Medication Optimization Use Case

HEALTHPARTNERS ▪ Bloomington, Minnesota	
Focus Area	Chronic disease model that incorporates the clinician providing CMM services into a primary care patient population. The chronic disease therapy model focuses on outcomes seen when the clinician provides CMM care for common primary care conditions such as cardiovascular disease, diabetes, etc.
At-a-Glance	■ **Organization Type:** Health plan/Integrated Health System ■ **Launch Date:** 2006 ■ **Payment and Funding Sources:** ▪ CMM is covered service for almost all health plan members (Commercial, Medicaid, Medicare). ▪ Contracts with other commercial payers, Managed Medicaid and Medicare Advantage plans
Organization Details	HealthPartners, an integrated health care organization providing health care services, health plan financing and administration, was founded in 1957 as a cooperative. It is the largest consumer governed nonprofit health care organization in the nation—serving more than 1.8 million medical and dental health plan members nationwide. Their care system includes a multi-specialty group practice of more than 1,800 physicians that serves more than 1.2 million patients. HealthPartners employs over 26,000 people, all working together to deliver the HealthPartners mission.
Brief History of CMM Program, Scope of Services	Medicare Part D and Minnesota Medicaid medication therapy management (MTM) provisions, both of which required the insurer to offer various levels of MTM jumpstarted this program. In 2007, a CMM pilot among patients with diabetes was successful and paved the way to offering CMM across HealthPartners' entire book of fully insured commercial business in 2008. Continued proven benefits of CMM led to CMM coverage as a standard for self-insured commercial business in 2010.

PRODUCED BY HEALTH2 RESOURCES GTMRX INSTITUTE 2020© | 10.2020

<table>
<tr>
<td>Results & Achievements

Focus on the Quadruple Aim
▪ Better Outcomes
▪ Cost Savings
▪ Patient Satisfaction & Engagement
▪ Clinician Satisfaction</td>
<td>Better Outcomes
▪ Significantly improved blood pressure lowering and goal attainment with clinician telemonitoring than usual care at six, 12 and 18 months (p<0.001).
▪ 30% increase in optimal diabetes control for approximately 300 patients, leading to almost 200 fewer emergency department visits and almost 100 fewer hospitalizations over eight years.
Cost Savings:
▪ Cost Avoidance (diabetes population above): $967,000.
▪ Return on Investment one-year pre-/post-CMM intervention: 3.5:1 leading to $1,268 per member per year savings.
Patient Satisfaction & Engagement:
▪ 98% of participants would recommend their CMM clinician.
▪ 96% of participants say they are more confident managing their medication after completing a visit.
▪ Clinician-provided CMM has filled “an unmet need with respect to quality and patient experience.”
Clinician Satisfaction:
▪ Value frequently acknowledged; collaboration has become the expectation, as well as shared accountability and team expectations.</td>
</tr>
<tr>
<td>Patient Success Story</td>
<td>A patient has been enrolled in the CMM program since late 2018 after his employer purchased a program that offered reduced copays in exchange for participating in the program. He has hypertension, hyperlipidemia, diabetes and reactive airway disease. At the first meeting, his A1C was 8.8% and blood pressure was 170/90, his medications were expired, he had overdue labs and provider visits, he had never had a foot exam, he was not taking any diabetes medications and he was only taking fish oil for his cholesterol. He has continued to meet with his pharmacist every three to six months since 2018. He and his wife have both commented how grateful they are for this program and have told the pharmacist she is one of the first people to really care about his health outcomes. They say he will do anything the pharmacist asks!

At the most recent visit his A1C is 7.1%, and his blood pressure is 114/78. He is now taking recommended statin, ACE-I and aspirin therapy. He is motivated by positive lab outcomes and the ability to afford his medications and receive them for $0.</td>
</tr>
</table>

<table>
<tr><td>Team-Based Care Strategy</td><td>

Interprofessional Team Roles:

All are trained in CMM care delivery process, "from the front desk staff to the physician providers."

"Pharmacy Navigators": customer service representatives who understand everything about the plan's pharmacy benefit.
Centralized disease/case management experts to coordinate referrals.

Role of the Pharmacist:

Scope of Advanced Practice:

There are broad in scope collaborative practice agreements (CPA); developed with deep involvement/input from physicians.

Care Delivery Modality:

In person telemedicine.

</td></tr>
<tr><td>Patient Referral Criteria</td><td>

Eligible Patients: 850,000 (Health Plan)
Invited to Participate: 22,000
Can Patients Self-Refer? Yes
Available as a benefit to all HealthPartners members with pharmacy benefits through HealthPartners (Medicare, Medicaid, Commercial). Optional for employers who carve out their pharmacy benefits to an outside PBM. It is a benefit—no minimum criteria required for participation.
High-risk candidates are targeted for services (invitations, financial engagement incentives for network providers) utilizing HealthPartners pharmacy and medical claims information and EHR data (when available) in a proprietary algorithm.
Part D Medicare medication therapy management members are targeted based upon CMS required criteria.

</td></tr>
<tr><td>Size of CMM Program</td><td>
Number of:

Pharmacists: 15
Pharmacist FTE: 11.8
Practice Sites: 23 outpatient clinics
Resident Pharmacists: 2
Support Staff: Pharmacy Navigators, outreach coordinators, program coordinator, CMM supervisors
Members Using Services (Health Plan):
7,000 members
13,300 visits
Unique Patients Using Services (Care Delivery)
8,900 patients
18,000 visits

</td></tr>
</table>

Program Success Factors	■ Solid buy-in from organizational/physician leadership ■ A consistent pharmacy practice philosophy: CMM ■ Verification that CMM practices are providing the expected level of service ■ Collection and sharing of data on the results of the program
Next Steps, Future Goals	■ Continued growth of the provider network to ensure local access to CMM services for the vast majority of health plan membership ■ Increased recognition of and payment for CMM services by Medicare and other commercial and government payers to support expansion of services that meets society's need
References	McInnis, T. Capps, K. Get the medications right: a nationwide snapshot of expert practices—Comprehensive medication management in ambulatory/community pharmacy. *Health2 Resources*, May 2016. Sorensen, TD, Sorge LA, Millonig, M et al. Integrating medication management: lessons learned from six Minnesota health systems. September 2014. Available from: https://www.pharmacy.umn.edu/sites/pharmacy.umn.edu/files/integrating-medication-management-lessons-learned.pdf Margolis KL, Asche SE, Bergdall AR, et al. Effect of home blood pressure telemonitoring and pharmacist management on blood pressure control: a cluster randomized clinical trial. *JAMA* 2013; 310(1):46-56.
Program Contact Information	**Dan Rehrauer, Pharm.D.** Senior Manager, Medication Therapy Management Program daniel.j.rehrauer@healthpartners.com (952) 967-5133
Developed by the Best Practices and Innovative Solutions Subgroup of the GTMRx Practice and Care Delivery Transformation Workgroup	