#FSHP2018

Implementing New Pharmacy Services In The Ambulatory Setting

The Road to Recognition

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Break Through Branch Out

Disclosures

None

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Objectives

- Discuss current opportunities for pharmacists in the ambulatory care setting.
- List strategies to expand pharmacists' role in the ambulatory care setting.
- Review credentialing and privileging strategies for various ambulatory care pharmacy services.

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We Need **Provider** Status to Practice in Primary/Ambulatory Care

(What makes you certain of that?)

Electronic Medical Records

Evidence Based, Protocol Driven Care

Collaborative Practice?.....(it's not about US...it's about what is best)

> Healthcare organizations also must understand that collaboration is more than just working together and working well with others outside the traditional care circle. It is also a commitment to a new operational framework and an acknowledgment that an integrated healthcare workforce will need innovative tools, resources and technology that can stand up to and promote the demands of team-based care delivery today.
>
> INTERPROFESSIONAL COLLABORATIVE PRACTICE IN HEALTHCARE
> *Getting Prepared, Preparing to Succeed*
> Elsevier 12/2013

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Providers of What?

- **What Is Value-Based Healthcare?**
- Article · January 1, 2017
- NEJM Catalyst
- Value-based healthcare is a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes. Under value-based care agreements, providers are rewarded for helping patients improve their health, reduce the effects and incidence of chronic disease, and live healthier lives in an evidence-based way.
- Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver. The "value" in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.

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What's a Pharmacist's Value In Ambulatory Care?

- **Fee for Service** = a method in which doctors and other health care providers are paid for each service they perform
- **Ambulatory Pharmacy Residency** – Tell me more
  - Coumadin Clinic Model
  - Disease state focused Model
  - Complexity Based Model
- **Consultant** Pharmacist Based Model
- **Value Based Care**, Team Based Care, Value Based Reimbursement
  - Paid based on what?.....

But We Should Be Recognized and be able to Bill for our Services !!

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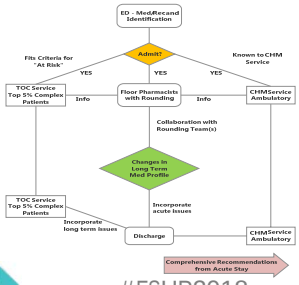
What Have We Provided?

Inpatient



Ambulatory

What Do We Need To Provide?

Your Future Depends On THIS!

VALUE-BASED CARE MODELS: MEDICAL HOMES

In value-based healthcare models, medical care does not exist in silos. Instead, primary, specialty, and acute care are integrated, often in a delivery model called a patient-centered medical home (PCMH).

A medical home isn't a physical location. Instead, it's a coordinated approach to patient care, led by a patient's primary physician who directs a patient's total clinical care team. PCMHs rely on the sharing of electronic medical records (EMRs) among all providers on the coordinated care team.

The goal of EMRs is to put crucial patient information at each provider's fingertips, allowing individual providers to see results of tests and procedures performed by other clinicians on the team. This data sharing has the potential to reduce redundant care and associated costs.

NEJM Jan 2017

VALUE-BASED CARE MODELS: ACCOUNTABLE CARE ORGANIZATIONS

Accountable care organizations (ACOs) were originally designed by the Centers for Medicare & Medicaid Services (CMS) to provide high-quality medical care to Medicare patients. In an ACO, doctors, hospitals, and other healthcare providers work as a networked team to deliver the best possible coordinated care at the lowest possible cost. **Each member of the team shares both risk and reward**, with incentives to improve access to care, quality of care, and patient health outcomes while reducing costs. This approach differs from fee-for-service healthcare, in which individual providers are incentivized to order more tests and procedures and manage more patients in order to get paid more, regardless of patient outcomes.

Like PCMHs, ACOs are patient-centered organizations in which the patient and providers are true partners in care decisions. Also like PCMHs, ACOs stress coordination and data sharing among team members to help achieve these goals among their entire patient population. Clinical and claims data are also shared with payers to demonstrate improvements in outcomes such as hospital readmissions, adverse events, patient engagement, and population health.

Opportunity Knocks

More than half (52%) of surveyed practices have *no business changes planned* as a result of the health exchanges opening.

The reasons for this inertia, according to Cooke, have less to do with nostalgia or avoidance, and much more to do with physicians and practice leaders—especially in generalist and primary care practices—**being stretched so thin already. "People (physicians) *are so busy that they don't really have time*** to take two hours or half a day to even think about who's there in the office and how they might reorganize things,"

5 ways the Affordable Care Act will transform primary care practices , Modern Medicine Dec 2013

How Does This Change Anything ?

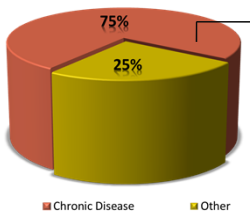
- **How Does Value-Based Healthcare Translate To New Delivery Models?**
- The proliferation of value-based healthcare is changing the way physicians and hospitals provide care. New healthcare delivery models stress a team-oriented approach to patient care and sharing of patient data so that care is coordinated and outcomes can be measured easily. Two examples are reviewed here.

NEJM Jan 2017

The National Imperative

5% of the population is responsible for **50%** of healthcare spending

What's 50% of $ 2.8 Trillion Dollars?



75% of all healthcare spending is for patients with one or more chronic diseases... **CMS 2012**

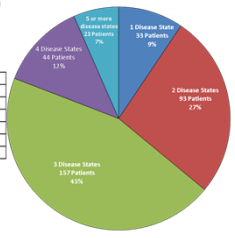
CMS 2012

Target Audience?

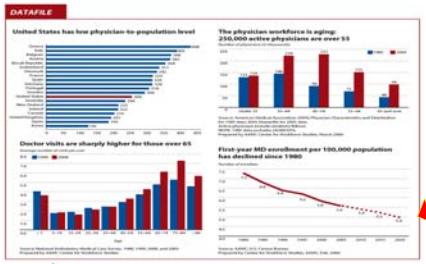
Well...It's Complex.

CHaMPS Patient Population
Patient Total: 350

Disease States	Number of patients with each disease	
Diabetes	327	93%
Hypertension	302	86%
Hyperlipidemia	101	29%
CKD	87	25%
COPD	72	21%
CHF	48	14%
Asthma	43	12%



But Wait There's More!!



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Under Opportunity See….
Medicare Chronic Care Management

Chronic Care Management (CCM) is defined as the non-face-to-face services provided to Medicare beneficiaries who have multiple (two or more), significant chronic conditions. In addition to office visits and other face-to-face encounters (billed separately), these services include communication with the patient and other treating health professionals for care coordination (both electronically and by phone), medication management, and being accessible 24 hours a day to patients and any care providers (physicians or other clinical staff). The creation and revision of electronic care plans is also a key component of CCM.

Clinical staff – Licensed clinical staff members (including APRN, PA, RN, LSCSW, LPN, **clinical pharmacists**, and "medical technical assistants" or CMAs) who are directly employed by the clinician (or the clinician's practice) or a contracted third party *and* whose CCM services are generally supervised by the clinician, whether provided during or after hours. Thus the "incident to" rules do not necessarily require that the clinician be on the premises providing direct supervision.

WHAT??!!

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Time is of the ESSENCE…

10,000 people in the U.S. turn 65 every day

And that will continue to happen … **EVERY DAY**…..

For the next 14 years

Jenkins, J. It's Time To Disrupt Aging:
The Realities of Aging Have Changed But Attitudes Have Not

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How Can I Get There..
It's all about ROI…

- **Every Healthcare Organization is looking for meaningful answers to Population Health, Minimizing Readmissions and Improved Quality Metrics (Both inpatient and Outpatient)**
- **All Payers have Quality Metrics for which there are either penalties or bonus dollars attached (Both inpatient and outpatient)**
- **Not for Profit Organizations MUST provide a certain amount of COMMUNITY BENEFIT and document that benefit in real dollars**
- **Patient Satisfaction = Patient Loyalty – We live in a Clinical Hospitality World and these patients KNOW they are not well cared for.**

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C.H.A.M.Ps
A Template for Progress

CHAMPS aims to integrate pharmacist services by working with physicians in the primary care setting to keep complex patients healthy at home. Pharmacists provide comprehensive medication management to patients who have uncontrolled Diabetes, Hypertension, Dyslipidemia, Heart Failure, Asthma, or COPD. Below is a description of eligibility criteria for the CHAMPS program.

Defined Selected Disease States:

Diabetes: HgA1c >8

CHF: EF <40%

HTN: BP >140/90 and an additional comorbid disease state

Hyperlipidemia: LDL >100 or TG >250

COPD: FEV1 <70%

Asthma: FEV1 <80%

Patients must have 1 of the selected, uncontrolled disease states (defined above) and meet **at least 1** of the following:

- >=1 Inpatient Admission or ED visit in the last 18 months with admitting or ED diagnosis related to one of the selected disease states
- >6 chronic medications (or inappropriate therapy)
- Referral from collaborating provider (defined above)

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Academically Evaluated

University of Texas and Virginia Commonwealth University Collaboration with Martin Health System

TABLE 1. DEMOGRAPHIC AND HEALTH-RELATED VARIABLES FOR MATCHED CHAMPS AND COMPARATOR GROUPS

Variable	CHAMPs (n = 312)	Comparator (n = 312)	p-value
Age (Years), Mean ± SD	65.6 ± 11.1	67.2 ± 12.5	0.09
Gender, No. (%)			0.21
Women	157 (50.3)	141 (45.2)	
Men	155 (49.7)	171 (54.8)	
Race, No. (%)			0.20
White	244 (78.2)	257 (82.4)	
Nonwhite	68 (21.8)	55 (17.6)	
Insurance, No. (%)			0.53
Medicare/Medicaid	224 (71.8)	215 (68.9)	
Commercial/other	88 (28.2)	97 (31.1)	
Charlson comorbidity index, No. (%)			0.10
0 – 2	145 (46.5)	167 (53.3)	
3 – 4	100 (32.1)	86 (27.6)	
≥ 5	67 (21.5)	59 (18.9)	
Smoking, No. (%)	44 (14.1)	38 (12.2)	0.49
Body mass index, No. (%)			0.92
< 25	42 (13.5)	42 (13.5)	
25 – 29.9	69 (22.1)	81 (26.0)	
≥ 30	201 (64.4)	189 (60.6)	
Diabetes, No. (%)	296 (94.5)	281 (90.1)	0.02
Hypertension, No. (%)	271 (86.7)	273 (87.5)	0.81
Hyperlipidemia, No. (%)	233 (74.7)	104 (33.3)	<0.0001
CHF, No. (%)	41 (13.1)	39 (12.5)	0.82
Asthma/COPD, No. (%)	85 (27.2)	71 (22.8)	0.19

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Relevant to MY Practice??

Study Group Decreases

- 35.2%

-18.6%

Humm.. Value Based Care?

Comparator Group Increases

Think of this as the Current State Of Healthcare in the US

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But I don't Know HOW!

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Credentialing

VCU Virginia Commonwealth University

Pharmacist Training in Collaborative Practice: Retooling for the Future

Key Learning Objectives of the Live Training Seminar:
1.Through the use of patient cases, discuss best practices for managing common chronic conditions and identify relevant patient assessment skills.
2.Learn a systematic process for assessing medications for appropriateness, effectiveness, safety, and adherence.
3.Learn how to use shared-decision making with patients and health care team to create an individualized care plan to optimize medication therapy.
4.Identify and practice using tools to assess health literacy and medication adherence that can be efficiently integrated with the patient visit.
5.Review recent evidence-based literature and best practices for team-based care.
6.Identify implementation strategies, including communicating pharmacist roles and responsibilities with care team, planning for patient care space and panel sizes, using registries to identify patients for services, developing collaborative practice agreements, and developing and maintaining relationships with care team.
7.Identify key elements needed to document pharmacist care and methods and tools for documentation.
8.Learn how to use quality improvement strategies to monitor implementation of services.
9.Construct a business model for a team-based health care service.
10.Make a business case to key audiences for a teambased health care service.

Agenda:
Tentative Schedule

Other information:
•Registration includes breakfast and lunch for both days.
•16 hours of live CE and 4 hours of home study prior to event for a total of 20 hours of CE credit

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Stop Waiting…Our Time is NOW !!

Thank You

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