PrimaryCare Learning Network

2015 Health Care Value Forecast:
Payers, purchasers and providers

An elegant solution: Advancing comprehensive medication management for better care, better health, lower costs

FEATURING

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Forecast

IMAGINE an opportunity to solve a problem that's killing millions and costing billions while, at the same time, addressing the shortage of primary care providers. And then imagine it's a solution both physicians and patients love.

In recent years, Terry McInnis, MD, MPH, CPE, FACOEM, president of Blue Thorn, Inc., has devoted considerable energy to advancing just such a solution: comprehensive medication management (CMM), which supports appropriate medication use.

To understand CMM's value, one must first understand the scope of the problem it solves: Medication is the primary way we prevent and control disease. In 2014, more than 4.1 billion prescriptions were filled at retail pharmacies.[1]

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Three-quarters of all physician office visits involve drug therapy, and 49 percent of Americans have used at least one prescription drug in the past 30 days.[2]

But using prescription medications and using the right ones the right way are two different things. Too often, McInnis says, consumers are not prescribed the most effective or safe drug, especially when they are seeing multiple providers. An oft-cited 2010 Office of Inspector General report identified medication errors as the top preventable cause of serious adverse health events in hospitalized Medicare patients, and medication errors and lack of reconciliation as top causes of avoidable readmissions.[3]

Getting it right

For too long, she says, we've focused on issues of patient "noncompliance" and "non-adherence" to account for these errors. But the problem isn't with the patient; it's with the system: Patients don't understand how the drugs affect them, how they interact or how they help achieve clinical goals. Sometimes, even the physician doesn't, McInnis says. Blaming the patient not only misses the point, it ignores a significant subset of drug-related problems—a lack of drug therapy or sub-therapeutic dosing. Non-adherence may be due to side-effects or the fact that the medication really isn't working. "In short, patients aren't receiving the medicine they need," she says.

When addressing medication-related problems, we need to look at the whole universe of issues,

1 Kaiser Family Foundation, State Health Facts. United States Prescription Drugs, based on IMS Health data

2 FastStats: Therapeutic Drug Use. CDC/National Center for Health Statistics

3 OIG Report on Preventable Serious Adverse Events in Hospitalized Medicare Patients

> "Our greatest opportunity to improve outcomes is to also address the untreated indications, like getting a severe asthmatic on a controller medication, and addressing the issue of sub-therapeutic dosages."
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not just patient non-adherence. "And we can't merely look at minimizing the negative impact that medications have when we see drug interactions, toxic dosages and adverse drug events," she adds. "Our greatest opportunity to improve outcomes is to also address the untreated indications, like getting a severe asthmatic on a controller medication, and addressing the issue of sub-therapeutic dosages."

Medication underuse represents over 50 percent of all medication-related problems.[4,5]

Overall, preventable medical errors are the third largest killer in the U.S., leading to roughly 400,000 deaths and costing $1 trillion each year; many of these are medication-related errors.[6,7] The medical savings from appropriate medication use could cover the majority of the approximately $374 billion spent on medications in 2014,[8] and reduce the number of deaths significantly.[9]

This is where comprehensive medication management can come into play, says McInnis, the former co-chair of the Center for Public Payer Implementation and co-leader of the Medication Management Taskforce for the Patient-Centered Primary Care Collaborative. She uses a definition she helped craft for the organization:

> *The standard of care that ensures each patient's medications (whether they are prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended.*[10]

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4 "Thinking Outside the Pillbox A System-wide Approach to Improving Patient Medication Adherence for Chronic Disease" NEHI Research Brief, August 2009

5 McInnis T. Medication Underuse: The Most Underappreciated Quality-of-Care Gap, *Pharmacy Times,* March 11, 2015

6 James JT. A new, evidence-based estimate of patient harms associated with hospital care. *Journal of Patient Safety.* 2013 Sep;9(3):122-8

7 Deaths by medical mistakes hit records, *Healthcare IT News,* July 10, 2014

8 IMS Institute- Medicines Use and Spending Shifts: A Review of the Use of Medicines in the U.S. in 2014

9 "Thinking Outside the Pillbox," op. cit

10 PCPCC Medication Management Task Force. *Integrating Comprehensive Medication Management to Optimize Patient Outcomes.* Washington, D.C.: Patient-Centered Primary Care Collaborative, 2010

Demonstrated success

Successfully integrating CMM services has been shown to not only improve patient outcomes and satisfaction/engagement, but to lower overall costs and improve provider/team efficiency and access. Such an approach also improves provider satisfaction.[11,12,13,14,15,16,17]

The concept continues to gain traction and is being tested in pilots around the country. It's also being used at the Veterans Administration, where pharmacists are part of the Patient Aligned Care Team—the VA's equivalent of the medical home, McInnis explains.

Fairview Pharmacy Services in Minneapolis serves as an excellent example, she says. It introduced a CMM approach in 1997 that includes collaborative practice agreements and coordination with expanded care teams and the utilization of patient data to ensure economic and clinical outcomes are identified and met. The Fairview findings demonstrate CMM can play a crucial role in helping ACOs meet quality and financial benchmarks. They also show the value of CMM for patients with the highest risk and greatest needs. Its success shows the important role pharmacists can play in ensuring the optimal use of medication and improving patient outcomes in an ACO.[18]

She also points to the work of Stephen Chen, PharmD, of the University of Southern California School of Pharmacy, and his colleagues. As part of a Center for Medicare and Medicaid Innovation initiative, the school collaborated with AltaMed Health Services to provide CMM for high-risk patients with poor chronic disease control.[19]

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[11] Pharmacists' Patient Care Process. Joint Commission of Pharmacy Practitioners, May 29, 2014

[12] Department of Health and Human Services, Office of Inspector General. *Adverse Events in Hospitals: National Incidence among Medicare Beneficiaries,* 2010

[13] Isetts, et al. "Clinical and Economic Outcomes of Medication Therapy Management Services: The Minnesota Experience." *J Am Pharm Assoc.* 2008;48(2):203-211)

[14] Smith M, Giuliano MR, Starkowski MP. "In Connecticut: improving patient medication management in primary care." *Health Affairs* 2011 Apr;30(4):646-54

[15] Report to the New York State Legislature The Impact of Pharmacist-Physician Collaboration on Medication-Related Outcomes Results of the New York State Collaborative Drug Therapy Management Pilot Project, May 6, 2014

[16] *Integrating Comprehensive Medication Management to Optimize Patient Outcomes, op. cit.*

[17] Isetts, et al., op. cit.

[18] Brummel A Lustig A, Westrich K. "Best practices: improving patient outcomes and costs in an ACO through comprehensive medication therapy management," *J Managed Care Specialty Pharm.* 2014;20(12):1152-1158

[19] Innovator Highlight: Integration of Pharmacy Teams into Primary Care, Center for Care Innovations

Clinical pharmacy services were embedded in 10 AltaMed medical home clinics. These patients—seen by clinical pharmacists operating under collaborative practice agreements with the physicians—had their chronic condition clinical outcomes optimized by identifying and resolving medication-related problems. The pharmacists identified, on average, 10 drug therapy problems per patient, she says.

More than 6,000 patients in the USC/AltaMed initiative have been seen by clinical pharmacy teams consisting of a pharmacist, resident and pharmacy technician. Preliminary results relative to savings, clinical outcomes and patient satisfaction are positive. They suggest the cost savings generated through a reduction in acute care utilization (hospitalizations, emergency department visits, and physician visits) pays for—at minimum—the cost of each pharmacist team.

Logical option

Katherine H. Capps, president of Health2 Resources, points out that in policy circles, the concept is far from new; the Patient-Centered Primary Care Collaborative advanced a similar approach a few years ago. Capps and McInnis were both part of the PCPCC team that published the guide *Integrating Comprehensive Medication Management to Optimize Patient Outcomes,* which contains the formula for success seen in the USC/AltaMed innovation project.

Putting pharmacists on the primary care team makes sense, Capps says: They are experts in medicine—medication Sherpas who can guide clinicians and patients to the appropriate treatment. McInnis agrees, noting that although they're already deployed effectively in hospital settings, they haven't been used as much on the ambulatory side. "Pharmacists are the most underutilized resource in health care today, and represent the third largest number of health care professionals," she says.

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Katherine Herring Capps, President, Health2 Resources

The ideal, says McInnis, is for them to work collaboratively with physicians and other team members to help coordinate and recommend appropriate use of medication. "Pharmacists are ideally suited to deliver CMM—not in silos, but as full members of the primary care team."

To make this work, pharmacists must enter into collaborative practice agreements and work directly with the patients in team-based care. Pharmacists on the team need access to medical information and timely communication with the rest of the care team; this allows them to effectively modify, add or eliminate medications that are preventing patients from achieving their clinical and personal goals of therapy. That's why an embedded pharmacist is the ideal. A community pharmacist *can* also be part of the team—provided, she says, he or she has access to current data about the patient, plus the ability to work with and be accepted by the rest of the team.

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But a bigger challenge than the pharmacist's setting is the reimbursement model.

Rethinking reimbursement and provider status

CMM calls for radical transformation—integration of clinical pharmacists with collaborative practice agreements and the ability to deliver CMM services *with payment* for those services. The first part isn't viable until the current fee-for-service approach to care delivery, which pays for treatment rather than prevention, changes.

CMM typically increases the cost for medications per patient. However, improved clinical outcomes, reductions in the number of primary care visits and in hospitalizations yield a much better value for everyone—the patient, the payer and the health system.

In the current fee-for-service world, incentives are not aligned to coordinate medications. Physicians and other caregivers are paid because patients are sick—not to keep them well, Capps says. That model is changing as the system moves to more accountable, risk-based models which focus on improving the quality of care and reducing unnecessary costs, such as emergency department visits and re-hospitalizations.

For now, compensation continues to be linked to dispensing products, especially on the ambulatory care side. Typically, pharmacists have not been recognized as providers, nor—for the most part—have they been paid for their clinical services. But with CMS and private insurers moving toward value-based reimbursements and penalizing avoidable readmissions, CMM is gaining traction, Capps and McInnis say.

CMM aligns closely with the goals of the patient-centered medical home and accountable care organizations. McInnis notes that 18 of the 33 Medicare ACO quality-of-care metrics depend on appropriate medication use to achieve goals. And because CMM focuses on the highest-risk patients, it aligns with the risk-stratification goals of all accountable care models, bringing a systematic approach to medication management.

Reimbursement *is* moving in the right direction but, McInnis warns, "We can't wait until we have a fully capitated system to start making pharmacists part of the primary care team. We have to figure out how to integrate them into care teams as we transition to more accountability-based models."

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A satisfying workforce solution

CMM also addresses another pressing need in health care: The shortage of primary care providers in many communities. Pharmacists can extend the primary care team.

"They are the biggest untapped resource we have in health care," McInnis says. It's

an obvious solution to an obvious problem. Primary care physicians can delegate many medication-management services to the pharmacist on the team.

"Medication management is one of our most critical needs. Pharmacists are experts in medication management, and they want to use that expertise. Talk to pharmacists and you will see they are eager to use their skills to more effectively interact with physicians and other providers."

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Physicians can see more patients—or spend more time with current ones—by empowering the clinical pharmacists to optimize the medications and reach the clinical targets, she says. This was one of the outcomes of the USC/AltaMed experience. In a larger data set, for each 10 clinical pharmacist visits, 8.2 physician/prescriber visits are avoided.[20,21] That contributes to high rates of satisfaction among clinicians and pharmacists, she says.

Patients, too, report high satisfaction. It makes sense, McInnis says. "Patients absolutely want to know about meds. They want to know the meds they are taking are safe and appropriate. CMM gets their questions answered." She points to some of the comments in response to the collaborative drug therapy management program in New York:[22]

- "Pharmacists give you a better understanding [of] what your meds are supposed to do."
- "Saved my life. Saved my sister's life. I'm thankful for their patience and taking the time with me."

The California Chronic Care Coalition, an alliance of patient-advocacy organizations, has made inclusion of CMM services a top policy priority, McInnis says.[23] Others are following suit.

"If you want patient engagement, look no further than comprehensive medication management. Patients are hungry for this approach," says McInnis. "And ultimately, it is all about the patient."

[20] http://www.careinnovations.org/knowledge-center/care-integration-webinar-4-integrating-pharmacy-care-and-primary-care/

[21] Medication Management System, Inc. dataset utilizing the Assurance IT documentation system (www.medsmanagement.com)

[22] Report to the New York State Legislature The Impact of Pharmacist-Physician Collaboration on Medication-Related Outcomes Results of the New York State Collaborative Drug Therapy Management Pilot Project, May 6, 2014

[23] http://www.chroniccareca.org/

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President,
Blue Thorn, Inc.

McInnis, as president of Blue Thorn, Inc., partners with providers, professional organizations, health plans and government on the critical delivery system roadmap and financial realignment necessary in transforming into a viable health care model. Her leadership in the Patient-Centered Primary Care Collaborative (PCPCC) resulted in the successful launch and widespread adoption of the PCPCC Resource Guide: *Integrating Comprehensive Medication Management to Optimize Patient Outcomes,* a critical element in PCMH/ACO success. Her 25 years' experience include chief of flight medicine as a U.S. Air Force flight surgeon, private and hospital-based clinical practice, and positions as corporate medical director for Michelin North America, GE associate medical director and benefits manager (NC/SC), medical director for health policy and advocacy for GSK and chief transformation officer for CHESS (Cornerstone Healthcare). Her unique executive experience from the provider, employer/payer, pharmaceutical industry and policy perspectives enables practical transformational solutions.

McInnis received her MD at Wake Forest University and her MPH and residency in occupational and environmental medicine at the University of Oklahoma. She is board certified in preventive medicine and a Fellow of the American College of Occupational and Environmental Medicine.

About the Primary Care Learning Network

Health2 Resources' Primary Care Learning Network is a vehicle for health care thought leaders to share ideas and analysis through forecast briefs, white papers, webinars, and other media. The PCLN amplifies leading-edge voices and offers a learning hub for payers, providers and employers seeking penetrating insights into health care challenges and solutions. Contact Health2 Resources to learn more at www.health2resources.com.

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Katherine Herring Capps,
President,
Health2 Resources

Capps, president of Health2 Resources, leads an experienced team of health policy experts and communications professionals who help clients to identify new customer segments, create effective communication campaigns, strengthen market position and enhance program revenue. Prior to establishing Health2 Resources, Capps served as president of the Alabama Healthcare Council and reported to an all-CEO business community board. During her tenure she managed a 76-member (350,000 lives) National Business Coalition on Health group.

Prior to her coalition work, Capps served for 12 years as a hospital administrator at both for-profit and not-for-profit hospital/health care systems such as HealthSouth, National Medical Enterprises (Tenet) and VHA-affiliated hospitals.
A noted health policy expert, Capps has served as a board member for the National Business Coalition on Health, the purchaser committee for the National Committee for Quality Assurance and the National Advisory Board of NBCH. She currently serves on the executive committee of Patient-Centered Primary Care Collaborative and the advisory board for the Health Care Industry Access Initiative. She also serves on various civic, advisory and editorial boards. She is a frequent writer on topics relating to quality, health care cost and market-based health care reform and use of information technology in health care.