Patient-Centered Medical Home: Integrating Medication Management to Optimize Adherence Outcomes in a PCMH
Patient-Centered Medical Home Best Practices: Case Study Examples

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Disclosures

• The faculty reported the following financial relationships or relationships to products or devices they or their spouse/life partner have with commercial interests related to the content of this CME activity:
  – Mona Chitre, PharmD, CGP
    • No financial relationships to report
Why Don’t Patients Take Their Medications?

- 10% difficulty in getting the prescription filled
- 14% decided they didn’t need the drug
- 17% medication was too costly
- 20% undesirable or debilitating side effects
- 24% forgetfulness
Overcoming the Barriers to Appropriate Medication Use and Medical Care

- **Education and Outreach**
  - Engage patient in their care
  - Explain disease state
  - Explain rationale for therapy
  - Identify barriers
    - (socioeconomic, economic)
  - Identify readiness to change
  - Offer strategies for coping with side effects
  - Offer strategies for cost-savings options

INTEGRATION OF EXPERTISE WITHIN A MEDICAL HOME OFFERS A SOLUTION!!
PCMH Pilot Activity and Planning

Discussions in 2009

- Multi-Payer pilot discussions/activity
- Identified pilot activity
- No identified pilot activity – 6 States
Single-Payer Health Plan Demonstration Pilots Initiated in 2009

- Key PCMH Pilot Programs Either in Place or in Development
  - Cigna PCMH Pilot in New Hampshire
  - Aetna has PCMH Pilots in
    - Colorado
    - Maine
    - Mid-Hudson Valley
    - Pennsylvania
    - Central New Jersey
  - Priority Health PCMH Pilot Program in Michigan
  - Wellpoint, Inc. PCMH Pilot in New York City
  - UnitedHealth Medical Home Pilot in Arizona (Tucson & Phoenix)
  - Blue Cross Blue Shield PCMH Pilot in Nebraska

= New Demonstration Pilots Taking Place or in the Process of Being Enacted
Blue Cross Blue Shield Plan Pilots

(as of January 2009)
### Evidence of Cost Savings and Quality Improvement

**Summary of Key Data on Cost Outcomes from Patient Centered Medical Home Interventions**

**Group Health Cooperative of Puget Sound**
- 29% Reduction in ER visits and 11% reduction in ambulatory sensitive care admissions
- Additional investment in primary care of $16 per patient per year was associated with offsetting cost reductions, with the net result being no overall increase in total costs for pilot clinic patients

**Community Care of North Carolina**
- 40% decrease in hospitalizations for asthma and 16% lower ER visit rate; total savings to the Medicaid and SCHIP programs are calculated to be $135 million for TANF-linked populations and $400 million for the aged, blind and disabled population

**Genesee Health Plan HealthWorks PCMH Model**
- 50% decrease in ER visits and 15% fewer inpatient hospitalizations, with total hospital days per 1,000 enrollees now cited as 26.6% lower than competitors

**Colorado Medicaid and SCHIP**
- Median annual costs $785 for PCMH children compared with $1,000 for controls, due to reductions in ER visits and hospitalizations. In an evaluation specifically examining children in Denver with chronic conditions, PCMH children had lower median costs ($2,275) than those not enrolled in a PCMH practice ($3,404)

**Johns Hopkins Guided Care PCMH Model**
- 24% reduction in total hospital inpatient days, 15% fewer ER visits, 37% decrease in skilled nursing facility days
- Annual net Medicare savings of $1,364 per patient and $75,000 per Guided Care nurse deployed in a practice
Group Health Cooperative of Puget Sound

- **Type of Practice/Facility:**
  - *Staff model HMO/medical home framework*

- **Pharmacist Relationship to Practice:**
  - *Physically present, salaried, employee staff, practicing under approved collaborative drug therapy management protocols; integrated as core team members within primary care clinics*

- **MMS provision:**
  - *Patient-specific care related to:*
    - *Identify/document medication-related problems*
    - *Group care registries for chronic disease panels*
    - *Patient education (in-person/telephonic)*
Group Health Puget Sound, cont.

- **Access to MM Service:**
  - Physician/PCP referral
  - Pharmacist-initiated follow up appointments
  - Direct patient request/appointments

- **Payment/Billing Methods:**
  - PM/PM Capitation Model
  - Patient-pay/co-pay

- **Service Assessment Measures (documented):**
  - Clinical treatment goals achievement
  - HEDIS/NCQA measures
  - Annualized cost avoidance/ROI
    - Medication/treatment adherence

**Physician/Staff View:**
“Most patient care interactions involve medications and the limitations both in knowledge and time on my part make the addition of a clinical pharmacist on the medical home team MANDATORY! I would have a difficult time maintaining our current standards without this person on board.”

- James Bergman, M.D. – Staff Physician
Group Health Puget Sound: Effect on Clinic Staff

<table>
<thead>
<tr>
<th>% with High Level Emotional Exhaustion</th>
<th>Baseline</th>
<th>12 Months</th>
</tr>
</thead>
<tbody>
<tr>
<td>Control Sites</td>
<td>34.5%</td>
<td>33.3%</td>
</tr>
<tr>
<td>PCMNH Site</td>
<td>30.0%</td>
<td>9.7%</td>
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</tbody>
</table>

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Community Care of North Carolina

• **Type of Practice/Facility:**
  – *Multi-specialty physician private group practice*

• **Pharmacist Relationship to Practice:**
  – *Physically present, contracted pharmacy staff practicing under collaborative drug therapy management protocols and “clinical pharmacist practitioner” licensing*

• **MMS provision:**
  – *Patient-specific care related to:*
    • *Identify/document medication-related problems*
    • *Multi-disease medication regimen optimization*
    • *Patient education*
    • *Longitudinal outcomes monitoring*
Community Care of North Carolina, cont.

- **Access to MM Service:**
  - Physician/PCP referral
  - Direct patient request/appointment
  - Benefit design/contract

- **Payment/Billing Methods:**
  - Incident-to-physician using E&M CPT codes
  - MTM CPT codes for Medicare patients
  - Patient-pay

- **Service Assessment Measures (documented):**
  - Clinical treatment goal achievement
  - Patient adherence
  - Adverse effects identified/prevented
• External evaluation results
  – Better quality
    • 93% of asthmatics received appropriate maintenance medications
  – Lower costs
    • 40% decrease in hospitalizations for asthma and 16% lower ER visit rate
  – Savings to Medicaid and SCHIP
    • $135 million for TANF-linked populations
    • $400 million for the aged, blind and disabled population

B.D. Steiner et al, Community Care of North Carolina: Improving care through community health networks. 
Health Partners “BestCare” Model

• Type of Practice Facility
  – 700 physician group, consumer-governed health organization in Minnesota

• Implemented a PCMH model in 2004 as part of its "BestCare" model of delivery system redesign
  – More convenient access to primary care through online scheduling, test results, e-mail consults, and post-visit coaching
  – Proactive chronic disease management through phone, computer, and face-to-face coaching

• 5-year prospective evaluation
Health Partners, cont.

- **Better quality**
  - 129% increase in patients receiving optimal diabetes care, 48% increase in patients receiving optimal heart disease care

- **Better access**
  - 350% reduction in appointment waiting time

- **Reduced cost**
  - 39% decrease in emergency room visits, 24% decrease in admissions

- **Overall costs in clinics decreased from being equal to the state network average in 2004, to 92% of the state average in 2008, in a state with costs already well below the national average**

Triple AIM: Health-Experience-Affordability

HealthPartners Clinics

Total Cost Index

9% 97% 34%

% patients with Optimal Diabetes Control

% patients “Would You Recommend” HealthPartners Clinics

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     • Practice Profiles

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Summary

- Non-adherence is a significant problem contributing to poor outcomes and high healthcare costs
- There is an important opportunity to engage pharmacists as part of the PCMH team
- The next step is arranging for a drug therapy expert to work with patients and their physicians in selecting and using the right medications, in the right ways, more often
- Emphasis must be placed on the plan, execution, documentation and quality assurance of the services
- The PCMH Medication Management Tool Box provides vehicle to develop, implement and integrate medication therapy management into the PCMH