“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
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

2010
Coverage: Immediate Insurance Reforms (Pre-existing conditions for children, dependent coverage to 26, State High Risk Pools)

2011
Coverage: Small Business Tax Credit

2012
Prevention Expansion – Wellness Visit and Personalize Prevention Plan

2013
Delivery System Reform: Creation of Center for Medicare and Medicaid Innovation

2014
Medicare Savings: Medicare Advantage Cuts, Productivity Adjustments

2015
Delivery System Reform: ACOs; Hospital Value-Based Purchasing

2016
Delivery System Reform: Hospital Re-admissions, Bundling of payments

2017
Medicare Savings: DSH Reductions / IPAB Medicare Proposals

2018
Coverage: Medicaid Expansion (133% FPL), Insurance Reforms (Shared Responsibility, Guarantee Issue, etc.)

Delivery System Reform: PQRS Penalties
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

<table>
<thead>
<tr>
<th>ACO Participants</th>
<th>ACO Professionals</th>
<th>ACO Providers/Suppliers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Individual or Groups of ACO providers/suppliers</td>
<td>ACO provider/supplier</td>
<td>Enrolled in Medicare and bills Medicare FFS</td>
</tr>
<tr>
<td>Identified by Medicare-enrolled TIN</td>
<td>Enrolled and bills Medicare FFS</td>
<td>Has a Medicare billing number assigned to ACO participant and listed on ACO legal forms</td>
</tr>
<tr>
<td>Alone or together with other ACO participants make-up an ACO</td>
<td>Physician Physician Assistant Nurse Practitioner Clinical Nurse Specialist (Pharmacist?)</td>
<td>PTPPS HHAs SNFs Rehabilitation Agencies</td>
</tr>
</tbody>
</table>
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
<table>
<thead>
<tr>
<th>Why pharmacists?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Transitions of Care</strong></td>
</tr>
<tr>
<td>Medication Reconciliation</td>
</tr>
<tr>
<td>Discharge Education</td>
</tr>
<tr>
<td>Formulary Assessment</td>
</tr>
<tr>
<td>Adherence Prediction</td>
</tr>
<tr>
<td>Medication Assistance</td>
</tr>
</tbody>
</table>

| **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 ____ different physicians
Fill ____ prescriptions each year
Account for ____% of all hospitalizations
Are ____ times more likely to have a preventable hospital admission
____% of adverse events leading to hospitalizations are medication related
Only ____% 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

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

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

- Over **24 months** (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)
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: Hemoglobin A1c < 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

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

### Domain: At Risk

<table>
<thead>
<tr>
<th>Measure</th>
<th>PY1 HCACO Score</th>
<th>All ACOs Mean Score</th>
<th>All ACOs Max Score</th>
<th>June</th>
<th>June</th>
<th>June</th>
<th>June</th>
<th>June</th>
<th>June</th>
<th>June</th>
<th>June</th>
</tr>
</thead>
<tbody>
<tr>
<td>At Risk Population - Diabetes (composite score)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>17%</td>
<td>31.09%</td>
<td>63.68%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ACO22 - Diabetes: HbA1c &lt; 8%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>44%</td>
<td>64.48%</td>
<td>84%</td>
<td>25%</td>
<td>12%</td>
<td>11%</td>
<td>20%</td>
<td>28%</td>
<td>27%</td>
<td>17%</td>
<td>38%</td>
</tr>
<tr>
<td>ACO23 - Diabetes: LDL &lt; 100</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>34%</td>
<td>53.01%</td>
<td>82%</td>
<td>17%</td>
<td>10%</td>
<td>8%</td>
<td>18%</td>
<td>22%</td>
<td>21%</td>
<td>14%</td>
<td>28%</td>
</tr>
<tr>
<td>ACO24 - Diabetes: BP &lt; 140/90</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>60%</td>
<td>66.06%</td>
<td>88%</td>
<td>7%</td>
<td>14%</td>
<td>14%</td>
<td>9%</td>
<td>26%</td>
<td>12%</td>
<td>7%</td>
<td>35%</td>
</tr>
<tr>
<td>ACO25 - Diabetes: Tobacco Non-use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>58%</td>
<td>71.69%</td>
<td>94%</td>
<td>8%</td>
<td>1%</td>
<td>11%</td>
<td>4%</td>
<td>10%</td>
<td>6%</td>
<td>7%</td>
<td>15%</td>
</tr>
<tr>
<td>ACO26 - Diabetes &amp; IVD: Daily Aspirin Use</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>58%</td>
<td>72.24%</td>
<td>100%</td>
<td>29%</td>
<td>22%</td>
<td>21%</td>
<td>22%</td>
<td>22%</td>
<td>15%</td>
<td>24%</td>
<td>16%</td>
</tr>
<tr>
<td>ACO27 - Diabetes: HbA1c &lt; 9% **</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>49%</td>
<td>25.94%</td>
<td>70%</td>
<td>27%</td>
<td>13%</td>
<td>13%</td>
<td>26%</td>
<td>29%</td>
<td>30%</td>
<td>19%</td>
<td>43%</td>
</tr>
</tbody>
</table>
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.\(^6\), \(^7\), \(^8\)

---

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 cost 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 Oasis Healthcare
and Heritage California ACO recommend

Simplify My Meds

DESERT REGIONAL MEDICAL CENTER
1150 N. Indian Canyon Drive
Palm Springs, CA 92262
(760) 323-6811

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

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?

Heritage California ACO / Desert Oasis Healthcare
Complex Case Management Enrollment - Average Claims Expense PMPM Trend
Based on DOS through Apr 30, 2013, Paid through July 31, 2013
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