High Performing Pharmacy Networks

Aaron Garst, PharmD

2016 -2017 Executive Fellow

Tennessee Pharmacists Association

Current Healthcare Landscape

- The Affordable Care Act is moving healthcare from a fee-for-service to an outcomes based model
- National Quality Strategy (NQS) is intended to build a national consensus on how to measure quality
- Monetary pressures to increase outcomes has presented opportunities for innovative patient-centered care teams

High Performing Pharmacy Networks (HPPN)

- Creation of the first network was through Community Care of North Carolina (CCNC)
- Nationwide expansion through the Multi-State High-Performing Community Pharmacy Collaborative (MSPC)
- Tennessee is one of the twelve states currently engaged with MSPC

Services Offered through CPESN

- Examples include, but are not limited to:
  - In-home delivery with patient status review
  - Medication synchronization with clinical review
  - Adherence packaging with patient coaching

What Services Would Benefit Patients in Your Community?

Seaming the Gaps Between Care and Better Health

Chronic Care Management (CCM)

- As of January 1, 2015, Medicare pays for non-face-to-face services provided to beneficiaries
- CCM is defined as "at least 20 minutes of clinical staff time directed by a physician or other **qualified health care professional (QHP)**, per month"
  - An exception under Medicare's "incident to" rules which allows for **general supervision** rather than direct supervision
- CPT 99490 = $38.35, $29.99

CCM Scope of Service Elements

- Patient eligibility
- Structured data recording
- Comprehensive care plan
- Access to care
- Care management
- Certified EHR

SeamlessCCM

Care Management

SeamlessCCM

- Patient Eligibility
- Provider Roles
- Care Plan Creation
- Care Management

Patient Eligibility

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decompensation, or functional decline
- A more specific target would be patients who qualify for Medication Therapy Management (MTM) OR those that affect readmissions

SeamlessCCM

Patient Eligibility

Provider Roles

Care Plan Creation

Care Management

Provider Roles

- Ideally sequential visits to form strong relationships
- Pharmacist role
  - A pharmacist will complete a comprehensive or targeted medication review (CMR/TMR)
- Physician (or mid-level) role
  - Perform a "comprehensive" visit
    - E/M, IPPE, AWV, or TCM

Joint Counseling

- After both visits, the pharmacist and physician will counsel the patient together and offer CCM services
- Explain how it works and if interested read/sign consent form
- Practitioner who initiates must ensure access to successive routine appointments for continuity of care

SeamlessCCM

Care Management

Care Plan Creation

- Comprehensive visit and CMR/TMR provides a large amount of the information required for care plan
  - Care plans will be patient-centered and address all health conditions, issues, and treatment
- A pharmacy technician will reach out to any additional parties involved in patients care to ensure a complete care plan
- Finalized care plans will be documented and sent to physician for revisions and approval before being sent to the patient

*Seamless*CCM

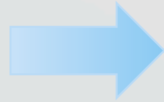
- Patient Eligibility
- Provider Role
- Care Plan Creation
- Care Management

Care Management

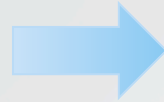
- ***Seamless*CCM** will ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services including:
  - Providing the patient with a means to make timely contact with health care practitioners
  - Systematic assessment of the patients medical, functional, and psychosocial needs
  - Ensure timely receipt of all recommended preventative services
  - Oversight of patient self-management of medications

Care Management

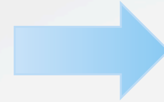
- ***Seamless*CCM** will ensure 24-hour-a-day, 7-day-a-week (24/7) access to care management services including:
  - Medication adherence and interaction reviews
  - Coordination with home and community based clinical service providers
  - Management of care transitions between and among healthcare providers and settings
  - Enhanced opportunities for patients and any caregiver to communicate with their primary practitioner



CMR/TMR

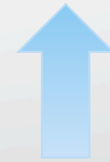


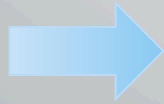
TCM



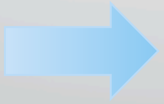
Joint Counseling

*Seamless*CCM ≠





CMR/TMR



IPPE/AWV

Joint Counseling

NQS Priorities

- Making care safer by reducing harm caused in the delivery of care.
- Ensuring that each person and family are engaged as partners in their care.
- Promoting effective communication and coordination of care.
- Promoting the most effective prevention and treatment practices for the leading causes of mortality, starting with cardiovascular disease.
- Working with communities to promote wide use of best practices to enable healthy living.
- Making quality care more affordable for individuals, families, employers, and governments by developing and spreading new health care delivery models.

Hospital Impact

- Mortality Measures
  - 30-Day mortality rate for multiple conditions
- Readmission Measures
  - 30-Day readmission rate for multiple conditions
  - Includes HWR hospital-wide all-cause unplanned readmission
- Patient Experience Measures

Health Plan Impact

- Triple weighted measures
  - C04 – Improving or Maintaining Physical Health
  - C05 – Improving or Maintaining Mental Health
  - C15 – Diabetes Care – Blood Sugar Controlled
  - C16 – Controlling Blood Pressure
  - C19 – Plan All-Cause Readmissions
  - D11 – High Risk Medication
  - D12 – Medication Adherence for Diabetes Medications
  - D13 – Medication Adherence for Hypertension
  - D14 – Medication Adherence for Cholesterol (Statins)

Why *SeamlessCCM*

- Integration of planned visits for care plan creation
- Increased outcomes by closing care gaps, with little effect on workflow
- Patient access to care management services to address urgent chronic care needs 24/7
- Having a pharmacist as a first point of contact could lead to less costly face-to-face visits or hospital readmissions