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Ambulatory Care Revolution – Value Based Purchasing Across the Continuum

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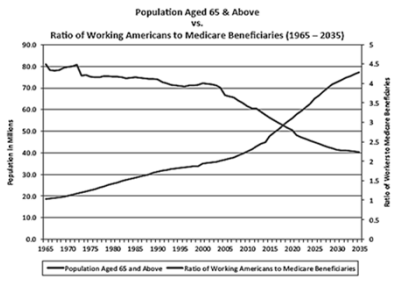
Objectives

- Discuss the revolution occurring with acquisitions and new businesses established to meet payer demands for performance and shared risk in health care costs.
- Discuss the perspectives of the C-suite on ambulatory care needs in infrastructure, management of work force, and revenue management to ensure sustainability and success.
- Describe implications of technology and personalized medicine for health systems.
- Identify areas of opportunity for pharmacy leaders preparing for success in the changing health care environment.

The American population over age 65 will double in size by 2035

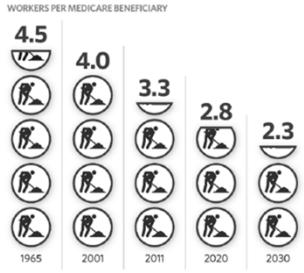


Source: US Census Bureau, Bureau of Labor Statistics, CMS.gov, AgingStats.gov

Workers per Medicare Beneficiary

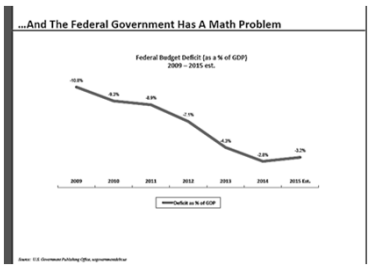
The number of workers per Medicare beneficiary is falling

Workers' contributions to Medicare aren't set aside for their own retirement—they pay for *current* beneficiaries. A main cause of Medicare's growing insolvency is that the ratio of workers to beneficiaries is falling.

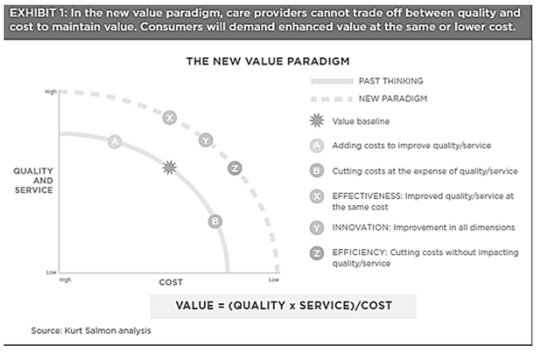


Source: Medicare Trustees 2012 Report

...And the Federal Government has a Math Problem



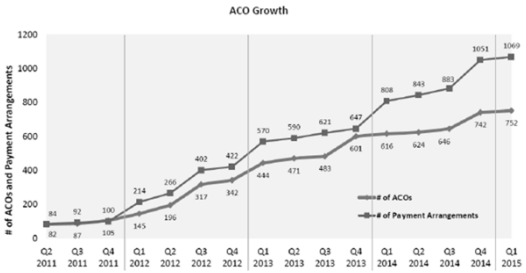
Source: US Government Publishing Office, usgovernmentdebt.us



Bundled Payments for Care Improvement (BPCI)

Source: Centers for Medicare & Medicaid Services

Shared Savings Models (ACOs)

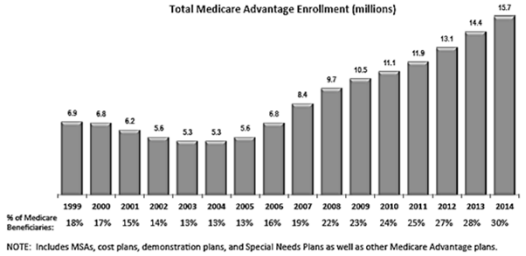


Source: Leavitt Partners Center for Accountable Care Intelligence

Shared Savings Models (ACOs)

Source: Leavitt Partners Center for Accountable Care Intelligence

Full / Partial Risk Capitation



NOTE: Includes MSAs, cost plans, demonstration plans, and Special Needs Plans as well as other Medicare Advantage plans.

Source: MPR/Kaiser Family Foundation analysis of CMS Medicare Advantage enrollment files, 2008-2014, and MPR, "Tracking Medicare Health and Prescription Drug Plans Monthly Report," 1999-2007; enrollment numbers from March of the respective year, with the exception of 2006, which is from April.

Aggregation Phase

- Health Systems and large groups acquire physicians to gain market share and defend referrals
- Physician organization is fragmented, lacking unified clinical or business processes or market presence as a group practice

Integration Phase

- Employed physicians evolve toward a group practice with standardized clinical and business processes and a governance model within the Health System
- Physician and hospital businesses managed separately
- Ancillary income locus drives economics
- Financial incentives are used to align behaviors

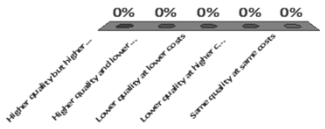
Alignment Phase

- Physician and hospital economics are integrated
- Physicians in key health system leadership roles
- Fully integrated service lines created
- Focus on optimizing overall performance rather than business unit performance

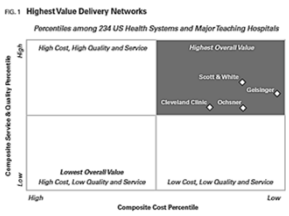
THE CHARTIS GROUP
Management Consultants

Multispecialty group practices as compared to primary care practices or specialty only practices provide

A. Higher quality but higher costs
B. Higher quality and lower costs
C. Lower quality at lower costs
D. Lower quality at higher costs
E. Same quality at same costs



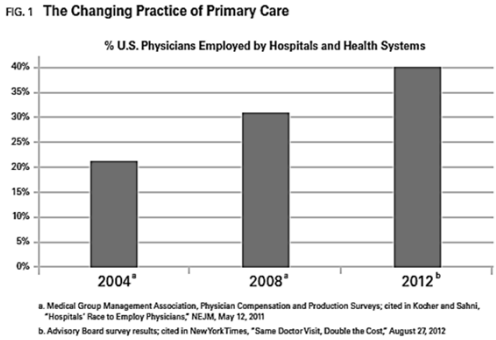
Value = (Quality + Service + Access)/Cost

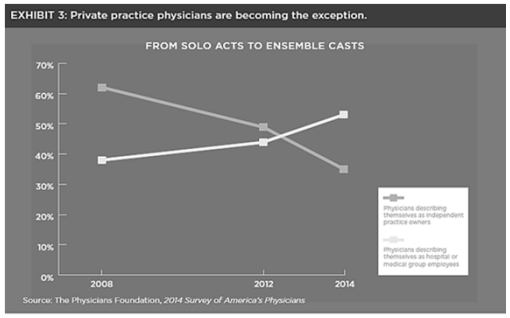


THE CHARTIS GROUP Management Consultants

Better Value in Multi-Spec Group Practices

- *Multispecialty group practices provide higher quality of care on selected preventive and process measures involving recommended screening tests and diabetes and asthma management…than smaller, looser forms of practice"*
  - Stephen M. Shortell 2008
- *Standardized physician spending was $239 (8.0 percent) lower; standardized hospital spending was $235 (9.7 percent) lower; and total standardized Medicare payments were $540 (7.1 percent) lower for such patients."*
  - Elliott Fisher 2010





Kurt Salmon Review

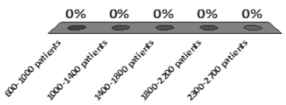
Why push for PCPs?

- ❖Increase patient population footprint
- ❖Diversification of disease burden
- ❖Create footprint for multispecialty systems
- ❖Limited resource
  - Strike now or be left behind

PCP=Primary Care Provider

A primary care physician panel size is typically

A. 600-1000 patients
B. 1000-1400 patients
C. 1400-1800 patients
D. 1800-2200 patients
E. 2300-2700 patients



Leverage the Team

- PCPs not enough in population health
  - Advanced Practice Practitioners
  - Nurses
  - Pharmacy
  - Case managers
  - Medical Assistants
- Population per unit team
  - Target 3k-5k patients per team – general medical patients
  - Target 300-500 patients per team – high utilizer clinic, patients with multiple chronic diseases

Bigger is Better

- Bigger Pie
- Greater Access
- Rationalization of Care

Mergers, Acquisitions Territorial Control

Imperialistic Approach

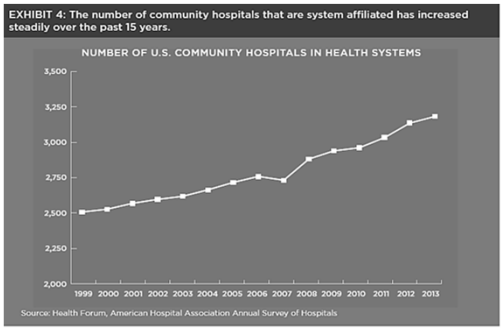
- Pros
  - Control, Integration, and Alignment
- Cons
  - Capital expensive
  - Resentment and Mutiny
  - Conflict with academic mission

Collaborative Network of Independent Organizations with Common Shared Risk

- Pros
  - Less capital resources
  - Rationalization of care
- Cons
  - Competition of collaboration over clinical and finances
    - Coopetition
  - Governance

What will the Alliance lead to?

- Rationalization of Care
  - Utilization
  - Location
- Care delivery models that meet the patient where they are
  - Traditional and digital
  - Physicians and non-physicians



Kurt Salmon Review

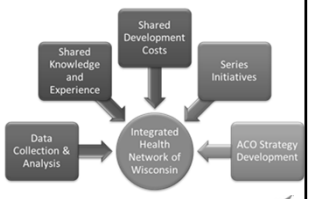
Taking Sides in Wisconsin

Integrated Health Network

abouthealth

Strategic Intent

- Create a broad based regional network of providers through clinical integration that has single-signature authority to contract on a non-exclusive basis with employers and other payers
- To respond to new payment methods by creating an integrated approach to care management
- Maximize opportunities to achieve scale, distributed geographic presence, and enhanced market coverage

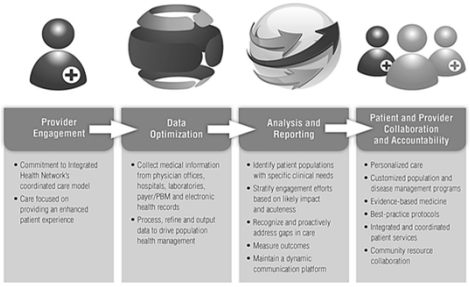


Linking with Other Providers

Need to Build Comprehensive Options

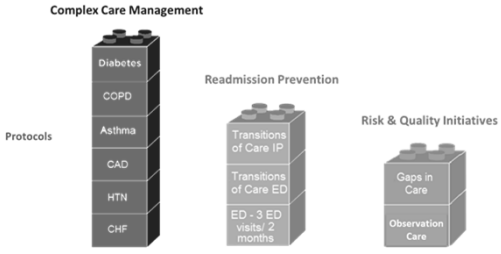
Essential to partner with other components of the delivery system

Population Health Management

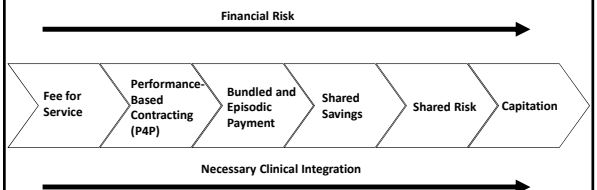


IHN Care Programs

Care programs are actions/processes aimed at specific patient groups to meet a financial and/or quality outcome.

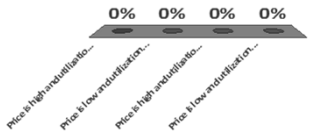


The Journey from FFS to Risk

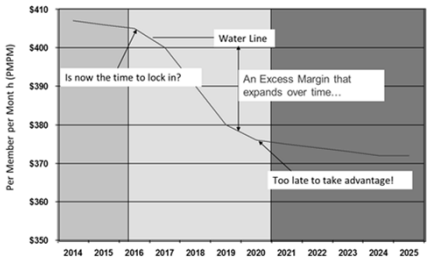


ACOs compete on price and utilization. They should accept risk contracts when their

A. **Price is high and utilization is high**
B. **Price is low and utilization is high**
C. **Price is high and utilization is low**
D. **Price is low and utilization is high**



Timing is Critical - If assuming full risk, when do we make the jump?



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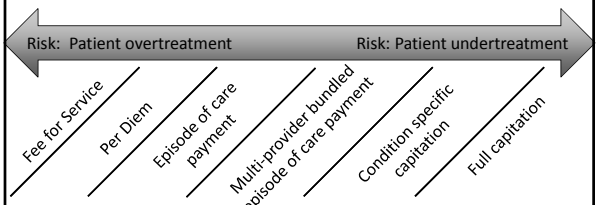
Value Proposition Breakout

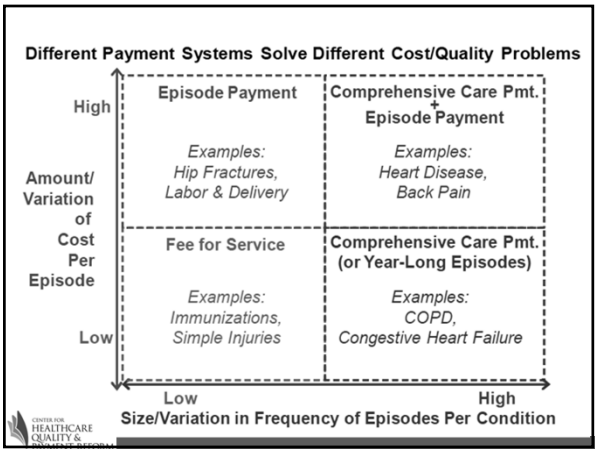
What type of value is expected from these teams and healthcare?

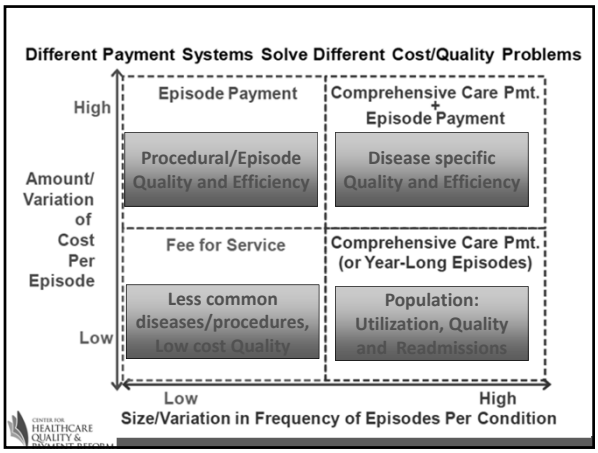
Report out from Breakouts

ashp



Modified from Miller HD. Creating Payment Systems to Accelerate Value-Driven Heatlh Care – September 2007

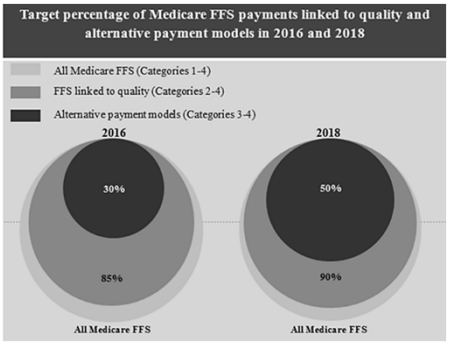




Where is CMS going?

Payment Taxonomy Framework

	Category 1 Fee for Service (FFS)	Category 2 Fee for Service with link to Quality	Category 3 Alternative Payment Model built on Fee For Service Platform	Category 4 Population Based Payment
Paid for:	Volume	Volume with a portion based on quality/efficiency	For effective management of a population or episode of care	Up front for population
Medicare Program	• FFS • Most linked to quality	• Value Based Purchasing • MD Value Modifier • Readmissions • HACs	• ACO • Medical Homes • Bundled payments • ESRD • Dual Eligible	Pioneer ACOs in future

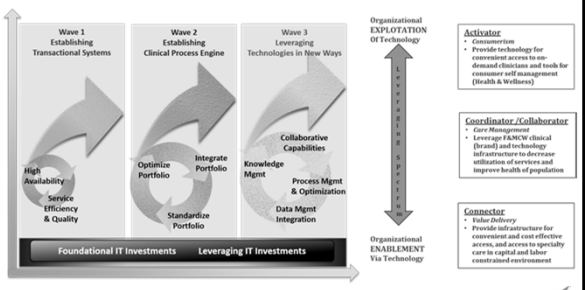


IT Support Breakout

What resources from IT are needed to enable teams to provide value?

Report out from Breakouts

Waves of Change within F&MCW



Waves of Change within F&MCW

Organizational EXPLOTATION Of Technology

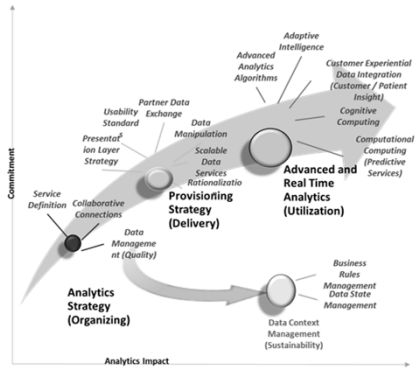
Leveraging Spectrum

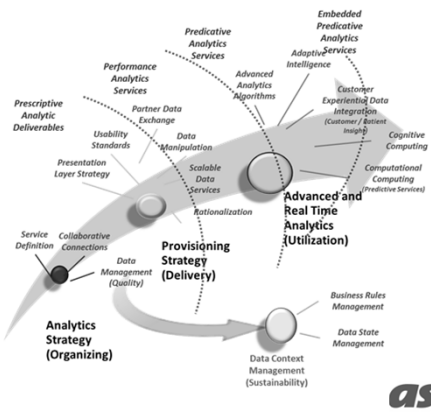
Organizational ENABLEMENT Via Technology

Activator
- *Consumerism*
- Provide technology for convenient access to on-demand clinicians and tools for consumer self management (Health & Wellness)

Coordinator /Collaborator
- *Care Management*
- Leverage F&MCW clinical (brand) and technology infrastructure to decrease utilization of services and improve health of population

Connector
- *Value Delivery*
- Provide infrastructure for convenient and cost effective access, and access to specialty care in capital and labor constrained environment



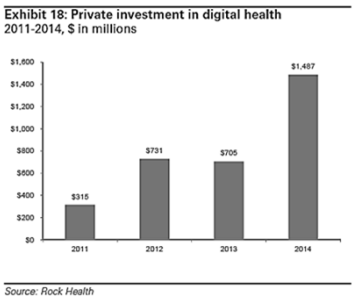


Digital Health Breakout

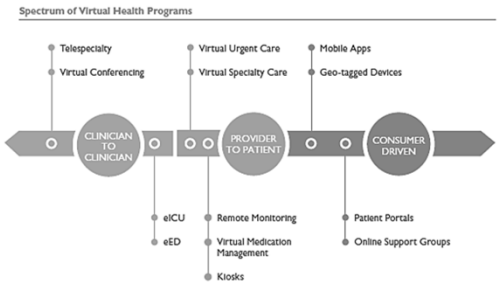
What digital opportunities are available to promote value?

Report out from Breakouts

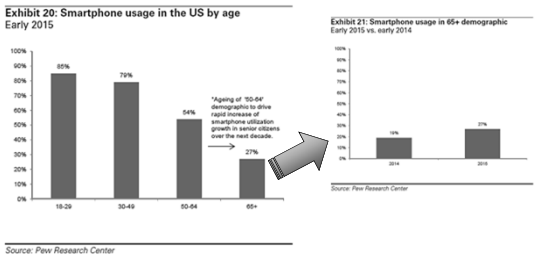
Dollars are Flowing into Digital Health



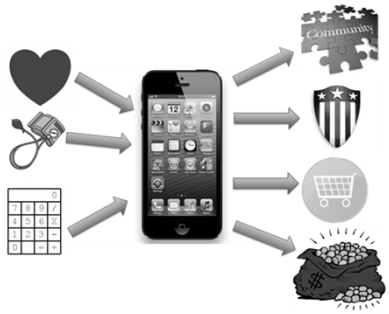
Spectrum of Digital Health Programs



Smartphone Usage in US by Age



The Quantified Self



HOSPITAL SYSTEM

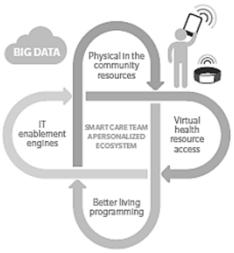
... a market-and/or region-leading hospital company

CLINICALLY INTEGRATED NETWORK

... an integrated, cross-continuum care delivery network

SMART CARE TEAM ECOSYSTEM

... a patient-centered population health management company



RETAIL/SMART PHONE PERSONALIZED MARKET

... a consumer-centered better living company

And Beyond

Froedtert & Medical College of Wisconsin

- F&MCW is developing and implementing a new paradigm to healthcare
  - Needs to be patient/consumer centered
  - Needs to reduce costs and utilization and improve quality and service
  - Needs to be work for different payment models
  - Needs to leverage our academic – community partnership, our growth and our multi-system ACO
- VIDEO

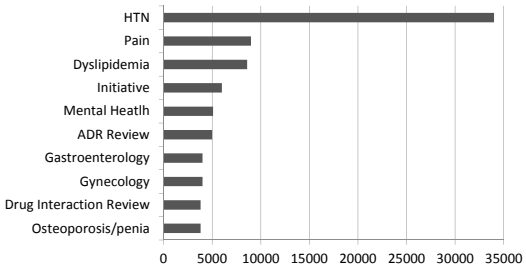
University Hospital Consortium model

Pharmacy Breakout

Given your findings during this session what role can pharmacy play to promote value?

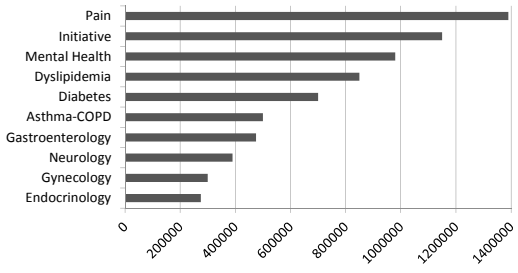
Report out from Breakouts

PCCPS: Drug-Related Consults by Volume



PCCPS=Primary Care Clinical Pharmacy Services
Heilmann RM et al. *Ann Pharmacother*. 2013; 47:124-31.

PCCPS: Consults by Drug Cost Avoidance



Heilmann RM et al. *Ann Pharmacother*. 2013; 47:124-31.

PCCPS Population Health Initiatives

❖ Patient Safety
- Eliminated "as needed" on long-acting opioid scripts
- Reduced NSAIAs in Chronic Kidney Disease patients
- Decreased use of diazepam for patients ≥65 years
- Reviewed long-acting β-agonists w/o inhaled corticosteroids in patients with asthma

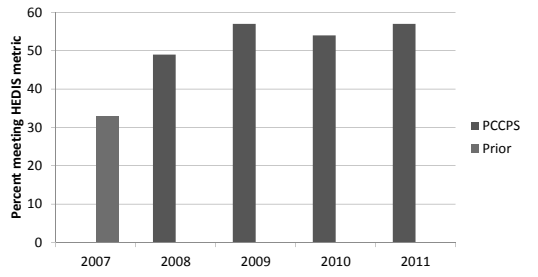
Heilmann RM et al. *Ann Pharmacother*. 2013; 47:124-31.

PCCPS Population Health Initiatives

❖ Quality of Care
- Reviewed/developed plans for HTN prior to RN visits
- Recommended change from raloxifene/etidronate to bisphosphonate when appropriate
- Reviewed meds for increased fall risk or urinary incontinence in patients ≥65 years of age
- Reviewed plans for females ≥67 years of age with fracture to determine need fro BMD or osteoporosis medication

Heilmann RM et al. *Ann Pharmacother*. 2013; 47:124-31.

PCCPS Moves the Needle in Osteoporosis



Heilmann RM et al. *Ann Pharmacother*. 2013; 47:124-31.

PCCPS Population Health Initiatives

❖ Affordability
- Assessed patients using multiple inhalations of inhaled corticosteroids for conversion to a more potent agent
- Evaluated patients for generics or lower cost substitution
  - Migraine – triptan, UC – mesalamine, HSV famciclovir to acyclovir, non-CHF patients: metoprolol succinate XL to immediate-release β-blocker

Heilmann RM et al. *Ann Pharmacother*. 2013; 47:124-31.

Team Based Care: PCMH and MTM

❖ CHF 12 RCTs (*n* = 2,060)
- CHF hospitalizations: **OR 0.69** (95% CI: 0.51 to 0.94)

❖ Hyperlipidemia 7 RCTs (*n* = 924)
- LDL reduced by **-13.4%** (95% CI: -23.0% to -3.8%)

❖ Hypertension 19 RCTs (*n* = 10,479)
- SBP reduced by **-8.1 mm Hg** (95% CI: -10.2 to -5.9)

❖ Diabetes 14 RCTs (*n* = 2,073)
- HgA1C reduced by **-0.76%** (95% CI: -1.06 to -0.47)

❖ CKD 8 RCTs (*n* = 688)
- ESRD/Death in DM Nephro: **14.8 v 28.2/100 patient-years**

Odum et al. *Cardiorenal Med*. 2012; 2:243-50.

Advocate Physician Partners

❖ Governance – led by physicians

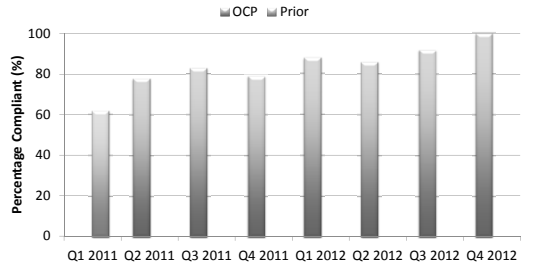
❖ Oncology Clinical Pharmacist
- Develop and maintain specialty/oncology related protocols

❖ Educate and collaborate with physicians
- Develop CME program that was mandatory

❖ Provide value added services

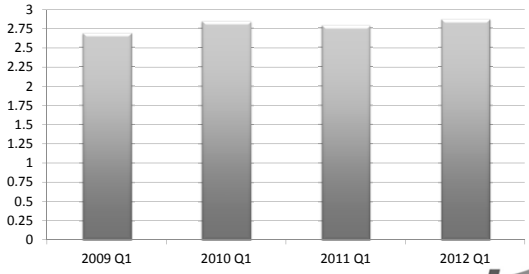
Patterson CJ. *J Manag Care Pharm*. 2013; 19:42-8.

Oncology Clinical Pharmacist



Patterson CJ. *J Manag Care Pharm*. 2013; 19:42-8.

Dollars Per Member Per Month (PMPM) for IV Chemotherapy



Patterson CJ. *J Manag Care Pharm*. 2013; 19:42-8.

Value Added Services Provided in FY12

Services Provided	Quantity
Claims Denial and approval consultations	7
Drug information questions answered	23
Drug summaries sent to providers	6
Educational presentations	11
Newsletter publications	12
In-office physicians visits	19
Pharmacy and Therapeutics presentations provided	31

Patterson CJ. *J Manag Care Pharm*. 2013; 19:42-8.

Unplanned Readmissions in Older Patients?

- ❖When led by hospital pharmacists
  - Risk Ratio 0.97 (0.88-1.07) NS
- ❖When led by community pharmacists
  - Risk Ratio 1.07 (0.96-1.20) NS
- ❖However
  - 3 RCTs for older patients with CHF show a 25% reduction in unplanned readmissions

Objectives

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