Evolving Roles of Pharmacists: Integrating Medication Management Services

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Objectives

• Discuss the role of pharmacists practicing in a patient-centered medical home (PCMH)
• Describe the measurable impacts of pharmacists on patient care in the community setting
• Identify the status and future of legislation recognizing pharmacists as health care providers
Pharmacist Training and Expertise

Education and Training

• Entry-level 6 or 7-yr degree (PharmD)
  ✓ 2 yrs Pharmacotherapeutics
  ✓ 1.5 yr Drug Info/Lit Eval’n
  ✓ 3 yrs Pharmacy problem-solving
  ✓ 4 yrs Patient-care exp + clinical rotations
• Postgraduate Residencies and Fellowships
• Board-certified Pharmacy Specialties (7)
  ✓ Ambulatory Care, Geriatrics, Nuclear,
  ✓ Nutrition Support, Oncology,
  ✓ Pharmacotherapy, Psychiatric
  ✓ Proposed: Pediatrics, Critical Care,
    Pain and Palliative Care
• Medication Management Certificate Programs
• Advanced Pharmacy Practitioner Credentials

Pharmacist’s Expertise

◆ Pharmacology
◆ Pharmacotherapeutics
◆ Pharmacokinetics and Pharmacodynamics
◆ Drug Toxicities – Adverse Drug Events, Interactions
◆ Drug Information and Evaluation
◆ Patient Medication Safety
◆ Medication Therapy Management (MTM)
  ➢ Identify, Resolve, and Prevent Med Problems
◆ Medication Adherence Assessment
  ➢ Compliance and Persistence
◆ Pharmacoeconomics
◆ Outcomes Research
◆ Patient Communications/Health Literacy
◆ Pharmacy Practice Systems

Pharmacists’ competencies are SYNERGISTIC (not duplicative) with those of other health professionals
# PCMHs and Advanced Primary Care

## Accelerating the Adoption of High-Value Primary Care — A New Provider Type under Medicare?

Richard J. Baron, M.D., and Karen Davis, Ph.D.

A bipartisan, bicameral proposal from the Senate Finance Committee and House Ways and Means Committee to replace and replace the Medicare sustainable growth rate formula (SGR) for physician payment would begin to reform provider payment to reward high-value care. It calls for replacement of the SGR with a 10-year freeze on physician payment levels and, beginning in

<table>
<thead>
<tr>
<th>Feature</th>
<th>PCMH</th>
<th>AMH</th>
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<tbody>
<tr>
<td>Whole-Person Centered Care</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Evidence-Based Clinical Decisions</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Care Coordination (outside of visits)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Expand Access to Care</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Team-Based Care Delivery</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Clinical Quality and Performance Metrics</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>HIT: EMR, E-Rx, Patient Portal</td>
<td>✓</td>
<td>✓</td>
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</table>

**Shared Decision Making**

- Targeted Care Management Strategies
  - Integrated Behavioral Hlth, Med Management, Self-Management
- Population Health Management
- Payment Blend (FFS, Risk-adjusted PMPM, Shared Savings)
  - partial ✓
  - full ✓
- Multi-payer ✓
- Transformation Accountability Milestones ✓
Primary Care - Dynamic Clinical Teams

Dynamic Teams

“A clinical care team for a given patient consists of the health professionals – physicians, advance practice registered nurses, other registered nurses, physician assistants, clinical pharmacists, and other health care professionals – with the training and skills needed to provide high-quality, coordinated care services specific to the patient’s clinical needs and circumstances.”

(American College of Physicians Position Paper, October 2013)

Complementary Skills

Primary care teams should include health care practitioners who have complementary skills to those of the physician to achieve quality improvement initiatives and improve physician productivity

(K Grumbach, T Bodenheimer JAMA 2004;291:1246-1251)
“Gaps” in safe and effective medication use are due to both clinician-influenced factors and patient influenced factors.
Medication Management Cycle

- Identify medication discrepancies (EMR, patient report, pharmacy fill history, discharge summaries)
  - Build/update a complete, accurate, and active patient medication list

- Set desired patient medication outcomes
- Determine best timing and frequency of routine lab tests for medications
- Monitor patient for therapeutic effects and potential toxicities in-between office visits/adjust medications as needed

- Coordinate drug therapy changes with patient/family, multiple prescribers, and community care providers (e.g., home health, dialysis, hospice)
- Verify drug therapy changes made across multiple pharmacies (e.g., community retail, outpatient clinics, specialty care, online, mail-order, infusion centers, oncology centers)

- Assess each medication for pharmacotherapy appropriateness, efficacy, safety, and adherence
- Prevent or detect/resolve drug-therapy problems
- Develop patient medication action plan – ongoing, new, changed, or discontinued medications
- Disseminate medication management report with actionable recommendations to PCP/other HCPs
Comprehensive Primary Care Initiative (CPC)

Moving towards Comprehensive and High-Value Primary Care

...strengthen freestanding primary care capacity by testing a model of comprehensive, accountable primary care supported by multiple payers

- **Selection criteria:** HIT use, recognized advanced primary care practice, patient panel covered by participating payers, participating in practice transformation and improvement activities, and diversity of geography, practice size and ownership structure.

- **7 regions – 497 practices - 2,347 providers** serving an estimated **315,000 Medicare beneficiaries**
  - New York: Capital District-Hudson Valley Region
  - New Jersey: Statewide
  - Ohio & Kentucky: Cincinnati-Dayton Region
  - Arkansas: Statewide
  - Oklahoma: Greater Tulsa Region
  - Colorado: Statewide
  - Oregon: Statewide

- **Multi-payer initiative:** 31 commercial payers/state Medicaid programs + Medicare
  - Payers implement strategies that align with the CPC approach to achieve comprehensive primary care

- Began in Fall 2012....4-year initiative....$ 322 Million funding (comparison: ACOs =$252Million, PFP=$500Million)

- Year 1 reporting and analysis being conducted now
CPC Payment Model

CMMI Payment (Practice-Level)
- Traditional fee-for-service
- Risk-adjusted care management fee: average $20 PBPM (range of $8 - $40) in year 1-2; $15 PBPM in years 3-4 (advanced payment used for expanded care teams)
- Shared Savings: start in Year 2
  - Based on quality measures: (1) population health /public health; (2) clinical processes, effectiveness, patient safety; (3) care coordination; and (4) patient experience

Other Payers’ Commitments
- Enhanced Financial Support for Participating Primary Care Practices
  - invest in the infrastructure, staffing, education/training for 5 comprehensive primary care functions
- Sharing Actionable Data with CPC Practices; Multi-payer common data sharing approach
- Aligning Quality Measures
- Common Approach towards Milestones and Accountability for Participating Practices
CPC Medication Management – started Jan 2014

CPC Implementation Guide for Medication Management

<table>
<thead>
<tr>
<th>CPC Change Package Driver</th>
<th>Change Concept</th>
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</table>
| 1.2 Planned Care for Chronic Conditions and Preventative Care | • Manage medications to maximize therapeutic benefit and patient safety at lowest cost.  
• Use team-based care to meet patient needs effectively. |
| 1.3 Risk Stratified Care Management | • Manage care across transitions. |
| 1.4 Patient and Caregiver Engagement | • Engage patients, families, and caregivers in developing a plan of care and prioritizing their goals for action. |
| 1.5 Coordination of Care | • Ensure patient information necessary to provide care is available across the medical neighborhood. |

Level of intensity for med management to achieve CPC aims will require practices to:

1. integrate a clinically-trained pharmacist as a member of the CPC care team (onsite, point-of-care)
2. adopt a collaborative practice model with face-to-face patient encounters
3. deliver comprehensive medication management services through an interdisciplinary team-based approach to achieve patient-specific goals of therapy with follow-up evaluation

- Targeted patients
  - high-risk medications, complex medication regimens, insufficient response to treatment, care transitions
- Focus on 4 medication management processes
  - med reconciliation, med optimization, med coordination, and med monitoring
- Establish collaborative drug therapy management (CDTM) agreements
Value of pharmacists in ACOs and IC Teams

- Unmet Medication Needs
- Team-based Care
- Pharmacists as Collaborative Medication Managers
- Pharmacist Integration Models
- Workflow Revisions
- Challenges
  - Medication measures that matter
  - Workforce development
  - Payment reform

Two examples where pharmacists were involved in clinical care teams and provided medication management services for high-risk, complex patient populations:

- Overall directional trend to decrease inpatient admissions, preventable admissions, ED visits

- Transitional care group of patients were 20% less likely to experience a readmission during the subsequent year

# Pharmacist Impact on HEDIS Measures

<table>
<thead>
<tr>
<th>HEDIS Measure</th>
<th>2013 HEDIS Plan Rate (Administrative)</th>
<th>EPC Practice Community Pharmacist Model</th>
<th>Embedded Pharmacist Model Family Practice A</th>
<th>Embedded Pharmacist Model Internal Med Practice B</th>
<th>National 90th Percentile (2012)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pharmacotherapy management of asthma (ASM)</td>
<td>87.71%</td>
<td>88.18%</td>
<td>97.37%</td>
<td>87.50%</td>
<td>95.24</td>
</tr>
<tr>
<td>Monitoring of persistent medication - ACE/ARBs &amp; diuretics (MPM - C)</td>
<td>87.36%</td>
<td>92.40%</td>
<td>96.40%</td>
<td>97.60%</td>
<td>86.96%</td>
</tr>
<tr>
<td>Potentially harmful drug-disease interactions in the elderly (DDE) *Inverted Measure</td>
<td>15.36%</td>
<td>13.12%</td>
<td>10.71%</td>
<td>13.64%</td>
<td>14.29%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - HbA1c Testing</td>
<td>86.03%</td>
<td>91.09%</td>
<td>91.33%</td>
<td>91.30%</td>
<td>94.69%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Eye Exams</td>
<td>52.98%</td>
<td>55.03%</td>
<td>50.67%</td>
<td>75.65%</td>
<td>73.72%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - LDL-C Screening</td>
<td>82.71%</td>
<td>89.88%</td>
<td>92.00%</td>
<td>89.57%</td>
<td>90.88%</td>
</tr>
<tr>
<td>Comprehensive Diabetes Care - Attention for Nephropathy</td>
<td>78.91%</td>
<td>82.64%</td>
<td>85.33%</td>
<td>92.17%</td>
<td>90.42%</td>
</tr>
</tbody>
</table>

Yellow = better than CDPHP Plan Rate  
Green = better than National 90th Percentile performance

Source: Used with permission of Capital District Physicians Health Plan (Albany NY)
Admissions and Medication Therapy Management Services

Source: Used with permission of Capital District Physicians Health Plan (Albany NY)
Business Case for Medication Management

• Published studies demonstrate ROI 2:1 to 12:1
• “Incident to” billing for Pharmacist-provided Medication Management services
  ✓ AAFP clarification - letter from CMS
• Maximize Medicare wellness visits
• Lower referrals to specialists for med management challenges
• Fewer preventable readmissions and ED visits
• Maximizing quality improvement targets/performance incentives
Collaborative Drug Therapy Agreements

• Agreement between pharmacist and physician; state-level practice acts allow CDTM in 47 states

Source: CDC State Law Fact Sheet, Dec 2012
Provider Status for Pharmacists

Is it necessary?
- Depends on payment structure
- Fee-for-service
- Global Payment or ACOs

HR 4190 – Amend SSA Medicare Part B for Pharmacists as Providers
- Pharmacy Coalition: 116+ congressional sponsors
- Bill to **increase access and improve quality** by enabling pharmacists to provide patient care services as consistent with their education, training and license in medically underserved areas or populations or health professional shortage areas (designated by HRSA).
- Consistent with Medicare reimbursement for other non-physician practitioners, pharmacist services would typically be reimbursed at 85% of the physician fee schedule.