



# PHARMACISTS

*as Vital Members of*

# ACCOUNTABLE CARE ORGANIZATIONS

*Illustrating the Important Role  
That Pharmacists Play on Health Care Teams*

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## Introduction

The Accountable Care Act authorizes the Centers for Medicare and Medicaid Services (CMS) to contract with accountable care organizations (ACOs) under the Medicare program. ACOs are defined as networks of physicians and other providers that work together to improve the quality of health care services and reduce costs for a defined patient population. The ACO model has emerged as a potential way of promoting integration while avoiding some of the perceived problems of previous systems. Discussions of ACOs have broadened from a focus on hospital-centered systems to include models based on various physician practice models including large, multispecialty groups and independent practice associations. People have different ideas about how an ACO might operate — tightly or loosely structured, formed voluntarily or with the organization imposed on providers by Medicare or other insurers, and so on.

On March 31, 2011, CMS issued the proposed regulations for implementing the Medicare Shared Savings Program which allows health care providers to form ACOs in which they agree to be accountable for the quality, cost and overall care of at least 5,000 Medicare beneficiaries. The goal of the Shared Savings Program is threefold: to improve care for individuals, to improve health for the population, and to reduce growth in expenditures. Under the program, an ACO is allowed to share in the savings it achieves for Medicare if it meets specified quality measures and cost reduction targets. CMS estimates that up to five million Medicare beneficiaries will receive care from providers participating in ACOs, and the program could save Medicare up to \$960 million over three years.

Current discussions related to ACOs focus primarily on the involvement of hospitals and physicians and seldom address pharmacists or medication management. There are multiple

examples of integrated approaches to the delivery of care that incorporate medication therapy as an essential element. These arrangements may not be known as ACOs, but their *modus operandi* typifies what ACOs are striving to achieve. Therefore, ACO designers can learn from these “ACO-like” organizations.

Studies have demonstrated that pharmacists participating in team-based care models have made positive contributions to patient care and safe medication use. Pharmacists are uniquely positioned in the health care system to help optimize appropriate medication use, reduce medication related problems and improve health outcomes, but their contributions are often unrecognized. As a clinical expert working as part of an interdisciplinary team, pharmacists can assess whether medication use is contributing to unwanted effects and can help achieve desired outcomes from medication use.

This document illustrates the pharmacist’s contribution in today’s ACO-like organizations. The document includes descriptive vignettes of integrated systems of care that depend on the inclusion of appropriate medication therapy by pharmacists as an essential component of health care delivery. The vignettes describe current arrangements within six ACO-like organizations that typify productive inclusion of medication related services within patient care systems. These organizations are: Advocate Physician Partners, Geisinger Health System, Group Health Cooperative, HealthCare Partners, Hill Physicians Medical Group, and Kelsey-Seybold Clinic. They are offered as models for how pharmacists can play important roles in an effective ACO.



## Background

The accountable care organization, or ACO, has been proposed as a new and novel way to slow rising health care costs and improve quality of care. However, most stakeholders are still working to outline how ACOs will differ from other previously tried approaches to improve health care.<sup>1</sup>

Policy makers agree there is a need for provider payment and delivery system reforms that create financial incentives for providers of care to work together to bend the cost curve and improve quality.<sup>1</sup> A criticism of health care's traditional fee-for-service payment system is that health care providers are paid based on each individual service provided, with poor coordination across providers regarding the treatment of an individual patient and the potential incentive for providers to furnish more services than are actually needed.<sup>2</sup>

Recent data suggests that moving patients from uncoordinated care systems to integrated care systems with targeted interventions and coordination across providers could reduce the cost of care by 35 percent.<sup>3</sup> Through the years, integrated approaches to health care, such as Kaiser Permanente and others that own hospitals and employ salaried physicians, have been developed to provide an environment where health care can be coordinated. Providers within these prototype systems work to improve quality and efficiency through the sharing of patient information and/or following practice guidelines. Unfortunately, the same level of coordination has been difficult to achieve when providers operate independently. Some physician groups or joint ventures between physicians and hospitals have, however, attempted to emulate the integrated health care model and have contracted with health insurers to provide total care to an enrolled population. Many of these arrangements involve capitation payment models, where the contracting group accepts a fixed monthly payment per patient that is intended to cover a range of services for their enrollees. While these arrangements exist in several parts of the country, many consumers have resisted this health care model as it restricts the choice of providers and creates concerns that the capitation payment method replaces incentives to provide too many services under fee-for-service arrangements with incentives to deny care.<sup>2</sup>

The ACO concept began through observations that physicians who are tied to a particular hospital often function as an informal network, and their patients tend to stay within this network for most of their care. If these groups, consisting of one or more hospitals and the doctors who use these hospitals, can be brought together into an organized system, public and private payors of health care might then be able to hold these systems accountable by assessing the quality of health care provided. Organizations that take steps to improve their performance could then be financially rewarded by the payor, leading to fur-

ther improvements and eventual evolution to a fully coordinated care system.<sup>2</sup>

The Affordable Care Act (ACA) enacted in March 2010 authorizes the Centers for Medicare and Medicaid Services (CMS) to contract with ACOs to provide health care to Medicare beneficiaries under a shared savings program beginning in January 2012. ACOs are defined by ACA as an organization of health care providers that "shall be willing to become accountable for the quality, cost and overall care of Medicare fee-for-service beneficiaries assigned to it."<sup>4</sup>

ACA specifies that an ACO may include the following types of providers of Medicare-covered services:<sup>5</sup>

- ACO professionals (i.e., physicians and hospitals meeting the statutory definition) in group practice arrangements
- Networks of individual practices of ACO professionals
- Partnerships or joint ventures arrangements between hospitals and ACO professionals
- Hospitals employing ACO professionals
- Other Medicare providers and suppliers as determined by the Secretary

It is expected that these ACOs will include some basic features, including:

- **Enrollment.** Patients who receive most of their care from ACO-affiliated providers would be treated as being "assigned" to the ACO. At least at the outset, patients would not be formally enrolled, and would not be required to obtain services through the ACO.<sup>2</sup> CMS would require providers to notify the beneficiary that they are participating in an ACO, and that the provider will be eligible for additional payments for improving quality of care while reducing overall costs.<sup>5</sup>
- **Performance Measurement.** Payors would collect data on utilization and costs for the ACO population and on measures of quality of care and population health. A provider could be required to meet minimum quality standards in order to continue to participate in the ACO, and/or to be eligible to receive any shared savings.<sup>2,5</sup>
- **Shared Savings and Costs.** Spending for the population of patients in a particular ACO would be compared to targets based on past experience for the same patients, or to spending for similar patients in the community who were not assigned to the ACO. If the ACO was found to have saved money, it may receive some share of the savings. ACO's may also be held accountable for repaying Medicare for a portion of losses (*expenditures over benchmark*).<sup>2,5</sup>

While discussions regarding ACOs have so far been primarily in the context of Medicare, there is growing interest in the concept in other health care sectors including Medicaid and private insurance. Collaboration across multiple payors in developing and promoting ACOs may prove to have positive outcomes if uniform performance measures and quality standards can be employed.<sup>2</sup>

## The Importance and Role of Pharmacists in the ACO

In 2006, 71 percent of physician visits resulted in at least one prescription medication.<sup>6</sup> The proper use of medication is especially important considering the treatment of chronic disease costs the health care system over \$1 trillion dollars annually.<sup>7</sup> Reportedly, 32 percent of adverse events leading to hospitalization are due to medications, and only 33 to 50 percent of patients with chronic conditions adhere to their prescribed medication therapies.<sup>6</sup> Data suggests that Medicare beneficiaries with multiple chronic illnesses see on average 13 different physicians, fill 50 prescriptions each year, account for 76 percent of all hospitalizations and are 100 times more likely to have a preventable hospitalization than those with no chronic illnesses.<sup>8</sup>

The Institute of Medicine has suggested that while only 10 percent of total health care costs are spent on medications, their ability to control disease and impact overall morbidity, productivity and costs, when used appropriately, is enormous.<sup>8</sup> However, 58 percent of physicians state that their patients have difficulty affording their medications, thus revealing an opportunity for pharmacists to play an important role in achieving desired therapeutic outcomes while promoting cost-effective medication use.<sup>6</sup>

Over the past twenty-five years, studies have demonstrated that pharmacists participating in team-based care models have made positive contributions to patient care and safe medication use. Pharmacists are well trained in pharmacotherapeutics and are uniquely positioned in the health care system to help optimize appropriate medication use, reduce medication related problems and improve health outcomes, yet they are often underused.<sup>6,7</sup> As a clinical expert working as part of an interdisciplinary team, pharmacists can assess whether medication use is contributing to unwanted effects and can help achieve desired outcomes from medication use.<sup>6</sup>

Pharmacist-provided care can reduce drug expenditures, hospital readmissions, lengths of stay and emergency department visits.<sup>9</sup> Similar to the patient-centered medical home (PCMH) concept, the ACO model requires the coordination of care and communication across multiple providers, including pharmacists.<sup>10</sup> Pharmacists in community settings, hospitals and managed care organizations are already actively involved in communications with prescribers and patients that are intended

to improve quality and appropriateness of care. Incorporating pharmacists within the ACO health care team will be essential to achieving CMS required quality improvement benchmarks.

Organizations across diverse care settings are already implementing pharmacy services, including medication management, within their settings. Medication therapy management (MTM) services are a distinct group of services whose overarching goal is to ensure the safe, effective, appropriate and economical use of medications for eligible beneficiaries by utilizing a patient-centered, interdisciplinary, evidence-based approach.<sup>11</sup> These programs, which primarily focus on improving adherence to therapy and reducing hospital re-admissions, are forming the basis for likely pharmacist activities in the ACO environment. Examples of activities that fit the MTM definition include:<sup>11</sup>

- **Drug Therapy Management Clinics.** Including anti-coagulation clinics, transplant programs, and human immunodeficiency virus (HIV), hepatitis C, psychiatric and lipid management clinics to ensure that patients are taking their medications correctly and that drug-related problems are identified and managed.
- **Comprehensive Medication Reviews and Medication Reconciliation.** Including brown bag clinic programs and more specifically situations where post-hospital discharge patients review each of their medications with a pharmacist to discuss proper use and patient understanding and coordination with pre-hospitalization medication therapies.
- **Drug Utilization Review and Identification of Gaps in Care.** Including programs where pharmacists assess medication appropriateness and possible patient safety issues, such as identifying patients with asthma or heart failure who are not on appropriate medications and then making recommendations for therapy changes and/or additions to the patients' physician.
- **Prescription Drug Adherence Clinics.** Including situations where pharmacists work with and counsel patients who have been identified as non-adherent to medications used for a chronic disease to increase adherence rates and ultimately improve outcomes.

The following examples showcase pharmacist-based programs that have been implemented within the respective health care settings, any of which may become ACO's in the future. They were obtained through interviews with representatives from the organizations operating these programs. As described in the summaries, activities of the pharmacist within these organizations fall into one or more of the medication management areas outlined above. Additionally, many of the activities being implemented are already directed at one or more of the 33 CMS quality performance standards within the dimensions of

improved care and improved health that will serve as the basis for assessing, benchmarking, rewarding, and improving ACO quality performance. The CMS domains and a sample of corresponding drug therapy related performance measures include:<sup>12</sup>

- Better Care for Individuals:
  - Care Coordination/Patient Safety
    - Medication Reconciliation: Reconciliation After Discharge from an Inpatient Facility (*measure 12*)
- Better Health for Populations:
  - Preventive Health
    - Influenza Immunization (*measure 14*)
    - Pneumococcal Vaccination (*measure 15*)
  - At-risk Population — Diabetes
    - Diabetes Composite (All or Nothing Scoring): Aspirin Use (*measure 26*)
  - At-risk Population — Ischemic Vascular Disease
    - Ischemic Vascular Disease (IVD): Use of Aspirin or Another Antithrombotic (*measure 30*)

- At-risk Population — Heart Failure
  - Heart Failure: Beta-Blocker Therapy for Left Ventricular Systolic Dysfunction (LVSD) (*measure 31*)
- At-risk Population — Coronary Artery Disease
  - Coronary Artery Disease (CAD) Composite: (All or Nothing Scoring): Drug Therapy for Lowering LDL-Cholesterol (*measure 32*)
  - Coronary Artery Disease (CAD) Composite: (All or Nothing Scoring): Angiotensin-Converting Enzyme (ACE) Inhibitor or Angiotensin Receptor Blocker (ARB) Therapy for Patients with CAD and Diabetes and/or Left Ventricular Systolic Dysfunction (LVSD) (*measure 33*)

Additionally, these profiled organizations are continuing to look at new and expanded roles pharmacists might play in reducing costs and improving the quality of care provided to their patients.



## Advocate Physician Partners

### **Structure:**

Advocate Physician Partners (APP) is a joint venture physician hospital organization representing 3,800 physicians. The system has 10 hospitals, offers home care and employs 900 physicians in large multi-specialty groups who are members of the partnership. Also in the partnership are 2,900 independent physicians who work in solo or small group practices of three physicians or fewer and 1,900 other independent physicians that are on staff at the various hospitals but not part of the partnership.

### **Patient Population:**

Advocate physicians care for almost one million commercially enrolled patients across northern and central Illinois, with 230,000 in health maintenance organization (HMO) plans and another 700,000 in fee-for-service preferred provider organization (PPO) programs.

### **Pharmacists' Role:**

Pharmacists are an integral part of the Clinical Integration (CI) Program at Advocate. The CI Program is a pay-for-performance incentive system that is designed to improve health outcomes and reduce unnecessary costs.

Two full time equivalent (FTE) pharmacists support several key clinical and efficiency measures including increasing the use of generic medications, promoting the use of controller medications in asthma, increasing use of beta-blockers post myocardial infarction (MI), increasing use of angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB) agents in heart failure (HF) and the appropriate use of anti-platelet medications in coronary artery disease (CAD) patients.

Pharmacists use data from health plan prescription drug programs, internal claims data and electronic health records to identify opportunities for improvement and then meet with physicians to discuss findings and potential actions. Much of this academic detailing program occurs in face-to-face small group meetings, but the pharmacists also interact with physicians at large quarterly meetings, telephonically, etc. Complementing the use of generic medications efforts is a partnership program with a major retail pharmacy chain to provide vouchers to offset the generic drug copay on select first fill generics to help reduce out-of-pocket expenses for patients.<sup>13</sup>

An additional five to seven FTE pharmacists are also employed at the large multi-specialty clinics and act as members of the anticoagulation and diabetes clinic teams to monitor patient labs, educate patients on medication use, assess adverse events and adherence to therapy, and recommend dosing adjustments/alternate therapies when needed.

Through the efforts of the Clinical Integration Program, which includes pharmacists as well as nurses, Advocate typically exceeds results for quality measures that involve significant condition management, such as control of blood sugar, cholesterol and blood pressure, and significantly increased their generic prescribing rates (*increase of 19 percentage points*) between 2005 and 2009.<sup>14</sup>

New for 2011 is the addition of two new pharmacists to the Advocate team:

- One FTE pharmacist to focus on increasing standardization across oncology practices by working face-to-face with the oncologists to improve adherence to protocols.
- One FTE pharmacist to implement medication therapy management with high-risk patients including those on multiple medications, and those prone to hospitalization, such as heart failure patients, to assist with reducing re-admissions. Meetings/discussions with identified/referred patients will initially take place in person, where possible, and then patients will be monitored through follow-up telephonic interactions.



## Geisinger Health System

### **Structure:**

Geisinger Health System is a physician led fully integrated health care delivery system that includes three hospitals, approximately 40 primary care medical clinics, an insurance company (Geisinger Health Plan, GHP), Geisinger Medical Laboratories, and other services across 43 counties in Pennsylvania. Geisinger Health System employs approximately 800 physicians and has a contracted relationship with more than 7,000 primary care providers and specialists within the state.

### **Patient Population:**

Geisinger Health System contracts independently with all private and public payors within the State of Pennsylvania and cares for approximately 2.5 million patients, including those insured by GHP.

### **Pharmacists' Role:**

Geisinger Health System employs more than 100 pharmacists, the majority of which work within owned hospital and clinic pharmacies in operational and dispensing roles including patient counseling and education, and approximately an additional 15 that work within the health plan. Nearly 75 percent of the pharmacists employed by Geisinger are primarily involved in integrated clinical activities, which include:

Approximately 12 FTE hospital and/or clinic pharmacists monitor and manage patients taking anticoagulants through face to face visits upon hospital discharge to review medications, and through follow-up phone calls post discharge to assure medications have been obtained and are being taken correctly in order to prevent possible rehospitalizations due to inappropriate anticoagulant therapy. Pharmacists then provide ongoing management of these patients to monitor patient labs, educate patients on medication taking, assess adverse events, adherence to therapy, and recommend dosing adjustments/alternate therapies when needed in order to prevent adverse events and potential hospitalizations.

Five FTE health plan pharmacists monitor medication adherence by monitoring medication possession ratios (MPR) and then providing physician directed reporting on non-adherent patients. Additionally, telephonic educational outreach calls are made to remind patients of needed refills and where

possible converse with the patient regarding the importance of medication adherence. The program focus is both on medications prescribed that may not have been picked up from the pharmacy, as well as refill lapses in chronic use medications in areas such as diabetes, hypertension, cholesterol management, asthma, COPD, etc. Additionally, these pharmacists provide medication therapy management according to CMS MTM program guidelines for the organizations MA-PD membership. Based on member location within the state, Geisinger also contracts with external pharmacy networks and other service providers to conduct certain MTM services.

Additionally, all pharmacists within the system are charged with identifying drug errors and managing drug dosing where appropriate, for example in patients with chronic kidney disease (CKD). Pharmacists are also encouraged to work to ensure medication reconciliation is accomplished across changes in level of care.

Geisinger Health System is in the process of building an enterprise-wide pharmacy approach to determine the best ways to utilize pharmacists and ensure the systems investment in pharmaceutical treatments is used wisely and efficiently. This system wide pharmacy group will be responsible for better organizing current pharmacist activities and implementing integrated pharmacy programs across the various practice settings. The group will be responsible for measuring results with outcomes, safety, and cost-effectiveness being the primary objectives and measures of performance.

## Group Health Cooperative

### **Structure:**

Group Health Cooperative, is a mixed model HMO with 990 physicians within an exclusive group model structure across 26 clinics in the greater Seattle area and eastern Washington, and another 6,500 contracted independent physicians practicing in other rural locations within the state of Washington.

### **Patient Population:**

Group Health cares for approximately 675,000 patients, including approximately 65,000 Medicare enrollees. About two-thirds of Group Health's membership receives care from a Group Health Medical Center.

### **Pharmacists' Role:**

Group Health employs more than 200 pharmacists, most of which work at a Group Health Medical Center pharmacy in traditional pharmacist operational and dispensing roles. However, approximately 35 percent of the pharmacists employed by Group Health support health plan and integrated delivery system programs.

Three FTE pharmacists are involved in developing medication use management initiatives that focus on improving the safe and cost effective use of medications including:

- Improving Healthcare Effectiveness Data and Information Set (HEDIS) scores by identifying patients with gaps in care and designing programs that outreach to members that should be on medications they are not currently taking such as ACE inhibitors or statins in patients with atherosclerotic coronary vascular disease (ASCVD) and/or diabetes.
- Increasing the use of generics and preferred formulary medications.
- Working with Group Health physician leaders to gain sponsorship for initiatives, assure initiatives are in alignment with the evidence based formulary and guidelines, and then implementing the initiatives through the clinic based clinical pharmacists.

Eleven FTE pharmacists work with specific specialists to both provide education and gain key opinion leaders input regarding activities focused on specialty pharmaceuticals including drug use guidelines development, evidence based drug reviews, medication utilization strategies, and medication safety strategies.

Another 10 FTE pharmacists work within the pharmacy call center taking calls from members regarding medication questions/concerns and performing pre-visit interviews with new members to obtain a full drug history prior to the patient's

first visit so that therapy change recommendations from the pharmacist can be addressed during the patient's first physician encounter.

Two FTE pharmacists provide medication reconciliation upon physician request/referral as patients transition between levels of care, sites of care and/or between primary care and specialty providers.

Group Health has an additional 38 FTE pharmacists that work in partnership with Group Health physicians to assist in the management of patients including those identified as having gaps in care and pulling through many of the drug use management initiatives developed in collaboration between pharmacists and physicians. Specific activities may include:

- Pharmacist review and outreach to patients with cardiovascular disease, asthma, and/or diabetes identified as having care gaps through an auto referral algorithm. Pharmacists address the gaps in pharmaceutical care and any other care gaps identified; such as reminders about needed lab work, preventative screenings, etc.
- Medication management activities such as medication review based on CMS medication therapy management guidelines for Medicare enrollees.
- Medication reconciliation calls with patients upon hospital discharge to ensure changes in therapy are understood to reduce possible readmissions.
- Referrals from physicians to provide patient education or therapy initiation/management. Pharmacists initiate and titrate the therapy based on collaborative drug therapy agreements with the physicians.
- Discuss and review real time data/reports with physicians related to baseline and ongoing physician performance on implemented initiatives.
- Provide ongoing drug information education to the physician and care team through daily huddles, provider meetings, newsletters, and face-to-face communication.

Initiatives are measured for improvement and modified as needed to obtain the desired goals. Use of preferred formulary agents and reduction of unsafe medications in the elderly are two areas where Group Health has now moved to quarterly continuous improvement goals.

There are also two FTE pharmacists that support medication related clinical programs for members who receive care from independent contracted physicians. Activities include:

- Develop patient strategies or tools to help promote cost effective use of medicines.
- Track physician performance for select quality and cost-effective drug use measures such as reduction of poten-

tially high-risk medications in the elderly, overall percent generic, percent generic proton pump inhibitors (PPIs), percent generic statins and percent mail order.

- Develop physician-prescribing tools, meet with physician groups to provide evidence based drug information, and

support improved performance on select drug related measures.

- Meet with local physician leaders once a quarter to obtain input on medication quality and utilization management strategies as well as drug formulary placement.

## HealthCare Partners

### **Structure:**

HealthCare Partners, is a mixed-model medical group based in California with more than 1,200 employed and affiliated primary care physicians and more than 3,000 employed and contracted specialists. They have over 50 clinics and contract with more than 57 hospitals within Los Angeles and Orange counties. HealthCare Partners has built their care delivery model around the coordination of care, the use of quality metrics, and robust reporting systems under a fully delegated health care system.

### **Patient Population:**

HealthCare Partners cares for approximately 740,000 patients including approximately 100,000 Medicare enrollees, 500,000 commercial HMO and approximately 140,000 PPO members.

### **Pharmacists' Role:**

HealthCare Partners employs approximately 16 FTE pharmacists who are involved in integrated clinical and medical management activities.

Eleven FTE pharmacists monitor and manage patients taking warfarin through face-to-face clinic visits and telephone calls (for patients in outlying areas). Pharmacists monitor patient labs, educate patients on medication taking, assess adverse events and adherence to therapy, and then recommend dosing adjustments/alternate therapies when needed in order to prevent adverse events and potential hospitalizations.

Three FTE pharmacists manage patient refill requests under 23 refill protocols approved by the group's primary care staff physicians. These protocols allow the pharmacist to approve refills and move patients to lower cost medications, including generics when appropriate. Pharmacists also look for and remind patients about needed lab work and other similar gaps in care. This program reduces physician time to manage patient refill requests and improves the group's performance under their contracted health plan pay-for-performance programs.

Two FTE pharmacists work with group physicians on the development of drug use guidelines for injectable agents including the selection of preferred products in order to efficiently manage drug spend on therapies where the medical group is at financial risk.

Additionally, pharmacists are actively involved with educating physicians on cost-effective prescribing including increasing generic drug use where possible, and management of the group's Clinical and Pharmaceutical Management (CPM) committee where policies around medications, diagnostics, medical devices etc. are developed.

HealthCare Partners also continues to explore areas where pharmacists can be deployed to help the group meet its quality and cost metrics. Pilot programs have been implemented in two areas that, depending on results, may be expanded to all group members:

- Involvement of pharmacists to identify patients with gaps in therapy such as CAD and diabetic patients not at LDL goals and then initiating and titrating therapy under protocol with their physicians.
- Performance of telephonic medication reconciliation with high-risk patients post discharge to minimize readmissions due to inappropriate medication use. High-risk patients being explored include patients with atrial fibrillation, heart failure (HF), COPD, CKD, dementia, pneumonia and those requiring anticoagulation.

## Hill Physicians Medical Group

### **Structure:**

Hill Physicians is a pure independent practice association (IPA) model medical group contracted with over 1,000 primary care providers (internists, family practitioners, and pediatricians) and over 2,000 specialists across several counties in Northern California.

### **Patient Population:**

Hill physicians care for approximately 300,000 HMO patients enrolled in commercial, Medicare Advantage and managed Medicaid programs across eight health plan payors.

### **Pharmacists' Role:**

Hill currently employs five FTE pharmacists that not only conduct traditional drug utilization activities, but also have significant involvement in guiding general medical practice across the groups 3,000 contracted physicians. While approximately 30 percent of the pharmacy group's time is spent on creating criteria for the use of injectable therapies and identifying/communicating opportunities for improvement in generic prescribing, the pharmacists at Hill spend a larger percentage of their time focused on helping to improve quality and reduce costs in areas beyond the use of pharmaceuticals, such as inappropriate use of diagnostics, unnecessary surgery, etc. Areas of involvement include:

- Provision of guidance and education to physicians on all health plan required pay-for-performance (P4P) and NCQA measures such as achieving target LDL and HbA1c levels, ensuring asthmatics are using controller therapy, ensuring patients receive appropriate vaccinations, etc.
- Development and implementation of initiatives to meet/exceed P4P and NCQA measure goals.
- Development of clinical measures/guidelines and education to physicians on identified gaps in care, both drug and non-drug related, across all specialties.
- Development and maintenance of the oncology case rate program.

Additionally, pharmacists are involved in direct patient care for high-risk patients identified through data analysis or referral from case management for activities such as:

- Patient counseling on drug use/adherence to increase the percentage of patients getting to goal.
- Recommendations for interventions and drug additions, deletions and switches.
- Medication reconciliation upon discharge to ensure patients understand changes in drug regimens and reduce possible readmissions.

Hill is looking at expanding their pharmacists' role in the coming year(s) to act as virtual physician extenders, providing direct patient care including therapy initiation and management under protocol in select disease areas.

## Kelsey-Seybold Clinic

### **Structure:**

Kelsey-Seybold Clinic is a multi-specialty group practice led by more than 370 physicians providing care across 20 locations within the greater Houston area. Twelve of the clinics have on site pharmacies. Contracts with health plans are predominantly structured as a medical services capitation, which includes office based therapies.

### **Patient Population:**

Kelsey-Seybold Clinic physicians care for approximately 350,000 patients enrolled in 18 percent commercial HMO, 75 percent fee-for-service (FFS), and 7 percent Medicare Advantage health plan payors.

### **Pharmacists' Role:**

In addition to traditional pharmacy operations and dispensing activities within the clinic pharmacies and ambulatory infusion/surgical centers, Kelsey-Seybold has three FTE pharmacists and two managed care pharmacy residents that are specifically devoted to health plan pharmacy operations, direct patient care and educational activities, which include:

- Medication therapy management (MTM) based on CMS guidelines for the KelseyCare Advantage MA-PD enrolled membership. Under this program pharmacists provide medication management through direct communication with patients that have diabetes, hypertension, hyperlipidemia, and heart failure via a web-based software system that utilizes medical and pharmacy claims to aide in completing the comprehensive and targeted medication reviews. Patients are educated on issues such as adherence, polypharmacy, reducing cost of therapy, potential duplicate therapy, possible drug interactions, appropriate medication use, etc. Pharmacists communicate directly with Kelsey-Seybold physicians through internal staff messaging, while external physicians are faxed recommendations. Over half of the eligible members (57 percent) are receptive and sign up to communicate with pharmacists through a live, telephonic consultation. Similarly, at least 75 percent of recommendations made by pharmacists to physicians regarding changes in patient therapy are accepted.

- Management of Kelsey-Seybold Clinic's RX Quality Initiative (RXQI) Program which identifies patients on certain high cost brand medications that may be eligible for lower cost generic alternatives. The goal is to improve medication adherence while educating patients and physicians of lower cost alternatives. The program focuses on the following six drug classes: ARB's, PPI's, bisphosphonates, anti-depressants (SSRI's), HMG-CoA reductase inhibitors (statins), and nasal steroids/antihistamines. Utilizing pharmacy claim records, the web tool creates a personal prescriber profile for each Kelsey-Seybold physician and compares the physician's generic utilization rate with that of the department and organization. It also lists and compares, by drug class, the cost associated with each targeted brand drug and the cost of the therapeutic alternative. The web tool also assists physicians with identifying patients who are using a brand name drug product for which there is a lower cost alternative available.
- Coordination with utilization management/disease state nurses to monitor patient data to identify gaps in care related to pharmacy HEDIS measures, and to build best practice alerts (BPAs) in the electronic medical record (EMR) systems to alert physicians and increase quality within the clinics.
- Continuous monitoring and evaluation of drug related concerns specific to patient safety, medication recalls, and/or medication shortages. Pharmacists conduct and provide medication literature evaluation including issue-minimizing recommendations to medical directors, the Kelsey-Seybold Pharmacy & Therapeutics (P&T) Committee and other health care professionals as deemed necessary.
- Coordination with contracted health plans for the physician group to facilitate interventions to help patients maximize their prescription drug benefit, improve adherence and maximize outcomes.

Future projects include expansion of MTM services into the commercial patient base, medication reconciliation upon discharge through a welcome home call from the pharmacist to verify medications to be taken based on a review of medications prescribed before and upon hospitalization discharge to reduce medication duplications/omissions, and adding medication safety alerts to the physician web tool.

## References

- <sup>1</sup> Devers K and Berenson R. Can accountable care organizations improve the value of health care by solving the cost and quality quandaries? October 1, 2009. <http://www.urban.org/publications/411975.html>. Accessed March 31, 2011.
- <sup>2</sup> Robert Wood Johnson Foundation. Health Policy Brief: Accountable care organizations. August 13, 2010. [http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief\\_id=23](http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=23). Accessed March 31, 2011.
- <sup>3</sup> Owens M. Identifying and quantifying the cost of uncoordinated care: opportunities for savings and improved outcomes. 2009. <http://www.edhoman.com/public/files/HBpcb-14.pdf>. Accessed March 31, 2011.
- <sup>4</sup> Patient Protection and Affordable Care Act, P.L. 111-148, 111-152.
- <sup>5</sup> Center for Medicare and Medicaid Services. Medicare Fact Sheet – Summary of proposed rule provisions for accountable care organizations under the Medicare shared savings program. March 31, 2011. <http://www.cms.gov/sharedsavingsprogram>. Accessed March 31, 2011.
- <sup>6</sup> Smith M, Bates DW, Bodenheimer T, Cleary P. Why pharmacists belong in the medical home. *Health Affairs*. 2010; 29(5):906–913.
- <sup>7</sup> Pharmacy Health Care Reform Coalition. Pharmacy principles for health care reform. December 2008. [www.ashp.org/DocLibrary/News/PharmacyHealthCareReformPrinciples.pdf](http://www.ashp.org/DocLibrary/News/PharmacyHealthCareReformPrinciples.pdf). Accessed March 31, 2011.
- <sup>8</sup> Patient-Centered Primary Care Collaborative. The Patient-Centered Medical Home-Integrating comprehensive medication management to optimize patient outcomes. <http://www.pcpcc.net/files/medmanagepub.pdf>. Accessed March 31, 2011.
- <sup>9</sup> Chisholm-Burns MA, Lee JK, Spivey CA et al. US pharmacists' effects as team members on patient care. Systematic review and meta-analyses. *Med Care*. 2010; 48(10):923–33.
- <sup>10</sup> Patient-Centered Primary Care Collaborative. Better to best; Value-driving elements of the patient centered medical home and accountable care organizations. [http://www.pcpcc.net/guide/better\\_to\\_best](http://www.pcpcc.net/guide/better_to_best). Accessed March 31, 2011.
- <sup>11</sup> Academy of Managed Care Pharmacy. *Sound Medication Therapy Management Programs*. <http://www.amcp.org/amcp.ark?p=AA8CD7EC>. Published October 2008. Accessed March 31, 2011.
- <sup>12</sup> Centers for Medicare & Medicaid Services. 42 CFR Part 425. Medicare Program; Medicare Shared Savings Program: Accountable Care Organizations, Final Rule. <http://www.gpo.gov/fdsys/pkg/FR-2011-11-02/pdf/2011-27461.pdf>. Accessed March 5, 2012.
- <sup>13</sup> Bhargava V, Greg M, Shields M. Addition of generic medication vouchers to a pharmacists academic detailing program: Effects on the generic dispensing ratio in a physician-hospital organization. *Journal of Managed Care Pharmacy*. 2010; 16(6): 384–92.
- <sup>14</sup> Shields MC, Patel PH, Manning M, Sacks L. A model for integrating independent physicians into accountable care organizations. *Health Affairs*. 2011; 30(1): 161–172.





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