QUALITY MEASURES:
HOW PHARMACISTS CAN MAKE AN IMPACT
FRIDAY/10:00-10:45AM

ACPE UAN: 0107-9999-17-019-L04-P 0.075 CEU/0.75 hr

Activity Type: Knowledge-Based

Learning Objectives for Pharmacists: Upon completion of this CPE activity participants should be able to:
1. Outline current quality metrics of various organizations and programs
2. Identify the impact pharmacists can have on quality improvement measures
3. Describe strategies to adapt the attendee’s pharmacy practice in order to participate in quality measurement and improving outcomes

Speaker: Amanda Brummel, PharmD, BCACP
Amanda Brummel, PharmD, BCACP serves as the Director of Clinical Ambulatory Pharmacy Services. Dr. Brummel has been employed by Fairview Pharmacy Services since 1999 when she graduated from the University of Minnesota. While at Fairview, she has built and practiced Medication Therapy Management (MTM) in multiple clinic locations, was the clinical supervisor for the MTM department, the MTM Operations & Program Manager. Currently Dr. Brummel has responsibility for the MTM program, the clinical development and integration of pharmacy services in the Fairview Health Network including our transitions of care approach and our retail clinical services. She works closely with the Fairview Medical Group and the Fairview Network in our population health approach and new payer product development. Dr. Brummel is also an Adjunct Associate Professor at the University of MN. She has published multiple articles on MTM and pharmacy’s role in the care team. She has chaired and served on multiple committees and is a current member of the Minnesota Pharmacists Association, the American Society of Health-System Pharmacists, the American College of Clinical Pharmacy and Pharmacy Quality Alliance (PQA).

Speaker Disclosure: Amanda Brummel reports that she was an advisory board member for Johnson & Johnson. Off-label use of medications will not be discussed during this presentation.
Quality Measures: How Pharmacists Can Make an Impact

Amanda Brummel, PharmD, BCACP
Director, Clinical Ambulatory Pharmacy Services

Disclosure

- Amanda Brummel reports:
  - Participated on Advisory Board on transitions of care for Johnson and Johnson
Learning Objectives

• Upon successful completion of this activity, participants should be able to:
  • Outline current quality metrics of various organizations and programs.
  • Identify the impact pharmacists can have on quality improvement measures.
  • Describe strategies to adapt the attendee’s pharmacy practice in order to participate in quality measurement and improving outcomes.

The only constant in healthcare

ChangeEvent Ahead
Evolving Trends

- Physicians feel the financial pinch
- Financial viability a priority
- Technology advancements continue
- Value-based contracting increasing
- Population health management critical
- Stakeholder collaboration must increase

MACRA Quick Review

- Legislation passed in April 2015 repealing the Sustainable Growth Rate (SGR)
- Locks provider reimbursement rates at near-zero growth
  - 2016-2019: 0.5% annual increase
  - 2020-2025: 0% annual increase
  - 2026+: 0.25% annual increase or 0.75% increase depending on payment track
- Stipulates development of two new Medicare payment tracks
  - Merit-Based Incentive Payment System (MIPS)
  - Advanced Alternative Payment Models (APMs)
- Programs to be implemented on Jan 1, 2017
- Payouts begin in 2019
MIPS | Merit-Based Incentive Payment System

MIPS Combines
- Rolls existing quality programs into one budget-neutral pay-for-performance program
  - Medicare Meaningful Use (MU)
  - Physician Quality Reporting System (PQRS)
  - Value-Based Modifier (VBM)

MIPS Scoring
- Providers will be scored on
  - Quality (50%)
  - Resource use (10%)
  - Clinical practice improvement activities (15%)
  - EHR3 use / advancing care information (25%)


APMs | Alternative Payment Models

APM Track
- Significant revenue share with two-sided risk
  - Quality measurement
  - EHR requirements
- APM track participants would be exempt from MIPS payment adjustments and qualify for a 5 percent Medicare Part B incentive payment in 2019-2024
- APM’s include
  - CSM Innovation Center Model
  - MSSP (Medicare Shared Savings Program)
  - Demonstration Under Health Care Quality Demonstration Program
  - Demonstration Required by Federal Law
  - Examples: ACOs, Patient Centered Medical Homes, and bundle payments

Quality Measure Programs

- HEDIS
- MNCM
- CAHPS
- PQRS
- Meaningful Use
- Value Based Purchasing
- Medicaid
- Commercial ACO
- STARs
- Enhanced MTM

Measurement Burden

- 1,000+ Measures In Use
- Health Plan Measures
- State Measures
- Institutional Measures
- Ratings

Example Medicare Measures

Effective Clinical Care
- Diabetes: Hemoglobin A1c Poor Control (A1C >9)
- Diabetes: Low Density Lipoprotein (LDL-C) Control (<100 mg/dl)
- Heart Failure: ACE Inhibitor or ARB Therapy, Metabolic Therapy
- Coronary artery disease: Antiplatelet Therapy
- Anti-depressant medication mgmt

Efficiency and cost reduction
- Appropriate treatment/testing

Communication and care coordination
- Medication reconciliation: Post discharge med rec (>65yr)
- Advanced care plan (>65yr)

Community/Population health
- Preventive care and screenings
- Flu, pneumovax, pain, depression

Patient safety
- High-risk medications in elderly
- Adherence to antipsychotic medications/schizophrenia

Medicare ACOs – domains & measures

Patient experience (CAHPS)
- Timely care, appointments & info
- Doctor communication
- Patient rating of doctor
- Access to specialists
- Health promotion & education
- Shared decision making
- Health status/Functional status
- Stewardship of Patient Resources

Preventive health
- Influenza immunization
- Pneumococcal vaccination
- Adult weight screening/Follow up
- Tobacco use assessment and cessation
- Depression screening
- Colon cancer screening
- Mammography screening
- Depression remission at 12 months

At-risk populations
- Hypertension – Blood pressure control
- Diabetes - Hemoglobin A1c poor control
- Diabetes - Eye exam
- IVD: Use of Aspirin or another Antithrombotic
- Use of Imaging Studies for Low Back Pain
- Ambulatory Sensitive Condition – Acute Comp.

Care coordination/Safety
- COPD
- Congestive heart failure
- Risk standardized, all condition readmission
- Screening for fall risk
- SNF 30 day all cause readmission measure
- Med reconciliation post discharge
- All cause unplanned admission for DM
- All cause unplanned admission for MCC
Part D STAR Measures (2017)

- D01: Call Center – Foreign Language Interpreter and TTY
- D02: Appeals auto-forward
- D03: Appeals upheld
- D04: Complaints about the drug plan
- D05: Members choosing to leave the plan
- D06: Beneficiary Access and Performance Problems
- D07: Drug plan quality improvement
- D08: Rating of drug plan
- D09: Getting needed prescription drugs
- D10: Medicare plan finder price accuracy
- D11: High risk medication ** will be display in 2018
- D12: Medication adherence for diabetes medications
- D13: Medication adherence for hypertension (RAS antagonists)
- D14: Medication adherence for cholesterol (statins)
- D15: MTM Program Completion Rate for CMRs

HEDIS Measures

- Persistence beta-blocker treatment after heart attack
- Controlling high blood pressure
- Comprehensive diabetes care
- Cancer Screenings (Breast, cervical, colorectal)
- Medication management (Antidepressant, COPD, asthma)
- High risk medications in the Elderly
- Annual monitoring - persistent medications
  - (ACEI/ARB, digoxin, diuretics)
- Flu and pneumovax vaccinations
- CAHPS survey
- Statin Therapy for Patients with Diabetes & CVD

Questions to ask yourself

- What partnerships are available to you?
- What metrics are your pharmacists impacting today?
- What metrics could your pharmacists be impacting?

Determine your opportunity

- What practices or plans are you affiliated with that are open to partnership (or should be).
  - Know your nearby practices
    - Performance Transparency Tools
    - What metrics are they focusing on/what ones are they measuring?
Find Synergy

• Start by setting up what data you need to collect to demonstrate your value.
• Determine what impact the pharmacist has had on the measures.
• Determine the value of that impact.

Provide Feedback = Results

• Start by setting up what data you need to collect to demonstrate your value.
• Determine what impact the pharmacist has had on the measures.
• Determine the value of that impact.
The Bottom Line –

- Determine your opportunity
- Understand your partners’ needs
- Determining areas of greatest impact
- Think long term
- Measure your impact
- Determine your value

Appendices
Comprehensive Medication Management

Ensure comprehensive MTM services are available where there is need across the population
Will likely focus on the most complex patients
- Multiple conditions not at goal
- High utilization/risk

Example Metrics:
Diabetes - Hemoglobin A1c poor control (A1c >9)
Hypertension – Blood pressure control
Statin Therapy for Patients with Diabetes

Fairview Example

Optimal Diabetes Care Outcomes Following Face-to-Face Medication Therapy Management Services

- Results: The percentage of diabetes patients optimally managed was significantly higher for MTM patients compared to the year earlier (21.49% vs. 45.45%, P < 0.01).
- HbA1c showed a mean reduction of 0.54%
- Patients who opted in for MTM had higher Charlson scores, more complex medication regimens, and a higher percentage of diabetes with complications
Kaiser Permanente

Enhancing diabetes care by adding a pharmacist to the primary care team: an analysis of short term clinical markers and long-term cardiovascular outcomes.

- Results: HbA1c value was decreased from 9.5% to 6.9% in the enhanced care group and from 9.3% to 8.4% in the control group (p < 0.001) over 12 months.

- Patients in the enhanced care group were significantly more likely to attain goals for HbA1c, LDL-C, and BP reduction and were three times more likely to attain all three goals.


Continuum of Care Services

Transitions of Care services

- Inpatient and Outpatient teams working together to reduce readmissions through improved medication management, reconciliation, and patient education.

Example Metrics:

- All cause unplanned readmission for DM
- All cause unplanned readmission for HF
- All cause unplanned readmission for multiple chronic conditions
- Medication Reconciliation Post Discharge
Group Health

Postdischarge pharmacist medication reconciliation: Impact on readmission rates and financial savings:

- Results: Patients who received medication therapy assessment and reconciliation had decreased readmission rates at 7, 14, and 30 days postdischarge, with statistical significance at 7 and 14 days.
  - 7 days: 0.8% vs. 4% (P=0.01); 14 days: 5% vs. 9% (P=0.04); and 30 days: 12% vs. 14%

- Financial savings for Group Health who received medication reconciliation was an estimated $35,000 per 100 patients


Hennepin County Medical Center

ASHP-APhA Medication Management in Care Transitions Best Practices

- Results: The baseline 30-day readmission rate for the target population during the pilot was 23%. For patients who completed all steps of the process, there was a reduction in the 30-day readmission rate to 8%.

- Health-system pharmacists are tasked to complete medication reconciliation upon discharge and MTM at the follow-up clinic appointment that occurs 5 to 7 days following discharge.

ASHP-APhA Medication Management in Care Transitions Best Practices 2013
Reviewing pharmacy data to find trends or opportunities for better management

- Brand to generic opportunities
- Safety alerts
- High risk meds
- Best practice algorithms

**Example Metrics:**
- High risk medications in the elderly
- Heart Failure: ACE Inhibitor or ARB Therapy, Beta Blocker therapy
- IVD: Use of Aspirin or another Antithrombotic

VA Medical Centers

*Improvement of Guideline Beta-Blocker Prescribing in Heart Failure: A Cluster-Randomized Pragmatic Trial of a Pharmacy Intervention*

- Eligible patients had a beta-blocker prescription that was not guideline concordant. Two types of interventions were reviewed.

- Results: The intervention which provided a list of patients not meeting goals and asked the pharmacist to report back data was associated with 1.9-fold greater odds of improvement in prescribing (95% CI 1.1–3.2). Those patients also had greater odds of a higher dose (1.9, 95% CI 1.1–3.3).
Therapy Management

Focused disease/medication management to a single condition
- Hepatitis C
- RA/MS
- Oral Oncology
- Anemia
- Coumadin

Example Metrics:
- Hypertension: Blood pressure control
- Medication Management: Antidepressant, COPD Exacerbation, Asthma
- Coronary Artery Disease: Antiplatelet Therapy

Health Partners

Effect of Home Blood Pressure Telemonitoring and Pharmacist Management on Blood Pressure Control: A Cluster Randomized Clinical Trial

- Intervention patients received home BP telemonitors and transmitted BP data to pharmacists who adjusted antihypertensive therapy accordingly.

- Results: The proportion of patients with BP control at both 6 and 12 months was significantly greater in the telemonitoring group than in the usual care group. Systolic BP decreased more from baseline among patients in the telemonitoring intervention group at 6 months (-10.7 mm Hg; P<.001), at 12 months (-9.7 mm Hg; P<.001), and at 18 months (-6.6 mm Hg; P = .004).

Pharmacists manage medications until they reach recommended clinical targets. They are referred members with diabetes, high blood pressure, or high cholesterol who are not at goal, or are taking anticoagulation therapy.

Results: Dec 2010 – March 2012 of nearly 3,000 patients with diabetes, hypertension, high cholesterol who received the service:

- 84% reduced A1C levels, 64% reached their clinical goals with A1C <7 or <9%.
- 72% reached LDL goals
- 70% achieved BP goal of <140/90 or <130/80

Community Pharmacy Services

Clinical Pharmacy Services
- Hypertension management
- Asthma/COPD intervention programs
- Adherence program
- Diabetes management/education

Vaccination Program
- Flu, pneumovax, Zoster, Tdap, etc

Example Metrics:
- Medication Adherence for Diabetes, RAAS antagonists, statins
- Influenza immunization
- Pneumococcal vaccination

Geisinger

Advancing Best Practices in Medication Therapy Management: A Compendium of Health Plan Initiatives

Pennsylvania Project

Pharmacist Intervention Improved Medication Adherence and Reduced Health Care Costs

• Evaluated the impact of a pharmacy based intervention on adherence to 5 chronic medication classes. (CCB, oral diabetes, beta blockers, statins, RAAS)

• Results: The intervention group had significantly improved adherence (PDC > 80) for all medication classes. There was also a significant reduction in per patient annual health care spending for those taking statins ($241) and oral diabetes medications ($341).

Transparency Tools

Hospital Compare
https://www.medicare.gov/hospitalcompare/search.html

Physician Compare
https://www.medicare.gov/PhysicianCompare/search.html
https://www.medicare.gov/physiciancompare/staticpages/data/pqrs.html

Health Plan Compare
http://healthinsuranceratings.ncqa.org/2015/search
Self-Assessment Questions

Which is not an evolving trend of our health care market today?
   a) Physicians/Practices are feeling a financial pinch
   b) Technology advancements decline
   c) Value-based contracting increasing
   d) Population health management critical

Self-Assessment Questions

The Merit-Based Incentive Payment System (MIPS) is combining which existing quality programs into it?
   a) Medicare Meaningful Use (MU)
   b) Physician Quality Reporting System (PQRS)
   c) Value-Based Modifier (VBM)
   d) All the above
Self-Assessment Questions

Of the quality programs outlined today, which measure falls into each one (PQRS, MU, ACO, Part D Star, HEDIS)?

a) Pneumonia vaccination
b) High Risk Medications
c) Diabetes - A1c Poor Control
d) None of above