GTMRx Institute™

Get the medications right

Issue Brief | August 2020

Physicians and pharmacists, providers and payers: Partnerships at the heart of CMM

We're facing the most monumental change in health care in more than a century, argues Paul Grundy, MD, president of the GTMRx Institute. He points to several factors, including unsustainable costs. But perhaps the most significant—and overwhelming—is the unprecedented access to data—in particular, medical information.

In 1950, medical information doubled every 50 years. Now, in 2020, experts estimate it will take only 73 days for medical knowledge to double.[1] It is impossible for any provider, *even within a specialty*, to remember all the information and keep up with the literature potentially available to care for a given patient. Fortunately, they don't have to, Grundy says.

"No longer are we going to be master builders as physicians. We're going to be engineers. The data is going to be available for us to actually see and plan for every patient that we have, and it's going to be a team sport."

The physician has two primary tasks that only she can do: difficult diagnostic dilemmas and creating trusting patient relationships of trust. She needs to surround herself with other professionals with complementary skills. "The behaviorist does a much better job of integrating above the neck with below the neck," Grundy says. And more to the point of our current discussion, the clinical pharmacist does a much better job of managing medication and supporting patient needs around medication.

Fully embracing a team-based approach cannot happen soon enough, he says. The transformations taking place in the health system hold tremendous promise, but for clinicians, too often change means more work and more stress for primary care providers. Just as they cannot hold all the data in their heads, neither can they carry the burden of patient care on their shoulders.

Power players on the team share the burden

The shift to an interprofessional team in general and CMM in particular means physicians will have "power players" to support them, help alleviate burnout and "really help us fundamentally shift the way we deliver care," Grundy says.

One of these power players—the clinical pharmacist—is the focus of ongoing research by Kylee Funk, PharmD, BCPS, associate professor, pharmaceutical care and health systems, University of Minnesota College of Pharmacy, and her team.

1 "Clinical Decision Support as 'A Bright Future for Healthcare Delivery." Episode 66, May 2019.

They are exploring how pharmacists practicing CMM can mitigate primary care providers' (PCPs) burnout, and how comprehensive medication management (CMM) more generally can improve the PCP's overall work life. What have they learned so far? *They learned that engaging physicians and other team members to optimize medication use through CMM in practice mitigates burnout for PCPs.*

Why the focus on burnout? Burnout has tremendous repercussions, both personal and professional. When we look at these physicians who are burned out and compare them to their colleagues who are not, we see they are providing decreased quality of care, and there are increased medical errors as well, she explains.

It's difficult to provide a precise number of physicians suffering burnout. One paper finds that an estimated 35% to 54% of physicians have substantial symptoms.[2] Another found 78% of physicians suffered from it, an increase of 4% since 2016.[3]

CMM can alleviate this problem. To demonstrate the connection between CMM and reduced burnout, Funk and her research team cross-walked the seven drivers of burnout and engagement[4] with some of the themes from primary care physician perception of CMM.

The drivers of physician burnout:

- workload and job demands
- control and flexibility
- work-life integration
- social support and community at work
- organizational cultures and values
- efficiency and resources
- meaning at work

They set out to answer the question *"How do primary care providers perceive the impacts of comprehensive medication management—both the service and the role of the pharmacist—on their work-life?"*

They interviewed PCPs—physicians, physician assistants and nurse practitioners—from four health systems in Minnesota. For the purposes of the study, comprehensive medication management was defined as

> 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.[5]

It's important to note that researchers held fast to this definition, which is the established definition for comprehensive medication management. To adequately evaluate the benefit, researchers required that a standard of practice be in place to ensure the fidelity of practice necessary to inform perceived value. (For more on what CMM is and isn't and the importance of fidelity of practice, see sidebar on next page.)

What they found

In terms of the PCPs' perception of the value of CMM services using a medication expert, two key themes emerged. First, CMM gives PCPs a collaborative partner—the clinical pharmacist. "And specifically the PCPs talked about someone that's really having a shared journey with them."

Second, it provides someone who offers an added skill set or resource to the interprofessional team. "One physician described the pharmacist as kind of performing magic. They'll go into the room, they'll perform some sort of magic that I can't really do and then they'll come out with a plan that resolves the problem," Funk recalls.

Providing a collaborative partner and the added skill set leads to seven different ways clinical pharmacists,

[2] National Academy of Medicine. *Taking Action Against Clinician Burnout: A Systems Approach to Professional Well-Being,* Oct. 2019.

[3] *Lancet,* "Physician burnout: a global crisis," 13 July 2019. https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(19)31573-9/fulltext

[4] Shanafelt TD, et al. *Mayo Clin Proc* 2015.

[5] McInnis T, Webb E, and Strand L. *The Patient-Centered Medical Home: Integrating Comprehensive Medication Management to Optimize Patient Outcomes,* Patient Centered Primary Care Collaborative, June 2012.

as medication experts on the team providing CMM in practice, affect the PCPs. (See Figure 1 on next page.)

1. **Decreased workload.**

2. **Satisfaction that patients are receiving better care.** "PCPs expressed that it's so unsatisfying when you can't solve a problem." Even if PCPs can't solve the problem themselves, they appreciate knowing patients are having their problems solved.

3. **Reassurance.** And this would include PCPs feeling like they're doing the right thing with medications and even some reassurance around decreased liability.

4. **Decreased mental exhaustion.** In particular, PCPs talked about how having the pharmacist as a partner decreased mental exhaustion, especially when it came to caring for complex patients.

5. **Enhanced professional learning.** The PCPs enjoyed learning through caring for shared patients, Funk reports. "They'll see the pharmacist's notes, and they'll learn more about certain medications, and then they might apply it to other patients."

6. **Increased provider access.** Many of the PCPs stated that if some of their patients can see the pharmacist performing CMM for medication monitoring and optimization, there might be

What CMM is not

To understand CMM in practice, it's important to distinguish between CMM and other medication therapy management services.

First, CMM is not a dispensing service: The dispensing of medication, whether done in a health system or retail pharmacy or via mail order, ensures that patients *receive* their medications. CMM is a team-based, person-centered, value-added *service* or process of care that should wrap around any dispensing of medications that occurs, especially for high-risk patients. Through the delivery of CMM, the clinical pharmacist works in collaborative practice with the physician to make sure that all medications, whether they are over-the-counter or prescription, are assessed for appropriateness, effectiveness and safety. CMM ensures that the medications the patient receives are optimized for that patient to improve the quality of care.

More significant, CMM is not MTM: To optimize medication use, a comprehensive process of care called CMM has been shown to lead to better care, lower costs, increased provider and patient satisfaction and higher quality. CMM is frequently confused with discrete activities associated with medication therapy management (MTM) services used to address medication therapy problems. CMM is a comprehensive approach to assessing *all* of the patient's medications in collaboration with a team. MTM, which is typically associated with Medicare part D, can mean different things, depending on the context. Unlike CMM, MTM services have not been clearly defined, Sorensen explains.

Among the other differences:

- **MTM is siloed:** It attempts to address a single problem isolated from the disease process, the evaluation of the patient's other medications, etc.
- **MTM isn't accountable for change:** "In MTM, the reward isn't for an outcome, it's for the intervention itself. But the intervention may not have actually produced the outcome. In comprehensive medication management, one of the key differences is this accountability for the outcome, Sorensen explains.
- **MTM doesn't necessarily involve follow-up:** One of the most important aspects to CMM is it requires follow-up to confirm that whatever challenges were identified and changes that were either made directly or proposed to a prescriber were actually made and produced the outcome they were intended to. This gets back to the point about accountability, he says: "The provider is really taking accountability for producing the outcome." GTMR

more room on the PCP's own schedule to see other patients.

7. **Achievement of quality measures.**

Funk shared some of the comments from the PCPs who were part of the research project evaluating the value of CMM and the role of impact on physician burnout:

> *"I think a lot of the burnout comes from all the multiple decisions you have to make in a day. That can be exhausting. So just again, having someone you can collaborate with on some of those things is great… that collaboration absolutely reduces burnout."*

> *"It [CMM] does offload some of the work; it's another part of the team helping you take care of your very complicated patients that's equivalent to a provider in terms of their knowledge of medications, if not more; so it really helps take away some of that stress of managing all those chronically ill patients by yourself."*

> *"…it feels so nice to either know there's another set of eyes on this patient or 'oh, this person can handle this one chunk for me.'"*

These remarks point to an interesting theme that emerged from her research: The primary care physician's use of CMM in practice and resulting partnership with the clinical pharmacist is different than the partnership with other members of the interprofessional care team. Seeing the pharmacist as a collaborative partner and someone who provides that added skillset is unique here.

"For instance, when we might think about a physician partnering with a nurse practitioner or a physician assistant, their skill sets might be very similar, and so, likely the themes that we found wouldn't quite be as evident in that relationship because there wouldn't be that same sort of collaboration and shared journey and different skillsets kind of coming together to help out each other."

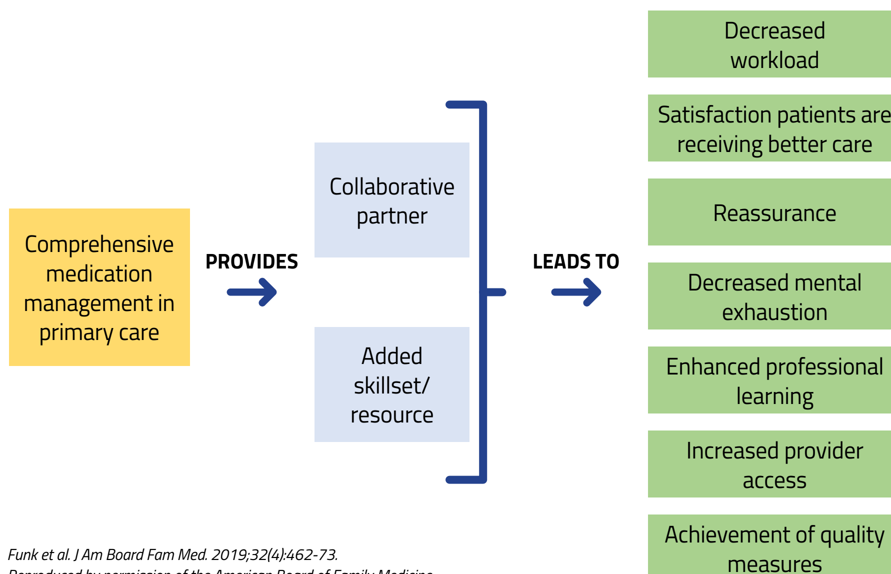
Figure 2 (see next page) illustrates the crosswalk between the seven drivers of engagement and the themes that emerged from the study interviews with PCPs. "This initial study leads us to think that there are many ways in which pharmacists providing CMM are impacting provider work life in a really positive way."

It's all about the value

In short, the research shows the value CMM in general and the pharmacist partner in particular bring to the PCP, says co-author Todd D. Sorensen, PharmD, FAPhA, FCCP, professor and associate dean for strategic initiatives, College of Pharmacy at the University of Minnesota, executive director of Alliance for Integrated Medication Management.

Value is not measured as merely "revenue," and confusion over that fact has historically inhibited adoption of services that will optimize medication use like CMM in practice. One of the biggest mistakes he sees in terms of building CMM programs is a single focus on direct revenue as the business driver rather than an

PCP Perception of how CMM Impacts their Work-Life



Funk et al. J Am Board Fam Med. 2019;32(4):462-73.
Reproduced by permission of the American Board of Family Medicine

Figure 1

> "There's only one way to herd a cat, and that's to move the food. And the food is being moved pretty rapidly away from purely fee for service to a much more at-risk capitated outcomes-based model."
>
> *Paul Grundy, MD, MPH, FACOEM, FACPM*
> *Chief Transformation Officer, Innovaccer*
> *President, GTMRx Institute*

evaluation of the "value" of the service. If physician practices, systems of care or ACO's think they will generate enough revenue to cover their costs, they won't pursue the adoption and delivery of CMM services. Those who succeed at providing programs designed to optimize medication use do it through a combination of revenues and an evaluation of how the programs had an impact on reduction in the ***total cost of care.***

Successful programs also consider all four elements of impact on the Quadruple Aim: enhancing patient experience, improving population health, reducing costs and improving the work life of health care providers. "They really recognize that those four elements bring value to different partners, and that will help generate the full scope of what you need to create a sustainable business model," he says. "But the quicker we start to look at value rather than just revenues, the sooner we'll get to sustainability and implementation."

Today, successful CMM programs *are* generating value. He offered a look at some of the clinical and financial outcomes that could be used in a value framework. *(Internal CMM Program Performance Data, HealthPartners health plan, Bloomington, MN)*

- Optimal diabetes control—67.1% vs. 37.5% (control)
- Optimal blood pressure control—71.8% vs. 57.1% (control)
- 97% of patients are willing to recommend service
- 96% agree/strongly agree with "After talking with the pharmacist, I feel more confident to manage my medications"
- 3:1 ROI for commercially insured members across the entire book of business
- ROI increases as patient complexity increases—as high as 11:1 or 12:1

He offers an additional way to assess the value proposition of CMM, using what's called a "value proposition canvas." (See sidebar on next page for more.)

Beyond the care team: Health plan as partner

Any discussion of value gets back to the importance of value-based payment models. "There's only one way to herd a cat, and that's to move the food. And the food is being moved pretty rapidly away from purely fee for service to a much more at-risk capitated outcomes-based model," Grundy says.

Sorensen agrees. CMM *can work* in the fee-for-service environments,

Themes are Linked to Known Drivers of Burnout and Engagement

Seven Drivers of Burnout and Engagement*	Related Themes from PCP Perception of CMM**
Workload and job demands	▪ Decreased workload ▪ Achievement of quality measures
Work life integration	▪ Decreased workload ▪ Decreased mental exhaustion
Social support and community at work	▪ Collaborative partner ▪ Reassurance
Efficiency and resources	▪ Added skillset/resource ▪ Decreased workload ▪ Increased provider access
Meaning in work	▪ Satisfaction patients are receiving better care ▪ Enhanced professional learning
Organizational culture and values	▪ Findings do not connect to this driver
Control and Flexibility	▪ Findings do not connect to this driver

**Mayo Clinic Proceedings* 2017 92, 129-146DOI: (10.1016/j.mayocp.2016.10.004)
** Funk et al. *J Am Board Fam Med.* 2019;32(4):462-73

Figure 2

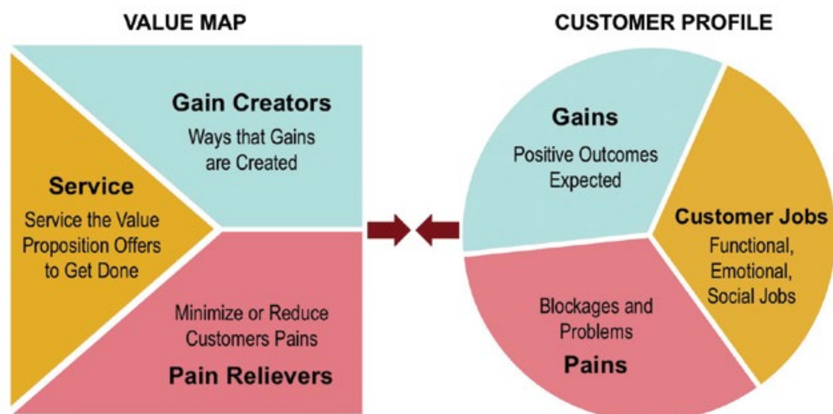


Figure 3

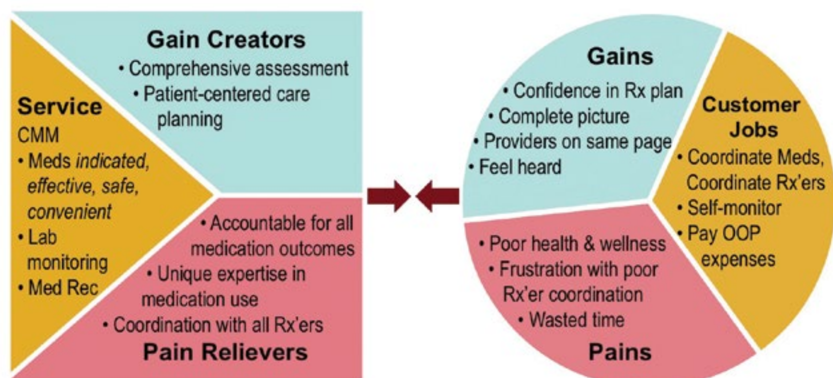


Figure 4

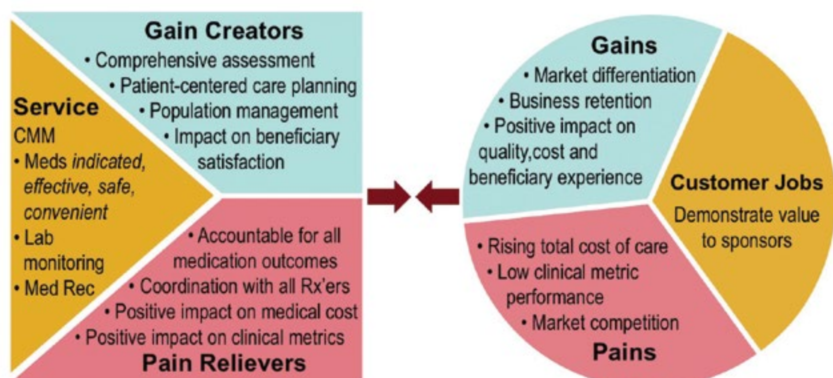


Figure 5

The CMM value prop

Sorensen makes the case for viewing CMM as a service to drive value in health care, using the value proposition canvas. The value-proposition canvas is a tool that can help ensure that a product or a service is positioned around what customer values are or what they need.

"It's a part of mental exercise for those who are trying to develop the value proposition—to really systematically go through thinking about what are the customer needs, what is it that we offer and how do we link those two together," he explains.

Figure 3 illustrates how it works. It outlines the services around which the value proposition is being developed, the ways in which we can relieve the pains a potential customer is experiencing and the ways we create the gains that the customer is looking for.

So how does that apply to CMM? "What are the things that happen when a provider is delivering this service that are potentially not occurring in other forms in the health care system and then would produce this added value, this new value that a customer would receive?"

Figure 4 illustrates how it works with the patient as the customer, and Figure 5 illustrates how this works with the health plan as customer.

To learn more about how CMM offers reduced costs, improves access to care, provides better care and enhances provider work life, please read "The Outcomes of Implementing and Integrating Comprehensive Medication Management in Team-Based Care: A Review of the Evidence on Quality, Access and Costs," updated in June 2020. It was prepared by M. Shawn McFarland, PharmD, FCCP, BCACP, national clinical pharmacy practice program manager, clinical practice integration and model advancement, clinical pharmacy practice office, pharmacy benefits management services, Veterans Health Administration; and Marcia Buck, PharmD, FCCP, FPPAG, BCPPS, director, clinical practice advancement, American College of Clinical Pharmacy.

but it's much better aligned with value-based payment models.

Value-base models encourage an important business partnership: One between the PCP and the medical carriers and TPA's. Health plans can use their analytical capabilities of claims experience, identifying their beneficiaries that are most at risk, creating registries and sharing that information with the providers. "It makes it easier to identify beneficiaries who are going to benefit from the CMM service the most," Sorensen says.

Ultimately, he argues, the delivery of CMM services becomes about a partnership opportunity between providers and payers.

To make that happen, payers and providers have considerable work to do, he says. (See Figure 6). It's work that must be done. "I don't think that we can achieve the value that CMM can produce if we don't look at how we create these partnerships."

"I don't think that we can achieve the value that CMM can produce if we don't look at how we create these partnerships."

Todd Sorensen, PharmD, Professor and Associate Dean; Executive Director College of Pharmacy, University of Minnesota; Alliance for Integrated Medication Management

Payers *are* looking for new product solutions and ways to decrease waste, enhance quality and partner with their network providers to create value. And, providers are more than ready—if support, data and payment can align—to ensure appropriate use of medications. "It's an exciting time to be a clinician, to be a healer and to be part of this transformation to better care," Grundy says. GTMR

Strategies to Produce Value From CMM

Provider-Payer Partnerships *Shared Responsibilities Between Providers and Payers*	
Provider Organizations	**Payer Organizations**
▪ Investment in CMM ▪ Taking on risk ▪ Commitment to CMM-specific measurement ▪ Focus on teams with rational allocation of clinical work ▪ Create/Join Communities of Practice	▪ Establish specific standards for service delivery ▪ Population-level analysis –Create beneficiary registries –Share actionable data ▪ Provide incentives ▪ Invest in provider network development

Figure 6

About the Experts

Paul Grundy, MD, MPH, FACOEM, FACPM
Chief Transformation Officer, Innovaccer
President, GTMRx Institute

PAUL GRUNDY, known as the "godfather" of the patient-centered medical home movement, has spent four decades focused on population health and a healing relationship of trust with a primary care provider. He currently serves as chief transformation officer at Innovaccer and prior to that was an IBM executive for more than 17 years. He is an adjunct professor at the University of California San Francisco, University of Colorado School and the University of Utah.

He has won numerous awards for his work in primary care transformation and is also a member of various organizations dedicated to advancing the practice. Paul is the founding president of the Patient-Centered Primary Care Collaborative. He served in the Carter, Reagan, George H. W. Bush and Clinton administrations and is a retired senior diplomat with the rank of Minister Consular in the U.S. State Department. He is also a health care ambassador for the nation of Denmark and served in Singapore as a medical director at International SOS.

(continued)

About the Experts *(continued)*

Kylee Funk, PharmD
Associate Professor
University of Minnesota College of Pharmacy

KYLEE FUNK, PharmD, is an associate professor at the University of Minnesota College of Pharmacy. In this role, she provides comprehensive medication management (CMM) in a primary care clinic several days a week. One aspect of her research focuses on the impact of CMM, and she is particularly interested in the way that interprofessional relationships contribute to this impact. In 2019, Dr. Funk and colleagues published research in the Journal of the American Board of Family Medicine around the finding that CMM improves provider work-life balance. Her most recent work continues to build on these findings and more deeply explore how interprofessional work impacts well-being and burnout.

Todd Sorensen, PharmD
Professor and Associate Dean;
Executive Director
College of Pharmacy, University of Minnesota;
Alliance for Integrated Medication Management

TODD SORENSEN is professor and associate dean for Strategic Initiatives and Innovation at the College of Pharmacy, University of Minnesota and executive director for the Alliance for Integrated Medication Management. His work concentrates on strategies that facilitate clinical practice development and developing change management and leadership skills in student pharmacists, pharmacy residents and practitioners. His research activities focus on collaborations with health care organizations to implement clinical strategies that improve health outcomes. This work is influenced by diffusion of innovation theory, principles of quality improvement, the discipline of implementation science and over 10 years of experience leading regional and national quality improvement collaboratives.

Our **VISION** is to enhance life by ensuring appropriate and personalized use of medication and gene therapies.

Our **MISSION** is to bring critical stakeholders together, bound by the urgent need to optimize outcomes and reduce costs by *getting the medications right.*

8230 Old Courthouse Road, Ste. 420
Tysons Corner, VA 22182
703.394.5398 ▪ www.gtmr.org

About the GTMRx Institute
The GTMRx Institute is a catalyst for change that brings critical stakeholders together, bound by the urgent need to get the medications right. We are physicians, pharmacists, caregivers, health IT innovators, drug and diagnostics companies, consumer groups, employers, payers and health systems—aligned to save lives and save money through comprehensive medication management, or CMM. By showcasing evidence and innovation, we motivate practice transformation and push payment and policy reform. Together, we ACT to champion appropriate, effective, safe and precise use of medication and gene therapies. Learn more at gtmr.org.

08.2020

Written and produced by Health2 Resources ©GTMR Institute 2020