Emerging Opportunities: Pharmacy Care

NACDS Total Store Expo
August 20, 2017
Presentation Objectives

• Current value based healthcare landscape

• Medication management as a critical component to achieve value based goals

• Developing evidence to expand and scale pharmacy interventions
Health Policy Driving the Movement to Value

CMS Timeline for Transition to Value-Based Reimbursement

By 2018, 50 Percent of Payments in Alternative Payment Models

- Payments linked to alternative payment models FFS
- linked to quality
- All Medicare FFS

### Historical Performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments Linked to Quality (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>&lt; 10%</td>
</tr>
<tr>
<td>2014</td>
<td>~20%</td>
</tr>
<tr>
<td>2016</td>
<td>30%</td>
</tr>
<tr>
<td>2018</td>
<td>50%</td>
</tr>
</tbody>
</table>

### Goals

<table>
<thead>
<tr>
<th>Year</th>
<th>Payments Linked to Quality (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2011</td>
<td>&gt; 80%</td>
</tr>
<tr>
<td>2014</td>
<td>85%</td>
</tr>
<tr>
<td>2016</td>
<td>90%</td>
</tr>
</tbody>
</table>

Source: Centers for Medicare and Medicaid Innovation (CMMI) Center, Bundled Payment Summit, June 2015
Public and Commercial Payers are Quickly Moving Toward Value Based Reimbursement

$38 Billion in value based contracts in 2015

$28 Billion in value based contracts in 2015

50% of Medicare Contracts will be Alternate Payment Models by 2018

75% value based contracts by 2020

$68 Billion value based contracts by 2018
Evolving Care Delivery to Achieve Value

Exhibit ES-1. Organization and Payment Methods

Source: The Commonwealth Fund, 2008
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Infrastructure Key to Payment Reforms

**Transparency:** Collecting and reporting quality and cost data to consumers enables informed decision-making.

**Health IT:** Use of HIT tools facilitates care integration, information collection and improves quality and efficiency.

**Measurement:** Linking payment to quality of care requires improved measurement and evaluation framework.

**Evidence:** New evidence from comparative effectiveness research helps define delivery and payment patterns.

Source: Avalere Health
The Medication Optimization Opportunity

A $500+ BILLION OPPORTUNITY

- PREVENTING MEDICATION ERRORS
- PREVENTING HOSPITAL READMISSIONS
- DECREASING ADMISSIONS FOR ACSC (AMBULATORY CARE SENSITIVE CONDITIONS)
- REDUCING EMERGENCY DEPARTMENT OVERUSE
- REDUCING VACCINE UNDERUSE
- REDUCING ANTIBIOTIC OVERUSE
- IMPROVING MEDICATION ADHERENCE

$21B
$25B
$31B
$38B
$53B
$63B
$290B
Medicare STAR: Health Plan performance

<table>
<thead>
<tr>
<th></th>
<th>2016</th>
<th>2017</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2017 Medicare Star Plan Performance</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Medicare Advantage Part D (MA-PD) Plans</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Average Star Score</td>
<td>4.03</td>
<td>4.00</td>
</tr>
<tr>
<td>Plans Attaining 4 Star or Greater</td>
<td>49%</td>
<td>49%</td>
</tr>
<tr>
<td>Members in 4 Star or Greater Plans</td>
<td>71%</td>
<td>68%</td>
</tr>
<tr>
<td>Number of 5 Star Plans</td>
<td>12</td>
<td>14</td>
</tr>
<tr>
<td>Number of 4.5 Star Plans</td>
<td>65</td>
<td>67</td>
</tr>
<tr>
<td>Number of 4 Star Plans</td>
<td>102</td>
<td>97</td>
</tr>
<tr>
<td>Number of 3.5 Star Plans</td>
<td>112</td>
<td>107</td>
</tr>
<tr>
<td>Number of 3 Star Plans and Below</td>
<td>78</td>
<td>79</td>
</tr>
<tr>
<td>Low Performing Plans Subject to Termination</td>
<td>6</td>
<td>2</td>
</tr>
<tr>
<td><strong>Standalone Part D (PDP) Plans</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Overall Average Star Score</td>
<td>3.4</td>
<td>3.55</td>
</tr>
<tr>
<td>Plans Attaining 4 Star or Greater</td>
<td>41%</td>
<td>49%</td>
</tr>
<tr>
<td>Members in 4 Star or Greater Plans</td>
<td>32%</td>
<td>41%</td>
</tr>
<tr>
<td>Number of 5 Star Plans</td>
<td>2</td>
<td>6</td>
</tr>
<tr>
<td>Number of 4.5 Star Plans</td>
<td>10</td>
<td>8</td>
</tr>
<tr>
<td>Number of 4 Star Plans</td>
<td>12</td>
<td>13</td>
</tr>
<tr>
<td>Number of 3.5 Star Plans</td>
<td>12</td>
<td>16</td>
</tr>
<tr>
<td>Number of 3 Star Plans and Below</td>
<td>23</td>
<td>12</td>
</tr>
</tbody>
</table>
Role of Pharmacy and Medication Adherence to the Star Ratings

Breakdown of a plan’s Star Rating:

10%
Member experience with drug plan
Based on member satisfaction information.

51%
Drug pricing and patient safety
Includes high-risk medication considerations, diabetes treatment, and medication adherence for diabetes, hypertension and cholesterol.

25%
Drug plan member complaints and Medicare audit findings
Includes how often members filed a complaint about the drug plan and findings from Medicare's audit of the plan.

14%
Drug plan customer service
Includes how well the drug plan handles calls and makes decisions about member appeals.

*Percentage that pharmacists contribute to a plan’s overall Star Rating

The Role of Medication Management with ACOs

ACOs' Top Priority Quality Metrics

<table>
<thead>
<tr>
<th>Metric</th>
<th>Rating (0-100)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Cost of Care</td>
<td>92</td>
</tr>
<tr>
<td>Reduced Hospital Readmissions</td>
<td>91</td>
</tr>
<tr>
<td>Patient Satisfaction</td>
<td>87</td>
</tr>
<tr>
<td>Reduced ER Utilization</td>
<td>87</td>
</tr>
<tr>
<td>Disease-specific Outcomes</td>
<td>85</td>
</tr>
<tr>
<td>Provider Satisfaction</td>
<td>73</td>
</tr>
<tr>
<td>Reduced Hospital Lengths of Stay</td>
<td>68</td>
</tr>
<tr>
<td>Lab / Screening Rates</td>
<td>65</td>
</tr>
</tbody>
</table>

Average Rating (Scale 0-100)

Commercial ACOs: Responsibility for Outpatient Rx Costs

% of ACOs with Commercial Contracts In-Place

- No  
  - n=5  
  - 16%

- Yes  
  - n=27  
  - 84%

Impacting Hospital Readmissions

**THE PROBLEM**

- Americans spend over $300B per year on prescription meds.
- $41B is spent on readmissions.
- 66% of readmissions are medication related.
- 56M Americans lack adequate access to primary care despite the majority being insured.

**THE SOLUTION**

- 90% of Americans live within 5 miles of a community pharmacy.
- Integrating pharmacists into direct patient care results in favorable outcomes across healthcare settings and disease states.

Source: Pennsylvania Pharmacists Care Network
Optimizing Meds – Need for Systems Approach

Visits 13 healthcare providers and fills 50 prescriptions every year¹

- An estimated 32% of adverse events leading to hospitalization are attributed to medications.
- Patients with chronic conditions are able to adhere to their prescribed medication regimens only 33% to 50% of the time².

Presentation Objectives

• Current value based healthcare landscape

• Medication management as a critical component to achieve value based goals

• Developing evidence to expand and scale pharmacy interventions
Medication optimization is a patient-centered, collaborative approach to managing medication therapy that is applied consistently and holistically across care settings to improve patient care and reduce overall healthcare costs.

CMOPP faculty have received three major grants garnering national visibility, each aiming to demonstrate the value medication optimization integration into new health care delivery models.

Four Critical Areas / Priorities

1. Advancing Practice Research
   - Evidence Creation to Transform Care Delivery

2. Creating Strategic Collaborations
   - Community Care of North Carolina
   - Payer & Policy Advisory Board

3. Enhancing Education
   - Curricular
   - Experiential
   - Research (RASP)

4. Shaping Health Policy
   - Independence
   - Thought Leadership
   - Evidence Dissemination
Translate Practice Research into Impact

• Transforming Primary Care Medical Practice through Comprehensive Medication Management (ACCP award)
  – Evaluate and replicate best practices in primary care
• Community Pharmacy Enhanced Services Network (CPESN)
  – CMMI award to CCNC testing new community pharmacy payment models
• Eshelman Institute for Innovation
  – Develop technology platform to collect and disseminate best practices in medication optimization
• Transforming Primary Care Initiative
  – CMMI award to CCNC to transform primary care practice
  – CMOPPP leading med optimization component
Research and Collaboration Pipeline

- Chronic pain management and opioid management with enhanced pharmacy services
- Next generation care transitions: Health system to community pharmacy care coordination with CHF patients
- Preventing ADEs through a Technology-enabled Care Coordination Hub (PATCH): Primary care clinics and community pharmacy
- Predictive analytics evaluation to develop individualized pharmacy services to improve care and lower cost in a self insured population
Community Pharmacy Enhanced Services Network (CPESN)

Core CPESN Services

- Ability to integrate with and augment Managed Care coordination and care management infrastructures
- Establish an ongoing professional relationship with the patient
- Provide in depth review of patient education regimens to identify opportunities to optimize therapy
- Work with providers and other health care professionals to resolve any concerns with the patient's medications
- Contribute to development of a patient-centered care plan
- Provide care coordination and additional mentoring between provider office visits for patients, especially those who are non-adherent to medications and/or are medically complex
- Engage in clear, clinically-relevant communication with the provider and care team

Provide a minimum set of enhanced services including, but not limited to:

- Medication reconciliation
- Clinical Medication Synchronization
- Adherence Packaging
- Immunizations
- Complete Medication Reviews with Chronic Care Management

Legend:
- AccessCare Network Sites
- AccessCare Network Counties
- Community Care of Western North Carolina
- Community Care of the Lower Cape Fear
- Carolina Collaborative Community Care
- Community Care of Wake and Johnston Counties
- Community Care Partners of Greater Huddersburg
- Carolina Community Health Partners

Source: CCNC March 2013
Lower Total Costs by Optimizing Meds

24%* ↑ PCP Utilization
20.7%* ↑ Pharmaceutical Utilization
46.8%* ↓ Inpatient Admissions
35.4%* ↓ Preventable Admissions
35.1%* ↓ Preventable Readmissions
16.1%* ↓ Emergency Department Visits

*Absolute percentage difference between actual and expected rates for CCNC enrolled vs. unenrolled
Tree Solutions Performance Analysis: Healthcare Utilization of CCNC-Enrolled Population - 2010 ABD Enrolled vs. ABD Unenrolled
QUESTIONS?

JCEASTER@UNC.EDU
Emerging opportunities: pharmacy care

David Nau, PhD, RPh, FAPhA
Nova Southeastern University
“I skate to where the puck is going, not where it has been...”

Wayne Gretzky
Intertwined Forces in Healthcare Evolution
Societal Forces in Healthcare Evolution

• Changing demographics
  • Population of U.S. adds 1 person every 13 seconds (2.4M/year)
  • More older adults due to gains in life expectancy
    • 2015: 13% over 65yo  2050: 20% over 65 yo
    • Baby boomers hitting Medicare (11,000 per day); not yet LTC

• Millennials are now larger segment than boomers (80M vs 74M); partly due to immigration
  • More racial/ethnic diversity to come in U.S.

• Consumer demands/expectations
  • Baby boomers are more demanding than pre-WWII population
    • Expect price/quality transparency
    • 70% of baby boomers to “shop” for doctor; 80% of GenX do the same
    • Millennials expect to have service “on demand” and personalized
THE HEALTH OF TOMORROW’S SENIORS
Comparing the middle aged population of 2014 (tomorrow’s seniors) to the health of today’s seniors when they were middle aged (in 1999) shows worsening rates for several health measures.

**THE PREVALENCE OF OBESITY INCREASED BY 24.9%**
- **1999**: 27.2%
- **2014**: 34.0%

**THE PREVALENCE OF DIABETES INCREASED BY 54.8%**
- **1999**: 10.1%
- **2014**: 15.6%

**OBESITY CHANGE AMONG MALES MORE THAN 2X HIGHER THAN CHANGE AMONG FEMALES**
- **MALE**: +36.8%
- **FEMALE**: +15.4%

**CHANGE IN DIABETES PREVALENCE BY RACE/ETHNICITY**
- **NON-HISPANIC WHITES**: +56.4%
- **HISPANICS**: +40.8%
- **NON-HISPANIC BLACKS**: +24.3%

**THE PREVALENCE OF SMOKING DECREASED BY 50.3%**
- **1999**: 38.2%
- **2014**: 19.0%

**THE PERCENTAGE OF MIDDLE-AGED ADULTS REPORTING VERY GOOD OR EXCELLENT HEALTH HAS DECREASED BY 9.4%**
- **1999**: 51.5%
- **2014**: 46.7%

**EDUCATION HAS A PROTECTIVE EFFECT ON SMOKING, WITH THE DROP IN PREVALENCE GREATER AMONG THOSE WITH HIGHER EDUCATION LEVELS.**
- **LESS THAN HS**: -34.0%
- **HS GRAD**: -40.8%
- **SOME COLLEGE**: -52.2%
- **COLLEGE GRAD**: -72.9%

**THIS DROP IN HEALTH STATUS IS MORE DRAMATIC AMONG THOSE WITH LOWER INCOME LEVELS.**
- **LESS THAN $25K**: -29.1%
- **FOR $25K - $49K**: -18.8%
- **FOR $50K - $74K**: -16.9%
- **MORE THAN $75K**: -8.1%
## Trend Forecast for Key Traditional Therapy Classes

Source: Express Scripts

### 2016 – 2018

<table>
<thead>
<tr>
<th>Therapy Class</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td>18.0%</td>
<td>17.7%</td>
<td>16.6%</td>
</tr>
<tr>
<td>Pain/inflammation</td>
<td>2.9%</td>
<td>10.2%</td>
<td>12.1%</td>
</tr>
<tr>
<td>High blood cholesterol</td>
<td>-11.5%</td>
<td>-14.1%</td>
<td>-13.3%</td>
</tr>
<tr>
<td>Attention disorders</td>
<td>9.2%</td>
<td>6.5%</td>
<td>5.5%</td>
</tr>
<tr>
<td>High blood pressure/heart disease</td>
<td>-4.6%</td>
<td>-9.1%</td>
<td>-7.6%</td>
</tr>
<tr>
<td>Heartburn/ulcer disease</td>
<td>-11.8%</td>
<td>-9.8%</td>
<td>-10.7%</td>
</tr>
<tr>
<td>Mental/neurological disorders</td>
<td>-4.0%</td>
<td>-7.0%</td>
<td>-3.0%</td>
</tr>
<tr>
<td>Asthma</td>
<td>4.0%</td>
<td>6.1%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Compounded drugs</td>
<td>-7.7%</td>
<td>-6.4%</td>
<td>-5.1%</td>
</tr>
<tr>
<td>Skin conditions</td>
<td>21.2%</td>
<td>16.2%</td>
<td>11.1%</td>
</tr>
<tr>
<td>Other traditional classes</td>
<td>-3.6%</td>
<td>-4.5%</td>
<td>-4.5%</td>
</tr>
<tr>
<td><strong>Total Traditional</strong></td>
<td><strong>0.4%</strong></td>
<td><strong>0.7%</strong></td>
<td><strong>1.3%</strong></td>
</tr>
</tbody>
</table>
Diversity of Population

• Non-white population is exploding in size
  • 2016: 30%  2050: 50%

• Growth in Asian / Hispanic populations in U.S.
  • Will triple in size by 2050
  • Language challenges
  • Cultural differences in health behaviors

• Pharmacist care programs will need to serve patients in languages other than English and we will need to understand the cultural differences in medication utilization and health behavior
Technology Advances

- Personalized Medicine
- Regenerative Medicine / Bioengineering
- Nanotechnology
- Biohacking
- Digital Health
  - Wearables
  - Mobile Health / Telehealth
Mobile Surpassed Desktop in 2014

75% of people over age 55 have a mobile device

Source: Morgan Stanley Research
Telehealth Market is Exploding

Global Forecast of Telehealth Patients and Device and Service Revenue
(Thousands of Patients and Revenue in Millions of US Dollars)

Source: IHS Technology, January 2014
Healthcare System Changes

Key components:

• Information flow (technology)

• Flexibility / personalization (TeleHealth)

• Team-based Care (coordinating people)

• Value-Based Payment (incentives aligned)
Pharmacy Care Trends

- ACO partnerships
- Transitions of Care
- Point of Care Lab Tests
- Medication Adherence (still important)

How can we deliver these services in a cost-effective and personalized manner (taking into account that the U.S. population is becoming older, more diverse, and more mobile)?
NSU Pharmacist Engagement in ACO Primary Care
NSU Pharmacist-Led Services in ACO

- Medication Therapy Management
- Transitions of Care
- Chronic Care Management
- Chronic Disease State Management
- Research/Scholarship
NSU Pharmacist-Led Services in ACO

Chronic disease state management
  Asthma, diabetes, heart failure, hypertension

Chronic care management
  Medicare patients with ≥2 chronic conditions for 20 minutes/month of telephonic care

Transitions of care (telephonic)
  Medication reconciliation
  Advise over the counter selection
  Immunizations
  Perform transition of care within 5 days of discharge
  Prevent readmissions
ACO Outpatient Rounding

Patient Identification
- Patients are identified by their primary care provider for CCM if they have: 1) two or more chronic conditions and 2) these chronic conditions place the patient at a significant health risk

Enrollment
- Patients are notified of CCM eligibility by primary care provider
- Patient signs written consent form, in which he/she agrees to share health information electronically with all health professionals involved in his/her care
- Patient is notified that they have the ability to discontinue this service at any time

ACO Rounds
- High-cost, high-risk chronic care patient is identified by primary care provider and Director of Quality Improvement for interdisciplinary team discussion and care planning
- Primary care provider implements team recommendations at their discretion

Follow Up
- CCM team follows patients via telephone or home visits
- Patient progress and care plan communicated to primary care provider
- Director of Quality Improvement updates CCM team on patient status monthly
Key Points

- Value-based payment models will shift a growing percentage of revenue to quality measures

- Significant expansion in the number of older adults with obesity and diabetes (which means adherence and care mgmt. for Medicare patients with diabetes will be crucial to bottom line)

- Significant growth in patients for whom English is not a primary language

- More than 75% of older adults, and nearly all millennials, have mobile devices and will expect personalization and flexibility in how they interact with pharmacist care providers

- Non-retail pharmacists who can support ACOs are taking a larger role in transitions of care and chronic care management (why not retail pharmacists?)