Expansion of Pharmacy Services within Patient Centered Medical Homes

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What is a Patient Centered Medical Home (PCMH)?

"an approach to providing comprehensive primary care that facilitates partnerships between individual patients, and their personal providers, and when appropriate, the patient's family"

Core Components of a PCMH

- Comprehensive Care
- Patient-Centered Care
- Coordinated Care
- Accessible Service
- Quality Safety

What does a PCMH look like?

Today's House	Tomorrow's Home
Patients are those who continue to make appointments at the practice	**Population Based Management**
Care is determined by today's problem and time available today	**Proactive Plans**
Care varies by scheduled time and memory or skill of the doctor	**Evidence-based Point-of-Service Care**
Patient trust providers deliver quality care	**Quality and Safety Measures**
Patients are responsible for coordinating their own care	**Team: Coordinated, Integrated**
It's up to the patient to tell us what happened to them	**Tracking: Tests and Referrals**
Clinic operations center on meeting the doctor's needs	**Optimal Function:** **An interdisciplinary team works at the top of our licenses to serve patients**

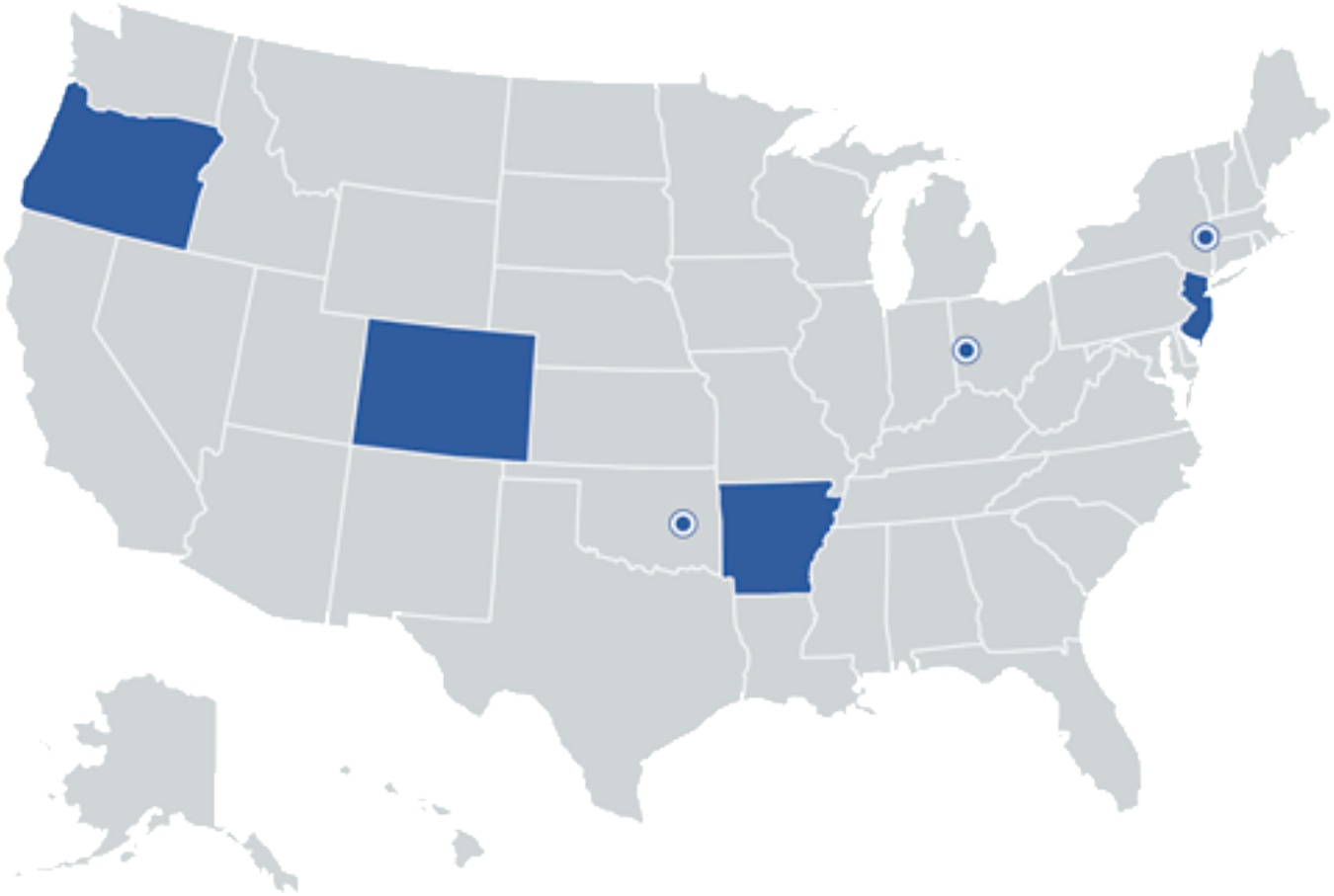
Why involve pharmacist in PMCH?

- 3.5 billion prescriptions written annually in US
- 4 of 5 patients leave physician office with Rx
- Rx's are involved in 80% of all treatments
- WHO estimates adherence rate of 50% for chronic medications

Primary Care Transformation in Arkansas

COMPREHENSIVE PRIMARY CARE INITIATIVE

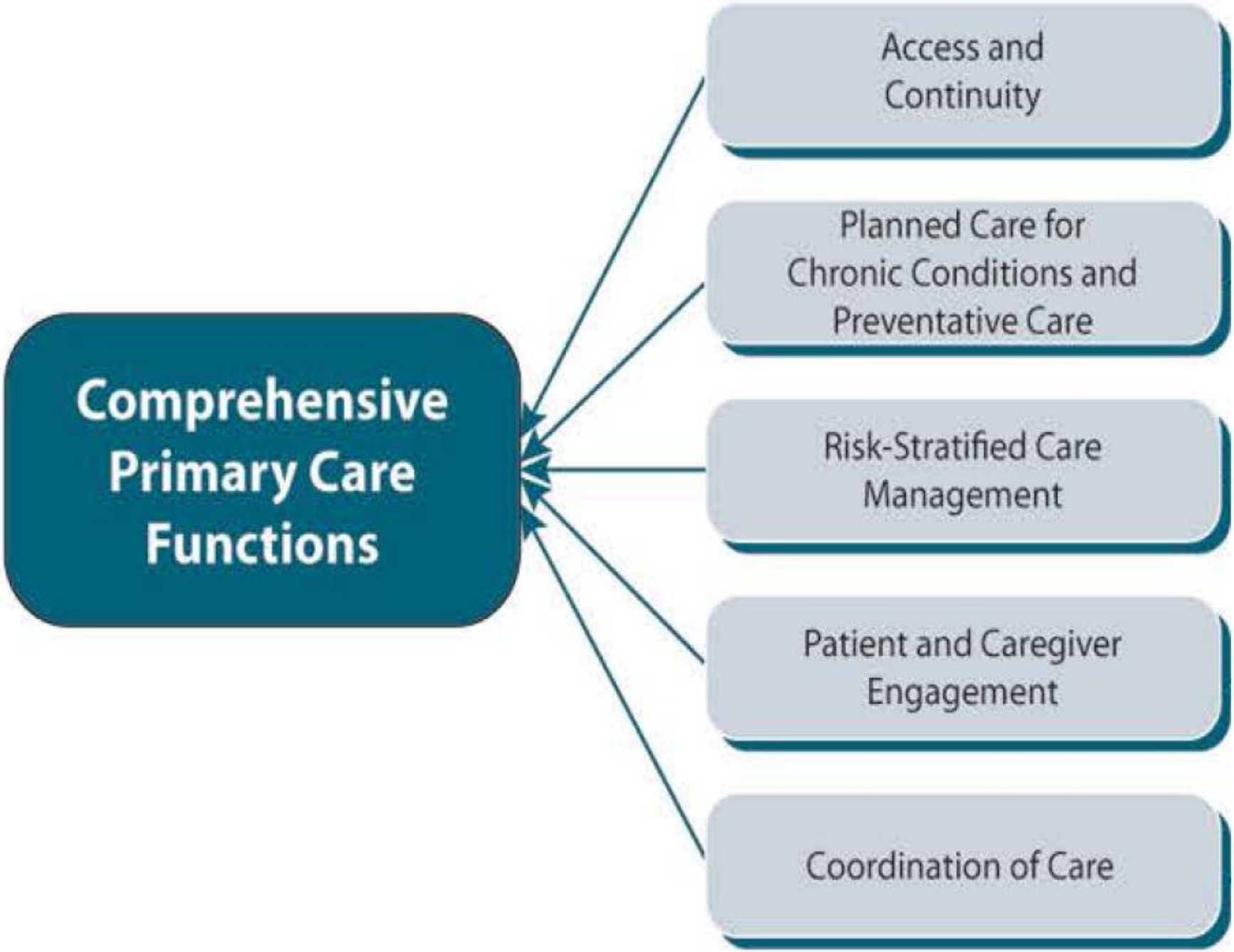
Comprehensive Primary Care Initiative (CPCI)



Source: Centers for Medicare & Medicaid Services

CPC Payment Model

- Monthly Care Management Fees
  - Per member per month: risk adjusted
  - Range of $4 to $40
- Shared Savings
  - practices share in cost savings when meeting quality indicators


Comprehensive Primary Care Functions
Access and Continuity
Planned Care for Chronic Conditions and Preventative Care
Risk-Stratified Care Management
Patient and Caregiver Engagement
Coordination of Care

Access and Continuity

- 24/7 access to provider or care team for advice about urgent and emergent care
- Provider/Care Team with access to medical record offsite
- Patient Portal with access to medical record
- E-visits, phone visits

Planned Care for Chronic Conditions and Preventive Care

- Personalized care plan for each patient
- Proactively manage chronic conditions
- Medication reconciliation
- Use team based care

Risk Stratified Care Management

- Assign a risk status to all patients
- Use care management pathways for high risk
- Actively manage high risk patients in care transitions
- Use evidence-based pathways for care management

CPCI 2014 Milestone: Care Management

- Provide care management to at least 80% of highest risk patients
- Care management strategies for 2014
  - behavioral health integration
  - self-management support
  - comprehensive medication management

"Your practice can build a comprehensive system of medication management by integrating pharmacist(s) into the care team".

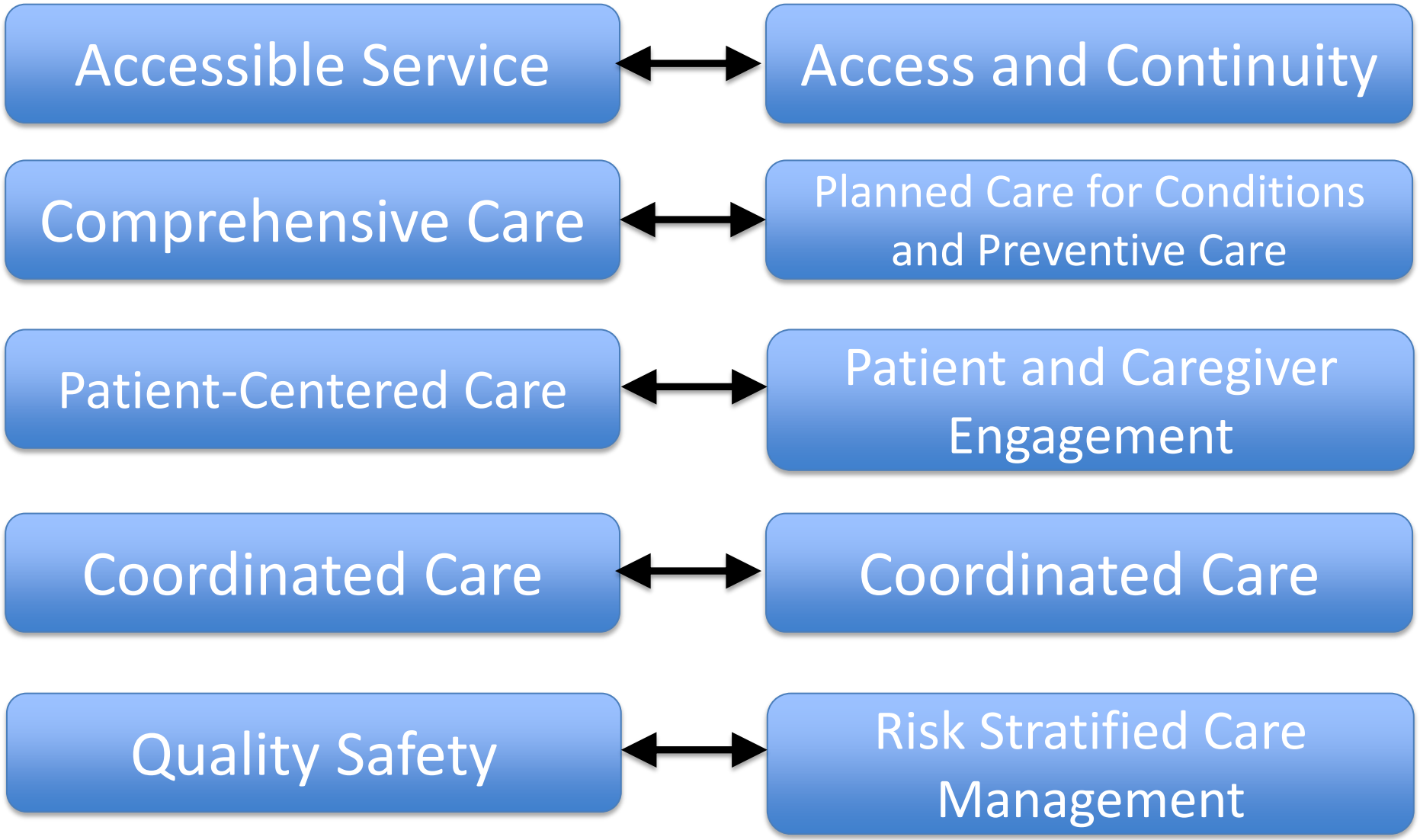
Patient and Caregiver Engagement

- Integrate Self Management Support into care
- Involve patient and family in decision making
- Engage patients to improve care system

Coordinated Care

- Ensure flow of patient information across medical neighborhood
- ED and hospital follow up
- Care Compact and agreements

PCMH and CPCI



Institute for Healthcare Improvement

The Triple Aim

- Improving the patient experience of care (including quality and satisfaction)
- Improving the health of populations
- Reducing the per capita cost of health care

CPCI Comprehensive Medication Management

- Medication reconciliation
- Medication coordination for transitions of care
- Reviews for safety and cost-effectiveness
- Development of a medication action plan

CPCI Comprehensive Medication Management

- Medication monitoring
- Support for medication adherence and self-management
- Collaborative drug therapy management (when within the state's scope of practice)

CPCI Pharmacists Roles/Responsibilities

- Works onsite
- Involved in patient care, either directly or through chart review and recommendations
- Documents care in the EHR

CPCI Pharmacists Roles/Responsibilities

- Participates in the identification of high-risk patients who would benefit from medication management
- Participates in care team meetings
- Participates in development of processes to improve medication effectiveness and safety

CPCI Med Management Patient Identification

- High risk status
- Not achieving therapeutic goals
- Recent care transition
- Multiple ED visits/hospitalizations
- Complex medication regimen
- High-risk medications

Patient-Centered Primary Care COLLABORATIVE

The Patient-Centered Medical Home:

Integrating Comprehensive Medication Management to Optimize Patient Outcomes

RESOURCE GUIDE

SECOND EDITION | JUNE 2012

PCPCC Comprehensive Medication Management

- medication management service needs to be delivered directly to a specific patient
- assessment of the specific patient's medication-related needs
- care plan is developed to resolve the problems
- service is expected to add unique value to the care of the patient
- work of pharmacists and medication therapy practitioners needs to be coordinated with other team members in the PCMH

Patient-Centered Primary Care Collaborative (PCPCC)

COMPREHENSIVE MEDICATION MANAGEMENT SERVICES

Assessment of the Patient's Medication-Related Needs

- all current Rx, OTC, Supplements, vitamins, meds from friends and family, etc.
  - current systems don't capture everything
- uncovering patient's medication experience
- complete medication history
- medications are linked to indicated condition
- goal is to determine if outcomes are achieved through medication use

Identification of the Patient's Medication-related Problems

- Each Medication is assessed for
  - Appropriateness
  - Effectiveness
  - Safety
  - Adherence

Development of a Care Plan

- Intervene to solve medication-related problems
- Establish individualized therapy goals
- Design personalized education and interventions
- Establish measureable outcome parameters
- Determine appropriate follow-up time frames

What else is going on now?

- Medicaid PCMH program quality metrics
  - % of DM with annual A1C
  - % of asthma patients on appropriate meds
  - % of CHF patients on appropriate meds
  - % of patients on thyroid drugs with TSH in past year
  - Inpatient admission/1000 patients
  - 30 day readmission rates
  - ER visits/1000 patients

Other PCMH initiatives

- Affordable Care Act
  - Requires PCMH payment structure for Medicaid Exchange patients
  - Payers currently writing payment structures for 2015
- Payment structures
  - Pay for performance is the language
    - Per member per month payment model
    - Shared cost savings

Considerations going forward

- Contracting with providers
- Location of services
- Pricing model
- Future payment structures

Summary

- The PCMH is a new approach of providing primary care
- Appropriate medication management is a vital component of providing comprehensive care
- Arkansas pharmacist are in a unique position to engage primary care practices and provide medication management