

Integrating Community Pharmacists' Services into an Accountable Care Organization

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Agenda

- ▶ Introductions
- ▶ Overview of Accountable Care Organization (ACOs)
- ▶ State Innovations Model (SIM)
- ▶ Opportunities to leverage learnings
- ▶ Team-based medication management
- ▶ Southern Prairie Community Care (SPCC) ACO
- ▶ SPCC Medication Therapy Management initiative
- ▶ Case studies
- ▶ Discussion

Today's Speakers



Dr. Brian Isetts is a practitioner, educator and researcher at the University of Minnesota College of Pharmacy. He is a former Health Policy Fellow at the Centers for Medicare & Medicaid Services in the CMS Part D MTM Program and at the CMS Innovation Center.



Jason Miller, Pharm.D., is the Pharmacy Clinical Program Manager for Coborn's Inc.. Dr. Miller is involved in several national and local organizations including ASHP, ACCP, MPhA, and MSHP. He currently serves on MPhA's MTM Academy, the Peer Advisory Panel for the MedEdgeRx Network, and the Pharmacist Advisory Board for Apothecary Products.



Laura Topor is President of Granada Health, and has worked with the Minnesota Department of Health, PharmaSmart, Argus Health Systems, PricewaterhouseCoopers, Allina and HealthPartners. Laura has been a member of NCPDP for over 17 years and is a member of AMCP and MPhA.

What's an ACO?

- ▶ According to the Robert Wood Johnson Foundation:
 - ▶ An Accountable Care Organization is a group of health care providers, with collective responsibility for patient care that helps coordinate services - delivering high quality care while holding down costs.
- ▶ The ACO model creates an incentive for providers to efficiently and effectively manage the health of their patients regardless of where the patient receives care.
 - ▶ Innovation lies in the flexibility of their structure, payments and risk assumption
 - ▶ The structure is likely to include Primary Care Providers, specialists, a hospital, and other provider and community agreements/partnerships.

ACO initiatives at CMS

- ▶ CMS, specifically Medicare, offers a variety of ACO programs. When an ACO succeeds in delivering high-quality care and spending health care dollars wisely, it will **share in the savings** it achieves for the Medicare program.
 - ▶ [Medicare Shared Savings Program](#)—a program that helps a Medicare fee-for-service program providers become an ACO.
 - ▶ [Advance Payment ACO Model](#)—a supplementary incentive program for selected participants in the Shared Savings Program.
 - ▶ [Pioneer ACO Model](#)—a (closed) program designed for early adopters of coordinated care.

- ▶ [CMS ACO Information](#)

Statewide Innovation Model

- ▶ In February 2013, CMS awarded six states grants to help its providers and communities work together to create healthier futures for their residents
- ▶ Minnesota received a \$45 million grant.
- ▶ The other states were Oregon, Maine, Massachusetts, Vermont and Arkansas.

- ▶ [Minnesota Health Reform - SIM](#)
- ▶ [Additional Minnesota SIM Information](#)
- ▶ [Minnesota DHS SIM Information](#)

Minnesota Accountable Health Model - State Innovation Model Grant

- ▶ The Model includes up to 15 Accountable Communities for Health. These will develop and test strategies for creating healthy futures for patients and community members.
- ▶ By expanding ACOs using a multi-payer approach, Minnesota will test how to provide and pay for value-based care.
- ▶ Multi-payer alignment will occur through initiatives such as
 - ▶ common measurement tools
 - ▶ improved clinical data exchange among providers
 - ▶ aligned payment and risk adjustment methods for complex populations.
- ▶ The project will also provide support to providers for health information technology and data analytics, and practice transformation to more effectively deliver high-quality, coordinated care.

ACOs in Minnesota

- ▶ There appear to be three distinct clusters, or levels, of market maturity within Minnesota.
 - ▶ One cluster has no alignment with ACO characteristics.
 - ▶ One has ACO-like business models that are in development, but are not yet achieving clinical integration, value-based performance alignment, or population health mentality.
 - ▶ One small cluster has strong clinical models who are pursuing risk arrangements.
- ▶ Most ACO arrangements in Minnesota began as hospital-based.
 - ▶ Few ACO-based organizations have revenue or risk-sharing contracts that include long term care, behavioral health, or non-clinical services.
 - ▶ Only a quarter have contracts that include community-based service providers.

Minnesota Accountable Health Model

- ▶ 41% of fully insured covered lives attributed to ACO models. Participation is heavily concentrated among the largest health plans.
- ▶ Approximately 50% of clinics, hospitals and physicians either belong to an ACO or belong to a larger organization that participates in an ACO.
- ▶ Most ACO arrangements in Minnesota are hospital-focused. Few ACO-based organizations have revenue or risk-sharing contracts that include long term care, behavioral health, or non-clinical services.
 - ▶ *Only a quarter have contracts that include community-based service providers.*
 - ▶ *Impact of pharmacy measured to date has primarily dealt with brand/generic dispensing rates.*

Opportunities

- ▶ PBMI recently released a report on pharmacy trends in ACOs.
- ▶ 101 ACOs across more than 30 states, which combined cover 6.5 million patients.
 - ▶ 43% do not employ a clinical pharmacist
 - ▶ 40% employ a clinical pharmacist
 - ▶ 17% contract one out
 - ▶ 56% of ACOs say they will decrease the cost of prescription drugs
 - ▶ 69% believe they will increase prescription drug therapy quality

*Enhancing Life and Health in our Communities
Through Accountable Care*



Southern Prairie Community Care

- SPCC is a **virtual** network focused on the Triple Aim
- Identified as an **Accountable Community for Health**
- 27 provider members - **clinics, hospitals, public health, mental health centers, and area human service agencies**
- Focused on **improving health** of people in our communities.
- The **strength** of our approach is **efficiently mobilizing “the community”** around those with highest need.
- Ability to leverage **connections in Governance** of SPCC and that of **HHS agencies, MHCs, and county hospitals.**

Medication Therapy Management Services (MTMS)

- ▶ Description of MTMS
- ▶ Overview of Comprehensive Team-based Medication Management
- ▶ The Southern Prairie Community Care Accountable Care Organization MTMS initiative

This is Reality in Homes Across America



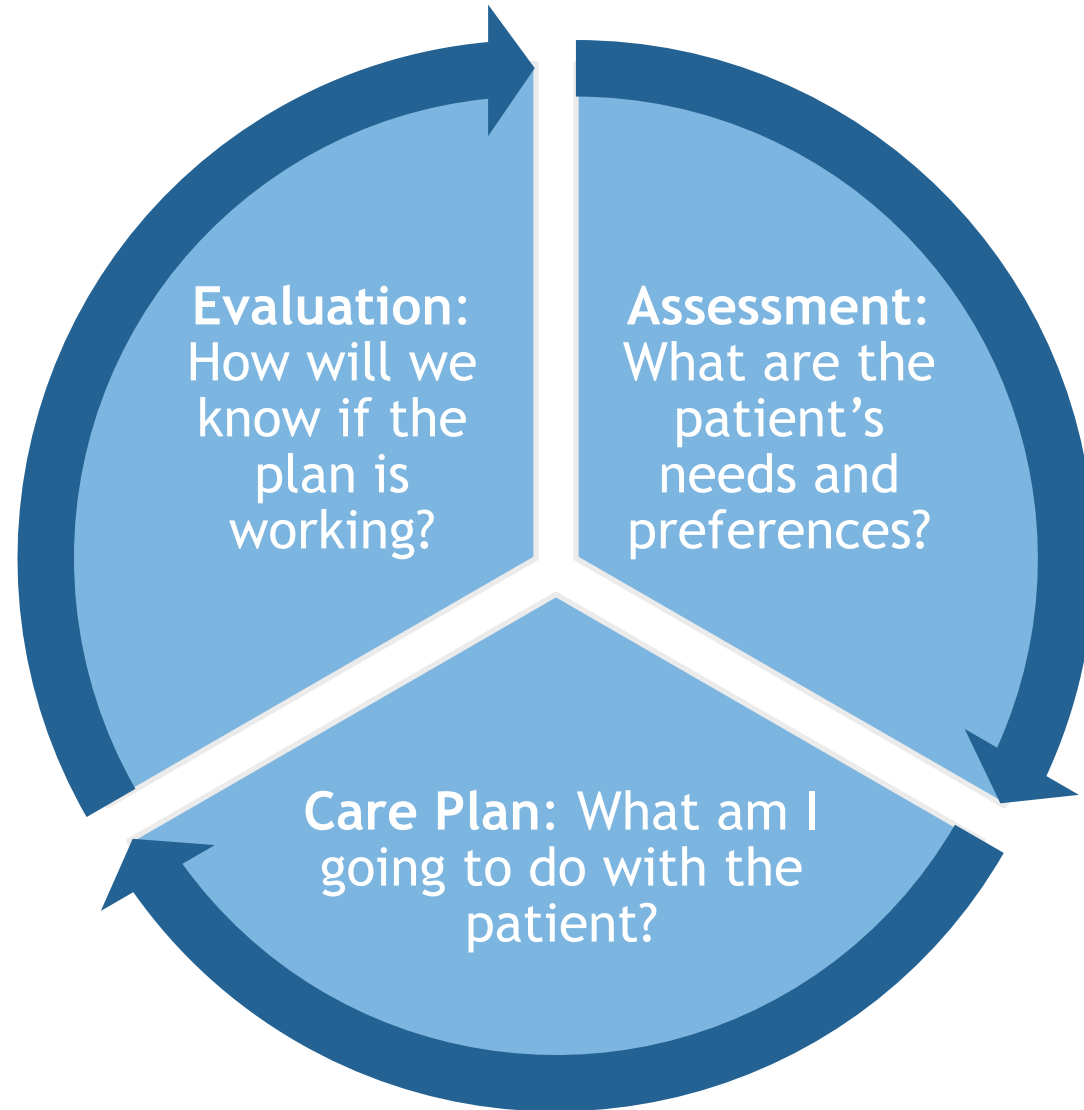
Reasons for Dysfunctional Medication Use

- Fee-for-Service (FFS) inadvertently rewards providers/organizations when drug therapies don't work or harm patients
- No one has stepped back and designed medication use systems from the patient perspective
- No one is responsible or accountable for what happens to patients when they take medications - that is, UNTIL NOW!

Service Level Expectations of MTMS

- ▶ Official Health Reporting Nomenclature - Current Procedural Terminology (CPT®), of the American Medical Association
- ▶ A pharmacist takes responsibility for all of a patient's drug-related needs and is held accountable for this commitment
- ▶ Separate and distinct from dispensing
- ▶ Systematic patient care process (assessment, care plan and evaluation)

The Patient Care Process



Establish a Therapeutic Relationship

Comprehensive Team-based Medication Management

All team members help set patient-specific drug therapy goals for each medical condition:

- ▶ Assessment of intended use, effectiveness, safety, and adherence embedded across continuum of care
- ▶ When patient is not achieving goals of therapy there is more efficient and effective use of pharmacists' skills on the team
- ▶ Coordination of care as hospital pharmacists conduct comprehensive assessments of drug-related needs
- ▶ Patients/care-givers help team define “high-risk” as core element of the patient-centered health home

Pharmacists Contributions to the National Three-Part Aim

- ▶ Over 50,000 studies of care provided by pharmacists
- ▶ Meta-analysis published in 2010
- ▶ Clinical outcomes: percentage of goals of therapy achieved, improved care (A1c, BP, LDL)
- ▶ Humanistic outcomes: quality of life, patient satisfaction, reduced sick days
- ▶ Economic outcomes: cost-benefit, fewer hospital visits; Return on Investment (ROI) = consistently \$4:\$1

The Minnesota Medicaid MTM Care Law

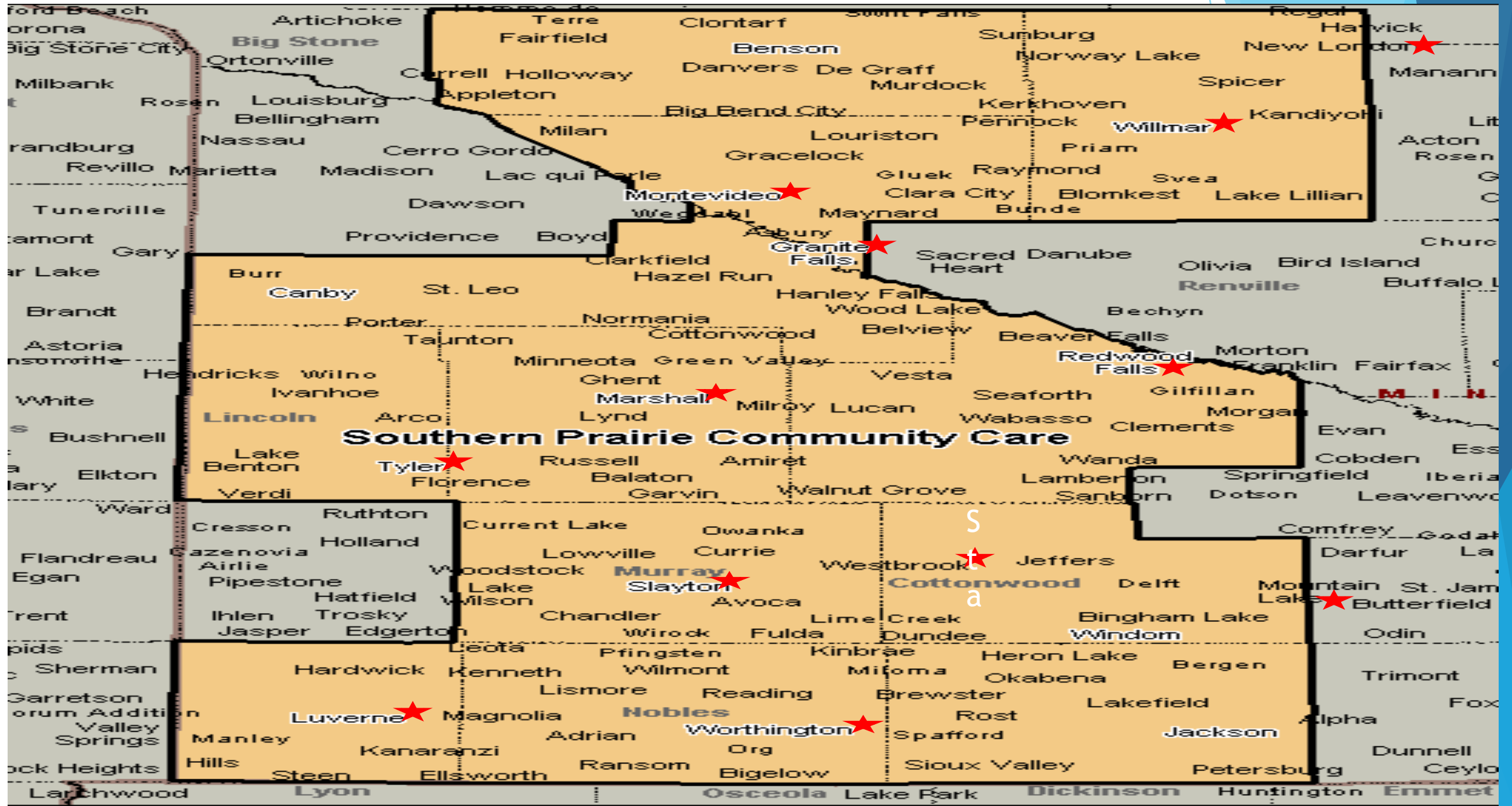
MN Statute § 256B.0625, Subd. 13h. Medication therapy management services

- ▶ Enacted July 2005 (12 years of legislation)
- ▶ Statutory definition of the MTM service
- ▶ Patient eligibility
- ▶ Pharmacist eligibility (training requirement for pre-1996's)
- ▶ Place of service specifications (non-hospitals)
- ▶ Electronic documentation requirement
- ▶ Billing framework using MTMS CPT codes

SPCC MTM Initiative

- ▶ Supported by a modest grant to the University of MN College of Pharmacy from the Community Pharmacy Foundation
- ▶ Goal: Integrate MTM by pharmacists into the care delivery system & H.I.T. infrastructure for SPCC recipients
 - ▶ Prepare pharmacists and health teams to improve care at lower cost
 - ▶ Access to more accurate medication use information
 - ▶ Help recipients more effectively manage their medications
- ▶ 24 pharmacists at 17 sites credentialed by Minnesota's Department of Human Services (MNDHS)
- ▶ Peer support & mentoring - MedEdge Rx MTM Network

SPCC MTM Network



Integration in Action

Case Studies from Coborn's/Cash Wise

Coborn's/Cash Wise

- ▶ Grocery store-based pharmacies
- ▶ 36 locations mainly in rural areas of Minnesota
 - ▶ 2 clinic locations
- ▶ Performing MTM sporadically for many years
- ▶ Shift in healthcare = shift in our business model
 - ▶ How do pharmacies optimize pay-for-performance?
 - ▶ More patient care services
 - ▶ Quality based initiatives
 - ▶ MTM is a big part of that

MTM in the retail setting

- ▶ Do you view the retail pharmacist as part of the healthcare team?
- ▶ Operating in a silo or as an external organization
- ▶ Providers unsure of what MTM is
- ▶ Patients seen are usually recruited, not referred
- ▶ Recommendations often not welcome/accepted

Integrated MTM Services - SPCC Case 1

Overview

- ▶ Patient referred for MTM encounter by SPCC Integration Coordinator
- ▶ 64 y/o Caucasian female
 - ▶ 19 medications
 - ▶ 9 medical conditions
 - ▶ Home care nurse sets up / re-orders meds (except insulin and oxygen)
 - ▶ Blood sugar running between 300-400 mg/dl (last A1C 9.8)
 - ▶ Approximately 60 ED visits in previous 3 months, mainly anxiety leading to shortness of breath
 - ▶ Unable to be followed by primary care as patient is constantly missing appointments

Integrated MTM Services - SPCC Case 1

Actions

- ▶ MTM encounter with SPCC Integration Coordinator present
- ▶ 8 Drug therapy problems identified, including:
 - ▶ Unnecessary drug therapy - Plavix and aspirin (8 years post-stent)
 - ▶ Cost Savings Opportunity - switch Crestor 40mg to atorvastatin 80mg
 - ▶ Adverse Effects - switched some medications with side effects
 - ▶ Adverse Effects - discontinued medications that were exacerbating conditions
- ▶ Also...
 - ▶ Worked with the county to arrange better transportation
 - ▶ Worked with the patient on anxiety action plan

Integrated MTM Services - SPCC Case 1 Results

- ▶ What happened?
 - ▶ Initially Nothing
- ▶ Integration Coordinator to the rescue!
 - ▶ Went with patient as advocate to appointments with pharmacy recommendations in hand
 - ▶ All recommendations for the 8 drug therapy problems eventually accepted
- ▶ What happened?
 - ▶ NO ED VISITS FOR NEXT 3 MONTHS!!!!
- ▶ Lesson learned - Integration matters

Integrated MTM Services - SPCC Case 2

Overview

- ▶ Patient referred for MTM encounter by SPCC Integration Coordinator
- ▶ 42 y/o Hispanic female
 - ▶ 4 medications
 - ▶ 3 medical conditions
 - ▶ Concerns of drowsiness, anxiety and constipation

Integrated MTM Services - SPCC Case 2

Actions

- ▶ MTM encounter with SPCC Integration Coordinator present
- ▶ 3 Drug Therapy Problems identified
 - ▶ Adverse Effects - switched antidepressant to evening dosing
 - ▶ Adverse Effects - split dosing of benzodiazepine for anxiety
 - ▶ Needs Therapy - scheduled stool softener / laxative
- ▶ Also...
 - ▶ Gave her a personal contact at the pharmacy to reduce anxiety around medication delivery and insurance coverage

Integrated MTM Services - SPCC Case 2

Results

- ▶ What happened?
 - ▶ Decreased drowsiness
 - ▶ Eliminated constipation
- ▶ Patient transferred all medications to our pharmacy
- ▶ Regularly follows up with MTM pharmacist
- ▶ Lesson learned - Integration is good business

Breakout Session Forum Questions

- ▶ How could team-based medication management help you in the work you're doing in your community?
- ▶ Turn to the person sitting next to you and share your reflections to this query.
- ▶ 2 minutes per person
- ▶ We will then go around the room so you can share the great ideas and observations from the person sitting next to you

Discussion



Thank you!

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