Patient-Centered Medical Home:
Integrating Medication Management to Optimize Adherence Outcomes in a PCMH

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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*

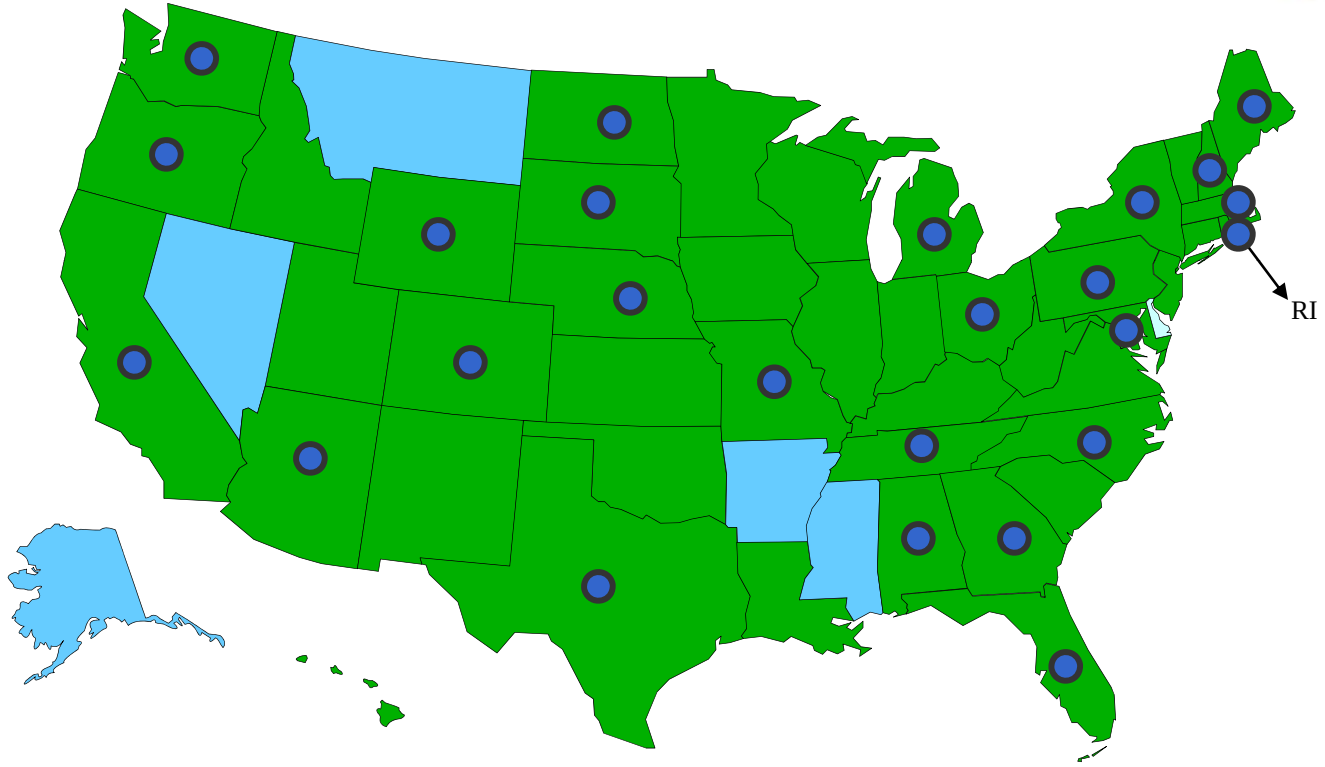
Why Don’t Patients Take Their Medications?

- 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*

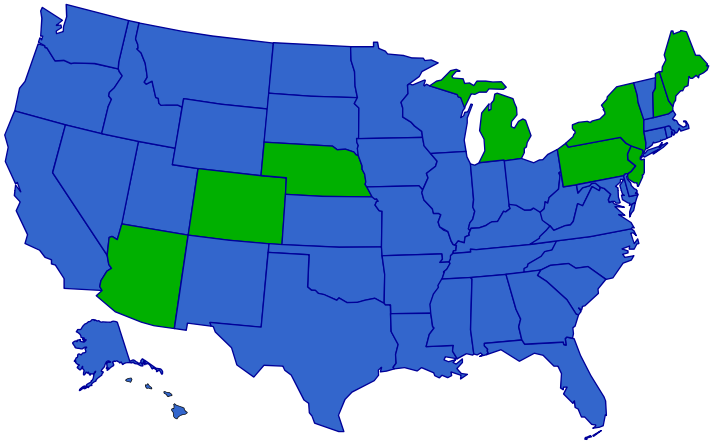
PCMH Pilot Activity and Planning Discussions in 2009



- Multi-Payer pilot discussions/activity
- Identified pilot activity
- No identified pilot activity – 6 States

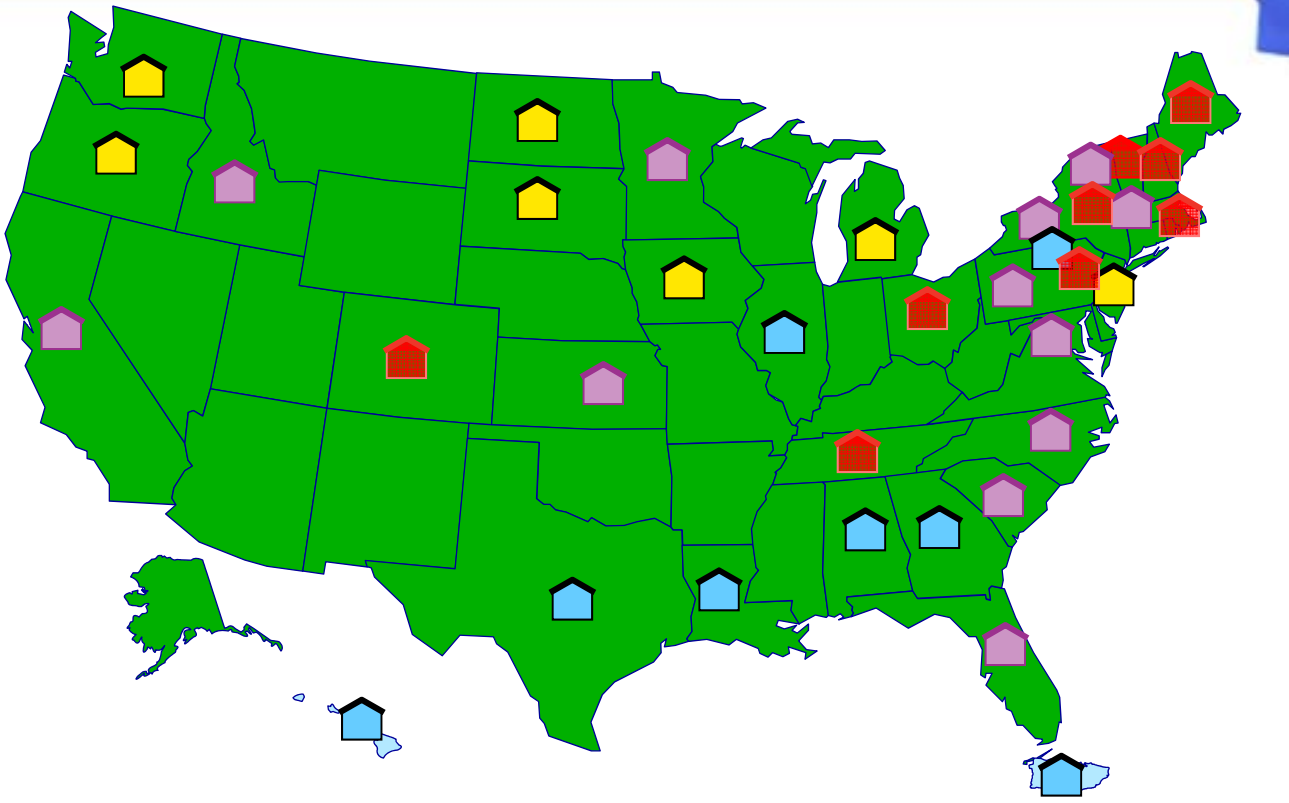
Single-Payer Health Plan Demonstration Pilots Initiated in 2009

- 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



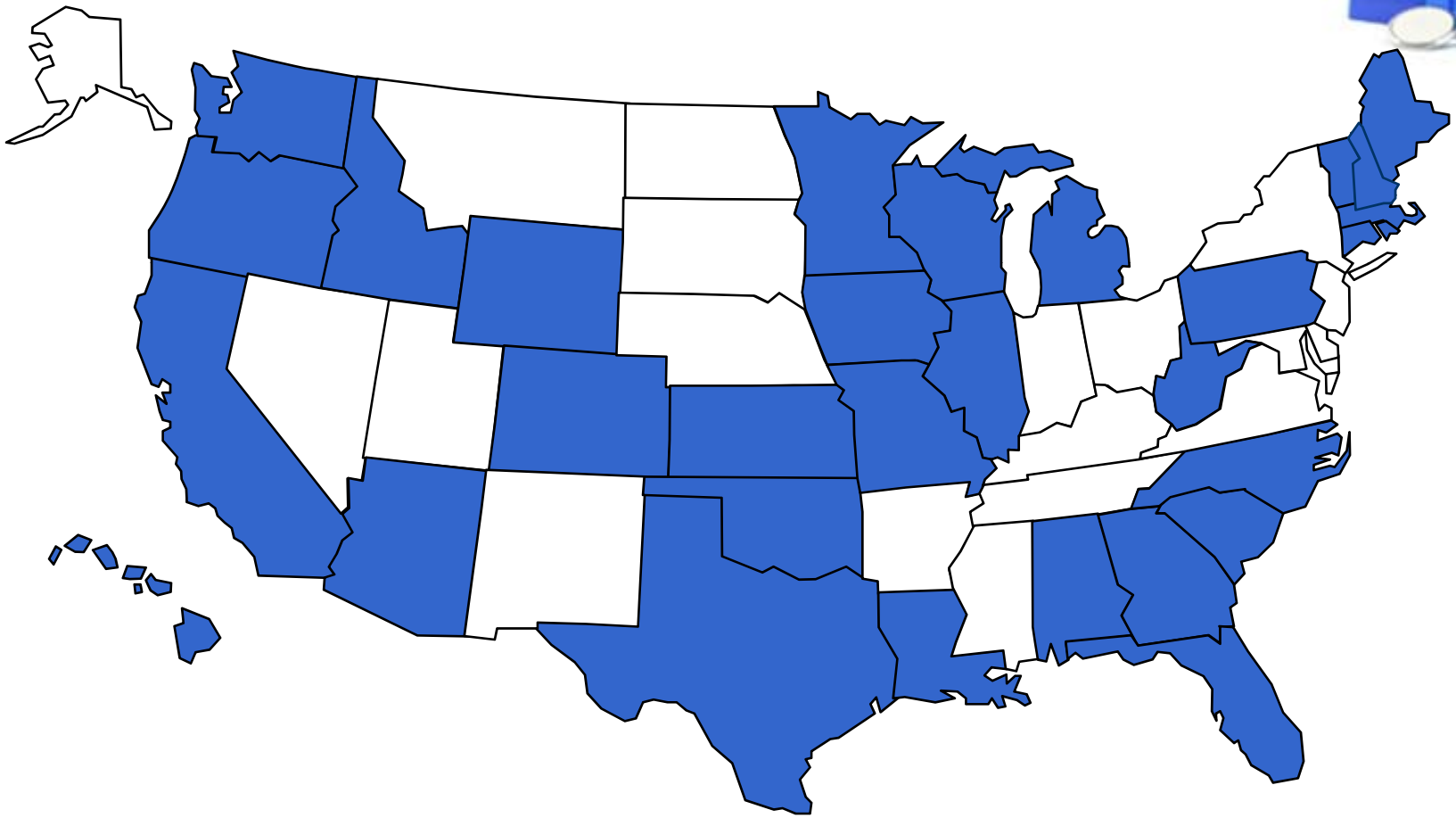
BlueCross BlueShield Association

An Association of Independent Blue Cross and Blue Shield Plans

- Pilots in progress
- Pilot activity in early stages of development
- Pilots in planning phase for 2009 implementation
- Multi-Stakeholder demonstration

(as of January 2009)

State Initiatives to Advance Medical Homes in Medicaid/SCHIP



= Identified to have a medical home initiative

National Academy for State Health Policy State Scan, November 2008.

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.

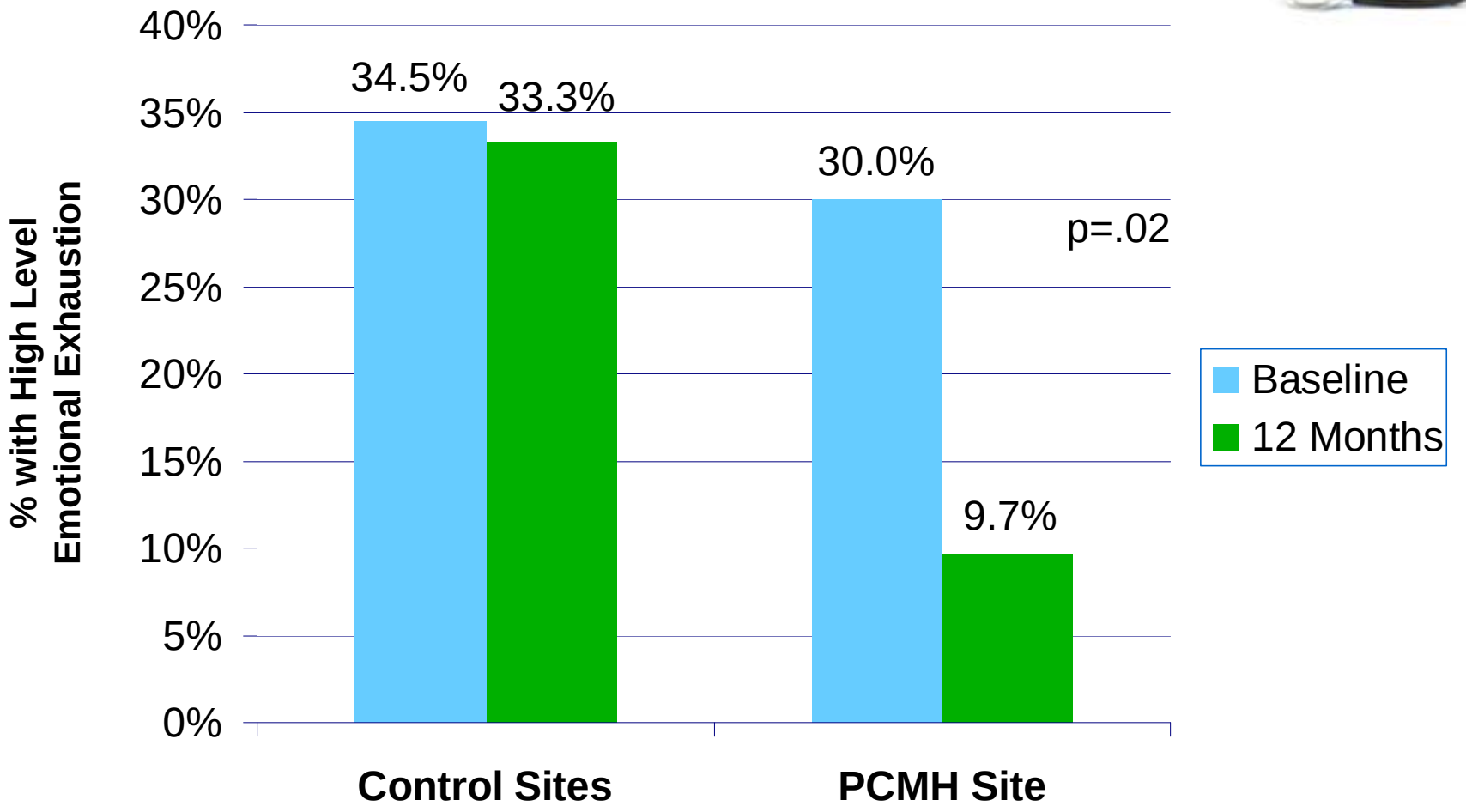
- Access to MM Service:
  - *Physician/PCP referral*
  - *Pharmacist-initiated follow up appointments*
  - *Direct patient request/appointments*
- Payment/Billing Methods:
  - *PM/PM Capitation Model*
  - *Patient-pay/co-pay*
- Service Assessment Measures (documented):
  - *Clinical treatment goals achievement*
  - *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



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*

Community Care of North Carolina, cont.

- 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. *Ann Fam Med.* 2008;6:361-367.
Mercer. Executive Summary, 2008 Community Care of North Carolina Evaluation. Available at http://www.communitycarenc.com/PDFDocs/Mercer%20ABD%20Report%20SFY08.pdf.

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

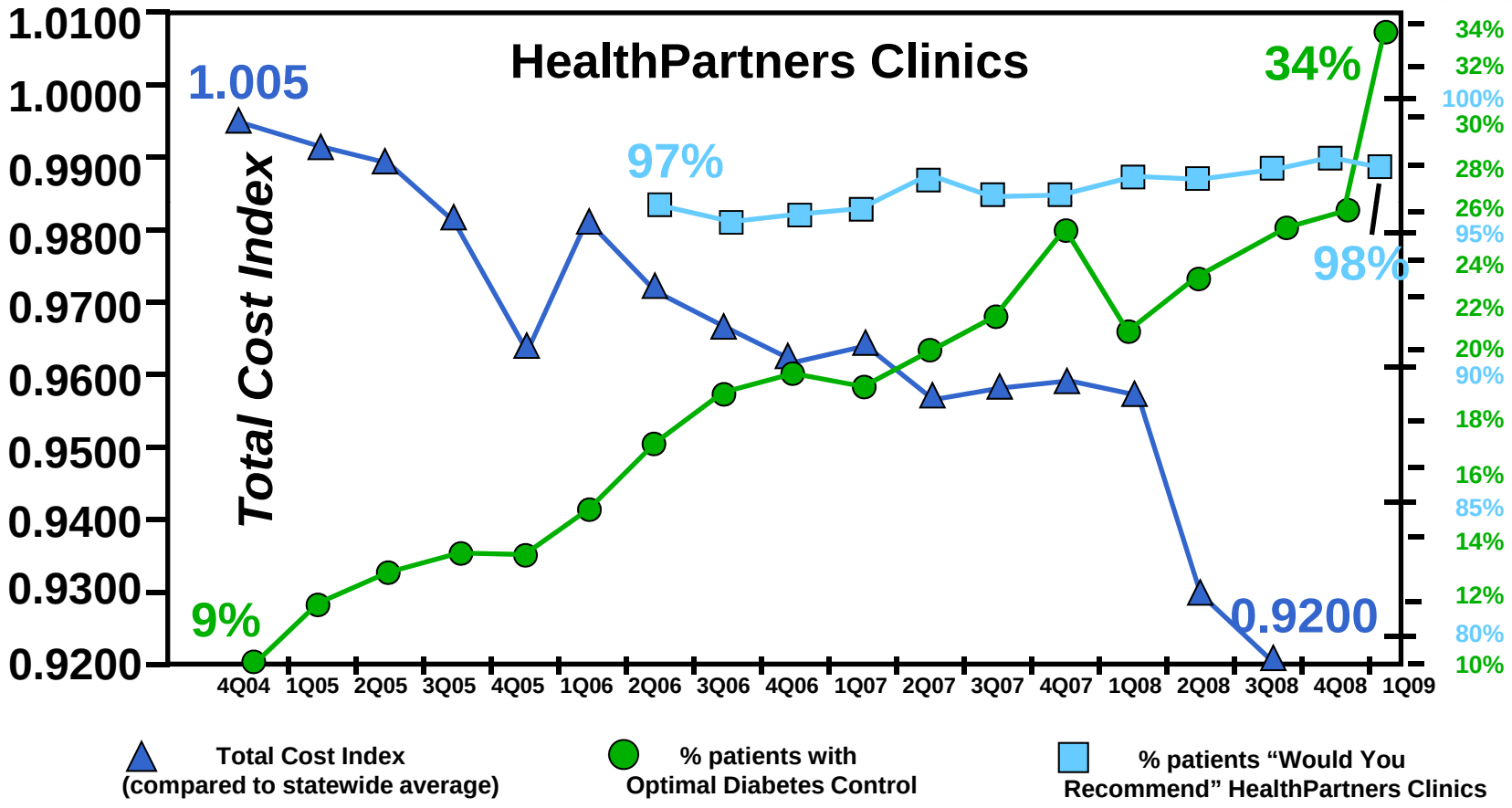
Health Partners, cont.

- 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

Institute for Healthcare Improvement. Available at http://www.ihi.org/NR/rdonlyres/7150DBEF-3853-4390-BBAF-30ACDCA648F5/0/IHITripleAimHealthPartnersSummaryofSuccessJul09.pdf.

Health Partners, cont.

Triple AIM: Health-Experience-Affordability



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PCMH Medication Management Tool Box

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PCMH Medication Management Tool Box, cont.

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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