

PCPCC Webinar Q&A 9/18/18
Optimizing Value and Patient Outcomes Through Comprehensive Medication Management

Q: How many pharmacists were a part of the team at Minnesota impacting the diabetes measure (slide 13)? And over how many clinics did this span?

[Joselyn Benabe] [jbena@bch.org]

A: [Amanda] Details can be found at: Brummel A, Soliman A, Carlson A, Ramalho de Oliveira D. *Optimal Diabetes Care Outcomes Following Face-to-Face Medication Therapy Management (MTM) Services. Population Health Management. October 31, 2012.*

Q: How was medication adherence assessed? Through payer data? (slide 16)

[Joselyn Benabe] [jbena@bch.org]

A: [Amanda] It was through claims data. More information can be found at: Brummel, A, Carlson, A. *Comprehensive Medication Management and Medication Adherence for Chronic Conditions. Journal of Managed Care Pharmacy 2016; 22 (1); 56-62.*

Q: Hi Amanda mentioned not focusing CMM on some patient populations.

In what populations did offering CMM result in no clinical significant changes?

What other processes would be helpful for these?

[Dr Jim Gaudino] [jag8nw@comcast.net]

A: [Amanda] Transitions of care is a good example. We determined to not meet with those not at an elevated risk for readmission, even if they meet other clinical criteria. More info at: Budlong, H, Brummel, A, Rhodes, A, Nici, H. *Impact of Comprehensive Medication Management on Hospital Readmission Rates. Population Health Management 2018.*

Q: Amanda, can you describe the difference between practice model and the patient care process?

[Debbie Pestka] [pestk003@umn.edu]

A: [Amanda] The patient care process may be a component of your practice model. In addition to the patient care process (the assessment, care plan and follow up) you may include the practice management areas into your practice model. Also it could include your philosophy of practice- that you are accountable and responsible for a patients medication related needs for example.

For more information, visit http://www.accp.com/cmm_care_process.

Q: Were the pharmacists going into the home together with nurses or would they enter the home alone for MTM visit? (slide 18) [Joselyn Benabe] [jbena@bch.org]

Q: During the post-hospital discharge MTM visit at HealthPartners, did the pharmacist go to the patient's home? [Christina Hansen] [christina.hansen@bhsi.com]

A: [Dan] Generally speaking, the pharmacists enter the home by themselves. We've been doing home visits for several years, now, and originally had the pharmacists go with the nurses for a first visit. We learned that trying to combine a medication assessment with the nurse's work was too difficult (too much information for patients/family to process, made the nurse and pharmacist less efficient). Now – pharmacists will only combine a visit in rare circumstances (i.e. – patient is uneasy about having someone new in the home or a reason having the nurse and pharmacist together makes sense).

Q: For health partners- can you elaborate on how the MTM services were delivered?

[Mariel Shull] [mariel.shull@nyulangone.org]

A: [Dan] For HealthPartners, MTM services are delivered to our health plan members through a network of pharmacist providers. That includes HealthPartners employed pharmacists who work in our own clinics alongside care teams and conduct visits face to face in exam rooms, pharmacists employed by HealthPartners who work centrally and provide telephone based services to members who have no local MTM providers, and contracted pharmacists who provide MTM services to our members in their own communities (pharmacy based, clinic based, and stand-alone MTM consulting practices). We also provide MTM services through our clinic-based HealthPartners employed pharmacists to patients of our clinics who are not HealthPartners health plan members.

Q: Re: the slide that showed the 11:1 ROI in the top 10% (i.e., high-risk) commercial patients, was it the top 10% highest total cost of care, or the top 10% of some other metric?

[Erica Guetzlaff] [eguetzlaff@ghcscw.com]

A: [Dan] It was the top 10% based upon the baseline total cost of care.

Q: What are the years that this was studied?

[Virginia Jones] [virginia.jones@unitypoint.org]

A: [Dan] I'm unsure which set of data you're referring to, but I'll provide some dates for all. The diabetes work was 2007-2015. The hyperlink trial was 2008-2010. The total cost of care data I presented covered the years 2013-2015.

Q: How do you do MTM? In home, telephonic etc.? We do home visits, but do not bill at this time

[Nyann Biery] [nyann.biery@lvhn.org]

A: [Dan] As a health plan, we pay for MTM via all of those methods. Every provider in our network is required to offer face-to-face MTM. We do not contract with telephonic only providers. In our own employed pharmacists, we provide clinic based, telephonic (usually for follow up), and in home MTM for a very small population.

Q: Do your programs target seriously ill patients for palliative care opportunities?

[Marisa Todd] [matodd@enclarapharmacia.com]

A: [Dan] It has been an area of exploration, but nothing formal at this time. We do work with our palliative care teams, we just haven't maximized the relationship at this point.

Q: What kind of overlap in services existed for patients receiving home health services---an element of care management---and what the CMM pharmacist was doing?

[Leslie McDowell] [leslie.mcdowell@mahec.net]

A: [Dan] The focus of the pharmacist revolves around the medications and their use (i.e. – CMM). Because of that, there is very little overlap of services. The pharmacist is not acting as the care manager, but works with others on that team to ensure the right meds are available (usually working with PCP and specialists on optimizing regimen) and able to be taken correctly by the patient (usually working with family members/care givers and/or the home health nurse on having an accurate med list and tools to help with administration - such as pill boxes, bubble packed meds, med sync, etc.).

Q: How did the pharmacist negotiate co-management of the patient under the care of both specialists and primary care?

[Leslie McDowell] [leslie.mcdowell@mahec.net]

A: [Dan] Anecdotally, that is one of the biggest success areas for CMM. Because the pharmacist takes responsibility for the medication outcomes of their patient, they are proactively reaching out to primary care and specialist providers to ensure the best mix of medicine. It isn't always easy, but it is expected.

We frequently see specialists making decisions about drug therapy with a key focus on their area and not necessarily having the knowledge to address drug therapy outside of their area, especially when the drug therapy is complex. That is frequently paired with a primary care provider who doesn't want to step on the specialist's toes and results in non-optimal outcomes for the patient. Our CMM pharmacists are comfortable (or forced to become comfortable) reaching out to specialists and primary care providers to find the best overall drug therapy.

Q: Did all of the research and data collection go through an IRB process?

[Elizabeth Murray] [eamurray@geisinger.edu]

A: [Dan] *For the HP data, the diabetes work is quality improvement. Hyperlink was approved by the IRB. The ROI was conducted by the health plan to assess the value of the service and wasn't initially intended to be used for publication.*

Q: What is the recommended ratio of pharmacist to population size?

[Elizabeth Murray] [eamurray@geisinger.edu]

A: [Dan] *Great question without a single answer. 😊 Different populations have different complexities and require differing resources. Based upon the populations of patients/members we target for MTM services – we figure each full-time pharmacist can have a panel of approximately 650-750 individual patients (our average number of visits per individual patient/year is 1.8, with a range of 1-35 visits/year). Our targeted patient population is very complex, though. With a less complex population, that number could grow. With a more complex population it could shrink.*

Q: Any experience with Faith Community Nurses to help with medication management?

[Edward Dick] [edward.dick@mhm.org]

A: [Dan] *No.*

Q: 1) What parameters do you recommend for identifying patients at "high-risk"? Do you have certain criteria you use? (# meds, certain conditions, etc.?)

A: [Dan] *We do – and they vary – and we attempt to tweak them as time goes by. The number of medications is an excellent starting place (how you define number of medications isn't as easy as it sounds, either). Targeting of certain conditions we know depend upon medication use for good outcomes is also good (i.e. – diabetes, heart disease, asthma, COPD, CHF, CKD, etc). We also look at medication adherence, hospital/ED use, office visits. We don't have a magic bullet, but we're constantly looking for how to make our bullets better.*

Q: 2) How broad is your pharmacist scope of practice, how many disease states can they directly initiate/modify medications for? [Alvin Oung] [aoung@uwyo.edu]

Q: What risk stratification method did you use?

[Sandy Pogones] [spogones@aafp.org]

A: [Dan] *We use a variety of methods for targeting patients for CMM services and it remains a moving target we're always looking to improve. We have a broad collaborative practice agreement which provides our employed pharmacists the ability to start/stop/change prescription medications and order relevant laboratory tests across a wide variety of conditions. We have 12 protocols under the CPA at the current time (asthma, benzodiazepine taper, COPD, diabetes, HIV, hypertension, thyroid, lipids, naloxone, opioid taper, therapeutic interchange, tobacco cessation).*

Q: Are the 5 diabetes measures the only quality measures you used?

[Sandy Pogones] [spogones@aafp.org]

A: [Dan] For the diabetes pilot program I discussed we looked at the 5 diabetes measures for our clinical outcome, we measured patient satisfaction, and completed an economic analysis. Across our program we focus on several quality measures where improving medication use improves those measures (across PQA/HEDIS/Stars). It is one of the key messages we use in justifying the use of pharmacists on our care teams when fee for service reimbursement for pharmacist provided services remains difficult.

Q: How is the pharmacist paid for their services?

[Sandy Pogones] [spogones@aafp.org]

A: [Dan] Any way possible. ☺ Our health plan reimburses fee for service for MTM services – so care provided to health plan members is reimbursed. Our care system has several value based contracts with other payers (local commercial payers, Next Gen ACO). While pharmacists aren't directly funded on a fee for service basis for caring for those patients, achieving quality and cost goals results in increased reimbursement which offsets some of the expense. As value based contracting and risk continues to grow, that is the likely funding area for pharmacist services.

Q: I currently work in a primary care ACO office as my faculty practice site. Besides my direct healthcare team, I also have a relationship with the ACO corporate office and am aiming for them to hire other pharmacists in all their primary care offices to assist them with their economic as well as clinical needs utilizing CMM. When focusing on my research to present to these individuals, in your opinion through your experience do you think I should focus on clinical or economic benefits of pharmacists in this setting? In other words, which should I focus my efforts on first - clinical or economic benefits?

[Genevieve Hale] [gh341@nova.edu]

A: [Dan] Great question and one I can't answer directly for you. My experience is to really pay attention and listen to the messages coming from your leadership. Which is going to resonate more with them and give you the best chance of success? In my opinion, you can't separate the 2 (and really 3, because patient experience is also incredibly important). You have to keep the lights on – and keep the patients well. One or the other doesn't work. ☺ With that being said – I think the clinical improvement is a "quicker" win. Economic analysis is more difficult and requires longer time frames. I'd recommend focusing on quick clinical wins – and use existing literature to provide an expected economic outcome.

Q: How can the small independent practice implement this, as they are unable to assume risk to the same extent as large systems”?

[Sandy Pogones] [spogones@aafp.org]

A: [Dan] Great question without an easy answer. As the health care world continues its march into value based care arrangements, I think the smaller practices will likely have to figure out how to band together so they can be large enough to assume risk. I think there are great opportunities for smaller practices and groups to partner with community pharmacies to help with medication use. I don't know exactly what that looks like, but is what I expect to see in the coming years.

[ACCP]: ACCP is currently exploring opportunities for professional collaboration between community-based and clinic-based pharmacists aimed at achieving medication optimization, with community pharmacists- focusing on optimizing medication use (through enhanced services such as synchronized refills, prescription delivery, patient education, etc.), and clinical pharmacists focusing on optimizing medication regimens (through the implementation and delivery of CMM). Both components of medication optimization are essential, yet distinctly different, in order to achieve positive health outcomes among others related to the quadruple aim.

Q: Can pharmacists bill Medicare/Medicaid/commercial insurance for these services?

[Leslie McDowell] [leslie.mcdowell@mahec.net]

Q: Can you discuss reimbursement for these services? Billing codes?

[Paula Carnaghi] [pcarnaghi@comcast.net]

Q: Do you bill for these services and what level of service would this be considered?

[Alvin Oung] [aoung@uwo.edu]

A: [Dan] *Billing is a whole topic unto itself. Suffice it to say, opportunities for pharmacists to bill fee for service are limited (certain areas of the country have more opportunity than others).*

[ACCP] CMM is currently not included in Medicare, although it is a standard of practice under many private sector and government health care delivery and insurance programs. For more information on the ACCP Medicare Coverage Initiative, visit <https://www.accp.com/govt/medicare.aspx>

Q: The team mentioned billing for MTM visits, how did they work with outside payers to identify eligible patients for this service? Particularly when outside retail pharmacies may be providing MTM services.

[Joselyn Benabe] [jbenabe@bch.org]

A: [Dan] *Each payer does something different. Some payers provide us with lists of attributed and eligible patients and we do our best to engage them in MTM services. For those who don't, we do not do proactive outreach.*

Our health plan provides our network providers lists of attributed and targeted members. In addition, we offer a payment bonus for achieving high levels of engagement of those attributed members.

Q: Are you able to utilize the Chronic Care Management (CCM) CPT code billing to supplement the cost avoidance type contracts?

[Jeffery Hildebrand] [Jeff.hildebrand.pharmd@gmail.com]

A: [Dan] *We do not currently have workflows within our care system that support use of these codes. It would, however, be a possibility for a practice to consider if looking to find a source of fee for service revenue for pharmacist services.*

Q: How do you (PCPs) partner with pharmacies? Logistically and realistically? I can see small pharmacies willing to come to the table as part of the care team, but what do you do to get larger commercial pharms like CVS or Walgreens to be willing spend time in really investing in care management? Do you leave it up to an intermediary like the health plan?

[Randy Yniguez] [randyyniguez@gmail.com]

A: [Dan] *I think there will continue to be opportunities for community pharmacies – no matter their size – to partner with PCPs in a way that will improve health, provide excellent experience, and reduce total costs. Ultimately, there needs to be a business case for the partnership. Are PCPs willing to take on more risk with their payers? Are pharmacies? Will the 2 together better be able to achieve payer targets than either on their own? I think the answer to those questions are yes, but we still need to find the best ways to work together to accomplish the triple/quadruple aim.*

Q: This is Katie Capps, I am so glad to see such innovative programs offering an oversight of how they optimized outcomes through CMM. Can you tell us what you think the biggest barriers are to getting the medications right? Why is there not broader adoption of this care practice?

[Katherine Capps] [kcapps@health2resources.com]

A: [Dan] *Ultimately, I think the biggest barrier is the lack of a clear business case for CMM services in*

today's fee for service dominated world. Pharmacists do not have a clear source of reimbursement that covers their services. As the clear value of CMM continues to be recognized, pharmacists continue to demonstrate their value and work successfully with other members of the care team, and value based reimbursement continues its march forward, the adoption will come.

Q: In your opinion, what are one or two of the top impediments to broader insurance coverage and reimbursement to CMM?

[Paul Kelly] [pkelly@capitol-advocacy.com]

A: [Dan] *1) Still living in a fee for service dominated world where we do things because that is what we get paid for instead of doing things because it results in the best outcome. 2) The pharmacy profession – as a result of #1 – can't rally around and promote CMM as the practice model for the profession. Instead we use the term MTM to signify whatever it is that we're doing individually in our own practices, causing confusion for patients, other care team members, researchers who want to study the value of our services, and providers about what to expect from pharmacists.*

Q: Are there any legal or regulatory roadblocks to wider use and recognition of this care?

[Paul Kelly] [pkelly@capitol-advocacy.com]

A: [Dan] *CMM services reduce costs by improving health and reducing medication related harm. The costs are saved on the medical spending side of the equation and not the drug spending side of the equation. Requiring PartD plan sponsors to provide MTM services, something that may increase their costs, doesn't provide a good incentive to provide a robust MTM/CMM experience. The enhanced MTM model hopes to establish a way for sponsors to share in the savings they produce. This is absolutely necessary to help spread programs.*

Establishing CMM as the practice model for MTM services under Medicare Part D would go a long way towards bolstering and ensuring access to CMM.

Documentation standards/reporting requirements: The current reporting requirements under Medicare PartD, which require collection and reporting of metrics not obtainable through administrative claims data, encourage Part D plan sponsors to keep MTM programs in house or utilize vendors who require documentation in proprietary platforms. This can lead to fragmented documentation and/or the requirement for double documentation in the pharmacist provider world (i.e. – document one time in the proprietary vendor system, one time in the pharmacist's own system). It also frequently leads to shutting out the ability of pharmacists to provide care to plan sponsor beneficiaries because the plan sponsor utilizes a centralized phone bank of pharmacists rather than a community based network. The profession is making strides towards the standardization of documentation of these services. With the establishment of the pharmacist e care plan, regulation preventing plan sponsors from requiring use of a proprietary documentation platform and instead requiring acceptance of the pharmacist e care plan as an alternative would reduce provider administrative burden and still allow plan sponsors to report necessary data to Medicare.

Q: Should a practice select a consultant to help incorporate CMM...if so which ones are reputable?

[Randy Yniguez] [randyyniguez@gmail.com]

A: [Dan] *I am not aware of any CMM consultants.*

Q: Any ideas on getting a CFO on board and justifying the salary of a pharmacist? Without CMS recognition of pharmacists as providers, there is no direct revenue and can be difficult for finance departments to see the value.

[Zachary Keene] [zac.keene@ketteringhealth.org]

A: [Dan] In the absence of fee for service revenue, you must tell a value story. Is your organization seeking or being asked to accept risk with your local payers? If not – should they be? If so – what are the dollars at stake and how can CMM help the practice achieve the payer goals? Would CMM allow you to take more risk and allow for more reward?

Q: How would you recommend implementing CMM into practice in a state where collaborative practice/pharmacist billing is not established?

[Sean Lasota] [seanlasota@gmail.com]

A: [Dan] Having a collaborative practice agreement certainly makes delivering CMM more efficient, but it is not a requirement. With that said, I'd encourage you to be active in your state to get collaborative practice act language added to your practice act. Fee for service billing is often seen as the holy grail for pharmacists, but there is a strong need to look beyond FFS to the future of value based contracting and establishing the pharmacists place in the care model to receive a piece of that pie.

Q: Can only pharmacists perform CMM? Have you seen success with training primary care providers or other practice staff to perform CMM, particularly small independent practices who struggle to find the upfront financial resources to hire/contract with a pharmacist?

[Tessa Arons] [tarons@healthteamworks.org]

A: [ACCP] As medication experts, clinical pharmacists are uniquely qualified to provide CMM to identify and resolve medication related problems. A qualified clinical pharmacist:

- has a doctor of pharmacy degree (Pharm.D.) or possesses equivalent clinical training/experience;*
- has a formal collaborative drug therapy management (CDTM) agreement with a physician/medical group or has been granted clinical privileges to provide the service by the care setting in which (s)he practices;*
- is certified or eligible for certification in a pharmacy practice specialty recognized by the Board of Pharmacy Specialties (BPS).*

In some instances, CMM is delivered from a central location where the clinical pharmacist is servicing a small population through video conferencing.