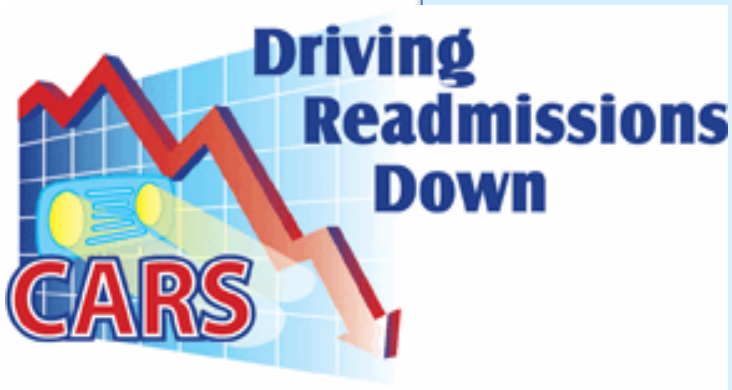


"It takes a village: How ACO's can partner with hospitals and community pharmacists to improve care transitions."

Brian Hodgkins Pharm.D, FCSHP, FASHP
Tim Perlick Pharm.D., CGP
Carpooling with Pharmacy
October 10, 2013

Who are we?

Heritage California ACO

Pioneer status

100K ACO lives

Part of Heritage Provider Network

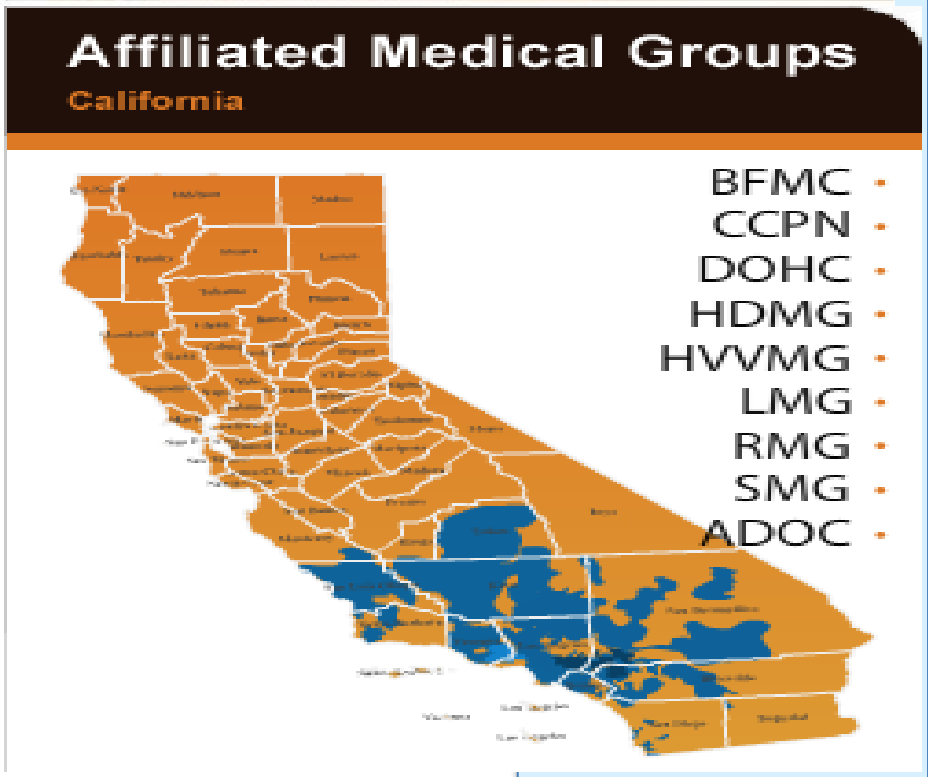
Integrated care delivery

1 million lives

New York and Arizona

Shared Savings ACO's

Blue Cross Commercial ACO



Who are we?

Desert Regional Medical Center

Tertiary Referral Hospital
367 beds
Level II Trauma Center
Level III NICU
Community for profit
UCR Medical School
Multiple Pharmacy School affiliations (USC, LLU, UOP)
Joint ASHP PGY-1 Residency Program

CARS

Objectives:

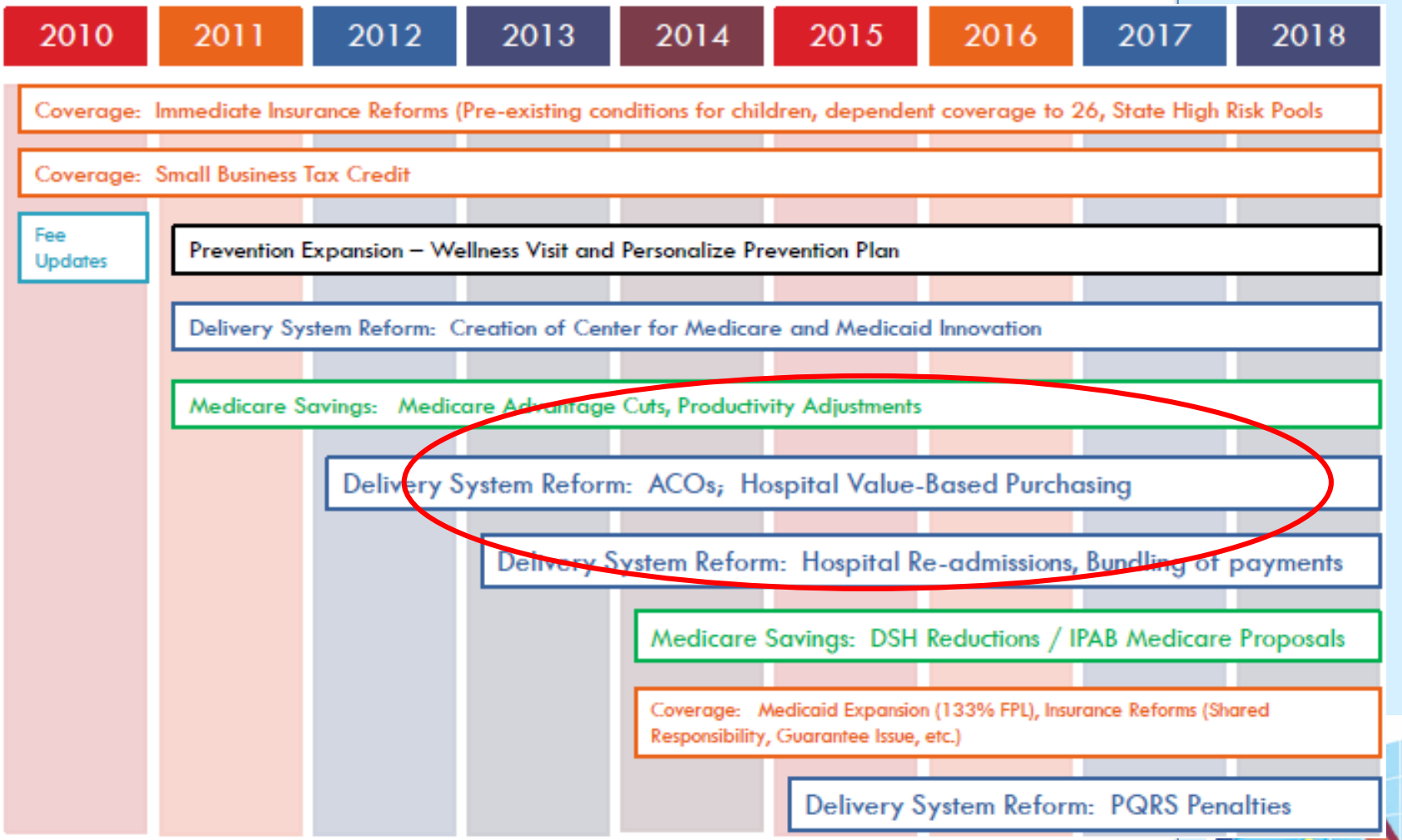
- By the end of this presentation participants will be able to:
- Describe the fundamental goals of an ACO and their impact on healthcare delivery
- Discuss the primary roles of pharmacists in an ACO model (and non-traditional roles) related to admissions
- Identify opportunities for pharmacists to collaborate within ACO's as an expansion of both delivery sites and scope of practice
- Determine transitional care gaps that can be filled by collaboration between hospital systems and community pharmacy practice
- Explore changes in population based payment models and how pharmacists are uniquely situated to excel in this integrated healthcare model

March 13, 2010 PPACA

Moving toward the triple aim…

- improving the individual experience of care;
- improving the health of populations; and
- reducing the per capita costs of care for populations

Key Timeline for ACA



ACA and the ACO

Insurance Reform

- More people covered
- More benefits and protections
- Lower costs

Health System Reform

- Improved quality and efficiency
- Stronger workforce and infrastructure
- Greater focus on public health and prevention

Dilemmas in health care

ACO Definitions

ACO Participants	ACO Professionals	ACO Providers/ Suppliers
Individual or Groups of ACO providers/suppliers	ACO provider/supplier	Enrolled in Medicare and bills Medicare FFS
Identified by Medicare-enrolled TIN	Enrolled and bills Medicare FFS	Has a Medicare billing number assigned to ACO participant and listed on ACO legal forms
Alone or together with other ACO participants make-up an ACO	Physician Physician Assistant Nurse Practitioner Clinical Nurse Specialist **(Pharmacist?)**	PTPPS HHAs SNFs Rehabilitation Agencies

ACO's Have promise for Improved Quality and Affordability

- Promotes holistic view of patient and care continuum rather than discrete events
- Fosters care coordination and management among providers
- Incorporates shared decision-making between patients/caregivers and practitioners
- Focuses on patient outcomes and continuous quality improvement
- Supports value through accountability for both quality measures and costs
- Drives alignment between public and private sector

How do ACO's achieve triple aim?

Barriers

- Health care payments drive volume and not value
- Fragmented delivery system does not promote accountability for capacity, quality or costs
- Absent or poor data hinders better performance
- Non-aligned payments reinforce problems, reward fragmentation, induce preventable complications, and inefficient care

Principles

- Achieve better health, better care, lower costs for patients and communities
- Foster provider accountability for the full continuum of care – and for the capacity of the local health system
- Better information that engages providers, supports improvement; informs consumers for best care
- Pay more for better, more efficient care by aligning financial incentives with professional aims

Hospital Systems can support the ACO and Triple Aim

- Early engagement (patient, HCP, and family)
- Timing and Sequencing
- Focused service lines
- Optimize care while present
- Help close the “hand-off” gap
- Shift thinking from “provider of care” to “manager of populations”

Key Elements of an ACO

1 Can provide or manage continuum of care as a real or virtually integrated delivery system

2 Are of sufficient size to support comprehensive performance measurement

3 Are capable of internally distributing shared savings payments

Important Caveats

- ACOs are not gatekeepers
- ACOs do not require changes to benefit structure
- ACOs do not require exclusive patient enrollment

Why pharmacists?

Transitions of Care

Medication Reconciliation
Discharge Education
Formulary Assessment
Adherence Prediction
Medication Assistance

Population Management

Lab Monitoring
Drug/Drug interaction
Non-Adherence Mgt
Treat to Target
Addressing Care Gaps

PCP
10 Chronic Conditions
3.5 hrs vs 10.5 hrs

Complex Disease Management

Disease Education
Patient Engagement
Treat to Target
Care Gaps
Focus areas:
Anti-platelets
ACS
Diabetes
HTN
ESA's
HCV
Oncology/Rare conditions
ID
Complex cases

GroupHealth – JAPhA 2013, Bellone et al JAPhA 2012

Who are we talking about?

Medicare beneficiaries w/ multiple chronic conditions or illnesses:

See 13 different physicians

Fill 50 prescriptions each year

Account for 76% of all hospitalizations

Are 100 times more likely to have a preventable hospital admission

32% of adverse events leading to hospitalizations are medication related

Only 40% of patients with chronic conditions are medication adherent

Transition of Care - DOHC

- Re-packaging patient for delivery into post-hospital care system

  Special programs offered by groups – “Priority Care Clinics”

  Physician, Nurse, Pharmacist, Case Manager
- Medication Reconciliation

  Poorly done = re-admissions

  Requirement for CMS/HEDIS/ACO quality measures
- Re-admission risks associated with lack of transitional **care coordination**
- Incentives for post-discharge **care coordination**

  Hospital penalties

  Physician re-imbursement

  Patient alignment with your system

Pharmacist role in Transitional Care

- Medication Reconciliation
- Dose optimization
- Drug education
- Reinforcement
- Engagement
- Follow-up/outreach
- Communication between practitioners/documentation

Readmission Measures

Measure	Quality Program	Penalty Structure
Acute Myocardial Infarction 30-day Risk Standardized Readmission Measure	Inpatient Quality Reporting (IQR) program •Hip/Knee Arthroplasty and HWR are new measures proposed for collection in FY2015	Pay for reporting: 2% reduction
Heart Failure 30-day Risk Standardized Readmission Measure		
Pneumonia 30-day Risk Standardized Readmission Measure		
30-day Risk Standardized Readmission following Total Hip/Total Knee Arthroplasty		
Hospital-Wide All-Cause Unplanned Readmission (HWR)		
30-day Comprehensive All-Cause Risk-Standardized Readmission Measure	Inpatient Rehabilitation Facility Quality Program •New FY2014	Pay for reporting: 2% reduction

The Hospital Pharmacist Partnership

- Hospitalist Team
- Readmission Team
- Leveraging technology across the continuum
- Think outside the box (residents, students, rounds, patient care not just pharmaceutical care, customer service, compliance, etc)
- Bring the care to the patient
- Risk stratification and target efforts for greatest impact

Tools predicting re-admission

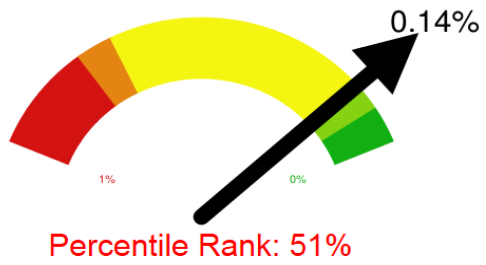
- Rothman Index
- Modified LACE program
- Disease registries
- Risk stratification
- Level of patient engagement

Readmission Financial Risks

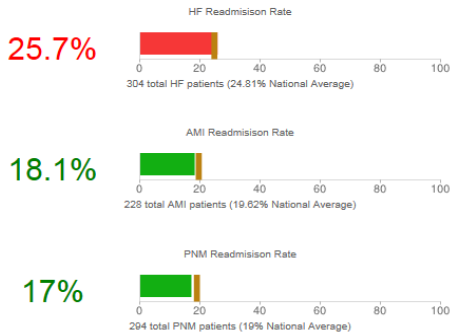
According to Kaiser Health News, federal records released on Aug. 2, show that Medicare will impose $227 million in fines on 2,225 hospitals in 49 states starting Oct. 1.

DESERT REGIONAL MEDICAL CENTER's current Medicare penalty percentages*

Readmission Penalty:



Readmission Rates Against Average:



Expected Revenue Change:

YEAR	EXPECTED LOSS
FY-2013	$65,553.71
FY-2014	$65,553.71

Excessive Patient Readmissions:

CONDITION	EXCESS READMISSIONS
CHF	4
AMI	0

The Great "Blondin"

Example: Disease Management & ROI

Poorly controlled diabetic patients contribute disproportionately to overall healthcare costs.

Cardiovascular complications of poorly controlled diabetics result in significant patient suffering, hospitalizations, reduced quality of life and productivity.
Every 1% drop in HbA1c translates into a 14% reduction in acute myocardial infarction and a 33% reduction in the incidence of microvascular complications from diabetes.

Internal analysis of our diabetic patients revealed longer lengths of stay when hospitalized and 40% of total acute care bed days were attributed to this population.

Despite enhanced diabetes screening and education programs at our medical group, 21% of our seniors and 34% of commercial members met criteria for having poorly controlled diabetes in 2010 (Hb-A1c > 9%).

HEDIS, CMS 5 STAR and ACO measures recognize the need to ensure improved Evidence Based Medicine management of diabetic patients.

DOHC implemented an innovative approach to target these patients via an expanded collaborative practice protocol using pharmacists to bridge the quality gap between these patients and their primary care physicians.

Disease Management cont.

Referrals by PCP, case manager, diabetic educator or specialist

Face to face (F2F) meeting with the pharmacist

Evaluation of medications, barriers to adherence

Initiation, deletion or titration of medications for diabetes, dyslipidemia or hypertension

Aggressive telephonic and F2F follow up

Glucose meter downloads for compliance and medication adjustment

PCP informed of changes and patient progress within 24 hour of patient meeting with the pharmacist

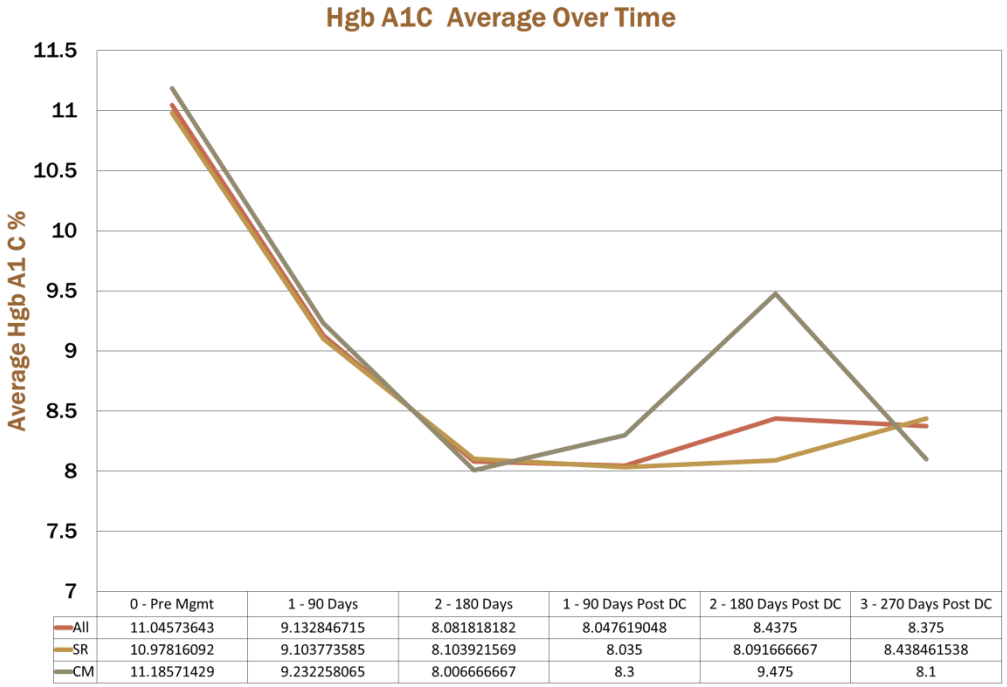
Cases reviewed weekly with medical director

Patients discharged when goal(s) achieved

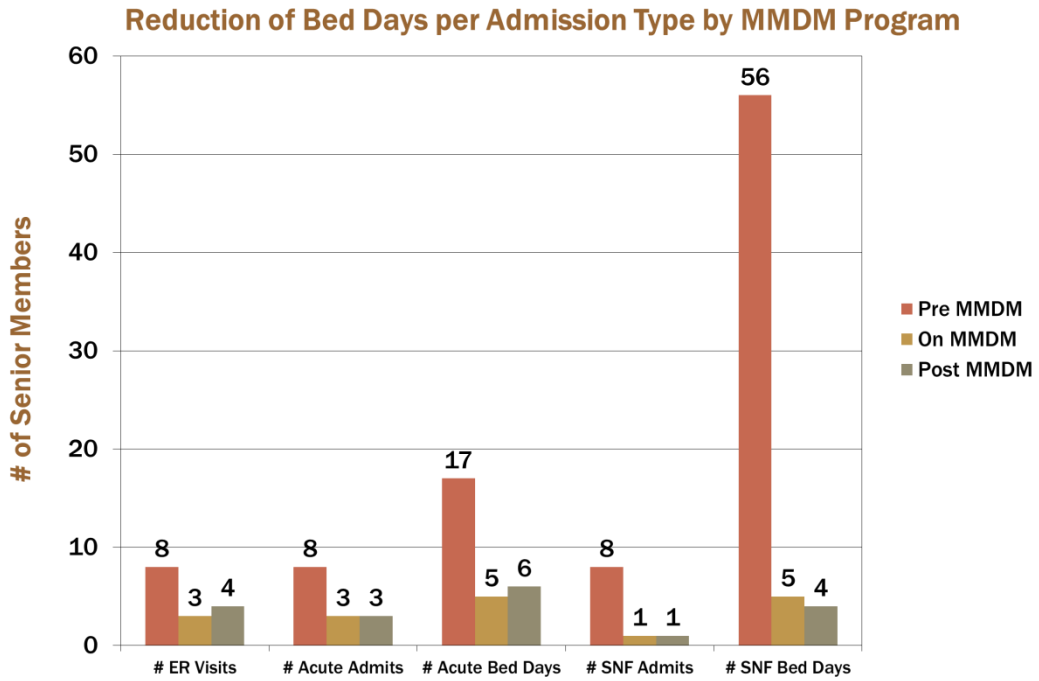
Measure	Pre-Management	180 days
Hb-A1C (n = 387)	11.05%	8.08%
Total Cholesterol	183.5 mg/dL	154.9 mg/dL
LDL	94.5 mg/dL	80.6 mg/dL
HDL	45.9 mg/dL	43.5 mg/dL
TG	194.0 mg/dL	159.0 mg/dL
Blood Pressure		
Systolic	129.7mmHg	128.6mmHg
Diastolic	75.6mmHg	74.3mmHg

Outcomes

- Over **<u>24 months</u>** (2011-2012) 387 patients with initial HbA1c > 9% were seen in the program
- Mean initial HbA1c 11.05%, HgA1c at 180 days 8.08%
- Poorly controlled seniors reduced from 21% to <12% (5 STAR rating in 2012 achieved)
- 45% improvement in poorly controlled senior diabetics in 24 months
- Reduction in bed day utilization realized during this period
- Patient Satisfaction: 100% of patients surveyed would recommend this program to friends and family (n = 100)

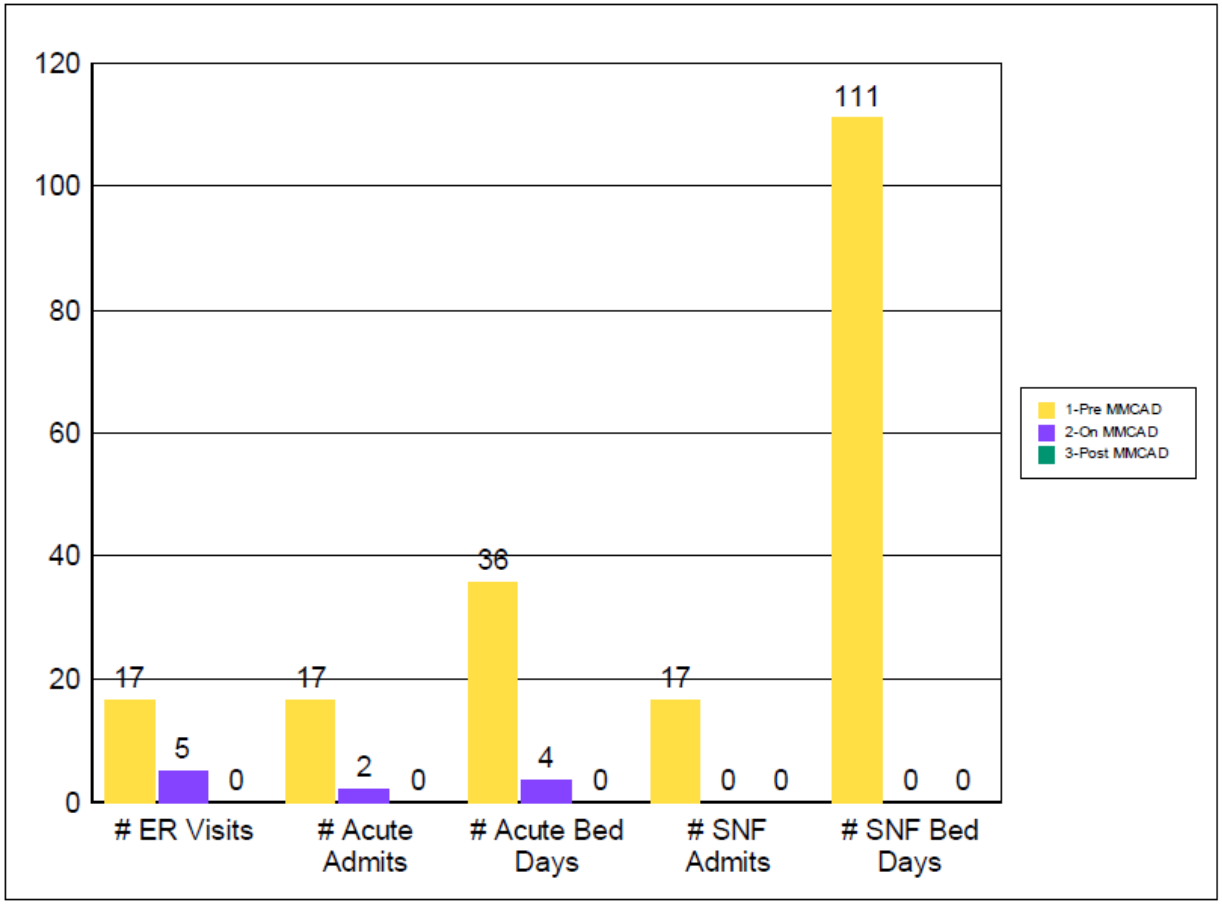


	0 - Pre Mgmt	1 - 90 Days	2 - 180 Days	1 - 90 Days Post DC	2 - 180 Days Post DC	3 - 270 Days Post DC
All	11.04573643	9.132846715	8.081818182	8.047619048	8.4375	8.375
SR	10.97816092	9.103773585	8.103921569	8.035	8.091666667	8.438461538
CM	11.18571429	9.232258065	8.006666667	8.3	9.475	8.1



CAD – reperfusion program

6 months pre-post enrollment N = 250



ACO Quality Standards

- Quality Performance Standards must be met to qualify for any shared savings
- CMS has established 33 Quality Indicators in four domains:
  - Patient/Caregiver Experience (Similar to CAHPs)
  - Care Coordination/Patient Safety
  - Preventive Health
  - At Risk Populations

Care coordination/Patient Safety

- Risk standardized, All Condition Readmission
- Medication Reconciliation after discharge from Inpatient Facility
- Screening for fall risk
- Ambulatory Sensitive Conditions Admission
  - ✓Chronic Obstructive Pulmonary Disease
  - ✓Congestive Heart Failure

Preventative Measures

- ✓Influenza Immunization
- ✓Pneumococcal Vaccination
- ✓Adult Weight Screening and Follow-up
- ✓Tobacco Use Assessment & Tobacco Cessation Intervention
- ✓Depression Screening
- ✓Colorectal Cancer Screening
- ✓Mammography Screening
- ✓Portion of Adults 18+ who had their Blood Pressure Measured within the preceding 2 years

At risk population measures

- Diabetes Control: HemoglobinA1c < 8.0 percent
- Diabetes Control: LDL - < 100 mg/dL
- Diabetes Control: Blood Pressure < 140/90 mmHg
- Diabetes Control: Tobacco non-use
- Diabetes Control: Daily aspirin use (IVD)
- Diabetes Control: % patient Hemoglobin A1c > 9.0%

ACO – Global Quality

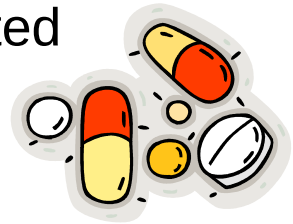
Measure Title	PY1 HCACO Score	All ACOs Mean Score	All ACOs Max Score
ACO-8 Risk Standardized, All Condition Readmissions **	15.76	15.42	18.13
ACO-9 ASC Admissions: COPD or Asthma in Older Adults **	1.1	1.13	2.96
ACO10 -ASC Admissions: Heart Failure **	0.82	1.09	1.85
ACO11- % of PCPs who qualify for HER Incentive Payment	7.20%	25.70%	92.50%
ACO12- Medication Reconciliation	63%	72.38%	100%
ACO13-Falls: Screening for Fall Risks	10%	28.28%	85%

ACO Global Quality

		PY1 HCACO Score	All ACOs Mean Score	All ACOs Max Score		June	June	June	June	June	June	June	June
Domain: At Risk	At Risk Population - Diabetes (composite score)	17%	31.09%	63.68%		Not Available at this time	Not Available at this time	Not Available at this time	Not Available at this time	Not Available at this time	Not Available at this time	Not Available at this time	Not Available at this time
	ACO22 - Diabetes: HbA1c < 8%	44%	64.48%	84%		25%	12%	11%	20%	28%	27%	17%	38%
	ACO23 - Diabetes: LDL < 100	34%	53.01%	82%		17%	10%	8%	18%	22%	21%	14%	28%
	ACO24 - Diabetes: BP < 140/90	60%	66.06%	88%		7%	14%	14%	9%	26%	12%	7%	35%
	ACO25 - Diabetes: Tobacco Non-use	58%	71.69%	94%		8%	1%	11%	4%	10%	6%	7%	15%
	ACO26 - Diabetes & IVD: Daily Aspirin Use	58%	72.24%	100%		29%	22%	21%	22%	22%	15%	24%	16%
	ACO27 - Diabetes: HbA1c < 9% **	49%	25.94%	70%		27%	13%	13%	26%	29%	30%	19%	43%

Community based pharmacy - Medication adherence

- Half of the 3.2 billion prescriptions dispensed in the United States are not taken as prescribed.[1]
- Numerous studies have shown patients with chronic conditions adhere only to 50-60% of medications as prescribed, despite evidence that medication therapy improves life expectancy and quality of life.[2, 3, 4]
- Approximately 125,000 deaths per year in the United States are linked to medication non-adherence.[5]
- The total cost estimates for non-adherence range from $100-300 billion each year.[6, 7, 8]



1 Osterberg L, Blaschke T. Adherence to Medication. N Engl J Med. 2005;353:487-97.
2 Benner JS, Glynn RJ, Jogun H, et al. Long-term persistence in use of statin therapy in elderly patients. Jama. 2002;288:455-61.
3 Mallion JM, Baguet JP, Siche JP, Tremel F, de Gaudemaris R. Compliance, electronic monitoring and antihypertensive drugs. J Hypertens Suppl. 1998;16:S75-9.
4 Haynes RB, McKibbon KA, Kanani R. Systematic review of randomised trials of interventions to assist patients to follow prescriptions for medications. Lancet. 1996:348:383-6.
5 Osterberg L, Blaschke T. Adherence to medication. N Engl J Med. 2005;353:487-97.
6 National Council on Patient Information and Education. Enhancing Prescription Medication Adherence: A National Action Plan. 2007. Retrieved on April 25, 2011 from: www.talkaboutrx.org/documents/enhancing_prescription_mediciand_adherence.pdf
7 Berg JS, Dischler J, Wagner DJ, Raia JJ, Palmer-Shevlin N. Medication compliance: A health care problem. Ann Pharmacother. 1993;27:S1-24.
8 New England Healthcare Institute. Thinking Outside the Pillbox. Retrieved April 28, 2011 from: www.nehi.net/news/press_releases/110/nehi_research_shows_patient_medication_nonadherence_costs_health_care_system_290_billion_annually.

More than prescription services:

Chains are getting involved in Care Coordination

- Increasing the work pool
- Sharing the risk pool

Walgreens – involved in 3 shared savings ACO's

CVS and UCLA – program connects hospitals to 11 CVS clinics

Rite-Aid – Health Alliance

Ralph's Collaborative Clinical Solutions

Dovetail Health-CVS-Aetna (30% ↓)

Simplify My Medications

How do I get started?

There is no additional costs to be enrolled in this program.

Visit Desert Hospital Outpatient Pharmacy
1180 N. Indian Canyon Drive, Suite E140
Palm Springs, CA 92262
760-323-1001

OR ask your local pharmacy if they have a similar program.

DESERT REGIONAL MEDICAL CENTER
1150 N. Indian Canyon Drive
Palm Springs, CA 92262
(760) 323-6611

DESERT REGIONAL OUTPATIENT PHARMACY
1180 N. Indian Canon Drive, Suite E140
Palm Springs, CA 92262
(760) 323-1001

DESERT OASIS HEALTHCARE
Your Health. Your Life. Our Passion.

Desert Oasis Healthcare
and Heritage California ACO
recommend

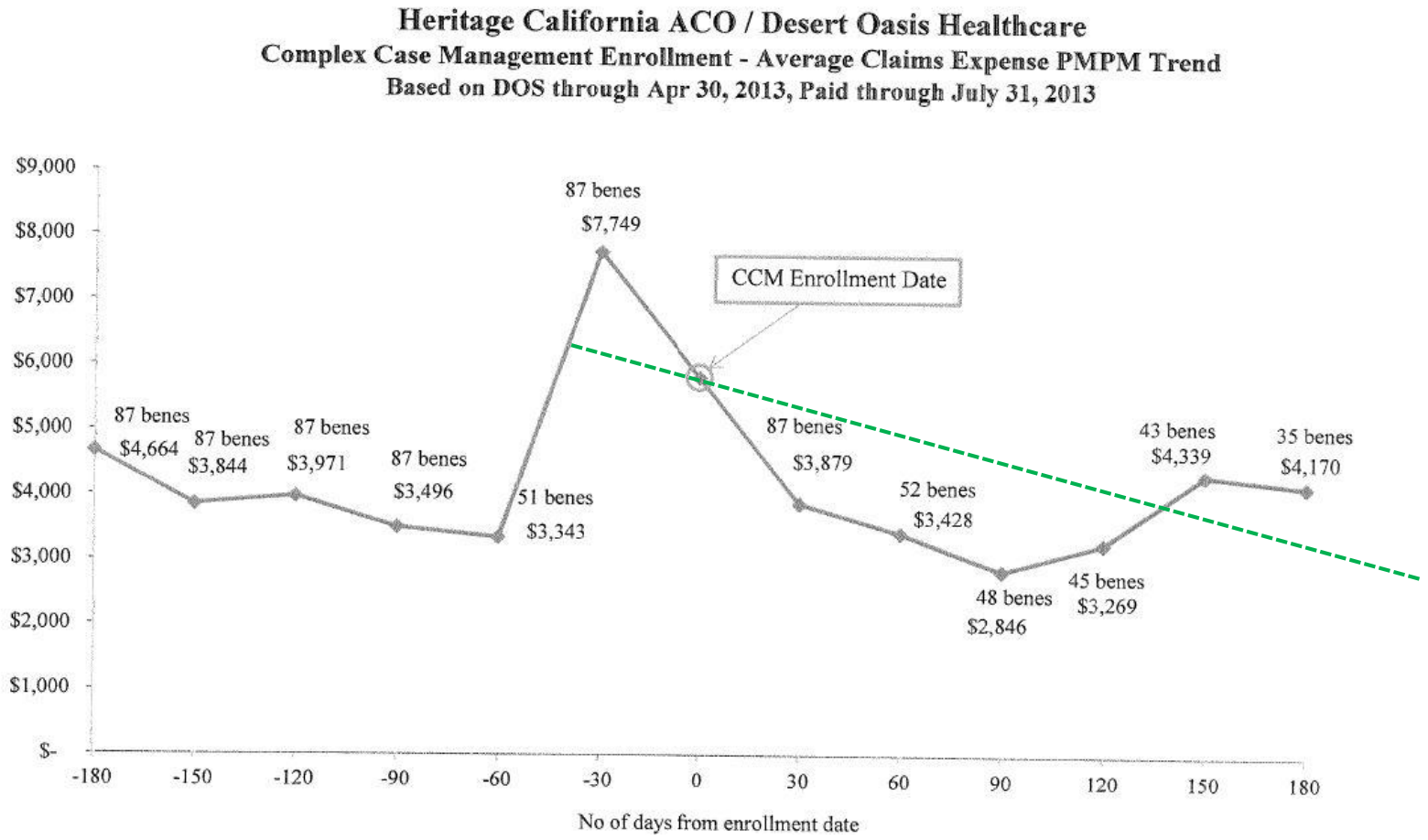
Simplify My Meds

Heritage California ACO
Bringing Teamwork to Healthcare

Are ACO's Going Away?

- Recent JAMA article – 3.4% reduction in spending against comparator population benchmark
- Statistically significant at the end of PY2
- Cost savings from:
  - Outpatient services
  - ER visits
  - Minor procedures, imaging and labs
  - Most significant in patients with 5 or more comorbid conditions
- No difference in quality between the two groups
- Pioneer Models show savings $77million (and improvement in CAHPS related scores)

Does care coordination in the ACO work?



Disruptive Innovation

- Requires thought leaders
- Challenge existing practice/culture
- Suggest new models
- Research and trial
- Achieve progress
- Re-design
- Engage and implement
- Do it again!

- Clayton Christensen

Future opportunities

- Provider status
- Payment models allow for pharmacist re-imbursement
  - PCM (PBM + MTM) (Ventegra) versus PBM
  - Population based global payments
  - Risk
- Covered California (HIE)
- Dual demonstration projects
- Technology is exponential

Take Home Points

- Innovation is what occurs prior to change being forced upon you
- Pharmacists move up the food chain (PCP shortage requires innovative care models)
- Transitional care coordination requires all providers to participate
- ACO's to date have demonstrated both cost savings and patient care experience improvement
- More change coming – Managed Medi-Cal, Duals, SNP
- Triple aim success = here to stay for all care delivery