Disclosures

Troy Trygstad: “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.”

Amanda Brummel: “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.”

Bob Davis: “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 Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

Learning Objectives

1. List factors that support the value proposition for pharmacist inclusion in ACOs and medical home models.
2. Describe pharmacists’ services that can impact measurable clinical and economic outcomes for patients within team-based care delivery models.
3. Discuss how to make the business case for pharmacist inclusion in team-based care models.
4. Discuss successful examples of pharmacist inclusion in team-based care models and the benefits realized by the practice.

Self-Assessment Questions

1. Currently, price increases are the main driver of health care expenditure for Public Payers.
   a) True
   b) False

2. By 2018 ____ of Medicare payments are projected to be in the form of an alternative payment model and ____ of fee-for-service payments will be tied to quality?
   a) 5%/15%
   b) 20%/35%
   c) 30%/50%
   d) 50%/90%
Self-Assessment Questions

3. Of the quality programs outlined today, which measure falls into each one (PQRS, MU, ACO, Part D Star, HEDIS)?
   a) Pneumonia vaccination
   b) High Risk Medications
   c) Diabetes- A1c Poor Control
   d) None of above

4. When primary care physicians engage pharmacists as care team members physician productivity is enhanced.
   a) True
   b) False

Self-Assessment Questions

5. Which of the following is not considered a key element of our business case?
   a) Marketing, banking and retail relationships.
   b) Assessment of leadership, practice needs, payer/disease mix, and expected outcomes.
   c) Proposal/Presentation including value messages.
   d) Plan outlining customer, activities, partners and revenue streams

The Panelists

- Amanda Brummel, PharmD, BCACP – Fairview Pharmacy Services
- Integrated Health System
- Bob Davis, PharmD, FAPhA – Kennedy Pharmacy Innovation Center, University of South Carolina
- Group Practice/Medical Home
- Troy Trygstad, PharmD, MBA, PhD - Community Care of North Carolina
- Community Pharmacy

Format – Three topics

1) Health Care Financing Megatrends
2) Measures that Matter (in the new system)
3) Making the Business Case

Panel Discussion

15 Minutes

10-15 minutes

5-10 Minutes

Health Care Financing Megatrends

Troy Trygstad
Megatrend #1:
Fee-For-Service Reimbursements
Subject to Downward Pressure from
Public Payers, Narrowing Networks

Public/Private Payer Mix
US Health Care Spending 1960-2016: Who Pays?
Total 2014 Spending: $3.3 trillion

Created by the California Healthcare Foundation

Public/Private Payer Reimbursement Dynamics

<table>
<thead>
<tr>
<th>Public</th>
<th>Private</th>
</tr>
</thead>
<tbody>
<tr>
<td>Units</td>
<td>Units</td>
</tr>
<tr>
<td>Reimbursement/Unit</td>
<td>Reimbursement/Unit</td>
</tr>
</tbody>
</table>

*One Motivation for Consolidation is to Create Leverage Against Downward Pressure on Reimbursement

Megatrend #2:
New Payment Models Growing Rapidly
(in both Diversity and Volume)

Number of Units vs. Unit Price Over Time

Health Reform is Here…

“Our first goal is for 30% of all Medicare provider payments to be in alternative payment models that are tied to how well providers care for their patients, instead of how much care they provide – and to do it by 2016. Our goal would then be to get to 50% by 2018.”

“Our second goal is for virtually all Medicare fee-for-service payments to be tied to quality and value; at least 85% in 2016 and 90% in 2018.”

-Sylvia Mathews Burwell, HHS Secretary

30 Day Read. Penalty
MSSP/Next Gen
MAPD
PDP
Medicaid FFS/PCCM
Commercial
Medicare FFS → MIPS
Bundled Payments
Readmission Penalties
Direct Pay Model
Star Ratings Bonus
Cash Pay/HSA Model
MCO/HEDIS Migration
ACO/P4P/Shared Savings

Emergence of the “Outcomes Marketplace”

Substitution Effect Does Not Have Homogeneous Effect Across Payers

<table>
<thead>
<tr>
<th>Drug Cost</th>
<th>Non-Drug Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicaid</td>
<td>$</td>
</tr>
<tr>
<td>Duals</td>
<td>$ $</td>
</tr>
<tr>
<td>Medicare</td>
<td>$ $</td>
</tr>
<tr>
<td>State</td>
<td>$ $</td>
</tr>
<tr>
<td>Employees</td>
<td>$ $</td>
</tr>
<tr>
<td>Commercial</td>
<td>$ $ $</td>
</tr>
</tbody>
</table>

The Substitution Effect

Megatrend #3:
“Inward Movement” to hybrid financing models and away from FFS and HMOs

Megatrend #4:
Providers become Payers, Payers lose appetite to become Providers – Everyone Consolidates

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Megatrend #5: Increasing Pressure on PBMs to Evolve beyond “Drug Cost Police”

Option 1: Hold PBM Accountable for Medical Spend and Global Outcomes

Option 2: Fund Med Optimization Service Providers & Hold Them Accountable for Medical Spend and Global Outcomes

CMS Elects to Pilot Option #1...
Megatrend #6 (The Wild Card):
Consumerism

Megatrend #7 (Early Phase):
PhRMA Getting Into the Risk/Reward/Outcomes Business

Health-care crunch: Patient costs rise, ability to pay drops

And it works in the other direction too....
Key Points

• We are in the Midst of a Dramatic Shift in how the Health Care System is Financed and Providers are Reimbursed (Away from Volume and Toward Value)

• The Emergence of the “Outcomes Marketplace” offers an opportunity for Pharmacists to provide value through better outcomes

• The Emergence of “Hybrid” Models such as shared savings, partial risk, and bundling offers an opportunity for Pharmacists to offer value through the “substitution effect”

• Consumers will play an ever increasing role in how we are remunerated for our services

Perspectives & Panel Discussion:
Health Care Financing Megatrends

Measures That Matter
(in the new system)
Amanda Brummel

ACA Impacts

• The Affordable Care Act (ACA) was a driver for new models of care to be developed.
  - Accountable Care
    • MSSP/Pioneer ACO
    • Advance Payment ACO Model
    • Nursing Home Value-Based Purchasing Demonstration
  - Episode based payment Initiatives
    • Bundled Payments for Care Improvement (BPCI) Initiatives
  - Primary Care Transformation
    • Comprehensive Primary Care Initiative
  - Initiatives Focused on the Medicaid and CHIP Population
  - Initiatives to Accelerate the Development and Testing of New Payment and Service Delivery Models
    - Innovation awards

From Volume to Value
Medicare FFS Payments

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Measurement Burden

1,000+ Measures In Use

Health Plan Measures
State Measures
Institutional Measures
Ratings

Quality measure programs

PQRS Measures- 2015

Effective Clinical Care
Diabetes: Hemoglobin A1c Poor Control
Diabetes: Low Density Lipoprotein (LDL-C) Control (>100 mg/dL)
Heart failure: ACE Inhibitor or ARB Therapy, Blotter therapy
Coronary artery disease: Antiplatelet Therapy
Anti-depressant medication mgnd

Efficiency and cost reduction
Appropriate healthcare testing

Community/Population health
Preventive care and screenings
Flu, pneumovax, pain, depression

Communication and care coordination
Medication reconciliation:
Post discharge med rec (>65yr)
Advanced care plan (>65yr)

Patient safety
High-risk medications in elderly
Adherence to antipsychotic medications/antidepressants

Meaningful Use (MU)

Core Measures
Blood pressure measurement
Tobacco use assessment / cessation
Adult weight screening

Additional measures (3/38)
Diabetes: Hemoglobin A1c Poor Control
Heart Failure (HF): ACE/ARB
CAD: Beta-Blocker with prior MI
Pneumonia vaccination (>65yr)
Screenings Breast cancer, Colorectal
CAD: Oral antiplatelet therapy
HF: Beta-blocker therapy
Anti-depressant medication management
Asthma medication therapy
Smoking and tobacco use cessation

Medicare ACOs – domains & measures

Patient experience (CAHPS)
- Timely care, appointments & info
- Doctor communication
- Patient rating of doctor
- Access to specialists
- Health promotion & education
- Shared decision making
- Health status/Functional status
- Stewartship of Patient Resources

At-risk populations
- Hypertension – Blood pressure control
- Heart failure – Beta-Blocker for LVD
- CAD – ACE and ARB Therapies
- Diabetes – Hemoglobin A1c poor control
- Diabetes – Eye exam
- FGM – Use of Aspirin or another Anti-thrombotic

Preventive health
- Influenza immunization
- Pneumococcal vaccination
- Adult weight screening/Follow up
- Tobacco use assessment and cessation
- Depression screening
- Colorectal cancer screening
- Mammography screening
- % adults with blood pressure screen, past 2 years
- Depression remission at 12 months

Care coordination/Safety
- COPD (PGMH)
- Congestive heart failure (PGMH)
- Screening for fall risk
- DM 30 day all cause readmission measure
- Med-reconciliation at each visit
- All cause unplanned admission for DM
- All cause unplanned admission for HF
- All cause unplanned admission for MDC
- PCPs meeting MU requirements

Part D Measures (2016)

- D01: Call Center – Foreign Language Interpreter and TTY
- D02: Appeals auto-forward
- D03: Appeals upheld
- D04: Complaints about the drug plan
- D05: Members choosing to leave the plan
- D06: Beneficiary Access and Performance Problems
- D07: Drug plan quality improvement
- D08: Rating of drug plan
- D09: Getting needed prescription drugs
- D10: Medicare plan finder price accuracy
- D11: High risk medication
- D12: Medication adherence for diabetes medications
- D13: Medication adherence for hypertension (RAAS antagonists)
- D14: Medication adherence for cholesterol (statins)
- D15: MTM Program Completion Rate for CMRs

HEDIS Measures

- Persistence beta-blocker treatment after heart attack
- Controlling high blood pressure
- Comprehensive diabetes care
- Cancer screenings (Breast, cervical, colorectal)
- Medication management (Antidepressant, COPD, asthma)
- High risk medications in the Elderly
- Annual monitoring - persistent medications
  - (ACEI/ARB, digoxin, diuretics)
- Flu and pneumovax vaccinations
- CAHPS survey
- Statin Therapy for Patients with Diabetes & CVD (NEW)

Core Measure Set

1. Life Expectancy
2. Well-being
3. Overweight & Obesity
4. Addictive behavior
5. Unintended Pregnancy
6. Health Communities
7. Preventative services
8. Care Access
9. Patient Safety
10. Evidence-based care
11. Care Match with Patient goals
12. Personal spending burden
13. Population spending burden
14. Individual engagement
15. Community engagement

How can Pharmacists Impact These Measures?

- Comprehensive Medication Management
  - Ensure comprehensive MTM services are available where there is need across the population
  - Will likely focus on the most complex patients
  - Multiple conditions not at goal
  - High utilization/risk

  Example Metrics:
  - Diabetes - Hemoglobin A1c poor control (A1c >9)
  - Hypertension – Blood pressure control
  - Statin Therapy for Patients with Diabetes

- Continuum of Care Services
  - Transitions of Care services
  - Inpatient and Outpatient teams working together to reduce readmissions through improved medication management, reconciliation, and patient education

  Example Metrics:
  - All cause unplanned readmission for DM
  - All cause unplanned readmission for HF
  - All cause unplanned readmission for multiple chronic conditions
  - Medication Reconciliation Post Discharge
Medication utilization/safety/gaps in care
Reviewing pharmacy data to find trends or opportunities for better management
– Brand to generic opportunities
– Safety alerts
– High risk meds
– Best practice algorithms

Example Metrics:
• High risk medications in the elderly
• Heart Failure: ACE Inhibitor or ARB Therapy, Beta Blocker therapy
• IVD: Use of Aspirin or another Antithrombotic

Therapy Management
Focused disease/medication management to a single condition
– Hepatitis C
– RA/MS
– Oral Oncology
– Anemia
– Coumadin

Example Metrics:
• Hypertension – Blood pressure control
• Medication Management – Antidepressant, COPD Exacerbation, Asthma
• Coronary Artery Disease: Antiplatelet Therapy

Community Pharmacy Services
Clinical Pharmacy Services
• Hypertension management
• Asthma/COPD intervention programs
• Adherence program
• Diabetes management/education
Vaccination Program
• Flu, pneumovax, Zoster, TDAP, etc

Example Metrics:
• Medication Adherence for Diabetes, RAS antagonists, statins
• Influenza immunization
• Pneumococcal vaccination

Key Points
• Healthcare is moving more to value than volume with the new care models being developed.
• There are multiple quality bodies, and although measurements may overlap from one to another, there are still too many measures that do not align causing measurement burden.
• Pharmacists can impact quality metrics, in various roles, while working as a member of the health care team.

Perspectives & Panel Discussion: Measures that Matter (in the new system)

Making the Business Case
Bob Davis
Patient Centered Medical Home

Patient Centered Accessible Quality Commitment

House graphic retrieved from: https://openclipart.org/image/2400px/svg_to_png/172843/Puzzle-house.png

Titles excerpts from: https://pcmh.ahrq.gov/page/defining-pcmh

NP, PA Social Workers Nutritionists

Physicians Community Coordinators

“Neighborhood”

Today you are gaining insight on pharmacist value in Comprehensive MTM including productivity and quality data.

Patient Centered Medical Home

Quality of patient care
Patient satisfaction
Practice revenue
Physician productivity
Cost avoidance
  - Reduced hospitalizations and ED visits
  - Reduced medication costs

Pharmacist Value

Quality-LDL Improvement

Patients with LDL-C >130
Mean LDL Improvement
53.9% Patients Improved

Patients with LDL-C >80
Mean LDL Improvement
52.2% Patients Improved

-186 patients – retrospective chart reviews
- Evaluation period November 2013-October 2014
-Minimum 2 pharmacist visits and pre/post LDL-C

Satisfaction (5-point Likert scale)

Willingness to Recommend/Refer

Provider 4.7  Patient 4.9  Staff 5.0

15% of patients volunteered they would change behavior based on pharmacist’s coaching.

Cost Avoidance

<table>
<thead>
<tr>
<th>Month</th>
<th>Encounters</th>
<th>Interventions</th>
<th>$ Avoidance</th>
<th>AVOID/Encounter</th>
</tr>
</thead>
<tbody>
<tr>
<td>April</td>
<td>205</td>
<td>909</td>
<td>$1,39,260</td>
<td>$ 6.91</td>
</tr>
<tr>
<td>May</td>
<td>197</td>
<td>969</td>
<td>$188,379</td>
<td>$ 753.19</td>
</tr>
<tr>
<td>June</td>
<td>200</td>
<td>990</td>
<td>$151,531</td>
<td>$ 757.66</td>
</tr>
</tbody>
</table>

Typical Interventions
- Medication reconciliation
- Allergy identified, clarified or prevented
- Lab/test evaluation, patient consultation or recommendation
- Medication change of dose adjustment
- Patient counseling-self care: diet, exercise, checking blood sugars, OTC recommendation, smoking cessation
- Adverse effect identified/remedied

Average savings per intervention was $153

1. Studies by Suh, Classen, and Bates and used by Pharmacy OneSource Quantifi software for reporting financial impact of pharmacist clinical interventions.


61 62 63 64 65 66
Physician Productivity

<table>
<thead>
<tr>
<th>Provider</th>
<th>2013 Payment/Work Day</th>
<th>2014 Payment/Work Day</th>
<th>% Increase Payment/Work Day</th>
<th>2013 Q2 Visits/Day</th>
<th>2014 Q2 Visits/Day</th>
<th>% Total Referrals</th>
<th>% Total Revenues</th>
</tr>
</thead>
<tbody>
<tr>
<td>MDA</td>
<td>$2,741</td>
<td>$3,499</td>
<td>27.9%</td>
<td>24.2</td>
<td>25.0</td>
<td>95%</td>
<td>95%</td>
</tr>
<tr>
<td>MD</td>
<td>$4,930</td>
<td>$3,701</td>
<td>36.4%</td>
<td>31.1</td>
<td>31.2</td>
<td>1%</td>
<td>1%</td>
</tr>
<tr>
<td>MDD</td>
<td>$3,802</td>
<td>$3,385</td>
<td>28.3%</td>
<td>23.5</td>
<td>23.7</td>
<td>25%</td>
<td>25%</td>
</tr>
<tr>
<td>MDT</td>
<td>$2,582</td>
<td>$3,000</td>
<td>16.2%</td>
<td>23.5</td>
<td>24.8</td>
<td>11%</td>
<td>11%</td>
</tr>
<tr>
<td>MDV</td>
<td>$2,878</td>
<td>$3,177</td>
<td>10.4%</td>
<td>24.0</td>
<td>25.7</td>
<td>7%</td>
<td>7%</td>
</tr>
<tr>
<td>AVERAGE</td>
<td>$2,781</td>
<td>$3,152</td>
<td>20.6%</td>
<td>25.3</td>
<td>25.4</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

Contributing Factors:
1. Fee Increase November 2013
2. More New Patient Visits
3. More Complex Visits

20.6%

Pharmacist Capacity and Revenue

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounters/Day</td>
<td>115</td>
<td>219</td>
<td>197</td>
<td>231</td>
<td>218</td>
</tr>
<tr>
<td>Capacity Used</td>
<td>34%</td>
<td>46%</td>
<td>59%</td>
<td>83%</td>
<td>72%</td>
</tr>
<tr>
<td>Encounters Billed</td>
<td>6.4</td>
<td>11.5</td>
<td>9.9</td>
<td>11.0</td>
<td>11.2</td>
</tr>
</tbody>
</table>

Where do you start?

PCMH Pharmacist Benchmarks

- Annual Work Days = 240
- PharmD Visits to Impact Quality Gap = 1.5
- Average Patient Contact Time = 24 min
- Physician Referral Rate of Total Visits = 12.5%
- Time to establish full referral patterns = 6-9 mo

Returning Home…An Opportunity

- There is a PCMH in your geographic area and you have a strong relationship with one of the physicians.
- Lead practice physician has expressed interest in understanding how pharmacists might participate in improving patient outcomes.
- You wish to launch business from your community pharmacy location to better manage start up cost.

Business Case: Assess

Leadership:
- What is the Practice or ACO vision and mission?
- Describe their collaborative approach to patient care?

Needs:
- What could improve the quality of patient care?
- What could enhance practice financial performance?
- What could improve productivity of your physicians?
- What improves satisfaction of providers and patients?
Business Case: Assess

Performance Measures:
- What practice performance measures are keys to success?

Practice Demographics:
- What is Provider, Payer, and Disease Mix?

Technology:
- How will pharmacist be integrated with EHR and Billing?

Revenue Sources:
- Practice participation level in FFS, FFV, P4P, and SS?

Compensation:
- What provider quality incentive options exist?

XYZ FAMILY PRACTICE

DEMOGRAPHICS
- ESTIMATED TOTAL PATIENTS = 17,000
- ANNUAL VISITS BILLED = 20,500
- PATIENTS UNCONTROLLED A1c = 1,750
- PATIENTS ON HIGH RISK MEDS = 350
- PATIENTS ON STATINS = 1,500
- COLLECTION RATE = 55%

PAY OR MIX DISEASE MIX
Medicare 28.5 Diabetes 40.5
Commercial 44.9 Hypertension 44.9
Medicaid 2.0 Upd Disorder 35.6
POCMH 38.8 Anticoagulation 15.8
Self 4.9 Heart Failure 4.9
Total 100.0 Asthma/OPO 14.5

What We Learned...Assessment
- Privately held PCMH with 4 FP-MDs, 2 ANPs, part-time nutritionist and psychologist. Refer to hospitalist.
- Vision reflects strong balance between patient, quality, satisfaction, and revenue.
- Performance metrics for diabetes management and readmissions are at average or below state benchmarks.
- Practice engaging in fee for value (FFV) and pay for performance (P4P) models.
- Providers experiencing burnout from patient load and managing chronic diseases.
- Key challenge is balancing need to improve quality while protecting revenue and personal time.

Pay for Performance (P4P) Contracting

Measure Definition Standard Practice Results PMPM Rate
A1c Control Diabetes Most recent A1c ≤8 >86% 73.5% 5 0.75
High Risk Medications of patients taking a high risk medication <3% 6.8% 5 0.25
Readmission rate <30D Hospital readmission acute and chronic <12% 14.0% 5 0.75
Adherence-Statuins refill status on time >75% 69.5% 5 0.50

Next: Develop Business Case

Customer Segments (Who we help)
- Physician - (patient 2nd)

Value Proposition (How we help)
- Revenue, Quality
- Provider Productivity, Satisfaction

Key Activities (What we do)
- Medication management, education, care standardization

Key Resources (What we have)
- Knowledge, treatment pathways, operating system

Adapted from Business Model You by Clark, Osterwalder, and Pigneur, publisher Wiley & Sons.
Business Case: Development

Key Partners (Who helps us)
– Payers, Colleges of Pharmacy

Cost Structure (What we spend)
– Salaries, facilities, equipment

Revenue Streams (What we get)
– FFS, P4P

Financial Model
– Forecast, Managing Risk

Graphic from Business Model Canvas
https://canvanizer.com

Key Points

• The Patient Centered Medical Home (Neighborhood) is a care model providing accessible, comprehensive, coordinated, accountable, quality focused care.

• Pharmacists in a PCMH create value beyond distribution including enhanced quality of care, physician productivity, patient satisfaction, and practice revenue while avoiding cost through reduced ED visits and hospitalizations.

• Pharmacists evaluating a PCMH should assess leadership collaboration, practice needs, expected outcomes, and practice demographics such as payer and disease mix.

Perspectives & Panel Discussion:
Making the Business Case

Questions & Answers
(All three topics)

1) Health Care Financing Megatrends
2) Measures that Matter (in the new system)
3) Making the Business Case

Self-Assessment Questions

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   a) True
   b) False
Self-Assessment Questions

2. By 2018, ____ of Medicare payments are projected to be in the form of an alternative payment model and ____ of fee-for-service payments will be tied to quality?
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   d) None of above

4. Which of the following is not considered a key element of our business case?
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5. When primary care physicians engage pharmacists as care team members physician productivity is enhanced.
   a) True
   b) False