary Care (Branch Health Clinic Representative)                         Psychiatry</td>
</tr>
<tr>
<td></td>
<td>Case Management                   Substance Abuse Rehabilitation Program (SARP)</td>
</tr>
<tr>
<td></td>
<td>TRICARE Management Activity      Drug and Alcohol Program Advisors (DAPA)</td>
</tr>
<tr>
<td></td>
<td>Emergency Medicine                Pain Management</td>
</tr>
<tr>
<td>Assistance</td>
<td>From Legal, Neurology, Orthopedics, etc.</td>
</tr>
<tr>
<td>Controlled Substance Drug Overlap Detection</td>
<td>• Aided by use of Composite Health Care System (CHCS) and Pharmacy Data Transaction Service (PDTS) to detect controlled substance drug overlaps</td>
</tr>
<tr>
<td></td>
<td>• Drug overlap → active prescriptions for</td>
</tr>
<tr>
<td></td>
<td>o Two medications in the same therapeutic class,</td>
</tr>
<tr>
<td></td>
<td>o Two or more prescriptions for the same drug, or</td>
</tr>
<tr>
<td></td>
<td>o Patient is requesting an early refill of an active prescription</td>
</tr>
<tr>
<td>Case Referrals to PDMS</td>
<td>• Any licensed provider involved in the care of a given patient who expresses concerns over suspected misuse or drug-seeking behaviors</td>
</tr>
<tr>
<td></td>
<td>• Any case where Pharmacy and/or provider identifies patient receiving early refills or multiple refills</td>
</tr>
<tr>
<td></td>
<td>• Any patient who has violated a treatment agreement/informed consent</td>
</tr>
</tbody>
</table>
**Prescription Drug Misuse Sub-Committee (PDMS)**

### Responsibilities of PDMS
- **Review** patient’s chart and drug profile to include accessing the State Prescription Drug Monitoring Program
- **Report** any action to Pharmacy

### Responsibilities of Primary Prescriber
- **Contact the patient** and schedule appointment
- **Take** appropriate action → counseling and titration withdrawal from controlled substances or referral to appropriate sources for evaluation
- **Report** back to PDMS

- **Patients may be restricted from obtaining all future prescriptions for controlled medications from an identified primary healthcare provider**

- **Patient’s TRICARE Pharmacy benefit may also be restricted** through Express Scripts MTF Restriction Program
Once concerning activity has been identified:

- A series of **3 letters are sent to the patients** notifying them that concerning activity has been identified.
- Single provider must **oversee use** of controlled substances.
- **Restrictions** may be placed on TRICARE Pharmacy benefits if concerns persists.
- If patient refuses to follow course of therapy, **provider may consult PDMS**
  - Multi-disciplinary conference
  - Referral to a Pain Extension for Community Healthcare Outcomes (ECHO)
  - Screening for a substance use disorder
- If an agreement can't be reached, case will be presented to the **next professional level of responsibility** for review and evaluation
  - Quality Assurance/Risk Management Committee
  - Professional Practice Evaluation Committee
  - Credentialing Committee
  - Command Executive Board

*NMCP currently follows 70 patients*
Alarming National Trends/Opiate Crisis

Navy Comprehensive Pain Management Program (NCPMP)
- Established 2012
-BUMEDINST 6320.101 – Pain Management/Opioid

Subcommittee under Medical Executive Committee (MEC)
- Monitor, Audit Long-Term Opioid Therapy (LOT)
- Improve care and safety of LOT patients

Long-Term Opioid Therapy Patient: >90 day Opioid supply
- Minimal breaks between prescriptions
- Excludes ≤1 pill/day of hydrocodone 5mg, oxycodone 5mg or tramadol 50mg
- Excludes pts with cancer diagnosis
## CPG Standards

### Audit
- **2017 VA/DoD CPG:** *Management of Opioid Therapy for Chronic Pain* is the source of Recommendations/Audit Standards
- **VA/DoD Guidelines require:**
  - Screening prior to Opioid Initiation
  - Opioid Care Agreement
  - Regular Safety, Pain, Function Assessment
- **Note:** Focus is on PRESCRIBER of Opioids (Limited Record Review for Network sources)

### Screening
- **Screening:** past psychiatric assessment and substance use Hx
  - Required at initial visit and annually
  - Opioid Risk Screening – DIRE, ORT, SOAPP-R
- **Absolute Contraindications for Opioids:**
  - Acute Psych Instability
  - Uncontrolled Suicide Risk
  - Non-nicotine Substance Use Disorder
  - Concurrent, Long-term Benzodiazepines

### Agreement
- **Opioid Care Agreement form**
  - At initiation of long-term opioid prescribing
  - BUMED Form with instruction
    - Labor intensive form
    - Recommendations, such as checkboxes, submitted to BUMED with instruction; however, would have delayed instruction signing by several months
    - NH Jax uses an overlay to the form to ease provider completion
- **Benefit and Risk**
  - Assessment (Every visit, at least every 90 days)
    - Degree of analgesia
    - Functional goals
    - Opioid-related adverse effects
    - Aberrant behaviors
  - Urine drug test (Initial, random at least annually)
    - Order as “Compliance Drug Analysis”

### Safety
- Scanned, uploaded and titled “Opioid Care Agreement” in AHLTA/HAIMS for ease in data collection
## Resources Overview

<table>
<thead>
<tr>
<th>Pain Consults</th>
<th>Provider Education</th>
<th>TSWF Chronic Opioid Therapy AIM form</th>
<th>Additional</th>
</tr>
</thead>
</table>
| • Pain Management Physician  
  • Pain Psychologist  
  • Pain Psychiatrist  
  • Pain Pharmacist (hospital, BHC Mayport, BHC Kings Bay)  
  o See all beneficiary categories  
  o Direct patient care  
  o LOTS Committee leadership/chart reviews  
  o Pain ECHO  
  o BFA | • PDMP better than “DPRX” in CHCS  
  • If Tricare doesn’t pay, Opioids not in CHCS/AHLTA  
  • Clinical pharmacists available for questions, do not manage opioids | • Contains All Required Items  
  • Challenge: primary care instructed to use TSWF-Core  
  • AHLTA TSWF developers emphasize use of multiple templates | • MTF Restriction Program  
  • Pain ECHO – Multidisciplinary Review, Didactic Presentations  
  • Training – JPEP, Do No Harm  
  • Provider Roadshows, Handouts  
  • SharePoint intranet resources for ease in provider access |
DHA-PI Pain Management and Opioid Safety in the MHS

Overview:

| Background | • DHA-PI 6025.04  
|            | • Signed 8 June 2018 (effective upon signature) |

Pharmacy Operations Division (POD) will do the following:

• Notify Managed Care Support Contractors (MCSCs) (via TRICARE Health Plan) of adverse prescribing trends among purchased care providers

• Provide solutions allowing MTF providers and pharmacies to use Prescription Drug Monitoring Program (PDMP) websites to monitor patients' opioid therapy and improve patient safety

• Provide solutions allowing civilian providers and pharmacies to use PDMP websites to monitor TRICARE beneficiaries' opioid therapy and improve patient safety

• Support availability of drug take-back services at MTFs
# Opioid Prescribing Guidance

<table>
<thead>
<tr>
<th>Opioid Prescribing Guidance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(1) Uncomplicated, opioid-na'ive patients</strong></td>
</tr>
<tr>
<td><strong>(2) Uncomplicated, opioid-na'ive patients who have had dental procedures</strong></td>
</tr>
<tr>
<td><strong>(3) Best clinical judgement</strong></td>
</tr>
<tr>
<td><strong>(4) Postoperative pain from major surgeries</strong></td>
</tr>
<tr>
<td><strong>(6) Escalating opioid use patients</strong></td>
</tr>
<tr>
<td><strong>(7) 90+ mg of morphine or equivalent patients</strong></td>
</tr>
<tr>
<td><strong>(8) Drug takeback program</strong></td>
</tr>
</tbody>
</table>
# Naloxone Prescribing and Dispensing by Pharmacists in MTFs (DHA-PI 6025.07): Overview

## DHA-PI 6025.07 Overview

<table>
<thead>
<tr>
<th>Date Signed</th>
<th>June 19, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Purpose</strong></td>
<td>Establishes procedures for prescribing and dispensing naloxone by pharmacists in MTFs to eligible beneficiaries, upon beneficiary request, or when the pharmacist determines the beneficiary meets the established criteria for being at risk for a life-threatening opiate overdose</td>
</tr>
</tbody>
</table>

## Roles and Responsibilities

<table>
<thead>
<tr>
<th>Role</th>
<th>Responsibility</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Director DHA</strong></td>
<td>Identify key DHA officials to carry out procedures</td>
</tr>
<tr>
<td><strong>Deputy Assistant Director, Healthcare Operations</strong></td>
<td>Provide oversight of the program implemented</td>
</tr>
<tr>
<td><strong>Division Chief, DHA Pharmacy Operations Division</strong></td>
<td>Assess utilization of the program with measures of performance and effectiveness</td>
</tr>
<tr>
<td><strong>Service Pharmacy Consultants</strong></td>
<td>Provide DHA-PI to all Pharmacy Directors for implementation</td>
</tr>
<tr>
<td><strong>Directors, MTF Pharmacies</strong></td>
<td>Obtain approval to dispense naloxone and disseminate DHA-PI to Section Supervisors</td>
</tr>
<tr>
<td><strong>MTF Pharmacy Department Heads/Section Supervisors</strong></td>
<td>Provide training to ensure all staff comprehends the appropriate use of the procedures</td>
</tr>
<tr>
<td><strong>MTF Pharmacists</strong></td>
<td>Ensure naloxone is available in the pharmacy according to the Basic Care Formulary; follow procedures on DHA-PI when the beneficiary meets the established criteria for being at risk for a life-threatening opiate overdose or based upon an assessment and professional judgement</td>
</tr>
</tbody>
</table>
Naloxone Prescribing and Dispensing by Pharmacists in MTFs (DHA-PI 6025.07): Timeline

**Pre-Implementation**
*Will begin within 60 days from signature of the DHA-PI on naloxone by MTFs pharmacists*

- Coordinate with Pharmacy and Therapeutics and Medical Executive Board for approval of implementation
- Standing orders will allow pharmacists the authority to dispense naloxone

**Prior to Implementation**
*Ensure all personnel are trained, and the naloxone and beneficiary education materials are stocked and ready for distribution*

**Implementation**
*Will begin once MTF pharmacists are trained, and when naloxone and beneficiary education materials are available in pharmacy*

- Once approval obtained, pharmacist will offer naloxone to beneficiaries being prescribed opioid prescriptions who have been identified with the CarePoint through the Patient Look up Tool
Naloxone Prescribing and Dispensing by Pharmacists in MTFs (DHA-PI 6025.07): Process

MTF Pharmacists will use the Patient Look Up tool available in CarePoint to determine beneficiary eligibility criteria for being at risk for overdose:

1. If beneficiary meets criteria, the screen will display “RECOMMEND NALOXONE”
2. Pharmacists will review patient’s profile for any contraindications prior to offering naloxone to beneficiary
3. If no contraindications and patient eligible, pharmacists will counsel beneficiary on availability of naloxone and dispense upon the beneficiary’s or caregiver’s request

- If patient is pregnant or planning to become pregnant, do not dispense naloxone and refer to provider
- If beneficiary under 18 years old, pharmacist should use their best clinical judgment and dispense naloxone when appropriate
- If beneficiary accepts naloxone, pharmacist will input a prescription using a standing order for naloxone and dispense
- If beneficiary requesting naloxone without filling opioid prescription, pharmacist will go through the same process of inputting using a standing order
- If beneficiary decline recommended naloxone prescription, pharmacist will document of the refusal
Naloxone Prescribing and Dispensing by Pharmacists in MTFs (DHA-PI 6025.07)

**Naloxone Dispensing**
- MTFs Pharmacists that don’t have access to a computer and is unable to login to CarePoint, use Attachment 5 “Naloxone Evaluation and Prescription” to dispense naloxone to beneficiaries
- To assist in determining eligibility, an opioid daily dose conversion chart is available for MTF Pharmacist

**Prescriber Notification**
- If beneficiary has received two or more naloxone prescriptions within the last 6 months, or asks for a refill of naloxone, the MTF pharmacist will request rationale for multiple naloxone prescriptions
- Beneficiary is not required to respond, but if they do, it will be documented
- MTF pharmacist will contact beneficiary’s prescriber to discuss opioid and naloxone use

**Performance Measures**
- DHA will use data collection capabilities to assess utilization of Patient Look Up Tool
Naloxone Prescribing and Dispensing by Pharmacists in MTFs (DHA-PI 6025.07)

- Attachment 1 → Naloxone Standing Order Example
- Attachment 2 → Opioid Safety Patient Education Brochure
- Attachment 2 → Administering Naloxone Quick Patient Education Guide
- Attachment 3 → Access to CarePoint
- Attachment 4 → Naloxone Patient Look Up Tool Screen Shots
- Attachment 5 → Naloxone Evaluation and Prescription
Patient Look Up Tool
Patient Look Up Tool Dashboard

PATIENT LOOKUP TOOL USAGE STATISTICS

DMIS: All

12/7/2017 to 3/13/2018

Percentage of Fills Utilizing the Patient Lookup Tool

Hover over a Pharmacy Employee to highlight their corresponding Lookup Tool Usage

11,733 Patients with ROSOED >32 during the specified time period

664 Naloxone dispensing to patients with ROSOED >32 during the specified time period

% of encounters where Naloxone dispensed among the high-risk, eligible population:

- Lookup Tool: 22.1%
- No Lookup Tool: 1.6%

Patient Lookup Tool Usage by Pharmacy Employee

Hover for Dashboard Instructions
TJC Standards

- Starting 1 Jan 2018 TJC will enforce new pain assessment and management standards
- Requirements include the presence of leadership regarding pain management and safe opioid prescribing, provision of non-pharmacologic pain treatments, and monitoring of opioid use to maximize patient safety.
- The MHS Stepped Care Model has been affirmed by TJC leadership as a potential best practice for implementing these standards.

TJC Leadership

*Effective January 2018*

- Identify a team that is responsible for pain management and safe opioid prescribing
- Involve patients in developing their treatment plans and setting realistic expectations and measurable goals
- Promote safe opioid use by identifying & monitoring high-risk patients
- Conduct performance improvement activities focusing on pain assessment/management to increase safety & quality
**TJC Standards: Hospital, Staff, and Provision of Care**

<table>
<thead>
<tr>
<th>Responsibilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Hospital – Standard LD.04.03.13</strong></td>
</tr>
<tr>
<td>Pain assessment, pain management, &amp; safe opioid prescribing is identified as an organizational priority for the hospital</td>
</tr>
<tr>
<td>• Provide nonpharmacologic pain treatments</td>
</tr>
<tr>
<td>• Offer educational resources and programs on pain and safe prescribing</td>
</tr>
<tr>
<td>• Give information on consultation/referral for complex pain needs</td>
</tr>
<tr>
<td>• Facilitate clinician access to prescription drug monitoring databases (PDMP) access and use</td>
</tr>
<tr>
<td>• Identify opioid treatment programs for referrals</td>
</tr>
<tr>
<td>• Acquire equipment needed to monitor patients at high risk for adverse outcomes from opioid treatment</td>
</tr>
</tbody>
</table>

| **Staff – Standard MS.05.01.01** |
| • The medical staff has a leadership role in organization performance improvement activities to improve quality of care, treatment, and services and patient safety |
| • Element of Performance #18 |
| • The medical staff is actively involved in pain assessment, pain management, and safe opioid prescribing through: |
|   o Participating in establishment of protocols/quality metrics |
|   o Reviewing performance improvement data |

| **Provision of Care – Standard PC.01.02.07** |
| • The hospital assesses and manages the patient’s pain and minimizes risks associated with treatment |
| • Elements of Performance #5-8 |
| • Numerical pain scales alone are inadequate – assess patient’s function and ability to reach treatment goals |
| • Involve patients in developing their treatment plans and setting realistic expectations and measurable goals |
| • Monitor high-risk patients for opioid adverse outcomes |
| • Educate patients and family on pain management plans, including side effects and safe use/storage/disposal of opioids |
### Performance Improvement - PI.01.01.01

- Data provide hospitals with important information that can be used in a variety of ways. Collecting and analyzing data on performance, outcomes, and other activities can help the hospital improve its ability to provide quality care, treatment, and services. The hospital can collect data from many areas, including internal data obtained from staff, patients, records, and observations. Data are also available from quality control, risk management activities, and research studies. Other valuable data can be obtained from external sources, such as regulators, insurers, the community. The Joint Commission has identified important areas that should be measured regularly. In addition, the hospital should establish data priorities particular to its needs.

- Element of Performance #40
- The hospital collects data on pain assessment and pain management including types of interventions and effectiveness.

### PI.02.01.01

- When data are collected, they are analyzed using statistical tools and techniques. When the hospital analyzes data over time, it transforms raw data into useful information. Analysis of data from internal sources allows the hospital to identify patterns and trends and to monitor its performance. The hospital may also have access to external databases that allow it to compare its performance with other organizations on a specific topic, such as a procedure or outcome.

- Elements of Performance #18-9
  - The hospital analyzes data collected on pain assessment and pain management to identify areas that need change to increase safety and quality for patients.
  - The hospital monitors the use of opioids to determine if they are being used safely (e.g., tracking of adverse events such as respiratory depression, naloxone use, and the duration and dose of opioid prescriptions.)
Florida House Bill 21

<table>
<thead>
<tr>
<th>House Bill 21 Overview</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Background / Purpose</strong></td>
</tr>
</tbody>
</table>
| **Requirements** | • Quantity Limits: 3 days with “acute pain exception” to 7 day supply  
| | • PDMP checks for ALL controlled substances: Providers and Pharmacies  
| | • Pain CE requirements |
| **Additional Notes** | • Communication with DOD Pharmacies across FL  
| | • Conflict with DHA-PI |
Key Points

- PDMS is a multidisciplinary sub-committee that reviews patient’s potential for misuse of controlled substances prescriptions as a method for opioid stewardship in a Command.
- DHA-PI 6025.07 pre-implementation was 60 days from signature. Implementation starts when naloxone and educational materials are available.
- Patient Look Up Tool is design to assist with the eligibility of beneficiaries for Naloxone.
- Pharmacy’s engagement in TJC response to pain standards is critical to appropriate response and can be satisfied through local committees.
Answers To Self-Assessment Questions

1. PDMS is a sub-committee of:
   a) Medical Executive Board
   b) Command Executive Board
   c) Long Term Opioid Therapy Safety
   d) Pharmacy and Therapeutics

2. DHA-PI 6025.07 Naloxone Prescribing and Dispensing by a Pharmacist pre-implementation begins ____ days from signature.
   a) 30
   b) 90
   c) 60
   d) 120 Question 3 and answer
3. **TRUE/FALSE**: If pharmacist doesn’t have access to a computer or the Patient Look Up Tool in CarePoint, pharmacist should use the Naloxone Evaluation and Prescription Form.

4. The following patient would fall within the criteria for a LOTS patient:
   a) 30yo received first Rx for 7 day supply of Percocet post/op,
   b) 70yo on Norco getting 30 tablets every 3-4 months,
   c) 25yo on tramadol getting #60 each month for the last 6 months.

5. The DHA-PI for Pain Management indicates for uncomplicated, opioid-na’ive patients, opioid prescriptions should be limited to no more than a **3** day supply of short-acting opioids for acute pain episodes, including postoperative pain from minor outpatient procedures.

6. The Joint Commission 2018 standards include three chapters involving pain: Provision of Care, Treatment and Services; Performance Improvement; and **Leadership**.
Closing Remarks

CDR Janel Rossetto/LCDR Reina Gomez
NH Jacksonville/NMC Portsmouth
janel.b.rossetto.mil@mail.mil
reina.gomez.mil@mail.mil
Clinical Pharmacy Update

Alexandra C. Vance, PharmD, BCPS
Naval Hospital Jacksonville
CPE Information and Disclosures

Dr. Alexandra Vance declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

The American Pharmacist Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Virtual Health
1) Virtual Health is the use of telecommunications and information technologies to connect people to healthcare across distance.

   a) True
   b) False

2) The virtual health provider needs to be _________________ at the originating site?

   a) Credentialed
   b) Privileged
   c) Credentialed and privileged
3) Benefits of providing clinical pharmacy services via virtual health include:

a) Ability to witness patient medication administration, storage, and disposal at home
b) Ability to determine social issues impacting medication and nutrition compliance
c) Enhance patient convenience for frequent follow-up appointments
d) All of the above
e) None of the above
Telehealth Endorsements

NDAA17: Enhancement of use of telehealth services in MHS
- To improve access to primary care, urgent care, behavioral health care, and specialty care
- To perform health assessments
- To provide diagnoses, interventions, and supervision
- To monitor individual health outcomes of covered beneficiaries with chronic diseases or conditions
- To improve communication between health care providers and patients
- To reduce health care costs for covered beneficiaries and the Department of Defense

Navy SG
- 30% of encounters via virtual health by 2020
Definitions

Virtual Health / Telehealth
• Use of telecommunications and information technologies to connect people to healthcare across distance

Synchronous (live video) / Telemedicine
• Live, two-way interaction between a provider and a patient, caregiver, or another provider
• Examples: Extension for Healthcare Outcomes (ECHO), tele-critical care

Asynchronous (store-and-forward)
• Transmission of recorded health history through secure electronic communications to a practitioner who uses the information to evaluate the case outside of real-time
• Example: Health Experts On-Line Portal (HELP)

Definitions

Remote patient monitoring (RPM)
- Personal health and medical data collection from an individual via electronic communication technologies, which is transmitted to a provider in a different location for use in care
- Example: Home INR monitoring

Mobile health (mHealth)
- Health care and public health education supported by mobile communication devices
- Targeted text messages to wide-scale alerts
- Example: Secure messaging

Definitions

Distant Site
- Provider location

Originating Site
- Patient location

Virtual Health in the MHS

- Virtual Medical Centers
  - Navy: NMCSD
  - Army: SAMMC

- ECHOs
  - Navy: Pain ECHO, Polypharmacy Pain Initiative Community of Practice ECHO
  - Army: Clinical Pharmacy Service Line (Expanding Clinical Pharmacy Opportunities)
  - Air Force: Diabetes ECHO

- Tele-critical care
  - Navy: NMCSD → NHJAX

- Tele-radiology

- Global Tele-Consultation
  - Health Experts On-Line Portal (HELP)
  - Pacific Asynchronous TeleHealth (PATH)

- Medical Carts

CAPT Valerie Riege, MSC, USN. Future Readiness Care Model Program Management Office Overview. 28FEB2018
Distant Site Provider

Request to practice current privileges at Originating Site

Originating Site

- Obtain copy of current privileges
- Perform credentials review on distant site provider
- Grant requested privileges based on credentialing and privileging information
Pharmacy Opportunities and Obstacles

**OPPORTUNITIES**
- Highly suited for clinical pharmacists due to frequent follow up care
  - Considered a face-to-face encounter
  - Physical exams are not a focal point of encounters
  - Facilitates patients doing show and tell with supplies/meds at home
  - Transition of care post discharge

**OBSTACLES**
- MTF pharmacy for medications
- IT connectivity
- Credentialing and privileging at distance sites
- Telemedicine specialists not aware of local policies/procedures & formulary
Other Technology

- Asutype
- Dragon Naturally Speaking
Naval Hospital Jacksonville Experience

Workflow

1. Clinical pharmacist offers virtual visit
2. Patient is enrolled via email invite
   - Clinical Pharmacy Technician can assist
3. Patient installs Navy Care app
4. Appointment is booked with “VH” code
5. Patient calls in for encounter via smartphone, home computer, laptop, tablet, etc.
6. Clinical pharmacist using iPad Pro
   - No disruption to workflow. iPad set up next to monitor. Pharmacist can type and look at patient at the same time
7. Encounter documentation
   - Patient verbal agreement annotated
   - Virtual health modifier
Naval Hospital Jacksonville Experience

Value-based care diabetes Integrated Practice Unit (IPU)
  - Skype for Business
  - Diabetes Follow-up

Virtual health
  - Navy Care (American Well platform)
    - Diabetes Follow-up (NHJAX & Gulfport BHC)
      - Anticoagulation Management

Future Services
  - Transitions of Care
  - Deployment Health
  - Pre-Diabetes/Weight Management
Key Points

- Virtual health (telemedicine) provision of care supports readiness by enhancing patient convenience and experience
- NDAA17 and Navy SG supports the use of and expansion of virtual health
- Many opportunities for pharmacy involvement
1) Virtual Health is the use of telecommunications and information technologies to connect people to healthcare across distance

   a) True
   b) False

2) The virtual health provider needs to be _________________ at the originating site?

   a) Credentialed
   b) Privileged
   c) Credentialed and privileged
3) Benefits of providing clinical pharmacy services via virtual health include:

a) Ability to witness patient medication administration, storage, and disposal at home
b) Ability to determine social issues impacting medication and nutrition compliance
c) Enhance patient convenience for frequent follow-up appointment
d) All of the above
e) None of the above
Auricular Acupuncture
1) Military medicine recently in the last decade widely accepted the practice of acupuncture.
   a) True
   b) False

2) Auricular acupuncture training requires which of the following?
   a) In-person or on-line course
   b) Hands-on practicum
   c) Passing written assessment
   d) None of the above
   e) All of the above
3) The BFA and ATP protocols may be used together.

   a) True
   b) False
History and Theory of Acupuncture

**History**
- Originated in China more than 5,000 years ago
- Acupuncture points connect with 12 main and 8 secondary pathways or meridians
- Meridians conduct energy or qi between surface of body and internal organs
- Qi regulates spiritual, emotional, mental, and physical balance; influenced by yin and yang

**Mechanisms of Action**
- Conduction of electromagnetic signals: Stimulating points along these pathways through acupuncture enables electromagnetic signals to be relayed at a greater rate than under normal conditions. These signals may start the flow of pain-killing biochemicals such as endorphins and of immune system cells to specific sites that are injured or vulnerable to disease
- Activation of opioid systems: Endogenous opioids may be released into the central nervous system during acupuncture treatment
- Changes in brain chemistry sensation, and involuntary body functions: may alter brain chemistry by changing the release of neurotransmitters and neurohormones

Auricular Acupuncture

- **Originated in France** by Dr. Paul Nogier

- **Subtype** of medical acupuncture

- The **entire body and all of its functions** are represented on various points on the ear

- “Inverted fetus”

Gori and Firenzuoli. CAM. 2007;4(S1)13-16
Acupuncture in the Military

- Medical acupuncture became widely used in military medicine in the mid-1990s

- Auricular acupuncture protocols
  - **BattleField Acupuncture (BFA)** is used for both acute & chronic pain; created by COL (ret) Richard C. Niemtzow, MD, PhD, MPH
  - **Auricular Trauma Protocol (ATP)** is used for anxiety and PTSD; draws on the known impact of stress and trauma on intracranial structures
  - **Post-Op Nausea and Vomiting (PONV)** is best provided prior to procedure
  - **National Acupuncture Detoxification Association (NADA) protocol** is used as an adjunct to substance use disorder treatments

Auricular Acupuncture – Basic: Navy Comprehensive Pain Program, 2018
### Acupuncture Supports Readiness

- May help reduce and possibly replace opioid usage
- Physicians are demanding to be educated in and practice acupuncture
- Mostly safe, effective treatment option that can produce rapid pain attenuation and return to duty without untoward effects
- Patients request BFA over narcotics
- BFA has been shown to have a favorable effect on operational readiness
- Long-term BFA may offer significant cost savings over narcotics

# Evidence for Auricular Acupuncture

<table>
<thead>
<tr>
<th>Evidence for Auricular Acupuncture</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain</strong></td>
</tr>
<tr>
<td>• <strong>Post knee arthroscopy</strong>: n=20; acupuncture patients took less ibuprofen and no tramadol compared to control group</td>
</tr>
<tr>
<td><strong>Anxiety, PTSD</strong></td>
</tr>
<tr>
<td>• Navy providers at the Concussion Restoration Care Center in Afghanistan have used the ATP for <strong>symptomatic treatment of TBI</strong> &gt; greater sense of calm, focus, better sleep</td>
</tr>
<tr>
<td><strong>PONV</strong></td>
</tr>
<tr>
<td>• <strong>Significantly less PONV</strong> for the first 12-hrs in the auricular acupuncture group (30%) compared to controls (68%), p&lt;0.01</td>
</tr>
<tr>
<td><strong>NADA</strong></td>
</tr>
<tr>
<td>• Equivocal results due to difficulties in conducting RCTs for monotherapy in addiction and behavioral health</td>
</tr>
<tr>
<td>• Trends toward <strong>improved maintenance of abstinence</strong> from alcohol, drugs, and tobacco when used in combination treatment</td>
</tr>
</tbody>
</table>

### Training, Credentialing & Privileging

<table>
<thead>
<tr>
<th>DoD Training</th>
<th>External Training</th>
<th>Credentialing &amp; Privileging</th>
</tr>
</thead>
</table>
| • Battlefield Acupuncture protocol  
• Auricular Acupuncture-Basic: Navy Comprehensive Pain Program  
• Four hours minimum  
• Didactic with practicum  
• Final assessment | • Different protocols  
• 1-7 day courses  
• 10-30 hours of training  
• Didactics with practicum  
• Final assessment | • BUMEDINST 6320.100 dtd 11 Mar 2013  
• Completion of course  
• At least 5 patient encounters meeting proctor approval |
Patient Selection

All non-pregnant patients 18 years of age or older, regardless of medications or diagnoses, may be considered for auricular acupuncture if they have:
- Diagnosis for acute or chronic pain
- An interest in participation
- Ability to be observed for the rare instance of inflammation
- Availability to follow up by phone or by visit

Patients should not receive auricular acupuncture if:
- Pregnant or might be pregnant
- Aversion to needles or a vasovagal response to needles
- There is active infection present in an ear which is to be treated (treat only the uninfected ear)
- A bleeding disorder is present (relative contraindication)
- Special mission or flight status (coordinate with Flight Surgeon)
Defense and Veterans Pain Rating Scale

0: No pain
1: Hardly notice pain
2: Notice pain, does not interfere with activities
3: Sometimes distracts me, can do usual activities
4: Intercepts some activities, hard to ignore, avoid usual activities
5: Focus of attention, prevents doing daily activities
6: Awful, hard to do anything
7: Can’t bear the pain, unable to do anything
8: As bad as it could be, nothing else matters

MILD (Green)
MODERATE (Yellow)
SEVERE (Red)
Procedure

- **Obtain** patient consent
- **Use** proper hand hygiene and personal protective equipment
- **Clean** patient’s ear(s) with alcohol wipe
- **Assess** initial pain level
- With patient seated, **insert** ASP Gold needles in prescribed order for each type of auricular acupuncture
- **Assess** for lightheadedness, vasovagal symptoms, and euphoria after each needle insertion
- **Ask** patient to walk briefly (BFA)
- **Reassess** pain level and side effects
- Document needle placement, final pain level, and any side effects.
- **Have** patient remain in clinic for 30 minutes
# Side Effects

<table>
<thead>
<tr>
<th>Effect</th>
<th>Additional Information / Next Steps</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Drowsiness, Lightheadness, or Euphoria</strong></td>
<td>• May occur up to 30 minutes after treatment</td>
</tr>
<tr>
<td><strong>Severe Lightheadness</strong></td>
<td>• Stop treatment</td>
</tr>
<tr>
<td></td>
<td>• Remove last needle placed</td>
</tr>
<tr>
<td></td>
<td>• Have patient lie flat</td>
</tr>
<tr>
<td><strong>Euphoria</strong></td>
<td>• Have patient remain in clinic until feeling subsides</td>
</tr>
</tbody>
</table>
Aftercare

Avoid strenuous exercise, heavy house work, or yard work
Avoid alcohol and sex for a minimum of six hours after
Return to normal activity on the day after treatment

Avoid alcohol and sex for a minimum of six hours after
Return to normal activity on the day after treatment

Needles may fall out in two (2) to four (4) days
• May be uncomfortable when sleeping or touching something
• If discomfort intolerable, may remove with tweezers or fingernails. Dispose of needles in a container with lid

Signs of inflammation include redness, warmth, swelling, or increasing pain at a needle site
• If inflammation suspected, remove the affected needle/s right away. After removing the needles, if the symptoms worsen, seek care immediately

Continue prescription medications as directed

Take written notes of response to the treatment
Include the status of pain, changes in depth/pattern of sleep, energy levels, and feelings of well being
At least 8 Navy Clinical Pharmacy sites providing auricular acupuncture

- NH Jacksonville ✓
- NH Pensacola ✓
- NMC Camp Lejeune ✓
- BHC Boone, BHC Little Creek ✓
- BHC Norfolk →
- TPC Chesapeake ✓
- NHC Annapolis →
Success Stories

- Patients weaned off chronic opioids
- 90-95% positive benefits. Majority of pts continue treatments
- ADSM returned to full sub duty after weaning off diazepam
- Pt returned to walking and ADLs with nearly no pain after 15 yrs of severe chronic pain
- Unilateral tinnitus worsened. Switched ears and con’t tx.

Unilateral tinnitus worsened. Switched ears and con’t tx.
Key Points

- Auricular acupuncture is showing promise as an adjunct to pain management
- Many patients are asking for and benefiting from auricular acupuncture
- Clinical pharmacists can and should be trained to obtain non-core privilege to provide auricular acupuncture
1) Military medicine recently in the last decade widely accepted the practice of acupuncture.
   a) True
   b) False

2) Auricular acupuncture training requires which of the following?
   a) In-person or on-line course
   b) Hands-on practicum
   c) Passing written assessment
   d) None of the above
   e) All of the above
3) The BFA and ATP protocols may be used together.

a) True
b) False
Closing Remarks

Alexandra C. Vance, PharmD, BCPS
Naval Hospital Jacksonville
Alexandra.c.vance2.civ@mail.mil
MTF Transition to DHA

CDR Janel Rossetto
NH Jacksonville
CPE Information and Disclosures

CDR Janel Rossetto declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

The American Pharmacist Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
1) MTF flexibility to support expeditionary forces is one of the ____ equities needed to meet the Navy/Marine Corps mission.

2) True/False: The NH Jacksonville execution plan for QPP metrics involves using Lean Six Sigma projects for initiatives and 4DX for gaps.

3) The following is NOT an example of a QPP metric:
   1) Pharmacy Percent Retail Spend
   2) Diabetes A1c Testing
   3) Pharmacy Wait Time
   4) Smoking Cessation
What does 702 give us? (the WHY)

<table>
<thead>
<tr>
<th>Integrated Military Medical Enterprise</th>
<th>Improved Medical Readiness</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Direct and purchased care</td>
<td>• Sharpened Service focus</td>
</tr>
<tr>
<td>• Measures of safety/quality/access</td>
<td>• Support to force medical readiness</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Decreased Variability/Standardized Care Experience</th>
<th>Improved Efficiencies across the Enterprise</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Standard clinical/business guidelines</td>
<td>• Streamlined governance</td>
</tr>
<tr>
<td>• MHS-wide standards for access</td>
<td>• Eliminating duplicative functions</td>
</tr>
</tbody>
</table>
MHS Future State (the WHEN): Path to Streamlined Headquarters Functions

Phase 1 (FY19)
- WRNMMC, FBCH, NH Jacksonville, Womack, Keesler, Charleston, Seymour Johnson
- +214 MTFs East Region

Phase 2 (FY20)
- +214 MTFs East Region

Phase 3 (FY21)
- +134 MTFs West Region

Phase 4 (FY22)
- +79 MTFs Pacific/Europe Regions

MTFs Reporting to DHA
- All MTFs adhere to the same policies, procedures, and standard clinical and business processes as established by DHA

MTFs Reporting to Services
- All MTFs adhere to the same policies, procedures, and standard clinical and business processes as established by DHA

End state – all MTFs report to DHA

DHA HQ/IMOs
- DHA Intermediate Management Organizations (IMO) established to support management and administration of MTFs

Operational Readiness
- Service Medical Departments and Regional Commands restructured and ultimately downsized to focus on Service operational readiness
**Enormous Opportunity to Significantly Increase Readiness**

- Healthcare delivery and readiness mutually dependent for success

**DoN Focus: Preserve Six Equities needed to meet mission**

- Navy Medicine Readiness and Training Commands: organizational construct
- Readiness as a separate product line
- Accurately identify, plan, program the cost of readiness

**SECNAV, CNO, Commandant of the Marine Corps are fully engaged/directing transition efforts; identified Six Equities needed to meet**

Navy/Marine Corps operational mission:
- Command and Control of Navy Military Personnel
- Command structure through Navy: preserve good order discipline, execution of Navy programs, sustain Navy lifelines
- Agility to rapidly deploy
- Resource control/oversight for Fleet, Fleet Marine Force (FMF) operational support missions
  - Aligns authority, responsibility, and accountability for operational missions
- MTF flexibility to support expeditionary forces
- Single Navy Medicine POC for all Fleet, FMF, and Installation Commanders for all things medical

**Navy ALL-IN! We cannot succeed unless transition and MTFs succeed**
Naval Hospital Jacksonville (the WHERE)

Hospital Campus

- 28-bed hospital and ambulatory complex
- ICU, Multi-service Wards, 6ORs
- Substance Abuse Rehab Center
- Family Medicine Residency
- Supports 27 Operational Platforms

Medical Clinics

- Naval Submarine Base Kings Bay 8 Submarines 3 Protection Units 25 Tenant Commands
- Marine Corps Logistics Base Albany 4 Tenant Commands
- Naval Station Mayport 15 Ships 3 Helicopter Squadrons 28 Tenant Commands
- Naval Air Station Key West 2 Squadrons 15 Tenant Commands

Provides readiness support to Navy/Marine Corps Operational and Installation Commanders. Ensures a Ready Medical Force through the delivery of high quality health care to beneficiaries.
Structure/Organization - Lines of Communication
Mutual Support: NMRTC-J and NHJ will be mutually supportive of each organization's success.

- Dual Hatted Service Commander / MTF Director
- Integrated system of readiness and health
- No change to delivery of patient care at NHJ
- No New Growth: Staff workload distributed between the NMRTC-J and NHJ based on functions/responsibilities
  - Productivity offsets provided to address cost of the readiness priority
- Optimizing local civilian partnerships to enhance readiness and healthcare delivery effectiveness and efficiency
- Executed through the QPP (reconcile tension between cost of readiness and beneficiary healthcare productivity)

Clear identification and optimization of two distinct missions. The NMRTC designed to support the Naval Expeditionary Force.
### Phase 1 – By Oct 1, 2018
- Transition all MHS MTFs in East TRO Region and establishment of Service Commands
- Establishment of IOC DHA IMO #1 (Market/Platform) and #2 (Community Care)
- Transition all MHS MTFs outside the United States and establishment of Service Commands
- Establishment of IOC DHA IMO #5 (Pacific, including Hawaii) and #6 (Atlantic/Europe)
- Transition 7 MTFs (WRNMMC, FBCH, NH JAX, Womack AMC, 4 MDG, 81 MDG, 628 MDG) to DHA and align under the NCR transitional IMO, and the establishment of Service Commands
- Establishment of DHA HQ functions to manage the East Regions MFS coming under the authority, direction and control of the DHA
- DHA assumes responsibility for the administration of all MTFs through the issuance of enterprise-wide standard policies, administrative processes and clinical practices

#### Phased Implementation

<table>
<thead>
<tr>
<th>Phase</th>
<th>Date</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1 OCT 2018</td>
<td>7 MTFs (WRNMMC, FBCH, NH JAX, Womack, 4 MDG, 81 MDG, 628 MDG)</td>
</tr>
<tr>
<td>2</td>
<td>1 OCT 2019</td>
<td>MTFs in East Region</td>
</tr>
<tr>
<td>3</td>
<td>1 OCT 2020</td>
<td>Remaining CONUS MTFs (MTFs in West Region)</td>
</tr>
<tr>
<td>4</td>
<td>1 OCT 2021</td>
<td>OCONUS MTFs (including Hawaii)</td>
</tr>
</tbody>
</table>

### Phase 2 – By Oct 1, 2019
- Transition all MHS MTFs in West TRO Region and establishment of Service Commands
- Establishment of IOC DHA IMO #3 (Market/Platform) and #4 (Community Care)

### Phase 3 – By Oct 1, 2020
- Transition all MHS MTFs in West TRO Region and establishment of Service Commands
- Establishment of IOC DHA IMO #3 (Market/Platform) and #4 (Community Care)

### Phase 4 – By Oct 1, 2021
- Transition all MHS MTFs outside the United States and establishment of Service Commands
- Establishment of IOC DHA IMO #5 (Pacific, including Hawaii) and #6 (Atlantic/Europe)
Timeline of Events

30 June
MHS Performance Measures Deadline - QPP determined

30 Jun – 02 Aug
Visit from BUMED transition team

17 Aug
Final QPP

01 Oct
DHA and NMRTC/U Command
### May 2018 ASD/HA Memo: Way Forward for MHS Measures for FY19

<table>
<thead>
<tr>
<th><strong>Fiscal Year 2018 MHS Core Measures</strong></th>
<th>Current set of core measures aligned to the Quadruple Aim of improved readiness, better health, better care, and lower cost</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Quadruple Aim Performance Plan Critical Initiative Measures</strong></td>
<td>Subset of the core measures that will be the focus of enterprise improvement in Fiscal Year 2019</td>
</tr>
<tr>
<td><strong>RMG Measures</strong></td>
<td>Set of measures that enable DoD leaders to monitor performance of the MHS</td>
</tr>
<tr>
<td><strong>National Defense Authorization Act for Fiscal Year 2017, Section 702 Transition Measures</strong></td>
<td>Used to monitor the transfer of management and administration of military medical treatment facilities from the Military Departments to the Defense Health Agency more</td>
</tr>
</tbody>
</table>
## MHS FY19 Core Measures (1/2)

<table>
<thead>
<tr>
<th>Quad Aim</th>
<th>Measure Name</th>
<th>Status</th>
<th>MHS FY18 Core Measures</th>
<th>QPP Critical Initiatives</th>
<th>RMG</th>
<th>NODA Transition</th>
<th>Proposed MHS FY19 Core Measures</th>
</tr>
</thead>
<tbody>
<tr>
<td>Improved Readiness</td>
<td>Individual Medical Readiness (IRF)</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>F. R. Surgery Capacity</td>
<td>To Be Replaced By Other Readiness Measures</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Humanitarian Assistance</td>
<td>To Be Replaced By Other Readiness Measures</td>
<td>●</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of Providers Meeting KSAs for General Surgery</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Percent of Providers Meeting KSAs for Orthopedic Surgery</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Active Duty Non-Deployability</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Success in Meeting Target Stipulations (IEEE) Residency Review Committee (ACOGC) Pass Rate</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Integrated Disability Evaluation System (Cycle Time)</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Health Related Quality of Life (HRQOL)</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Obesity Prevalence in Adults</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overweight Prevalence in Adults</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Overweight Prevalence in Children</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Smoking Cessation</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Eliminate Use Rate</td>
<td>Prototype R&amp;A</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Risk-Adjusted Mortality (Standardized Mortality Ratio)</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NSROF All Case Morbidity</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>NSROF At-Risk Morbidity</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Inpatient Readmit Hospital (Patient Satisfaction with Care)</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CAUTI SSN</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>CLABSI SSN</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Wrong Site Surgery</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>SSI</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>DVT</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pediatric A1C Testing</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Low Birth Weight</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Children with Phenytoin</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Breast Cancer Screening</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Cervical Cancer Screening</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Colon Cancer Screening</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>7-Day Mental Health Follow-Up</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>All Cause Readmissions</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Preventive Care Services (AHRQ 103.33)</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Post-Partum Hemorrhage</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Unintended Pregnancy Complications</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Well Child Visits</td>
<td>Currently Used</td>
<td>●</td>
<td>●</td>
<td>●</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
**MHS FY19 Core Measures (2/2)**

<table>
<thead>
<tr>
<th>Better Health</th>
<th>Preventive RAA</th>
<th>Preventive RAA</th>
<th>Preventive RAA</th>
<th>Preventive RAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Obesity Prevalence in Children</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
</tr>
<tr>
<td>Overweight Prevalence in Adults</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
</tr>
<tr>
<td>Obesity Prevalence in Children</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
</tr>
<tr>
<td>Tobacco Use Rate</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
</tr>
<tr>
<td>Acute Care Mortality (Standardized Mortality Rate)</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
</tr>
<tr>
<td>NSIP All Case Mortality</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
</tr>
<tr>
<td>NSIP All Case Mortality</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
</tr>
<tr>
<td>Preventive Medical Recommendations/Recommendations for Preventive Care</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
<td>Current Used</td>
</tr>
</tbody>
</table>

**Lower Cost**

- Total Purchased Care Cost
- Private Sector Care Cost
- Total Enactment
- Pharmacy Percent Retail Spend
- Active Duty: Specialty Care Provider Efficiency
- Operating Room Utilization
- PCM Enactment
- Savings from Enterprise Shared Services and Reimbursement
- Average Daily Patient Days/Intensive Care Unit Bed Days
- Preventive RAA

**Lower Cost**

- Total Purchased Care Cost
- Private Sector Care Cost
- Total Enactment
- Pharmacy Percent Retail Spend
- Active Duty: Specialty Care Provider Efficiency
- Operating Room Utilization
- PCM Enactment
- Savings from Enterprise Shared Services and Reimbursement
- Average Daily Patient Days/Intensive Care Unit Bed Days
- Preventive RAA
Intermediate Management Organization (IMO): Mission and Functions

Mission

The DHA IMO will enable an integrated system of readiness and health by supporting and holding accountable assigned MTFs to optimize delivery of the Quadruple Aim

Functions

- Accountable to DHA
  - IMO will be accountable to DHA for all functions
- Administer and Manage Assigned MTFs
  - MTFs will be accountable to IMO
- Support Assigned MTFs
  - IMO will support MTFs
The Functional Intermediate Management Organization (IMO) Model is based on NDAA 2017, Section 703 categories of MTFs in order to facilitate management specialization, oversight, and support to groups of MTFs with similar functions.

**Market/Platform**

- **East (IMO #1)**
- **West (IMO #3)**

Function: Delivery of comprehensive specialty and subspecialty inpatient and ambulatory health care services to support medical readiness of beneficiaries within Medical Center markets and drive Ready Medical Force generation.

**Community Care**

- **East (IMO #2)**
- **West (IMO #4)**

Function: Delivery of ambulatory and limited specialty and inpatient health care services to support medical readiness of beneficiaries outside of Medical Center markets with greater reliance on purchased care for specialty services.

**MTF TYPES WITHIN IMO:**

- Medical Centers
- Centers of Excellence
- Joint VA/DoD Facilities
- Large Platforms (e.g., Ft Campbell)
- Hospitals/Ambulatory Clinics within markets

**MTF TYPES WITHIN IMO:**

MTFs Outside of Markets:
- Hospitals
- Ambulatory Clinics

Locations are illustrative and do not represent recommendation.
Draft Facility List: East Market/Platform IMO
Phase 2-4
Draft Facility List: West Community Care IMO Phase 2-4

ALASKA
- ACH BASSETT-WAINWRIGHT
- AF-H-673rd MEDGRP-IBER-ELMNDRF
- AF-C-354th MEDGRP-IELSON
- AHC-GREELY
- COMBINED MED SVCS C-WAINWRIGHT
- KAMISH CLINIC-WAINWRIGHT
- THC RICHARDSON

CENTRAL
- ACH LEONARD WOOD
- AF-C-55th MEDGRP-OFFUTT
- AF-C-22nd MEDGRP-MCCONNELL
- AF-C-28th MEDGRP-ELLSWORTH
- AF-C-318th MEDGRP-GRAND FORKS
- AF-C-509th MEDGRP-WHITEMAN
- AHC-LEONARD WOOD
- AHC MUNSON-LEAVENWORTH
- CBMH OZARK-LEONARD WOOD
- CTMC RICHARD G WILSON-L WOOD
- EBH FORSCOM-LEONARD WOOD
- TMC #1-USDB-LEAVENWORTH
- TMC #2-USDB 2-LEAVENWORTH

CENTRAL CALIFORNIA
- AF-MC-99th MEDGRP-PELLIS
- NHC LEMOORE
- AF-366th MEDGRP-MT HOME
- AF-C-355th MEDGRP-LA
- AHC-VA MG GOURLEY CL-MONTEREY
- BMC BRIDGEPORT
- NBHC FALLON

NORTH CENTRAL
- ACH IRWIN-RILEY
- AF-C-75th MEDGRP-HILL
- AF-C-341st MEDGRP-MALMSTROM
- AF-C-377th MEDGRP-KIRTLAND
- AMH FARRELLY AHC-RILEY
- AVIATION CLINIC-RILEY
- CBMH FLINT HILLS-RILEY
- CUSTER HILL HC-RILEY
- TBI CLINIC-RILEY
- TMC-1-IRWIN

SOUTHERN CALIFORNIA
- ACH WEED-IRWIN
- AHC MONTEREY
- AF-C-30th MEDGRP-VANDENBERG
- AF-C-377th MEDGRP-KIRTLAND
- TMIRV-IRWIN
- EBH CLINIC-RIMIN
- CBMH FLINT HILLS-RILEY
- CUSTER HILL HC-RILEY
- TBI CLINIC-RILEY
- TMC-1-IRWIN

SOUTHWEST
- NH TWENTYNINE PALMS
- AHC MCAFEE-WHITE SANDS MSL RAN
- AHC R W BLISS-HUACHUCA
- AHC YUMA PROVING GROUND
- BMC YUMA
- NBHC ELCENTRO
Draft Facility List: OCONUS Indo-Pacific Model
Phase 2-4

DEFENSE HEALTH AGENCY

OCONUS INDO-PACIFIC IMO (#4)

GUAM
- NH GUAM-AGANA
- AF-C-36th MEDGRP-ANDERSEN
- BMC NAVSTA GUAM

JAPAN
- NH OKINAWA
- NH YOKOSUKA
- AF-C-18th MEDGRP-KADENA
- AF-H-374th MEDGRP-YOKOTA
- AF-H-35th MEDGRP-MISAWA
- AHC BG CRAWFORD SAMS-CAMP ZAMA
- BMA CAMP FUJI
- BMA HARIO SASEBO, JP
- BMC CAMP BUSH/COURTNEY
- BMC CAMP HANSEN
- BMC CAMP KINSEER
- BMC CAMP SCHWAB-OKINAWA
- BMC EVANS-CAMP FOSTER
- BMC IWAKUNI BIRTHING CTR
- BMC MCAS FUTENMA
- NBHC COMFLACT SASEBO
- NBHC NAF ATSUGI

KOREA
- ALLGOOD-SEOUL
- AHC CAMP HUMPHREYS-PYONGTAEK
- AF-H-51st MEDGRP-OSAN
- AF-C-8th MEDGRP-KUNSAN
- AHC CAMP CASEY TONGDUCHON
- AHC CAMP STANLEY
- AHC-CAMP CARROLL-KOREA
- AHC-CAMP RED CLOUD-UUONGBU
- AHC-CAMP WALKER-TAEGU
- AHC-DC MIDTOWN-PYONGTAEK
- AHC-YONGSAN-SEOUL
- BMC CHINHAE

PACIFIC ISLANDS
- NBHC NSF DIEGO GARCIA

HAWAII
- AMC TRIPLER-SHAFTER
- SCMH SCHOFIELD BARRACKS
- NHC HAWAII
- AF-C-15th MEDGRP JBHP-HICKAM
- AHC SCHOFIELD BARRACKS
- BMC MCAS KANEHOE BAY
- CBMH WARRIOR OHANA-SHAFTER
- EBH-SUB USE DISORDER-TRIPLER
- NBHC MCB CAMP H.M. SMITH
- NBHC NAVCAMS EASTPAC
Efforts to Date (the HOW – where got to today)

- Multiple tabletop exercises
- Identification of billets (Readiness vs Benefit)
  - -- NHJ split is 64% Readiness vs 38% Benefit
- Development of Quadruple Aim Performance Plan (QPP) NHJAX led w/ NME/BUMED/DHA support
- Review of Mission, Functions, and Tasks of NMRTC
- Communication Plan Development and Implementation
- Finalizing Execution Plan (ongoing)
The QPP is a Mutually Supportive Contract: Data-Driven tool to support the integration of Readiness and Beneficiary Healthcare at the MTF.
Execution Plan (HOW now and in the Future)

- QPP will close NHJ’s Quad Aim **gaps** – utilize 4DX
  - **WAR**: Improve patient experience....by improving NHJAX; Health Index (combination of metrics selected by ESC in line with QPP gaps)
  - **BATTLES**: Created at deckplate to close QPP gaps
- QPP will address NHJ’s **initiatives** – utilize LSS to improve processes then execute leaned process.
- Build NMRTC staff workload assignments by defining MFTs and realigning NHJ’s organization to support readiness.
- Optimize clinical productivity within MTF BSO18 (makes DHA happy) and closing readiness gaps by leveraging civilian partnerships for those things which aren’t achievable at the MTF.

**Integrated system of Readiness and Health**
Execution Plan (HOW now and in the Future)

Current Performance Measures
- MHS Vital Reports
- NME Dashboard

Benefit Focused

Desired Enhanced Performance Measures
- Navy Readiness
- KSAs Currency

Gaps in QPP
- IMR
- HEDIS
  - cervical/breast
  - ca screen
  - A1C
  - 7 day MH f/u

Initiatives
- Days for referral booking
- LIMDU (HERCULES)

Execution Plan (HOW now and in the Future)
1st WIG: Improve NHJ Health Index by X by 1 Dec

Better Health
Better Healthcare
Lower Cost
Improved Readiness
## Changes

### Lines of Communication

- tIMO Consultant (CAPT Gary West) – pharmacy operations management
- Navy Pharmacy SL/Consultant (CAPT Brandon Hardin) – readiness/deployments, pharmacy officer management

### Budget

- Pharmacy Budget
- Travel – CE/Medical Education must be in budget call; mission funding unchanged

### Personnel

- GS
- Contract
- Military

### Equipment
Key Points

- NDAA 17 Section 702 forces us toward an integrated system of readiness and health
- DHA transition makes healthcare delivery and readiness mutually dependent for success
- QPP measures for pharmacy engagement are ____
- Changes occurred in: ____ (personnel, OPTAR, equipment, budget)
- Your most important step in preparing your pharmacy is...
1) MTF flexibility to support expeditionary forces is one of the __six__ equities needed to meet the Navy/Marine Corps mission.

2) True/False: The NH Jacksonville execution plan for QPP metrics involves using Lean Six Sigma projects for initiatives and 4DX for gaps.

3) The following is NOT an example of a QPP metric:
   1) Pharmacy Percent Retail Spend
   2) Diabetes A1c Testing
   3) Pharmacy Wait Time
   4) Smoking Cessation
Closing Remarks

CDR Janel Rossetto
NH Jacksonville
janel.b.rossetto.mil@mail.mil
Pharmacy Enlisted Technical Leader

HMC (SW) Jennifer A. Muldrew
Naval Medical Center Portsmouth
CPE Information and Disclosures

HMC (SW) Jennifer A. Muldrew declare(s) no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

The American Pharmacist Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Self-Assessment Questions

1) The Enlisted Technical Leader has the following responsibilities:
   a) Act as conduit between BUMED and community
   b) Provide Pharmacy technical advice
   c) Recommend changes to billet file
   d) All of the above

2) COCOM taskers are a key role for ETL
   a) True/False

3) Current manning (snapshot) of 8482s is _____?
Enlisted Technical Leader Responsibilities

Provide technical advice to the Chief, Bureau of Medicine and Surgery via the Director, Hospital Corps (BUMED-M00C5), on matters relating to Pharmacy

Advocate for constituents within the NEC represented

Provide advice regarding NEC specific proposals, projects, and programs, taskers, etc.

Act as a conduit for communications between the community and BUMED

Recommend changes for consideration to the billet file, Catalog of Navy Training Courses, and NEC manual as required

Provide advice regarding education and training issues
COCOM TASKERS

**Review** EMPARTS info for the enterprise
- IA / GSA / HMR
- Platform assigned / Tier / 1 / 2 / 3
- Boots on Ground / Sea time

**Ensure** Department Heads, Division Officers, and Departmental Chiefs are made aware of tasker selections prior to forwarding to NME/ NMW POMI SELS

**Maintain** a log of deployment taskers for Regional Consultants and SL awareness

**Ensure** tasker and backfill selections are fairly distributed across the Navy Pharmacy enterprise
# L22A (8482) MANNING SNAPSHOT

<table>
<thead>
<tr>
<th></th>
<th>E1-3</th>
<th>E-4</th>
<th>E-5</th>
<th>E-6</th>
<th>E-7</th>
<th>E-8</th>
<th>E-9</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>% INV to BA</strong></td>
<td>106%</td>
<td>117%</td>
<td>78%</td>
<td>94%</td>
<td>105%</td>
<td>0%</td>
<td>0%</td>
<td>97%</td>
</tr>
<tr>
<td><strong>BA</strong></td>
<td>118</td>
<td>168</td>
<td>213</td>
<td>112</td>
<td>21</td>
<td>-</td>
<td>-</td>
<td>632</td>
</tr>
<tr>
<td><strong>Total Inventory</strong></td>
<td>125</td>
<td>197</td>
<td>167</td>
<td>105</td>
<td>22</td>
<td>-</td>
<td>-</td>
<td>616</td>
</tr>
<tr>
<td><strong>SJA Inventory</strong></td>
<td>113%</td>
<td>84%</td>
<td>105%</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
</tbody>
</table>
**L22A (8482) Placement**

### L22A

<table>
<thead>
<tr>
<th>INVENTORY</th>
<th>F(SHR)</th>
<th>M(SHR)</th>
<th>F(SEA)</th>
<th>M(SEA)</th>
<th>Total Inv</th>
<th>TPP&amp;H/S Distr Inv.</th>
</tr>
</thead>
<tbody>
<tr>
<td>HMCM</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HMC</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>HM1</td>
<td>17</td>
<td>67</td>
<td>3</td>
<td>18</td>
<td>105</td>
<td>6</td>
</tr>
<tr>
<td>HM2</td>
<td>29</td>
<td>87</td>
<td>9</td>
<td>27</td>
<td>152</td>
<td>10</td>
</tr>
<tr>
<td>HM3</td>
<td>49</td>
<td>115</td>
<td>4</td>
<td>26</td>
<td>194</td>
<td>6</td>
</tr>
<tr>
<td>HN</td>
<td>45</td>
<td>104</td>
<td>-</td>
<td>1</td>
<td>150</td>
<td>5</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>149</td>
<td>386</td>
<td>18</td>
<td>73</td>
<td>626</td>
<td>28</td>
</tr>
</tbody>
</table>

### General Data

<table>
<thead>
<tr>
<th>Total</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>459</td>
</tr>
<tr>
<td>Female</td>
<td>167</td>
</tr>
<tr>
<td>MCAFBA</td>
<td>91</td>
</tr>
</tbody>
</table>

### TPP&H/Student

<table>
<thead>
<tr>
<th>TEMDU (Other)</th>
<th>Total</th>
<th>BA</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Students</td>
<td>13</td>
<td>16</td>
<td>81.25%</td>
</tr>
<tr>
<td>TPP&amp;H</td>
<td>15</td>
<td>14</td>
<td>107.14%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>28</td>
<td>30</td>
<td>93.33%</td>
</tr>
</tbody>
</table>

### Pregnancies & LIMDU

<table>
<thead>
<tr>
<th>Pregnancy Tour</th>
<th>LIMDU (ACC 105)</th>
<th>BA</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0.60%</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td>1</td>
<td>1</td>
<td>0.06%</td>
</tr>
</tbody>
</table>

### Sources

- TFMMS, NES & BBD
- Prepared by Almirol, Archival P HMC NPC, Pers-4013
- Prepared on 6/1/2018
Placement Coordinators Contact Information

**Navy Medicine East**
HMC Matthew Sirheek  
matthew.b.sirehek@navy.mil  
901-874-4504

**Navy Medicine West**
HMC Maria Reinosa  
maria.d.reinosa@navy.mil  
901-874-4504

**L22A Pharmacy Detailer**
HMC Diana Jucutan  
diana.jucutan@navy.mil  
901-874-3869
Current Deckplate Challenges

8482 gaps/ MEDMACRE* losses/COCOM Taskers

Improve ETL-SEL communication/networking

Training & Professional Development
• Work closely with SELs to ensure 8482s
  - Complete Inpatient and Outpatient Pharmacy PQS to qualify for deployment
  - Complete PTCB certification as an enterprise standard
  - Complete Hospital Corpsman PQS as an enterprise standard (currently not a requirement)
  - Receive community announcements/initiative updates/news SELs can use to improve business ops and train staff.
• Future movement of Pharmacy C’ school to Fleet Concentrated areas
• Future NEC driven advancement exams
1) The Enlisted Technical Leader has the following responsibilities:
   a) Act as conduit between BUMED and community
   b) Provide Pharmacy technical advice
   c) Recommend changes to billet file
   d) All of the above

2) COCOM taskers are a key role for ETL
   a) True/False

3) Current manning (snapshot) of 8482s is 616?
Closing Remarks

HMC (SW) Jennifer A. Muldrew
Naval Medical Center Portsmouth
757-953-3462
jennifer.a.muldrew.mil@mail.mil
USNH Guantanamo Bay and Its Unique Mission

LCDR Jone’ Tillman PharmD
LT Sebastian Garcia PharmD
USNH Guantanamo Bay
CPE Information and Disclosures

LCDR Jone’ Tillman and LT Sebastian Garcia declare no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

The American Pharmacist Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
Self-Assessment Questions

- Civilians and Foreign Nationals are required to undergo medical screening prior to coming to Guantanamo Bay.
  - True/False

- The Pharmacist supports what two commands at Guantanamo Bay?
  - ____________

- Prime Vendor delivers medications daily to the hospital?
  - True/False
Outpatient Pharmacy Hours
- M – F: 0800 – 1600
- Weekends / Federal Holidays / After Hours: Pharmacy Pager

Workload
- 10 IV’s per week
- 170 Unit Doses per week
- 110 New Rx’s per day
- 20 Refill Rx’s per day
- Servicing 5,500 beneficiaries

Current Staff
- 2 Pharmacists
  - 2 Military
- 6 Technicians
  - 6 Military

Technology & Automation
- ScriptPro
- Q-flow
- Omnicell/Pxyis
- PickPoint
- REES
- Medidose

Areas of Responsibility
- Emergency Room
- Multi-Service Ward
- Labor and Delivery
- OR/APU
- Pediatrics
- Psychiatry
- Primary and Specialty outpatient clinics
- Ortho
- Physical Therapy
- Optometry Clinic
- Dental
- Home Health Care
- Home Health Care
- JMG-Detainee Camps
- Veterinary Medicine
- JTC-Trooper Clinic
USNH Guantanamo Bay Population

- Active Duty
- Reservist
- Dependents
- Retirees
- Cuban Special Category Residents
- Detainees
- Foreign Nationals
- Civilians (Contractors/Civil Service)
Home Health

- DOD’s only home health program
- Serve 11 home health patients between ages 45 to 85 years of age
- Multidisciplinary Team: 1 Physician, 3 Nurses, 1 Social Worker, 1 Dietician, 1 Pharmacist, 1 Pharm Tech
- Quarterly meetings to review multiple disease states and overall health outcomes for patients
- Monthly meeting with Pharmacist, Physician and home health nurse to review medication profiles
### JOINT TASK FORCE

- Pharmacist are Dual hatted supporting both the Naval Hospital and Joint Task Force.
- 2 independent pharmacy technicians assigned to Joint Task Force to fill orders.
- On-Call to camp providers when needed.
- Weekly trips to check multiple prescriptions, review patient profiles for undisclosed number of patients with multiple disease states.
- Attend monthly Pharmacy and Therapeutics meetings and check in with medical staff.

### JOINT TROOP CLINIC

- Mission falls under Joint Task Force and Joint Medical Group.
- Small pharmacy providing services to support Joint task force.
- Naval Hospital fills all refills and maintenance medications.
- 1 independent pharmacy technician
- Pharmacist provide bimonthly technical assist visits.
## Overview of Challenges and Opportunities

<table>
<thead>
<tr>
<th>CHALLENGES</th>
<th>OPPORTUNITIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>Civilians and Foreign nationals are not required to be screened.</td>
<td>Broaden and enhance your clinical pharmacy skills</td>
</tr>
<tr>
<td>Supply Chain.</td>
<td>Opportunity for continuous process improvements</td>
</tr>
<tr>
<td>Pharmacist covering a large area of responsibility and clinical scope.</td>
<td>Pharmacy plays a critical role in both Naval Hospital and Joint Task Force operations and missions.</td>
</tr>
<tr>
<td>Conflicting missions required to support both simultaneously.</td>
<td>Be apart of the only Home Health Program in DoD.</td>
</tr>
<tr>
<td>Junior inexperienced support staff.</td>
<td>Veterinary medicine falls under Naval Hospital.</td>
</tr>
<tr>
<td></td>
<td>Interact with multiple diverse populations. Weekly AMC flights to Jamaica.</td>
</tr>
</tbody>
</table>
Leadership Opportunities

- Director positions available for O-4
- Department Head positions available for O-3/O-4
- Directly involved on all levels and specialties when it comes to Pharmaceutical Care operations
- High level Collateral duties available throughout the command
- Positions constantly open due to length of tours (12 months, 18 months, and 30 months)
Guantanamo Bay is a remote OCONUS location serving wide patient population from Active Duty to Civilians/Contractors to Detainees.

Pharmacists are Dual hatted supporting both the Naval Hospital and Joint Task Force.

Ability to broaden and enhance your clinical pharmacy skills.
Answer to Self-Assessment Questions

- Civilians and Foreign Nationals are required to undergo medical screening prior to coming to Guantanamo Bay.
  - True/False

- The Pharmacist supports what two commands at Guantanamo Bay?
  - Naval Hospital & Joint Task Force

- Prime Vendor delivers medications daily to the hospital?
  - True/False
Closing Remarks

LCDR Jone’ Tillman Pharm D.
LT Sebastian Garcia Pharm D.
USNH Guantanamo Bay
jone.l.tillman.mil@mail.mil
sebastian.f.garcia.mil@mail.mil