Role of Pharmaceuticals in Achieving ACO Success: Developing a Framework

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Medication and ACO Topics

• Framework for medications in an ACO
• Role of the pharmacist
• Using data to understand and manage medication use
Is this a Retread of 1990s Managed Care?
Today Is Very Different

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>90’s</th>
<th>Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>Providers at Risk</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Bundled Payment</td>
<td>Capitation</td>
<td>Various</td>
</tr>
<tr>
<td>Risk Adjustment</td>
<td>Minimal</td>
<td>Increasing Sophistication</td>
</tr>
<tr>
<td>Healthcare IT</td>
<td>Little</td>
<td>Growing Backbone</td>
</tr>
<tr>
<td>Care Coordination</td>
<td>Fragmented</td>
<td>Medical “Home”</td>
</tr>
</tbody>
</table>
Today Is Very Different (con’t)

<table>
<thead>
<tr>
<th>Characteristic</th>
<th>90’s</th>
<th>Today</th>
</tr>
</thead>
<tbody>
<tr>
<td>Quality Measurement</td>
<td>Plan Level</td>
<td>Provider &amp; Plan (ACO, PCMH)</td>
</tr>
<tr>
<td>Bonus Incentive</td>
<td>Cost Control</td>
<td>$, Quality</td>
</tr>
<tr>
<td>Role of Rx</td>
<td>Economic Risk</td>
<td>Solution</td>
</tr>
</tbody>
</table>
New Payment Approaches Can Shift the Dialogue
Siloed Resources Must Merge
AMGA-Premier-NPC Collaboration: The Role of Pharmaceuticals in ACOs

Goal: develop a framework for considering the role of pharmaceuticals in helping ACOs succeed

• Meet financial targets
• Meet quality benchmarks
Working Group Encompassed a Breadth of Value-Based Knowledge & Experience

- Provider Organizations
  - Baystate
  - Billings
  - Fairview
  - Geisinger
  - Marshfield
  - Sharp
  - University of Utah

- Premier
- American Medical Group Association
- National Pharmaceutical Council
Framework Development Process

- Literature Review
- Survey
- Working Group Meeting
# Congestive Heart Failure

<table>
<thead>
<tr>
<th>Condition</th>
<th>Condition Type: Chronic or Hospital</th>
<th>Rx Focus: Inpatient or Outpatient</th>
<th>Quality Benchmarks</th>
<th>Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quality Measures Impacted by Pharmaceuticals</td>
<td>Rx Share of Cost</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Quality Measure in CMS ACO Regulations?</td>
<td></td>
</tr>
<tr>
<td>Congestive Heart Failure</td>
<td>Chronic, Hospital</td>
<td>Outpatient</td>
<td>Receiving Rx therapy; % of patients requiring re-hospitalization</td>
<td>Yes</td>
</tr>
<tr>
<td>Rheumatoid Arthritis</td>
<td>Chronic</td>
<td>Outpatient</td>
<td>Receiving Rx therapy; Functional Status</td>
<td>No</td>
</tr>
</tbody>
</table>
# Population View

<table>
<thead>
<tr>
<th>Population</th>
<th>Intervention</th>
<th>Quality Measures Impacted by Pharmaceuticals</th>
<th>Cost Offsets from Rx</th>
</tr>
</thead>
<tbody>
<tr>
<td>Low Risk</td>
<td>Prevention</td>
<td>Receiving vaccines</td>
<td>TBD</td>
</tr>
<tr>
<td>Moderate Risk</td>
<td>Address individual conditions; Assess drug-drug/drug-condition interactions</td>
<td>See condition grid for individual condition measures; Medication reconciliation</td>
<td>See condition grid for individual condition offsets</td>
</tr>
<tr>
<td>High Risk</td>
<td>Polypharmacy</td>
<td>Medication reconciliation</td>
<td>TBD</td>
</tr>
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The work group also explored the role of the pharmacist in the ACO environment

• Thought to be important because pharmacists play an expanded role in advising prescribers regarding the relative effectiveness and value of their drug treatment options in an ACO.

• In the ACO environment, we see pharmacists and other health care professionals accept greater responsibility for the ongoing management of medication therapy and outcomes measurement.

• Ensuring efficient and consistent pharmacotherapy as patients move across the health care continuum is critical to help ACOs achieve quality benchmarks and financial targets.
All ACOs must ensure that their members properly use drug therapy to gain their ROI

- 32 Million Americans take three or more medications daily.
- Nearly 75% of Americans report not always taking their medications as prescribed.
- Almost 30% of Americans stop taking their medicine before it runs out.
- Only about half of patients with high blood pressure take their prescribed doses of drugs.

*Clearly the dollars are being spent but the value not being completely derived.*

Source: PhRMA; National Council on Patient Information and Education; WSJ reporting.
How can an ACO set the stage to gain the full value from its medication investment?

- Establish effective communication amongst all prescribers to ensure consistent drug selection and remove redundancy.

- Incorporate economic analysis that includes the downstream impact of drug therapy made possible by averting other treatments.

- Remove the formulary disparities that exist between ambulatory and acute care settings.

- Eliminate drug payment models that reward the use of more expensive products when less costly options are available.
Several ACOs where transformation of the pharmacists’ role has started

- **Marshfield Clinic** has focused on the application of evidence-based information to define the “place in therapy for drugs.” They have incorporated clinical pharmacists in their ambulatory drug use and evaluation committees.

- **Geisinger Health** has included clinical pharmacists in their patient management clinics focused on anticoagulation, lipids and diabetes.

- High risk patients have benefited through the **Patient Safety and Clinical Pharmacy Services Collaborative** funded by the Health Resources and Services Administration of the Government.
What are a few common drug use situations that cost ACOs needless dollars?

- Use of more expensive pharmacologic stress test drugs because the current reimbursement is better for the more expensive products. The delta between inpatient and ambulatory testing.

- Patients remain on IV therapy longer than clinically needed because they cannot be placed outside of the acute care environment. An old work-around due to capacity challenges.

- Drugs dispensed in full month increments on initial fill that are then discontinued due to patient’s inability to tolerate the new therapy. Smaller “test therapy” or “starter supplies” could help.
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<tr>
<td>Moderate Risk</td>
<td>Complete course of antibiotic therapy; Use spacers for aerosolized drugs; Proper IV to PO Streamlining</td>
<td>Reduced hospital readmissions</td>
<td>Minimal drug costs if used properly with significant gains when decreasing readmission</td>
</tr>
</tbody>
</table>
School is out...not all stakeholders agree that pharmacists play a role in reducing costs?

**PROs**

- ACOs are investing in Emergency Department pharmacists to ensure proper reconciliation at that point in the care process for high risk patients recognizing that this step increases efficiency through the down stream inpatient admission.

**CONs**

- The current dispute between ExpressScripts and Walgreens involves paying pharmacists more for their clinical counseling services assuming that this will decrease the total cost of care. One party is focused on the “cost of the pill.”
The value of detailed comparative data in understanding the role of pharmaceuticals in the cost of care
Type 2 Diabetes: First Drug after Metformin

- At least 2 E&M visits in each of 2 successive years
- 6 months on metformin (only), followed by change in Rx
  - “First drug” after metformin includes all DM Rx’s within 30 days of ΔRx
- Last A1c prior to ΔRx, first A1c after 80 days beyond ΔRx
- Defines 4 cohorts:
  - 6 Mo. on Metformin, Change DM Rx (→ ΔRx Date)
  - 6 Mo. on Metformin, Continue Metformin
  - Other DM Rx
  - No DM Rx (during entire timespan of data)
Change DM Rx + Continue Metformin, by Initial A1c

- Half of patients with A1c < 7 are continued on metformin
  - Why is drug therapy changed in nearly half of patients who are achieving good glycemic control?
- Not surprisingly, diabetes therapy is changed in most patients with initial A1c ≥ 7
Break Out “Change DM Rx” Cohort by Drug Class

- Proportion of patients at each initial A1c level receiving each drug class or combination
  - Include all DM eRx activity within 30 days of ΔRx
  - Combined data from 11 medical groups

ΔRx dates 1/2008 – 4/2011
Prescribing Patterns Vary across Medical Groups

• Variation across groups in use of insulin, DPP-4 inhibitors, TZDs, and GLP-1 agonists
• Practical questions raised by collaborative participants
  – Are physicians pushing metformin to max dose before adding other drugs?
  – How are these choices changing over time?

Medical groups are identified by two-letter codes

- Other
- TZD
- Sulf + TZD
- Incretin (GLP-1)
- DPP-4 Inhibitor
- Insulin
- Sulf + Insulin
- Sulfonylurea
- Continue Metformin
Ambulatory Visit Ratio

Clinical Value Matrix - Diabetes Mellitus

[Diagram showing a scatter plot with axes labeled Pay-for-Value and Fee-for-Service, and another axis labeled Number of E&M Visits (#). The plot displays data points scattered across the graph, indicating different levels of improvement and number of visits.]
Inpatient Days Ratio

Clinical Value Matrix - Diabetes Mellitus