APhA2010 Annual Meeting and Exposition

Washington, DC

March 12 - 15, 2010

Date: Sunday, 3/14/10
Time: 3:30 PM - 5:30 PM
Location: Convention Center, Room 152B

Title: **The Evolving Role of Outcomes for MTM Services**
ACPE # 202-000-10-065-L04-P • 0.2 CEUs

Level: Level 2
Activity Type: Knowledge-based
Speaker(s): Laura J. Cranston, RPh, Pharmacy Quality Alliance, Inc.
William R. Doucette, PhD, University of Iowa
Jon Schommer, PhD, University of Minnesota

Learning Objectives:

At the completion of this activity, participants will be able to:

1. Describe why it is important for pharmacists to be engaged in quality initiatives.
2. Describe the results of the 2009 APhA MTM Digest.
3. Discuss the results of selected scientific studies that evaluate MTM implementation and the impact of MTM services on patient outcomes.
4. Discuss outcomes from Pharmacy Quality Alliance demonstration projects using of a report card system to assess the quality of pharmacy performance.

Disclosures:

- Laura Cranston, RPh, Pharmacy Quality Alliance, Inc. declares no conflicts of interest or financial interests in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, or honoraria.

- William Doucette, PhD, University of Iowa declares no conflicts of interest or financial interests in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, or honoraria.

- Jon Schommer, PhD, University of Minnesota declares no conflicts of interest or financial interests in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, or honoraria.

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Supported by an independent educational grant from Community Pharmacy Foundation.

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See the instructions on page 13 of the Education Guide.
All CPE participation must be recorded by April 30, 2010, 11:59pm EDT.

The Evolving Role of Outcomes for MTM Services

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The Pharmacy Quality Alliance, Inc.

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Jon C. Schommer, Ph.D.
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CPE Information and Disclosures

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To receive credit for this activity, you must attend this activity in its entirety and complete your CPE information and program evaluation online using the voucher code assigned to this session.

The American Pharmacists Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.

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Self-Assessment - Content Review

- Describe key reforms in health care that are raising the importance of quality initiatives for pharmacists.
- Identify quality-related outcomes that are important to the providers and the payers of Medication Therapy Management (MTM).
- Describe the findings from at least one scientific study that evaluated the impact of MTM services on outcomes.
- Describe quality-related outcomes that have emerged from Pharmacy Quality Alliance demonstration projects.

Self-Assessment – Thought Questions

- What do you think are useful ways to link payment for MTM services to quality outcomes?
- Why do you think providers of MTM currently associate value from these services in altruistic (rather than economic) terms?
- Why is it difficult to attribute changes in clinical, humanistic, and financial outcomes to MTM service provision?

Quality & Health Care Reform:
How Are They Connected?

- Who are the driving forces **on quality issues?**
- What are they advocating?
- Where will the dollars for quality flow?
- How can pharmacy/RPhs ensure quality?
- How is quality measured?

Performance Measurement & Healthcare Reform: Is There a Connect and Where?

Opening Statements:

"It has become increasingly evident that the way healthcare is paid for in our system does not always encourage the right care, at the right time for each and every patient. Today's payment systems more often reward providers for the quantity of care delivered, ***rather than the quality of care.***

In 2008, the United States spent more than 17 percent of our gross domestic product (GDP) on health care....while spending is high, our nation ranks low in many areas of quality....

(Excerpts from 4/29/09 Senate Finance Committee Policy Options document)

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Who are the Driving Forces on Quality?

Friends of the Stand for Quality Enterprise

www.standforquality.org

Major Players (Steering Committee):

- National Quality Forum
- America's Health Insurance Plans
- Federation of Hospitals
- Pacific Business Group on Health
- American Medical Association
- Brookings Institution
- American Benefits Council
- AFL-CIO
- AARP
- American College of Physicians
- National Partnership for Women & Families

NOTE : 165 organizations have signed onto the principles/recommendations which are being strongly pushed in both the House and Senate

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Six Recommendations *Stand for Quality* is Advocating:

- Set national priorities and provide ***coordination for quality improvement;***
- Endorse and maintain **nationally standardized measures:**
- **Develop measures** to fill gaps in priority areas;
- Ensure that providers and other stakeholders have a role in developing policies on use of measures;
- Collect, analyze and make ***performance information available and actionable***
- Support a sustainable **infrastructure for quality improvement**

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Recommendations aimed at creating a safe, efficient, patient-centered health care system

Build on successes of work already underway, create an integrated national infrastructure that will put into the hands of providers of care, purchasers of care, and consumers of care **information to inform their decisions.**

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The Quality Enterprise is Advocating:

- HHS should receive **$75 million annually to develop measures** for national endorsement
- NQF should receive **$50 million annually to support the expanded work of that organization in priority setting, measurement, endorsement and maintenance of measures.**
- **$75 million** of public support for expanded collection of **performance information**
- **$100 million annually to support research that will help us better understand which quality improvements make the biggest difference** in helping clinicians, hospitals and "others", ***deliver higher quality, more affordable care***.

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Linking Payment to Quality Outcomes

For hospitals:

- Establish a **Hospital Value-based Program (VBP)**
- Develop procedures for making reported quality data available to the public.
- Ensure that the hospital has the opportunity to review the data prior to such data being made public.
- Financially reward hospitals differently for PERFORMANCE, rather than simply reporting quality data.
- The VBP would lead to value-based payments for acute care hospitals in FY 2012.

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Linking Payment to Quality Outcomes:

For doctors:

- The 2006 Tax Relief and Health Care Act required the establishment of a Physician Quality Reporting System, named Physician Quality Reporting Initiative.
- MIPPA made this program permanent...and built in incentive payments.
- Eligible to participate in this program are Medicare physicians, nurse practitioners, physicians assistants, clinical psychologists and therapists.
- CMS is developing a plan to transition this program to a value-based purchasing program as well (plan to be in place by May 2010).

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Where does Pharmacy Fit into Quality & into Health Care Reform?

- Pharmacy, in general, is not often delineated separately in healthcare reform policy options;
- Pharmacists/Pharmacy providers might fall into the "all other" categories; and
- Even when pharmacy is delineated (as it was in the MMA legislation with regard to MTM), ***being given those opportunities does not always result in the expected outcomes***.

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Pharmacy Quality Alliance

- Established in 2006 as a public-private partnership by former CMS administrator Dr. Mark McClellan and is now an independent, nonprofit organization
- Consensus-based, membership alliance with 50+ members and over 250 active representatives from these company;
- Recognized leader in pharmacy quality measurement
- **Mission:** ***Improve the quality of medication use across health care settings through a collaborative process in which key stakeholders agree on a strategy for measuring and reporting performance information related to medications.***

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Where do we go from here?

- PQA, working with other quality organizations, **needs to begin embracing performance measurement, public reporting and building pay-for-performance models**.
- PQA needs to work with you to ensure pharmacists have a seat at the Quality table.
- PQA, and stakeholders involved in ensuring appropriate **medication use**, need to define how they want to be measured.

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APhA Medication Therapy Management Digest

Medication Therapy Management Survey Advisory Board


William R. Doucette PhD


Kathleen A. Johnson, PhD


Lourdes G. Planas, PhD


Jon C. Schommer PhD

Survey conducted during 2009 yielding responses from 739 MTM providers and 69 MTM payers.

This project was funded by the American Pharmacists Association through an unrestricted grant from Wyeth Pharmaceuticals. In addition, data were collected and made available for analysis by the American Pharmacists Association. We gratefully acknowledge APhA staff and consultants with whom we collaborated for this project: Anne Burns, Maria Gorrick, Judy Lofton, James Owen, Deborah Ruddy, and Margaret Tomecki.

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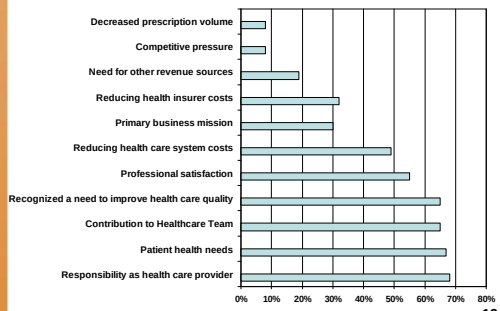
Value Associated with Pharmacist – Provided MTM (Provider Perspective - % reporting 'very significant')



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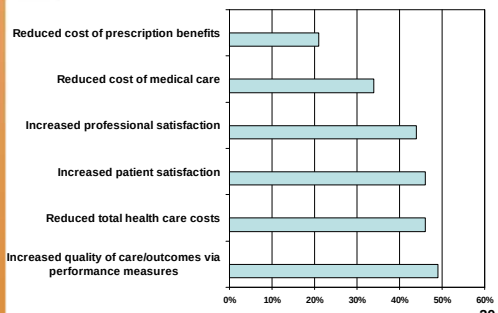
Value Associated with Pharmacist – Provided MTM (Payer Perspective – % reporting 'very significant')



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Return on Investment (Providers)

- 92% of MTM providers did not know the ratio of return-to-costs for MTM services.
- Of those who reported a return-to-costs ratio estimate:

- 22% reported a ratio less than 1
- 9% reported a ratio equal to 1
- 69% reported a ratio greater than 1

- Median -- 3 to 1

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Return on Investment (Payers)

- 91% of MTM payers did not know the ratio of return-to-costs for MTM services.
- Of those who reported a return-to-costs ratio estimate:

- 0% reported a ratio less than 1
- 25% reported a ratio equal to 1
- 75% reported a ratio greater than 1

- Median -- 3 to 1

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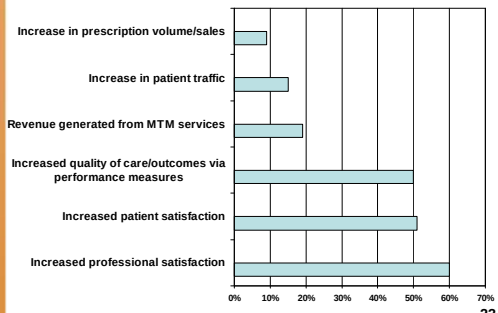
Monitoring Value Associated with Pharmacist – Provided MTM (Provider Perspective – % reporting 'very significant')



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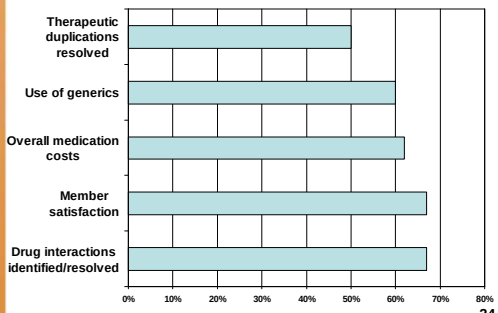
Monitoring Value Associated with Pharmacist – Provided MTM (Payer Perspective – % reporting 'very significant')



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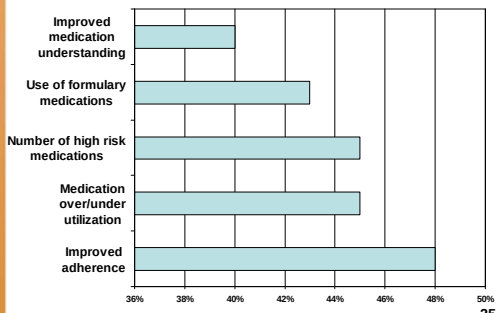
Monitoring Value Associated with Pharmacist – Provided MTM (Payer Perspective – % reporting 'very significant')



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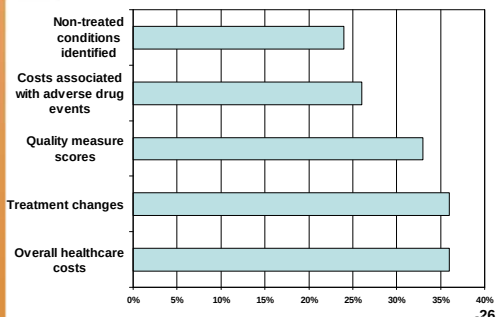
Monitoring Value Associated with Pharmacist – Provided MTM (Payer Perspective – % reporting 'very significant')



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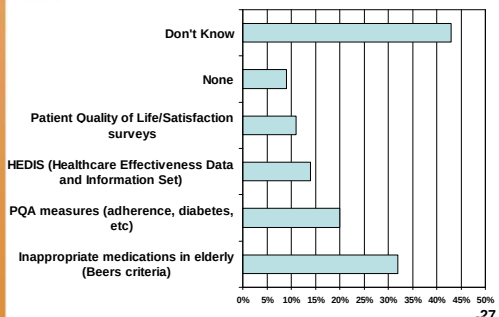
Measures That Have Been Improved by MTM (% of payers reporting 'Yes')



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Summary Comments

- **Providers** may view MTM as an avenue for applying their expertise, advancing their profession, and – for some providers – developing revenue streams.
- **Payers** may view MTM provision as a way to improve their ability to meet performance standards and reduce total health care costs. Based on written comments, it appears that some payers are still working on identifying and measuring end points to serve as indicators of value.

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Questions for Discussion

- How can providers and payers with differing motivations regarding MTM provision come to congruence so that both parties can achieve their goals?
- Can a common script be developed for MTM provision so that providers and payers can be 'reading from the same page'?

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Pharmaceutical Case Management (PCM) in Iowa

- PCM implemented for Medicaid beneficiaries by Iowa legislature in 2000; continues in Iowa
  - Eligible patients
    - 2 or more chronic diseases
    - 4 or more scheduled, non-topical prescription medications
  - Eligible providers
    - Pharmacists with PharmD or equivalent; Approved care plans and approved pharmacy; Care team with patients and physicians
- Other states (MN, MO) have modeled Medicaid programs after Iowa's lead

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PCM Program

- Public Sector
  - Pharmacists identify patients; Submit eligibility request to Medicaid
- Private Sector Pilot program
  - Eligible patients identified through claims data; Pharmacists notified of patient list
- PCM consistent with consensus core principles for MTM
  - Regimen review by pharmacist, Develop action plan for problems, Work with patient & MD to implement plan

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PCM Program

- Initial Assessment
  - Comprehensive regimen review by pharmacist, Develop action plan, Begin to implement plan
- Follow-up Assessment
  - Assess progress towards goals in action plan, Update action plan as necessary
- New Problem Follow-up Assessment
  - New problem identified unrelated to original action plan
- Preventative Assessment
  - If no medication problems identified at initial assessment, preventative assessment scheduled in 6 months, Same process as initial assessment

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Evaluation of PCM Services

- Two assessments
  - 1) Initial evaluation of PCM for Iowa Medicaid beneficiaries
  - 2) Assessment of PCM for beneficiaries of a private insurer
- PCM for Iowa Medicaid
  - 3,037 eligibles in 117 pharmacies with 9 month follow-up
  - Funding from the Iowa Pharmacy Foundation
- PCM for Private Insurer
  - 255 eligibles in 55 pharmacies with 18 month follow-up
  - Funding from the Community Pharmacy Foundation

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Results of PCM Evaluations

- PCM for Iowa Medicaid
  - 524 patients received 1,599 PCM services
  - 2.6 drug therapy problems/patient receiving PCM
  - Medication appropriateness improved
  - Use of high risk meds decreased for patients at least 65 y.o.
  - Cost neutral program – Total care costs
- PCM for Private Insurer
  - 83 patients received 160 PCM services
  - 2.9 drug therapy problems/patient receiving PCM
  - No significant change in medication appropriateness
  - No significant change in high risk meds for older adults
  - Cost neutral program – Total care costs

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PCM Discussion

- Medication appropriateness index (MAI) vs. # DTPs
  - MAI focused on safety of current medications – Does not address effectiveness as well, nor untreated conditions
- Costs balanced by benefits at total cost perspective
  - Drug plan (PDP/PBM) perspective may miss larger picture
  - MTM as a Medicare Part B benefit might address this
- Medication use-based eligibility inhibits capacity growth
  - Too few MTM eligibles stated as barrier to offering MTM
  - Could use patient cost sharing approach to manage MTM

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Evaluating MTM Services

- Providers & payers (E.g. CMS, employers) interested in evaluating MTM programs
- Can address processes, outcomes and/or quality of the MTM services
  - Processes: Actions that occur during the delivery of care
    - E.g. MTM visit; Patient education
  - Outcomes: Results of processes of care
    - Clinical: physiological parameters (E.g. BP, HbA1c)
    - Humanistic: health status, patient satisfaction, adherence, behavior change
    - Financial: related to costs & benefits of care and productivity of people
  - Quality: Care is consistent with a standard

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Focus of MTM Programs

- All Medicare Part D MTMPs will include a comprehensive medication review (CMR)
  - Comprehensive outcome measures tend to be burdensome to use (E.g. MAI) – Starting with CMR occurred (Y/N)
  - Further development of outcome measures would be helpful
- MTMPs commonly target beneficiaries with multiple conditions – More likely to have a drug-related problem
  - Condition-specific outcome measures more likely to be available (E.g. claims-based adherence to oral diabetes medications, BP readings)

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Evaluating MTM Processes

- CMS tracks Medicare Part D MTM process variables:
  - MTM service provider type (Pharmacists: 98.1% of MTMPs; Community pharmacists: 21.9% of MTMPs; In-house staff only: 48.0%)
  - Type of intervention (E.g. Annual comprehensive medication review)
  - Participation in MTM (E.g. 12.9% of Part D enrollees were eligible for MTM; 85.2% of eligibles participated in MTMP)
- CMS will collect in 2010: Number of CMRs, Number of targeted med reviews, Number of prescriber interventions, Changes in therapy resulting from interventions

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Evaluating MTM Processes

- Retrospective chart reviews – Described drug-related problems identified, Pharmacist action: Project ImPACT and Iowa Medicaid PCM
  - ImPACT: 4.9 visits/pt/yr – PCM: 1.7 visits/pt/yr
  - ImPACT: 4.5 (2.4) meds – PCM: 7.5 (3.1) meds
  - ImPACT: 2.4 DRPs/pt/yr – PCM: 2.6 DRPs/pt/yr
  - Needs new drug (39.8%, 22.0%)
  - Non-adherence (31.1%, 25.9%)
  - Adverse drug reaction (11.7%, 11.1%)

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Evaluating MTM Outcomes

- Clinical Outcomes
  - Pharmacists helped improve diabetes outcomes (HbA1c, lipids) and asthma control (Asheville Project)
  - Pharmacist-physician team management of HTN showed high BP control rates: 30% vs. 64% (Carter)
  - Mixed support for pharmacists in managing diabetes
- Humanistic Outcomes
  - Patients satisfied with pharmacist-delivered telephone MTM services (Moczygemba)

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Evaluating MTM Outcomes

- Financial Outcomes
  - Pharmacists helped decrease costs for diabetes and asthma care (Asheville Project)
    - Decreased medical costs
    - Fewer missed or non-productive work days
  - MTM services showed net profit after 16 months (~200 MTM visits) (McDonough)

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Discussion / Issues

- Difficult to attribute change in outcomes to MTM services
  - E.g. Impact of MTM on secondary prevention of AMI
- Medicare likely to be vital driver of MTMPs
  - 2010 MTMPs more in-line with consensus elements of MTM
  - Outcomes of MTM services a stated future interest
- Research on outcomes of MTM services is needed

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How are Pharmacies'/Pharmacists' Performance Measured Today?

- **Number of prescriptions filled/day.**
- **Generic conversion.**
- **Prescriptions filled per unit of time.**
- **Labor Cost per prescription.**
- **Rx sales.**
- **New/Refill prescription ratio.**
- **Customer Satisfaction – convenience oriented.**

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Measures that pharmacy (PQA) has created: New ways to measure pharmacy performance

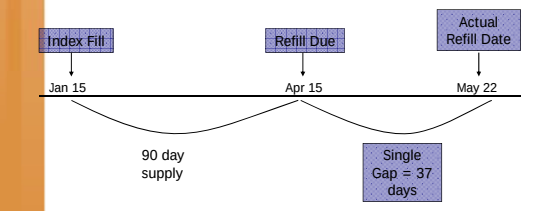
- **Proportion of Days Covered:**
  1. Beta Blockers
  2. Angiotensin-Converting Enzyme Inhibitor/Angiotensin Receptor Blocker (ACEI/ARB)
  3. Calcium Channel Blockers
  4. Dyslipidemia Medications
  5. Diabetes Medications
- **Gap in Therapy Measures:**
  6. Beta Blockers
  7. ACEIs / ARBs
  8. Calcium Channel Blockers
  9. Dyslipidemia Medications
  10. Diabetes Medications
- **Diabetes Measures:**
  11. Excessive Doses of Oral Medications
  12. Suboptimal Treatment of Hypertension
- **Asthma Measures:**
  13. Suboptimal Control
  14. Absence of Controller Therapy
- **High Risk Medications**
  15. Use with caution in the elderly

An Example: PQA Adherence Measure

Measure Title	Measure Description/Definition
Gap in Therapy	Percentage of prevalent users who experienced a significant gap in medication therapy.

- This measure will determine the proportion of patients treated with a medication who experience a significant gap in refills. It is calculated among patients known to be taking the medication of interest at any time during the measurement period.
- A significant gap may be 30 days in a 6-month measurement period.

PQA Adherence



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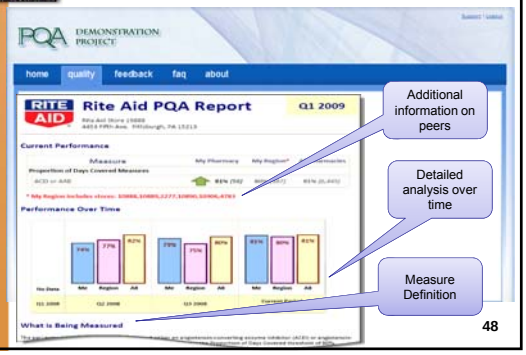
Pharmacy Provider Performance Report Cards: a future reality?

See Your Measure Value Across Time



Shaping the Future: If you were a Pharmacy Measure Developer...

Propose 3 future measures for pharmacy quality. For each proposed measure, please provide the following:

- Description of the measure.
- Why is this relevant to pharmacists?
- Data Source: Will you get the data from claims databases, electronic or paper charts, patient reports, or other?
- What are the possible barriers to the measurement?
- What should the incentives be to RPhs whose pharmacies meet or exceed optimal measurement?

Q & As, Feedback, Thank you & Contacts

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