Healthcare Reform, “Medical Home”...and Pharmacists

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Health Care Reform: Goals

- Expand Coverage
  - Expand current public programs
  - Create federally funded universal health plan
  - Create employer & individual mandates

- Improve Quality
  - Pay-for-performance
  - Medical home model/Accountable Care Orgs

- Reduce Costs
  - Cuts to service fees & product reimbursement
  - Cuts to MA-PD Plans
Patient Protection and Affordable Care Act (PPACA) PL 111-148

- Health Insurance Reform – Certainly
- Health Care System Reform - Probably
- Health Care Payment Reform – Marginally now…but promising future
- Health Care Quality Reform – Conceivably
- Health Care Delivery Reform – We’ll See
Why Healthcare Reform Will Continue to Matter

Health Insurance Coverage in the U.S., 2007

- Employer-Sponsored Insurance: 53%
- Uninsured: 15%
- Medicaid/Other Public: 13%
- Medicare: 14%
- Private Non-Group: 5%

Total = 298.2 million

NOTE: Includes those over age 65. Medicaid/Other Public includes Medicaid, SCHIP, other state programs, and military-related coverage. Those enrolled in both Medicare and Medicaid (1.7% of total population) are shown as Medicare beneficiaries.

SOURCE: Kaiser Commission on Medicaid and the Uninsured/Urban Institute analysis of March 2008 CPS
Approach to Expanded Access

- Require citizens/legal residents to HAVE insurance
- Provide financial support for purchase based on income
- Impose financial penalties on individuals/employers who do not obtain/provide insurance coverage
- Create state-based exchanges for individuals and “small businesses” to purchase coverage (including multi-state exchanges)
- Provisions related to exchanges effective January 1, 2014
- Employers with > 200 employees must provide insurance coverage
- Extend Medicaid coverage to all individuals age < 65 with incomes up to 133% of FPL (Federal $ > states) between 2011 and 2014
- Premium supports for those between 133% and 400% of FPL
Insurance Market Reforms

- Required guaranteed issue and renewability
- Rating variations limited to age (limited to 3:1 ratio), family composition, premium rating area, and tobacco use.
- Required reports on premium dollars paid for clinical services, quality, and cost measures – rebates for medical “loss ratios” less than 85% for large group plans and 80% for small group and individual plans
- Dependent coverage expanded through age 26 on individual and group policies
- Prohibit lifetime limits on dollar value of coverage (& annual limits beginning in 2014).
- Limit waiting periods to no more than 90 days (phase-in)
- Prohibit rescission of coverage except in cases of fraud
- Various “grandfathering” provisions on existing plans
Tax Changes/Financial Impacts
(Various Phase-in Dates)

- Tax on individuals: > of $695/year up to 2.5% of income
- Limit contributions to FSA to $2,500/year
- Increase threshold for unreimbursed expenses from 7.5% to 10% of AGI
- Increase tax rate on wages from 1.45% to 2.35% for “high income” individuals/families (to Medicare Part A)
- Tax of 3.8% on “unearned income” (to Medicare Part B)
- Graduated annual fees on pharmaceutical manufacturing sector ($2-4.5 billion/year)
- Annual fees on insurance sector ($8-14 billion/year)
Family Income & the Uninsured

Source: Kaiser Family Foundation

- N=approximately 36 million U.S. citizens
- Blue, green, orange slices = approximately 30 million
- Income levels shown = cutoff points for families of four at percentages of federal poverty level: 100%, 100-200%, 200-400% and 400% and above
Other Quality, Effectiveness, Payment Reform, & Coverage Provisions

- Establish “Patient-centered Outcomes Research Institute”
- Center for Medicare Innovation
  - Pilots for payment reform approaches
- “Independence at home” demonstration program
- “Medical home” grant programs supporting interprofessional team-based care development, including medication management services and behavioral health programs
- Close Part D drug benefit “doughnut hole” over several years
Pharmacy’s “Big Picture”

PRINCIPLE 1 – Quality and Safety

- Improve quality & safety of medication use
  - A. Coverage for pharmacists’ patient care services in public and private health programs;
  - B. Appropriate and reasonable payment for services, with pay-for-performance and evidence-based components.
Pharmacy’s “Big Picture”

PRINCIPLE 2 – Infrastructure

- A. Well-educated workforce through comprehensive federal workforce strategy;
- B. Patient access to/choice of providers;
- C. Appropriate payment for pharmacy services that provide accurate/efficient/safe medication distribution;
- D. Support cost-effective medication selection through active promotion and use of approved generic medications and biologic products.
Pharmacy’s “Big Picture”

PRINCIPLE 3 – Health IT

- A. Access to patient information/data, including diagnostic, laboratory through interoperable IT systems;
- B. Federal/state grants to support health IT infrastructure development for pharmacists and other providers;
- C. Enhance flow of information/data between providers to promote quality treatment decisions for patient care while providing necessary protections for patient privacy.
Pharmacy’s Big Picture
“Pharmacy”-specific provisions

- Section 3503 – Medication management services in the treatment of chronic disease:
  - Grants/contracts to implement, thru “Patient Safety Research Center”
  - Uses profession’s consensus definition; recognizes collaborative practice
  - Targets services to disease, medication, and care transition parameters
  - Evaluation report by HHS on effectiveness, patient/provider satisfaction, impact of cost-sharing, potential COI issues.
“Pharmacy”-specific provisions

- Section 3502 – Establish community health teams to support the PCMH:
  - Grant program for public or private entities
  - “such teams may include........pharmacists...”
  - “transitional care program that provides....medication reconciliation...”
  - “assuring that post-discharge care plans include medication management as appropriate....”
Perspectives………..

■ “The beginning of the end………..

……..or just the end of the beginning………..?”
The principles were written and agreed upon by the four Primary Care Physician Organizations – the American Osteopathic Association, the American Academy of Family Physicians, the American Academy of Pediatrics, and the American College of Physicians.

<table>
<thead>
<tr>
<th>PRINCIPLES</th>
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<tbody>
<tr>
<td>Ongoing relationship with personal physician</td>
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<td>Physician directed medical practice</td>
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<td>Whole person orientation</td>
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<td>Coordinated care across the health system</td>
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<td>Quality and safety</td>
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<tr>
<td>Enhanced access to care</td>
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<td>Payment recognizes the value added</td>
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February 2007
Why Primary Care?

• In the US and Britain, each additional primary care physician per 1000 is associated with a decrease in mortality of about 5%\textsuperscript{1A}

• Adults with a primary care physician as their personal physician
  – had 33% lower costs of care\textsuperscript{1B}
  – were 19% less likely to die\textsuperscript{1B}

• Primary care physician supply has been consistently associated with improved health outcomes for conditions like cancer, heart disease, stroke, infant mortality, low birth weight, life expectancy, and self-rated care\textsuperscript{2}

\textsuperscript{1A} Adjusting for limiting long-term illness and for various demographic and socioeconomic characteristics, 
\textsuperscript{1B} Controlling for age, gender, income, insurance, smoking, perceived health (SF-36) and 11 major health conditions 
2. Barbara Starfield, Primary Care Policy Center, John Hopkins Bloomberg School of Public Health
Care that is:

“accessible, accountable, coordinated, comprehensive, and continuous care in a healing physician-patient relationship over time”
A move from

*reactive, episodic management of individuals*

to

*proactive, continuous management of a population*
Medical Home Core Processes

• Clinical visits on demand
  – access
• Ability to understand and stratify patient population
  – by risk and by conditions
• Care management and coordination
  – based on risk/stratification
• Patient engagement/support
• Quality measurement/reporting
Single-Payer Health Plan Demonstration Pilots Initiated in 2009

- Key PCMH Pilot Programs Either in Place or in Development
  - Cigna PCMH Pilot in New Hampshire
  - Aetna has PCMH Pilots in
    - Colorado
    - Maine
    - Mid-Hudson Valley
    - Pennsylvania
    - Central New Jersey
  - Priority Health PCMH Pilot Program in Michigan
  - Wellpoint, Inc. PCMH Pilot in New York City
  - UnitedHealth Medical Home Pilot in Arizona (Tucson & Phoenix)
  - Blue Cross Blue Shield PCMH Pilot in Nebraska

= New Demonstration Pilots Taking Place or in the Process of Being Enacted
### Medical Home Pilots Have Varied in Design and Impact

#### Comparison of PCMH Pilot Features

<table>
<thead>
<tr>
<th>Feature</th>
<th>VA-CHF</th>
<th>Inter-mountain</th>
<th>Group Health</th>
<th>Geisinger</th>
<th>VA-Diabetes</th>
<th>North Carolina</th>
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<tbody>
<tr>
<td>Care Coordination</td>
<td>✔</td>
<td>✔</td>
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<td>Health IT</td>
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<tr>
<td>24/7 access*</td>
<td>✔</td>
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<tr>
<td>Community Teams</td>
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<td>P4P</td>
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<td>PMPM Payment</td>
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<td>Performance Evaluations</td>
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<tr>
<td>Transitional Care*</td>
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<tr>
<td>Specialist Involvement*</td>
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<td>✔</td>
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<tr>
<td>Flex Scheduling*</td>
<td>✔</td>
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<td>✔</td>
<td>✔</td>
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<tr>
<td>Shared Savings</td>
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<td>✔</td>
<td>✔</td>
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<tr>
<td>Hospitalization Reduction**</td>
<td>+33%</td>
<td>+3.3%</td>
<td>11%</td>
<td>20%</td>
<td>24%</td>
<td>34%</td>
</tr>
</tbody>
</table>

* Characteristics as reported

** % reduction from baseline 5
Today: Providing Care for the Sick

FACE TO FACE WITH PATIENTS

Check-in | Room | MD/NP/PA | Order | Check-out | Follow-up
--- | --- | --- | --- | --- | ---
Third party Payers | Patient Forms | Medication Refills | Care Coordination | Paper Communications |
Regulatory | Patient Messages | Test Results | Mail/Email Communications |
Phone calls to Patients | Follow-up Consultation | Patient Letters | Quality Management |

MD, PA, NP Key Tasks | RN Key Tasks | MA Key Tasks
Tomorrow: Keeping Patients Healthy

**Multi-Disciplinary Team**

### FACE TO FACE WITH PATIENTS

**Check-in**
- MD/NP/PA

**Room**
- MD, PA, NP

**Order**
- Transition to review & approval, clinical decisions

**Check-out**
- MA

**Follow-up**
- RN

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**Prerequisite Processes**
- Med Reconciliation
- Std Rooming
- Std Room Set-up
- Std In-Basket Management
- MyChart sign-up/activation
- Problem Solving Methodology (PDSA)
- Communication Process (aka. Huddles, team design, operational meetings.)

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**RN Key Tasks**
- Transition to review & approval, clinical decisions

**MA Key Tasks**
- Develop patient self mgmt plan
- Outreach

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**Adult Preventative**
- Pre-visit planning
- Shared documentation
- Standard Care Guidelines

**Chronic Care Packages**
- CV suite and CKD
- Population management
- RN Management by protocol
- Registry mgmt/ gaps in care

**Chronic Care Packages**
- (Migraine, asthma, LBP)
- Condition-specific RN Triage
- Condition-specific education
- Develop patient self mgmt plan

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**Paper Communications**
- Mail/Email Communications
- Patient Messages
- Phone calls to patients
- Patient Letters
- Follow-up Consultation
- Quality Management
- Third Party Payers
- Patient Forms
- Regulatory
- Medication Refills
- Care Coordination
- Test Results
Medical Homes Have the Potential to Improve Quality, Costs, and Satisfaction

Medical Homes yield promising results

- 29% reduction in ED visits at Group Health
- 20% reduction in hospitalizations at Geisinger
- Achieve 94% of diabetes patients having ≥2 primary care visits per year for NC Medicaid
- Over $400 million saved over 4 years for NC Medicaid
- 3.8% total cost savings in Iowa
- 11% expected cost savings in VT
- $640/year saved per patient for the community at Intermountain

Country wide adoption

- More than 40 states are involved in medical home pilot activity
- Multi-Payer pilot discussions/activity
- Identified pilot activity
- No identified pilot activity – 6 states
**Evidence of Cost Savings and Quality Improvement**

<table>
<thead>
<tr>
<th>Summary of Key Data on Cost Outcomes from Patient Centered Medical Home Interventions</th>
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<tbody>
<tr>
<td><strong>Group Health Cooperative of Puget Sound</strong></td>
</tr>
<tr>
<td>• 29% Reduction in ER visits and 11% reduction in ambulatory sensitive care admissions</td>
</tr>
<tr>
<td>• Additional investment in primary care of $16 per patient per year was associated with offsetting cost reductions, with the net result being no overall increase in total costs for pilot clinic patients</td>
</tr>
<tr>
<td><strong>Community Care of North Carolina</strong></td>
</tr>
<tr>
<td>• 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; total savings to the Medicaid and SCHIP programs are calculated to be $135 million for TANF-linked populations and $400 million for the aged, blind and disabled population</td>
</tr>
<tr>
<td><strong>Genesee Health Plan HealthWorks PCMH Model</strong></td>
</tr>
<tr>
<td>• 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6% lower than competitors</td>
</tr>
<tr>
<td><strong>Colorado Medicaid and SCHIP</strong></td>
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<tr>
<td>• Median annual costs $785 for PCMH children compared with $1,000 for controls, due to reductions in ER visits and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median costs ($2,275) than those not enrolled in a PCMH practice ($3,404)</td>
</tr>
<tr>
<td><strong>Johns Hopkins Guided Care PCMH Model</strong></td>
</tr>
<tr>
<td>• 24% reduction in total hospital inpatient days, 15% fewer ER visits, 37% decrease in skilled nursing facility days</td>
</tr>
<tr>
<td>• Annual net Medicare savings of $1,364 per patient and $75,000 per Guided Care nurse deployed in a practice</td>
</tr>
</tbody>
</table>
Patient-Centered Medical Homes and the Importance of Medication Management

• On a worldwide basis, the World Health Organization projects that only 50% of patients take medicines as prescribed.
• In the U.S., non-adherence affects patients of all ages, both genders, and is just as likely to involve higher-income, well-educated people as those at lower socioeconomic levels.
• Poor adherence is estimated to cost approximately $177 billion annually in total direct and indirect health care costs and includes:
  – Direct costs such as hospitalizations, ED visits, physician office visits, etc.
  – Indirect costs such as reduced productivity, increased absenteeism, increased mortality, etc.
How the Current Health Care System’s Interactions Affect Medication Use

**Patient-Provider Communication**
- The patient has a poor understanding of the disease, the benefits and risks of the treatment, or the proper use of the medication
- Physician prescribes an overly complex regimen for the patient

**Patient Driven**
- Poor access or missed clinic appointments
- Switching to a different formulary
- Lack of patient access to pharmacy
- High medication costs
- Forgetfulness
- Side effects

**Provider Driven**
- Poor knowledge of drug costs, formulary coverage
- Lack of knowledge of other medications prescribed
- Unfamiliarity with current guidelines

Successful Medication Management Requires A Team Approach

Payer restrictions, increased drug costs & patient copays decrease utilization

Prescriber compliance with clinical guidelines

Often affected by fear of adverse events, route of administration, etc.

Skipped doses due to forgetfulness, drug cost, side effects

12% - 33% of prescriptions never reach pharmacy

22-24% take less dosage than prescribed

29% of patients stop Rx prematurely

Average month 12 persistence <50%

Medication Adherence Drop Off Points

75 % of patients don’t take Rx as prescribed

National Council on Patient Information and Education (1); National Community Pharmacists Association 12/15/06 (2).
“Pharmaceuticals are the most common medical intervention, and their potential for both help and harm is enormous. Ensuring that the American people get the most benefit from advances in pharmacology is a critical component of improving the national health care system.”

The Institute of Medicine (IOM)\textsuperscript{1}

Medication Management Defined

• A standard of care that ensures each patient’s medications are appropriate, effective, safe, and able to be taken as intended

• Involves an assessment of each patient’s medication experience, identification of drug therapy problems, defining goals of therapy, a care plan, and follow-up evaluation

• Represents continuous care with measurable goals and outcomes reflecting a positive return-on-investment
10 Steps to Comprehensive MTM

1. Identify patients
   – who have medication issues
   – who have not achieved clinical goals of therapy
   – who want help with their medications

2. Understand the patient’s reality
   – personal medication experience
   – history and preferences
   – beliefs
3. Identify patient’s ACTUAL usage of ALL medications
   - OTC’s
   - Bioactive supplements
   - Prescribed medications
   - Rx claims data aren’t ACTUAL and aren’t ALL

4. Systematically review for drug interactions, then assess each medication’s:
   - Appropriateness – Effectiveness–Safety–Adherence (in this order)
   - Focused on achievement of the clinical goals for each therapy
5. **Identify all drug therapy problems**
   - *Bridge the gap between current therapy and what is needed to achieve optimal clinical outcomes*

6. **Develop a care plan**
   - *Recommend steps (including therapeutic changes) needed to achieve optimal outcomes*
7. Communicate care plan
   – Agreed upon and understood by patient
   – Communicated to the prescriber/provider for their consent/agreement

8. Document
   – All steps
   – Current clinical status vs. goals of therapy
9. Follow-up patient evaluation
   – Determine effects of changes & recommendations
   – Assess actual outcomes
   – Recommend further changes to achieve desired clinical goals/outcomes

10. Coordinate care
    – Patient specific goals are understood and worked toward by all
    – High level of engagement and empowerment by the patient
Pharmaceutical Care Practice

**Philosophy of Practice**
- Social Obligation
- Responsibilities
- Patient-centered approach
- Caring

**Therapeutic Relationship**

**Patient**
- Today’s wants and needs
- Responsibilities

**Medication Experience**

**Assessment**
- Care Plan

**Follow-up Evaluation**

**Pharmacotherapy Workup**
Drug Therapy Problems

- Appropriate
  - Needs additional drug therapy
  - Unnecessary drug therapy

- Effective
  - Ineffective drug
  - Dosage too low

- Safety
  - Adverse drug reactions
  - Dosage too high

- Adherence
  - Patient is willing to take
  - Patient is able to afford
## Contribution of Medication Management to the Medical Home Principles

<table>
<thead>
<tr>
<th>Principle</th>
<th>Medication Management Contribution</th>
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<tbody>
<tr>
<td>Personal Relationship with Physician or Other Practitioner</td>
<td>The therapeutic relationship is established and the patient’s medication experience is revealed and used to improve care</td>
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<tr>
<td>Team Approach</td>
<td>The rational decision-making process for drug therapy is utilized and the assessment, care plan and follow-up of drug therapy is integrated with the team’s efforts</td>
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<tr>
<td>Comprehensive/Whole Person Approach</td>
<td>All of a patient’s medications (regardless of source) are coordinated and evaluated to ensure they are appropriate, effective, safe, and convenient</td>
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<tr>
<td>Coordination and Integration of Care</td>
<td>The intended therapeutic goals, which are made measurable and individualized to the patient, serve to coordinate and integrate the patient’s care with other team members</td>
</tr>
<tr>
<td>Quality and Safety are Hallmarks</td>
<td>Drug therapy problems are identified, resolved, and prevented in a systematic and comprehensive manner to realize appropriate, effective, safe, and convenient drug therapy for the patient</td>
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<tr>
<td>Expanded Access to Care</td>
<td>Physicians are extended, made more efficient and more effective through the optimal management of a patient’s medications</td>
</tr>
<tr>
<td>Added Value Recognized</td>
<td>Clinical outcomes are improved, return-on-investment is positive, acceptance by patients is high, and physicians support the practice</td>
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</table>
Why Is Medication Management Needed in the PCMH?

- Facilitates the efficiency and effectiveness of the PCMH team in improving patient clinical outcomes, reducing morbidity and mortality, while lowering total healthcare costs
- Medications impact every other facet of work the team does – need to ensure it is optimal for the patient
Return on Investment

- On average, $16.70 saved for every $1 invested in clinical pharmacy services (review of 104 studies)\(^1\)
- Benefit: cost ratio ranged from 1.7:1 - 17.0:1 (literature review)\(^2\)

“Most patient care interactions involve medications and the limitations both in knowledge and time on my part make the addition of a clinical pharmacist on the medical home team MANDATORY! I would have a difficult time maintaining our current standards without this person on board.”

James Bergman, M.D. – Staff Physician, Group Health Permanente, Associate Professor, Family Medicine, University of Washington, Seattle
Structures for Service Delivery

- Practitioner at the practice site
- Referral system for off-site practitioners
Payment Mechanisms

• Resource Based Relative Value Scale and CPT codes
• Capitated payment
• Integrated payment approaches
Impact of Comprehensive Medication Management: The Patient’s Perspective

“I have been taking this medication for almost seven years. I have never been clear on why I am taking it or what it is supposed to do for me, and, I have never had anyone who had the time to explain it to me. Now I can ask questions and discuss my concerns about my medications.”

- J.P. (Patient receiving medication management services at a medicine clinic in Minneapolis, MN)
Summary

• The need for medication management has been established
• The value of the service has been validated
• The payment system for the service is defined
• Delivery of the system is now the challenge (practitioners, practices)
Common goals of therapy serve to drive efficiencies and improve effectiveness while decreasing costs.

Patient understands her medications and participates in a care plan to improve health.

Clinical goals of therapy are determined and medication recommendations are considered.

Appropriate, Effective, Safe and Adherent Medication Use!

Medication experience revealed, drug therapy problems identified, therapeutic recommendations made.

Comprehensive Medication Management in the PCMH
Comprehensive Medication Management in the Patient-Centered Medical Home (PCMH)

Elements of Comprehensive Medication Management

ASSESSMENT
Reveal the patient’s medication experience
Identify drug therapy problems in appropriateness of, effectiveness of, safety of, and compliance with medications

CARE PLAN
Establish personalized goals of therapy
Resolve drug therapy problems
Personalize Interventions

FOLLOW-UP
Effectiveness and Safety
Determine Actual Patient Outcomes

Core Principles of the Patient Centered Medical Home

Personal Relationship
Team Approach
Value
Comprehensive
Access
Coordinated
Quality Safety
Imperative for actions...

- Achieve practice model change
  - J CPP Vision
  - PCMH – the burden is on us
- Pursue health benefit design reform
  - Valuing the service/outcomes of clinical pharmacy practice
- Contemplate economic model change
  - Product ownership – burden plus COI?
Future Vision for Pharmacy Practice (2015)

*Pharmacists will be the health care professionals responsible for providing patient care that ensures optimal medication therapy outcomes.*

(Joint Commission of Pharmacy Practitioners; November 2004)

* Optimize medication therapy
* Manage health resources
* Promote Wellness
Questions??