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POLICY FORUM: INVITED COMMENTARIES & SIDEBARS

Integrating Medication Management and Access, Medicare Counseling, and Tailored Referrals: Planning to Scale a Community-Based Model

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Senior PharmAssist (SPA), a community-based not-for-profit agency, addresses medication-related challenges through 4 integrated services: medication therapy management, financial assistance for medications, tailored community referrals, and counseling on Medicare coverage. With expert input and community feedback, SPA articulated its model and selected pilot sites to adapt the program to other communities.

Background

Medication management for older adults in the United States is complicated for all involved. Medication-related health conditions not only pose a risk to the overall health of older adults but also exert pressure on health care systems, including public and private insurers, as well as overstretched long-term care providers. Family members, who often serve as primary caregivers for long-term services and supports within the home, are also often burdened by the challenges of obtaining, organizing, and managing medications, their effects, and the uncertainty of effectiveness. The daily process is further complicated by the challenges of communicating and coordinating with a health care team that is often extended across specialties, disconnected from one another, and without a complete record of information.[1]

Although adherence has received a great deal of attention through the years, including the more recent "heavy weighting" in Medicare Advantage Part D plan star ratings,[2] clinicians are now expected to consider both polypharmacy (taking 5 or more prescribed medications) and deprescribing when working with older adults who have complex medication regimens and health concerns.[3,4]

Senior PharmAssist (SPA)

Community-based programs can be an essential public health service for addressing older adults' needs for access and managing medications and other supportive services. In 1994, Senior PharmAssist (SPA), a community-based program in Durham, North Carolina, began helping older adults with

Table 1. Timeline of Events

Date	Events and Actions
1996–2020	• Developed 3 prior iterations of replication guide. • Provided consulting services in Louisiana. • Advocated to create statewide complementary programs (NC Senior Care, ChecKmeds, NCRx).
2020	• Prioritized replication in strategic plan by SPA Board of Directors. • Founding Executive Director connected with MPH students for replication efforts.
Early 2021	• Formed Expansion Task Force. • Distributed NC Statewide Readiness to Act Survey. • Shared results with participants, state leaders, and professional conferences.
Mid 2021	• Onboarded two consultants to work with SPA staff to support expansion effort – core team formed. • Core team began exploring and documenting key components of the SPA model.
Late 2021	• Formed implementation team with Duke Roybal Center. • Submitted NIH/NIA grant via Duke Roybal Center.
2022	• Issued call for pilot project applicants. • Selected three communities. • Received NIH/NIA grant approval.

limited incomes to both obtain and better manage needed medications. SPA's mission is to "promote healthier living for older adults in Durham, North Carolina by helping them obtain and better manage needed medications and by providing tailored health education, Medicare insurance counseling, community referrals, and advocacy".[5] Older adults enrolled in SPA reported positive outcomes; in one study evaluating 191 adults aged 60 or older with an income of 200% of the federal poverty level or less, the proportion of participants reporting an emergency department visit in the prior year declined from 49% at baseline to 31% at 24 months, and the average number of emergency department visits and hospital admissions decreased 36% and 26%, respectively.[6-8] The potential for population health benefits could be greater with a wider reach or with implementation in more communities.

Over the years, SPA established itself as a respected program with positive health outcomes, garnering attention and interest from community members, other service providers, and state and federal officials, which prompted requests for expansion beyond Durham County.[7-11] The internal capacity of SPA to support implementation beyond Durham was evaluated, and it was determined that planning for implementation in new communities would be supported internally by a task force of the Board of Directors and a core team of staff and consultants, as well as externally by key partnerships. Considerations for implementing SPA more broadly were inherent in the strategic plan in order to advance SPA's mission for greater public good and impact. Table 1 displays the timeline of events.

Model and Implementation Refinement

The task force prompted the core team to articulate essential elements of SPA in order to establish a model for implementation. Iterative design discussions were used to refine the defining characteristics of the SPA model's core service functions and delivery approach. The model description was revised in existing program replication materials.

The SPA model has 4 service domains, including medication therapy management, financial assistance for medications, tailored community referrals for unmet health and social needs, and counseling on Medicare insurance coverage. These service domains are interconnected by staff who work closely together to coordinate and share information, and who recognize the need to nurture trusting and long-term relationships with program participants. SPA incorporates 3 pillars within the planning, training, and daily delivery of the 4 services. These pillars are motivational interviewing, a racial equity framework, and continuity of care. Continuity of care and the development of authentic relationships are likely key ingredients in the agency's capacity to help participants in ways that enable them to feel respected and engaged in their own care journey.[6] Although a complex model, the overarching goal of providing whole-person care suggests that if only parts of the model are implemented, program outcomes and effectiveness may vary.

The core team and staff deconstructed each component and translated the service workflow and outcomes into a logic model. Implementation scientists recommended trimming "must have" services to 3 instead of 4. The core team considered delineating "tailored community referrals" as optional, since many community agencies already offer it, but SPA staff pushed back; all 4 services needed to remain. In particular, tailored referrals ensure that the model is person-centered, making it a central part of the program's "secret sauce." This iterative process, involving discussions with staff and partners, led to the identification of 4 specific services (Table 2) and clarified how they are interconnected to provide more person-centered care and reduce navigation barriers. Table 3 shows key pillars in delivering the 4 key services, helping to clarify how services are offered to older adults. During this process, the core team wanted to define low/medium/high impact levels with each of the 4 services. However, it became clear that options for service delivery are not linear, and that adopting communities might operationalize the services in ways that do not exactly mirror SPA but that best suit their unique health care and social environments. This was part of the effort to allow communities ownership over how to adapt the model to their individual needs while also considering which components SPA believed contributed to their positive health outcomes.

Table 2. Description of Senior PharmAssist's 4 Key Services

Service Name	Service Description
Medication Therapy Management (MTM)	• Offered by a pharmacist (preferably trained or with experience in geriatrics) in a HIPAA-compliant environment. • Face-to-face interviews (preferably); telehealth (phone or video) is available if needed. • Providing medication records and action plans (if needed) to individuals and clinical communication with providers and local community pharmacists as needed. • Conducting a medical history review, disease and health monitoring (blood pressure, blood glucose, etc.), and health education. • Pharmacists at SPA have access to the local health system's electronic health records. • Transportation to the office, located in a senior center, is provided to those with more limited incomes, and home visits can be arranged for individuals who are homebound. Eligibility: Individuals aged 60 years or older and who have incomes at or below 300% of the federal poverty level. This includes individuals who do not need or are not eligible for SPA's financial assistance (those with Medicare/ Medicaid, in retiree health plans, etc.).
Direct Financial Assistance for Medication Costs	• Directly pay for medications on the agency's geriatric formulary to lower medication co-payments after Medicare D plans pay first (stand-alone drug plan or a Medicare Advantage plan). • Contracting with a pharmacy benefits manager that coordinates benefits with retail pharmacies. Eligibility: Individuals aged 60 years old and older, including those with partial extra help (also known as Part D Low Income Subsidy), with incomes up to 200% of the federal poverty level (FPL). In 2023, SPA was able to increase the income limit up to 250% FPL, and beginning in 2024, individuals with partial extra help now have full extra help (minimal co-payments) and thus don't need SPA's direct financial assistance. SPA renews the pharmacy card benefit during 6-month MTM appointments.
Tailored Community Referrals	• Provide tailored referrals based on participant-defined need. • Assumes continuity of care or regular contact with the individual (at least 2–3 times a year) and tracking follow-up to see if/ when the referral is successful (or not and why not). There are no eligibility requirements for this, although those who have regular MTM appointments are the ones SPA habitually screened for other services, and there can be triggers for referrals during Medicare counseling appointments.
Medicare Counseling/ SHIP	• Seniors' Health Insurance Information Program coordinating (SHIP) site for Durham - Medicare-trained staff and volunteers, supported by the NC Department of Insurance. • Pharmacists join counseling sessions to monitor for any obvious medication concerns and to offer cost-saving measures that go beyond the Part D "extra help." This includes discussions about generic substitution, formulary alternatives, drug manufacturer Patient Assistance Programs, and ways to avoid "utilization management" barriers. • Offered in-person and via telehealth (phone and/or video) by appointment only. • Transportation is provided to those with more limited incomes. This service is offered at no charge to any Medicare beneficiary in Durham, regardless of age or income.

Leveraging the expanded team and partnerships, a survey was designed to serve as an environmental scan and help identify potential communities to pilot implementation of the model. Outreach and invitations to complete the survey were made possible through collaborations with other agencies and leaders throughout the state. The North Carolina Statewide Readiness to Act Survey was conducted in 2021 to establish a baseline understanding of service provision in each county. The survey included questions about the 4 core services (what is done), the 3 pillars (how it is done), and the staff and organizations involved. We aimed to identify organizations providing Medication Therapy Management (MTM), medication assistance, community referrals, and/or Medicare insurance counseling. We also sought to identify what counties might be ready to invest in and how they might strengthen similar work or share best practices with others. This initiative presented an opportunity to raise awareness of SPA's mission, model, and commitment to assisting others in similar endeavors. Responses were analyzed descriptively and discussed by the team ahead of engaging community leaders and inviting potential adopters to consider implementing.

Table 3. Key Pillars in Delivering Key Services

Key Pillar	Description
Motivational interviewing (MI)	• Motivational interviewing (MI) is an evidence-based approach to behavior change. It is a "collaborative, goal-oriented style of communication with particular attention to the language of change. It is designed to strengthen personal motivation for and commitment to a specific goal by eliciting and exploring the person's own reasons for change within an atmosphere of acceptance and compassion".[12] • Several examples of how SPA uses MI are: spending more time than most clinical settings getting to know participants (being less transactional and more relational); interview guides are designed to include open-ended questions; and the staff formally discuss MI with a coach at least several times a year to help move participant knowledge and intention to action.
Racial equity	• The Centers for Medicare & Medicaid Services (CMS) define *health equity* as the attainment of the highest level of health for all people, where everyone has a fair and just opportunity to attain their optimal health regardless of race, ethnicity, disability, sexual orientation, gender identity, socioeconomic status, geography, preferred language, or other factors that affect access to care and health outcomes.[13] • SPA strives to operationalize racial equity in several ways, beginning with trying to have the staff, board of directors, and volunteers reflect the diversity of the community served so that everyone feels they belong. • There is racial equity on-boarding training for staff and regular discussions about how racism impacts health. Black and Brown Medicare participants who have lived with discrimination for years now face trying to remain in their homes with comparatively less income, much less savings, and dramatically less home equity. Home equity allows someone to leverage their home for a reverse mortgage or generate rental income; it also allows home modifications, which can be restricted if renting property.[14] • The SPA model provides equitable access by offering financial and transportation assistance and an option for telehealth and extended operating hours (open 43 hours per week) for those who depend on working caregivers who want to accompany their family member to appointments.
Continuity of care	• SPA embraces continuity of care as the diligent process of consistently identifying and addressing the evolving needs of participants over time by ensuring seamless integration between the 4 key services. These services are accompanied by well-established procedures to ensure regular and consistent engagement with participants: ◦ Medicare counseling guarantees an annual interaction with each participant during the annual election period. ◦ Participants who qualify for direct financial assistance to lower copayment for medicines on the geriatric formulary (after Part D plans pay first) are required to have comprehensive MTM appointments every 6 months, and this appointment always includes preventive health education and screening individuals to see if they need other services and supports. ◦ For those engaging with tailored community referral services, additional interaction with staff often occurs between regular appointments to problem solve as needed. ◦ Continuity of care ensures that participants know the SPA staff is on their care team over time rather than providing only episodic services.

Ensuring the involvement of trusted messengers such as state-government agencies and professional organizations and securing their endorsements contributed to the success and credibility of our efforts. SPA engaged the North Carolina Department of Health and Human Services Division of Aging and Adult Services and the Office of Rural Health early in the planning process and worked with other statewide agencies (e.g., Area Agencies on Aging, the NC Association of Pharmacists) to help with application dissemination. These external stakeholders lent credibility to our initiative and broadened our reach across the State. Their established reputation and relationships enhanced the trustworthiness of our message and made it more appealing to a diverse audience. By leveraging SPA networks, we effectively disseminated the statewide survey to a wider audience, allowing us to capture the interest of those who may not have been initially engaged. We believe that this continuous engagement with state leaders fosters a sense of ownership and collective responsibility toward a shared goal.[15,16]

The task force and core team determined that engaging 3 communities would be programmatically feasible for a one-year pilot implementation project. The intent was to facilitate a cohesive, collaborative, and successful experience; have sufficient SPA team members to support community teams; and engage communities that were diverse in population, geography and assets. Inclusion criteria for communities to be invited into the pilot were as follows:

- explicit interest in implementing the SPA model (incorporating all four services) in their community;
- identification of a community champion (an individual to lead the charge and foster coalition building);
- established network/relationships among social service and health care providers
- Support from civic and faith-based communities;
- physical space for clinical and Medicare counseling appointments;
- ability to identify and bring in community stakeholders with specific skills (e.g., experience with private fundraising, SHIP/ Medicare Counseling, aging specialists, primary care provider champions);
- existing pharmacy partnership(s) represented on the team;
- ability to attend all learning collaborative sessions (mid-day 90-minute virtual monthly meetings);
- willingness to consider raising private funds to implement the SPA model.

The first community confirmed to participate had contacted SPA proactively and met the inclusion criteria. The remaining two communities were recruited from survey respondents. Of 376 respondents, 131 expressed interest in SPA's expansion efforts and were sent an application to assess for inclusion. Applications were also sent to 35 contacts who had previously requested copies of the implementation guide and the 15 state Area Agency on Aging directors. Eight of 181 completed the applications by the deadline of March 31, 2022. These included applicants representing entities such as Councils on Aging, schools of pharmacy, senior centers, and even local pharmacies. SPA connected some applicants who were co-located to encourage collaboration in expanding/solidifying some teams, bringing the number to 6 applicants. The SPA core team and task force explored the geographic and demographic representation of each applicant along with

current service levels related to the 4 components of the SPA model. Ultimately 3 communities were invited to participate in the pilot project, and each accepted.

Discussion and Implications

SPA highlights the importance of community ownership and collaboration among key stakeholders to foster long-term sustainability. Two critical model adaptations were needed for local adoption in other communities. First, the SPA model in Durham with the 4 services and 3 pillars is all housed in one agency, and applicants for early adoption were connecting and optimizing existing efforts across multiple agencies. SPA believes in leveraging and optimizing what communities have in place as a starting point. Having all of the services nestled in the Durham office allows for efficient and HIPAA-secure communication. It also supports the development of a cohesive team focused on a shared mission that can garner community support. Applicants for early adoption were proposing to connect and optimize existing efforts across multiple agencies. Developing a model across agencies presents practical challenges as well as new opportunities to leverage local resources, stakeholders, and relationships.

Second, as a long-standing community-based agency trusted by providers, local pharmacists, social service agencies, program participants, and their families, SPA's approach to conducting MTM is dramatically different from payer-driven initiatives. As a whole, the SPA model integrates MTM interventions with other supportive services. MTM was intended to be the cornerstone of the Medicare Part D benefit from its inception; however, the misalignment of financial incentives and a focus on process versus outcome evaluation has led to disappointing results from stand-alone and Medicare Advantage plan-driven MTM interventions.[17,18] In addition, comprehensive MTM is not regularly woven into community-based settings, including retail pharmacies, so older adults are not exposed to the potential benefits.

The Centers for Medicare & Medicaid Services (CMS) estimates that only 9% of Part D enrollees are eligible for MTM using their current targeting eligibility criteria, and the many people who are eligible do not receive a "comprehensive medication review." If they do, it is often conducted over the phone with someone unknown to the Medicare beneficiary. Funding to support MTM conducted by Part D plans (stand-alone or in Medicare Advantage plans) does not generate more funding for plan sponsors, as it comes from their administrative bid, so it is not surprising that they offer minimal services and produce minimal impact.[18]

We encountered several barriers to implementation in the planning phase, primarily stemming from the absence of a clear funding stream for the model to be adopted and implemented in other communities. Despite this challenge, community agencies still volunteered to be part of the work,

showcasing their dedication and passion for the service model rather than solely pursuing monetary incentives. This dedication proved beneficial in identifying individuals and agencies who were truly committed to the work. In addition, without grant funding for SPA to put towards training, it was difficult to envision how communities could effectively adopt the model. Although there was a written implementation guide (3 renditions over 14 years), it had not been designed with training modules to fully support service provision, including the 3 key pillars with fidelity.

Additionally, decisions in the pre-implementation phase of the project aimed to encourage collaboration among various organizations rather than centralizing all services under one entity, which added another layer of complexity. There was deliberation over whether to focus only on communities that appeared ready to implement the model (services in place and just need to pull them together) or to engage with agencies in a community excited about the model but early in planning stages of service provision. The decision to learn from communities with expressed excitement and dedicated commitment with varying levels of service delivery already in place meant the implementation training would need to adapt accordingly, balancing the pressure to streamline training while remaining flexible to accommodate diverse community needs.

Lastly, there was a desire to understand the potential outcomes of various approaches (e.g., only adopting 3 of the 4 services) and to refine the project accordingly. Without grant funding, external evaluation of implementation efforts would be challenging. Fortunately, as SPA leadership was beginning to approach possible funders, the team was also expanding their academic-community partnership and was eventually awarded the project grant via the Duke Roybal Center for Translational Research in the Behavioral and Social Sciences of Aging, funded through the National Institute on Aging (P30AG064201).

Conclusion

Older adults rely upon a patchwork of inpatient and outpatient Medicare services that do not prioritize medication management, and that are disconnected from disparate and underfunded private and governmental social care programs. Medicare beneficiaries face challenges navigating these services in different sectors to access what they need. The adage that "all health care is local" resonates for many older adults and community-based service providers. The SPA model is an example of how medication management and access, Medicare insurance counseling, and tapping other basic needs can be integrated at the community level to produce improved outcomes in a more user-friendly system. Adoption of the SPA model in multiple communities could extend the benefits to more older adults in need.

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Declaration of interests

The authors have no conflicts of interest to declare.

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