PrimaryCare Learning Network™

2016 Health Care Value Forecast:
Payers, purchasers and providers

Get the medications right: Comprehensive medication management and the role of the pharmacist in patient care

FEATURING

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Forecast

It's long past the time to talk about "pilots" or "emerging practices" when discussing comprehensive medication management (CMM). CMM programs have been tested and retested, the results studied and documented. It's not emerging: It has emerged—as a practice to improve outcomes, control costs and enhance the satisfaction of clinicians and patients alike. Health systems, patients, physicians—even payers—are beginning to understand the value of advanced clinical pharmacy services and the importance of integrating those services collaboratively into community/ambulatory team-based care, explains Terry McInnis, MD, MPH, CPE, FACOEM, president of Blue Thorn Inc.

Highlighting the state of CMM and what lies ahead are the focal points of a new report from Health2 Resources and Blue Thorn, *Get the medications right: a nationwide snapshot of expert practices—Comprehensive medication management in ambulatory/community pharmacy*. Sponsored by a grant from the Community Pharmacy Foundation, the report is based on completed responses from 618 practitioners and program directors from 45 states and Puerto Rico. (See methodology sidebar for details on next page.) It offers deep insights into CMM services.

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> **President, Blue Thorn, Inc.**

The report works from a definition of comprehensive medication management that McInnis—its principal investigator—helped create:

> 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.[1]

Broad adoption of comprehensive medication management practice in the ambulatory/community setting has been a long time coming. Almost a decade ago, the Institute of Medicine called for change: "Ensuring that the American people get the most benefit from advances in pharmacology is a critical component of improving the national health care system."[2]

CMM programs offer precisely that, says McInnis. Moreover, they have a profound impact on three of the most significant issues in health care

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[1] *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes.* PCPCC. Second edition, June 2012.

[2] The Institute of Medicine, National Academy of Sciences. *Informing the future: Critical issues in health.* Fourth edition, page 13. www.nap.edu/catalog/12014.html

Methodology: Clarity about CMM

In identifying practices to feature in *Get the medications right: a nationwide snapshot of expert practices—Comprehensive medication management in ambulatory/community pharmacy,* Health2 Resources and Blue Thorn Inc. used a multistep process.

In total, 935 individual program managers started and 618 completed the initial practice evaluation instrument—the McInnis Index for Advanced Medication Management Practice (MI-AMMP™).† From there, the research team applied a six-way filter and a relative value scoring methodology to determine if practices had adequate processes in place for CMM. To qualify, each had to score above a specified level or

- Self-identify as performing CMM;
- Have access to current clinical data to assess/determine patient clinical status;
- Have broad collaborative practice agreements in place;
- Provide interventions and develop care plans that are effectively shared with the team;
- Perform adequate patient follow-up; and
- Deliver CMM to a sufficiently large enough client base to ensure processes are in place for proficiency, sustainability and scalability.

The MI-AMMP scoring tool and the six-way filter allowed the research team to identify which practices were truly offering comprehensive medication management services. Ultimately, 22 were selected for evaluation by the project's advisory board, which narrowed it to the 15 included in the report.

† McInnis Index for Advanced Medication Management Practice (MI-AMMP). http://www.health2resources.com/comprehensive_medication_management.html

delivery today: Effective use of medications, physician workforce issues and the move from volume-based to value-based reimbursement.

Avoiding errors, improving outcomes, saving lives

As more medications come to market, they bring both promise and risk. Physicians struggle with high-risk patients with multiple chronic diseases, many of whom are seeing an array of doctors and are taking numerous medications, both prescription and over the counter. The more medications patients need, the greater the risk of error. Medication-related problems, including misuse and underuse, kill people; they are a top preventable cause of serious adverse health events and avoidable readmissions.[3] "The need for comprehensive medication management services has never been more urgent," McInnis says.

Beyond the human toll is the financial one: CMS and other insurers increasingly refuse to pay for avoidable readmissions, and medication-related problems will only become more costly.

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3 OIG Report on Preventable Serious Adverse Events in Hospitalized Medicare Patients. oig.hhs.gov/oei/reports/oei-06-09-00090.pdf

4 Chisholm-Barnes M et al. "US Pharmacists' Effect as Team Members on Patient Care." *Medical Care;* Volume 48, Number 10, Oct. 2010.

5 Smith M, Bates DW, Bodenheimer T, Cleary PD. "Why pharmacists belong in the medical home." *Health Aff* (Millwood). 2010 May;29(5):906-13.

6 Butler A, Dehner M, Gates RJ, et al. *Comprehensive Medication Management Programs: Description, Impacts, and 2015 Status in Southern California,* California Department of Public Health white paper, Dec. 2015

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The evidence proves it,[4,5,6] and the report illustrates how CMM programs work in real-world practice. One example comes from RiverStone Health Clinic in Billings, Mont. From April 2011 through July 2013, 154 patients completed 256 CMM visits. Clinical pharmacists identified and resolved a mean of 5.6 drug therapy problems and assessed 13.7 medications, per patient.

Many clinical pharmacists included in the report shared quality-of-life outcomes as well. "We have a big role in getting people back to their lives. My patients get better. They go back to school. They go back to work. They get back to their lives," said Carol Ott, PharmD, BCPP, clinical pharmacy specialist, outpatient psychiatry at Eskenazi Health/Midtown Community Mental Health.

Physician shortages and burnout: Easing the burden by broadening the team

Pharmacist delivery of CMM services can effectively address the impending physician shortage. And it is coming: By 2025, demand for physicians will exceed supply by between 61,700 and 94,700, including between 14,900 and 35,600 primary care physicians.[7]

Clinical pharmacists providing CMM services relieve some of this burden by maximizing the efficiency and effectiveness of the care team's other primary care providers. Specifically, when collaborative practice agreements are in place, they can work with patients who need medication management; this reduces physician workload—thus opening access to the acute needs of more patients. One analysis found that for each 10 clinical pharmacist visits, 8.2 physician/prescriber visits are avoided.[8] This allows physicians to focus on diagnosis and intervention, relying on the pharmacist for medication expertise. "CMM complements the work of the primary care physician and integrates behavioral and physical health needs," McInnis explains.

> Once physicians understand what clinical pharmacists offer via CMM services, they embrace it.

The ability to ease the workload of physicians and other providers on the care team emerged as a common theme in the report. Perhaps the most notable example comes from William S. Middleton Memorial Veterans Hospital, Madison, Wis., where pharmacists are part of the Patient Aligned Care Team—the VA's equivalent of the medical home. CMM services contributed to a 27 percent reduction in primary care provider workload. (See sidebar on next page.)

Once physicians understand what clinical pharmacists offer via CMM services, they embrace it. "Nearly every treatment team has a clinical pharmacist and they want it that way," Ott said. "We are accepted and integrated into treatment teams and our skills are recognized

[7] AAMC Physician Supply and Demand Through 2025 (updated April 2016) https://www.aamc.org/download/457558/data/physician_supply_demand_2025_keyfindings_2016update.pdf

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

and respected." This is what we found in our research, and what we expect to see moving forward: Physicians and other clinicians enthusiastically welcoming pharmacists—the professionals dedicated to the study and understanding of pharmaceuticals—to the team.

If CMM services can help address workforce issues, it follows they may provide a tonic for physician dissatisfaction and burnout. Many of those featured in the report say CMM enhanced physician and other clinical providers' job satisfaction. That's especially important, given that more than half of U.S. physicians report experiencing burnout.[9] "Instead of giving primary care one more metric to track or one more form to fill out, let's give them an expert who can help collaboratively manage the medication needs of their sickest patients," says McInnis. "CMM needs to be a national priority for patient access and the well-being of our primary care workforce."

The move to value-based reimbursement

"To successfully transition to a value-based model, provider organizations need to embrace

CMM at the VA: 27 percent reduction in physician workload

One sure way for CMM providers to win the hearts and minds of primary care providers is to solve their problems, says Ellina Seckel, PharmD, clinical pharmacy specialist at the William S. Middleton Memorial Veterans Hospital in Madison, Wis. And that's just what they did at Middleton: Pharmacists were able to manage the chronic disease patients, leaving appointment spots open for primary care physicians to see more patients with acute or diagnostic needs. The integration of pharmacists into primary care opened access significantly in primary care provider schedules, leading to a 27 percent reduction in primary care workload.

Seckel points out that the 27 percent estimate is actually quite conservative. It reflects only the initial appointment redirected from the primary care physician to the clinical pharmacist. It does not capture the primary care visits that were avoided when patients continued to follow up with the pharmacist until the clinical goals were met. "With only first appointments captured, this grossly underestimates the impact," says McInnis. "The 27 percent reduction is truly impressive, but the actual impact is even more remarkable."

This approach captured the attention of VA leadership. Seckel was named a Gold Status Fellow and her model, Increasing Access to Primary Care with Pharmacists, was deemed a Gold Status Practice. As a result, the VA will be standardizing staffing with a ratio of one pharmacist to every three primary care providers across the entire system. Seckel is now helping other VA hospitals implement the model. "Top level buy-in doesn't get better than that!" says McInnis.

[9] Shanafelt, Tait D. et al. "Changes in Burnout and Satisfaction With Work-Life Balance in Physicians and the General US Working Population Between 2011 and 2014." *Mayo Clinic Proceedings,* Volume 90 , Issue 12 , 1600 – 1613

CMM," McInnis says. Team-based care models that pay for value (vs. volume) require appropriate and effective use of medications to reduce unnecessary utilization and reduce costs—and that's the domain of the clinical pharmacist. The report offers several examples of how the move to risk is accelerating adoption of CMM. For instance, HealthPartners, as a health plan, is helping medical home practices in its networks launch CMM programs, showing how integrating pharmacist-led CMM can help them as their contracts with HealthPartners include increasingly more risk.

But, McInnis warns, the situation is too dire to wait for a complete transformation to value-based reimbursement. "We need to get the meds right today, even if we're stuck with an outdated fee-for-service model for a few years."

Moving the lever, removing the barriers

Across the country, clinical pharmacists are delivering CMM services to patients in diverse ambulatory settings that include outpatient clinics, homes, retirement communities, safety net clinics and community pharmacies. It is a mainstream practice but not yet widespread. Consider the opportunities this creates, says McInnis: Here we have a workforce of pharmacists—the third largest profession in health care[10]—available to engage in clinical management. And yet, they remain vastly underutilized.[11]

CMM—and the expanding role of the clinical pharmacist—needs to be better understood and more widely available, argues McInnis.

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She offers four recommendations to enable this and further leverage CMM programs in transforming health care delivery.

1. **Call it what it is: comprehensive medication management.** Medication therapy management (MTM) covers a broad range of activities, some of which are accurately termed CMM. Many, however, are not. Practices in the report resoundingly called for a consistent process of care—CMM. It is imperative, says McInnis, to enhance clarity, common use and standardization of terms to differentiate CMM from other MTM services.

   Variations in terminology make it difficult to discuss the value of CMM services outside of the industry, argues Katherine H. Capps, president of Health2 Resources and project director. "How can we educate physicians, health plans and policymakers if we don't use the right terms? This requires that we have a clear concept of what CMM truly is, identify those practices and then track and evaluate these programs' clinical value and

[10] "An Era of Growth and Change: A Closer Look at Pharmacy Education and Practice." Feb. 2014 University of California

[11] Mossialos E et al., "From 'retailers' to health care providers: Transforming the role of community pharmacists in chronic disease management." *Health Policy,* 2015

return on investment." (For more on understanding what constitutes CMM, see methodology sidebar.)

Unclear or inconsistent use of CMM—or simply lumping CMM services with other "medication therapy management" services like Part D CMRs—undermines this value and clouds understanding of it among providers, payers and the public, argue McInnis and Capps.

2. **Officially recognize clinical pharmacists as providers.** A few states have laws that establish provider status for pharmacists or in other ways enable payment for and integration of CMM services.[12,13,14] However, ACOs—and other relatively new models—do not include the costs of pharmacy products or services in the total cost of care.[15,16] "That must change. We need recognition of pharmacists as providers not just in a handful of innovative practices, not just in some states, but at the federal level," McInnis says. This allows them to be reimbursed appropriately and fully integrated into the clinical team. Pharmacists offer a unique skill set that complements the rest of the team's skills.

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3. **Develop a culture that supports CMM practice, training and leadership.** As CMM programs expand, the need for a qualified and experienced pharmacist workforce increases. Many of those interviewed spoke of the value of CMM ambulatory care residency programs in providing opportunities to build skills under supervision. One barrier to a more rapid spread of CMM is the lack of adequate residency program slots that fill this training need. "I would suggest that the profession needs to figure out a way to pay for more community pharmacy residency sites," says Ouita Davis Gatton, RPh, District A clinical coordinator for Kroger Pharmacy and an advisor for the report.

4. **Educate other clinicians—as well as patients and policymakers—about the pharmacist's role in direct patient care.** Getting the name right is the first step in awareness, but much more must be done to improve awareness of the value comprehensive medication management brings to the physician and patient. "Some of the responsibility falls on the payers and

[12] McBane S et al. "Collaborative Drug Therapy Management and Comprehensive Medication Management." 2015 American College of Clinical Pharmacy white paper. *Pharmacotherapy* 2015;35(4):e39–e50

[13] Bonner L. "Pharmacist provider status now law in Oregon." American Pharmacist Association website. www.pharmacist.com/pharmacist-provider-status-now-law-oregon. June 2015.

[14] California AB 2084 http://www.leginfo.ca.gov/pub/15-16/bill/asm/ab_2051-2100/ab_2084_bill_20160217_introduced.htm

[15] Guarini K. "Still Struggling to Find Their Role: Community Pharmacy Participation in ACOs." *Pharmacy Times,* August 21, 2015

[16] Yap D. "Community pharmacy to CMS: integrate pharmacists' services into ACOs." American Pharmacists Association website. www.pharmacist.com/community-pharmacy-cms-integrate-pharmacists-services-acos. July 1, 2014

policymakers who have not recognized clinical pharmacists and CMM services," says McInnis. But it also falls on clinical pharmacists themselves, Gatton argues: "We do a lousy job of selling what we do to other health care providers."

Gatton offers a call to action: The pharmacy profession must build a bridge—"a bridge from the old model of dispensing and fee-for-service to the new paradigm of providing patient-centered care where the pharmacist sees the patient concerning medication issues just as physicians see patients for diagnoses. Pharmacists need to decide whether they want to be on the bridge and help build this transition or get off the bridge and hand their hammer, brick and mortar to someone else—someone who wants be a part of this change. I hope the profession will move fast enough and be creative enough to make this change happen sooner than later."

Terry McInnis, MD, MPH, CPE, FACOEM
President,
Blue Thorn Inc.

As president of Blue Thorn Inc., Terry McInnis, MD, MPH, CPE, FACOEM, partners with providers, professional organizations, health plans and government on the critical delivery system roadmap and financial realignment necessary to transform 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.

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Katherine Herring Capps,
President,
Health2 Resources

Katherine H. Capps, president of Health2 Resources, leads an experienced team of health policy experts and communications professionals who help clients identify new customer segments, create effective communication campaigns. Past and current clients include URAC, NCQA, the Patient-Centered Primary Care Collaborative, Rocky Mountain Health Plans and Procter & Gamble. 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 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, cost and market-based reform, and use of information technology in health care.

PrimaryCare Learning Network™

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