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Influence of National Health Policy Objectives and Strategies on Pharmacists' Scope of Practice

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AACP/NABP DISTRICT IV MEETING

CHICAGO, ILLINOIS

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Disclosure

- I have no actual or potential conflict of interest in relation to this activity.

Learning Objectives

- Recognize the fundamental policy shift in Medicare and Medicaid payment policy to reward “value” rather than “volume” of health care services.
- Define the key principles of patient-centered and team-based care that facilitate improved clinical and safety outcomes from the use of medications.
- Explain the connection of a pharmacist’s “scope of practice” (a primarily state-based construct) to emerging national objectives, practice standards, and patient care needs.

Pre-Test 1. The announced goals of the Centers for Medicare and Medicaid Services (CMS) to shift the vast majority of its payment structure for physicians' and other providers' services toward quality/value-based performance are intended to occur over the next:

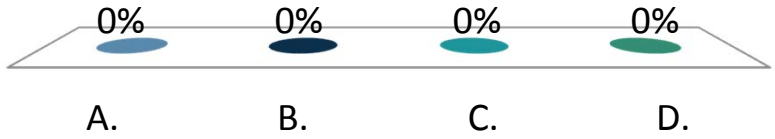
A. 6-12 months
B. 2-3 years
C. 5-10 years
D. 2 decades

Pre-Test 2. Which of the following is not considered an essential principle of high-performing health care teams?

A. Financial accountability
B. Effective communications
C. Shared goals
D. Clear roles

Pre-Test 3. Which of the following elements of a pharmacist's state-authorized scope of practice will likely be impacted by current national trends in delivery system and payment policy reforms?

A. Frequency of licensure renewal
B. Required number of hours of ACPE-approved continuing education activities
C. Structure and efficiency of collaborative practice agreements and clinical protocols
D. Increases in the pharmacist-to-technician ratio allowed under state regulations



Current “Truths” in Health System Reform

Patient-centeredness (e.g., the “baby boomer” demographic’s impact)

Health care teams, PCMH’s, and ACO’s

Payment Reform: ↓ FFS and ↑ quality, outcomes, and value

Risk sharing (and possible reward sharing)

Accountability for meeting quality measures

Care transitions; preventing readmissions

Proactive analysis of and care for populations

Technology innovations and adaptations (precision medicine, genomics, etc.)

MACRA 2015 – game changer for medicine

18th time is a charm: MACRA repeals the 1997 sustainable growth rate for Part B payments

Replaces the SGR with a new payment method meant to move physicians towards alternative payment models (APMs)

MACRA creates two available tracks

- MIPS: “fee-for-service plus quality link”
- APMs: accountable care organization or other risk-bearing organization

What is "MACRA"?

The **Medicare Access and CHIP Reauthorization Act of 2015 (MACRA)** is a bipartisan legislation signed into law on April 16, 2015.

What does Title I of MACRA do?

- **Repeals** the Sustainable Growth Rate (SGR) Formula
- **Changes the way that Medicare** rewards clinicians for **value** over volume
- **Streamlines** multiple quality programs under the new **Merit-Based Incentive Payments System (MIPS)**
- Provides **bonus payments** for participation in **eligible alternative payment models (APMs)**

MACRA is part of a broader push towards value and quality

In January 2015, the Department of Health and Human Services announced **new goals** for **value-based payments** and **APMs in Medicare**

Medicare Fee-for-Service

GOAL 1:

30%

Medicare payments are tied to quality or value through **alternative payment models (categories 3-4)** by the end of 2016, and 50% by the end of 2018

GOAL 2:

85%

Medicare fee-for-service payments are **tied to quality or value (categories 2-4)** by the end of 2016, and 90% by the end of 2018

STAKEHOLDERS:

Consumers | Businesses
Payers | Providers
State Partners

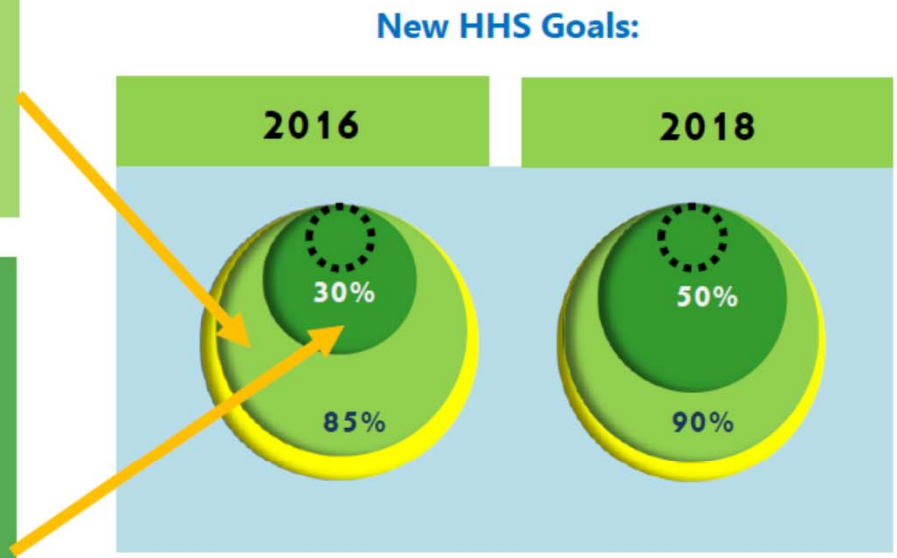
Set **internal goals** for HHS

Invite **private sector payers** to match or exceeed HHS goals

MACRA moves us closer to meeting these goals…

The new Merit-based Incentive Payment System helps to link **fee-for-service payments** to quality and value.

The law also provides incentives for **participation in Alternative Payment Models** in general and bonus payments to those in the most highly advanced APMs



All Medicare fee-for-service (FFS) payments (Categories 1-4)

Medicare **FFS** payments **linked to quality and value** (Categories 2-4)

Medicare payments linked to quality and value **via APMs** (Categories 3-4)

Medicare Payments to those in the most highly advanced APMs under MACRA

...and toward transforming our health care system.

3 goals for our health care system:

BETTER care
SMARTER spending
HEALTHIER people

Via a focus on **3 areas**

Incentives

Care Delivery

Information Sharing

What is patient-centered care?

"The experience (to the extent the informed, individual patient desires it) of transparency, individualization, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in health care."

Donald Berwick, M.D.
Former CMS Administrator
President, Institute for Healthcare Improvement
Health Affairs, August 2009

Any recent “significant” experience as a “real” patient?

Stop and Reflect

- What was it like?
- Did you feel:
  - Fully informed about your diagnosis and care plan?
  - Included in discussions/decisions about your care?
  - Empowered/expected to question and discuss?
  - Respected/valued as an individual?
  - Part of the team’s structure/activities?

What is team-based care?

"The health care we want to provide for the people we serve—safe, high-quality, accessible, person-centered—must be a team effort. No single health profession can achieve this goal alone."

Carol A. Aschenbrener, M.D.
Executive Vice President
Association of American Medical Colleges - 2011

IOM Paper "Team Members"

Pamela H. Mitchell
University of Washington

Matthew K. Wynia
American Medical Association

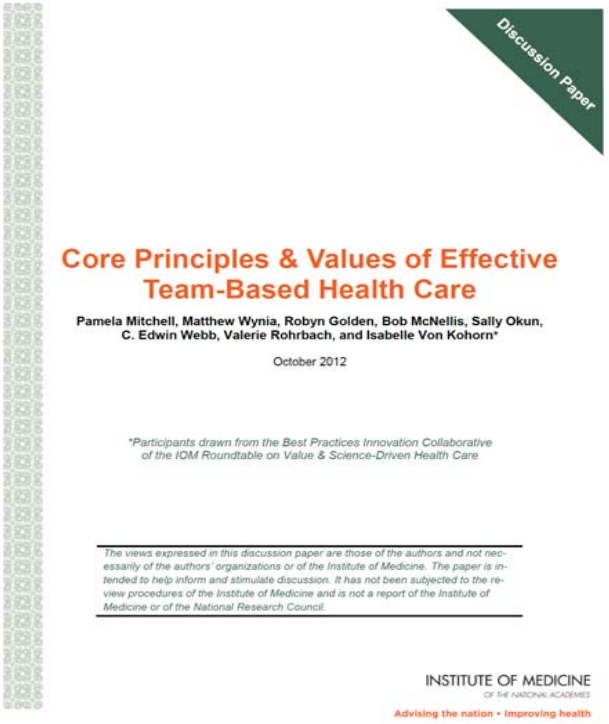
Sally Okun
PatientsLikeMe

C. Edwin Webb
American College of Clinical Pharmacy

Robyn Golden
Rush University Medical Center

Bob McNellis
American Academy of Physician Assistants (*former*)
Agency for Healthcare Quality and Research

Isabelle Von Kohorn, Institute of Medicine (*former*)
Valerie Rohrbach, Institute of Medicine



IOM Discussion Paper 2012:
A framing definition

Team-based health care is the provision of health services to individuals, families, and/or their communities by at least two health providers who work collaboratively with patients and their caregivers—to the extent preferred by each patient—to accomplish shared goals within and across settings to achieve coordinated, high-quality care.

IOM Discussion Paper 2012:

Necessary Principles of High-Performing Teams

- Shared Goals
- Clear (Distinct) Roles
- Mutual Trust
- Effective Communication
- Measureable Processes and Outcomes

IOM Discussion Paper 2012:

Necessary values of successful team members

- Honesty
- Discipline
- Creativity
- Humility
- Curiosity

So???.....what does all this have to do with pharmacists' scope of practice?

MTM Defined: Profession's Consensus 2005

"MTM is a service or group of services that optimize therapeutic outcomes for individual patients. MTM services include medication therapy reviews, pharmacotherapy consults, anticoagulation management, immunizations, health and wellness programs and many other clinical services.

Pharmacists provide MTM to help patients get the best benefits from their medications by actively managing drug therapy and by identifying, preventing and resolving medication-related problems."

MTM Defined: CMS, Medicare Part D

MTM generally refers to activities intended to optimize therapeutic outcomes by ensuring that patients are taking their medications safely and as prescribed, addressing any barriers to their doing so, and bringing any medication issues to the attention of the treating physician.

Under 423.153(d), a Part D sponsor must establish an MTM program that:

- Ensures covered Part D drugs are used to optimize therapeutic outcomes through improved medication use,
- Reduces the risk of adverse events,
- Is developed in cooperation with licensed and practicing pharmacists and physicians,
- May be furnished by pharmacists or other qualified providers.

CMS perspective on Part D MTM - ~ 2015

"Evidence suggests that the MTM services currently offered by Part D plans fall short of their potential to improve quality and reduce unnecessary medical expenditures, most likely due to misaligned financial incentives and regulatory constraints. Competitive market dynamics and Part D program requirements and metrics may incentivize investment in these activities only at a level necessary to meet the minimum compliance standards."

"Currently, Part D statutory and regulatory MTM provisions require uniform service offerings to enrollees who meet the plan's program criteria, based on numbers of medications and chronic conditions and expected annual prescription drug costs. These criteria both over-identify and under-identify beneficiaries who are either experiencing or at-risk of experiencing medication-related issues and could benefit from MTM interventions."

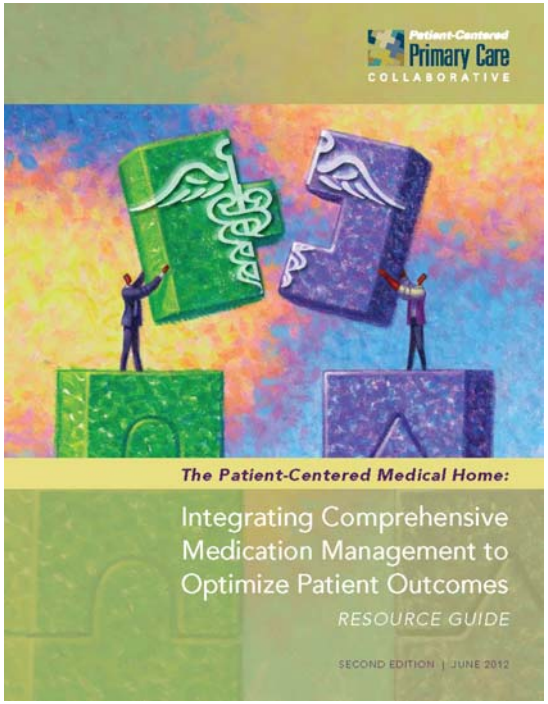
"The result is that Part D MTM programs may not include the level of resources nor the type of activities that could have the greatest positive effect on beneficiary outcomes."

PCPCC defines comprehensive medication management (CMM)

The PCPCC guide defines comprehensive medication management in the PCMH

Included in AHRQ's Innovation Center - Quality Toolkit

2nd Revision with Appendix A- Guidelines for Practice and Guidelines for Documentation



PCPCC Resource Guide: Integrating Comprehensive Medication Management to Optimize Patient Outcomes
http://www.pcpcc.net/files/medmanagement.pdf

CMM Defined: PCPCC

Comprehensive medication management is defined as the standard of care that ensures each patient's medications (whether they are prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that each medication is appropriate for the patient, effective for the medical condition, safe given the comorbidities and other medications being taken, and able to be taken by the patient as intended.

Comprehensive medication management includes an individualized care plan that achieves the intended goals of therapy with appropriate follow-up to determine actual patient outcomes.

This all occurs because the patient understands, agrees with, and actively participates in the treatment regimen, thus optimizing each patient's medication experience and clinical outcomes.

PCPCC Resource Guide: Integrating Comprehensive Medication Management to Optimize Patient Outcomes
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Contribution of Medication Management to the Medical Home Principles

Principle	Medication Management Contribution
Personal Relationship with Physician or Other Practitioner	The therapeutic relationship is established and the patient's medication experience is revealed and used to improve care
Team Approach	The rational decision-making process for drug therapy is utilized and the assessment, care plan and follow-up of drug therapy is integrated with the team's efforts
Comprehensive/Whole Person Approach	All of a patient's medications (regardless of source) are coordinated and evaluated to ensure they are appropriate, effective, safe, and convenient
Coordination and Integration of Care	The intended therapeutic goals, which are made measurable and individualized to the patient, serve to coordinate and integrate the patient's care with other team members
Quality and Safety are Hallmarks	Drug therapy problems are identified, resolved, and prevented in a systematic and comprehensive manner to realize appropriate, effective, safe, and convenient drug therapy for the patient
Expanded Access to Care	Physicians are extended, made more efficient and more effective through the optimal management of a patient's medications
Added Value Recognized	Clinical outcomes are improved, return-on-investment is positive, acceptance by patients is high, and physicians support the practice

“Provider Status”
An “experienced contrarian’s” viewpoint

We would need to look long and hard to find a more “tone-deaf” term for the real issue at hand (effective incorporation of pharmacists’ patient care services) in relationship to the current policy and care delivery issues just outlined

To succeed, the effort must be grounded in a commitment to patients’ care outcomes and quality, not to our own professional “status”…..it can’t be about US!

As an isolated goal, achieving “provider status” guarantees the profession very little (see Murawski and Ives, AJHP 2011, JAPhA 2013)

As an “integrated” part of broader practice and payment policy change, it can help position pharmacists to actually be meaningful and effective “providers”

Current Landscape of Provider Designation

- **37** • Provider designation
- **35** • State statute
- **9** • Medicaid

NASPA

Relevant Existing Approaches

Section 1861 of the SSA – the "holy grail"

- Physician "definition" vs. physician "services"
- Non-physician "providers"
  - Statute focuses FIRST on the services covered (PAID FOR!!!) by the Part B benefit, following by "qualifications" description

NPs and PAs	CSW
PT Services	Ph.D. Psychologist
OT Services	CRNA

Ultimate Irony – a "provider of services" means "…. a hospital, critical access hospital, skilled nursing facility, comprehensive outpatient rehabilitation facility, home health agency, hospice program, or, for purposes of section 1814(g) and section 1835(e), a fund."

Relevant Existing Approaches

State-based – Is it CDTM, “mid-level” or “provider status”?

- North Carolina (2000) – “clinical pharmacist practitioner”
  - Joint Regulatory oversight by BOP & BOM
  - Differentiated training and credentialing requirements
  - Protocol requirements
- New Mexico (1993) – “pharmacist clinician”
  - Primarily “prescriptive authority” initiative
  - Requires diagnostic and physical assessment training equivalent to a physician’s assistant (included in revised Pharm.D. curriculum)
  - Direct supervision of a single physician
  - Policy support outside of pharmacy due to concerns about access to “primary care”

Relevant Existing Approaches

California's "Solution" (2013) – a lesson?

- Amends the "business and professional code" to designate all pharmacists as health care providers
  - Some progressive modifications to general scope of practice
- Establishes "advanced practice pharmacist"
  - Education, training and/or specialist certification requirements beyond licensure
  - Expanded scope of practice, not limited to a pharmacy setting
  - Regulatory framework still in development in 2016

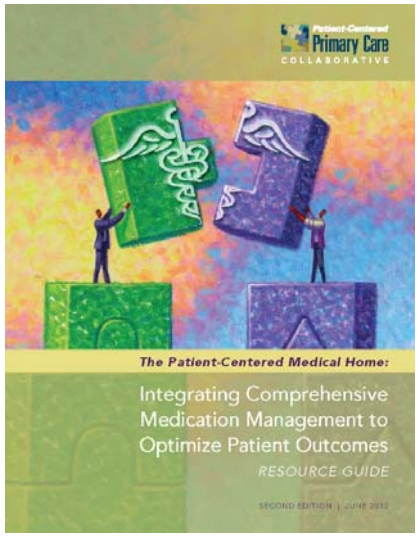
So…what are we still missing…?

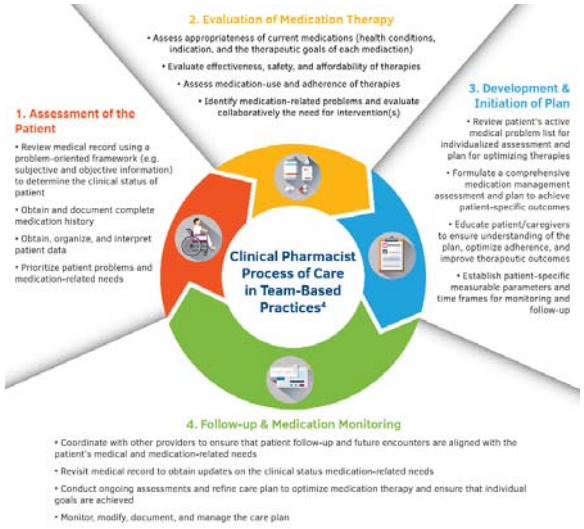
With very limited exceptions, health insurance coverage and payment policies don't explicitly include medication management services as a defined benefit for discreet **PAYMENT**!

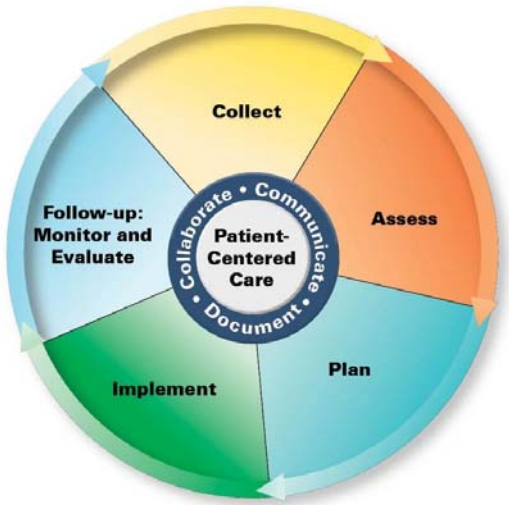
A clearly defined "*what*" delivered using a consistent and standardized process of care

More complete understanding that current trends in payment policy will increase the "*value over volume*" challenge for ALL providers…and the future is no longer far away

Process of Direct Patient Care: Toward standardization and alignment….







Do you know this man?

Photo copyright 2012 - DreamWorks Studios

“Roles” vs. Responsibilities

Some quotes from the Linda Strand Keynote at ACCP 2012:

“‘Linda, when what you do looks like patient care, sounds like patient care and is patient care, then I will pay you for patient care.’”

(BCBS Minnesota executive – circa 1995)

“Each of us developed our own clinical activities, which we define around ourselves, based on our special interests that emphasize our strengths, delivered on our preferred timetable. ***That is not a patient care service - that is a hobby.”***

(On the “early history” of clinical pharmacy)

Responsibilities of “Providers”

A philosophy grounded in an ethical framework that puts patients/families at the center of one’s practice

Clinical performance that is evidence-based, continuously accessible, and rigorously consistent in its process of care

A process of care that is standards-based, recognizable, and understood by patients and the team

A practice infrastructure that assures availability/exchange of essential clinical data, unfailing documentation of care, measures results, and validates value sufficient to justify payment

What Success Looks Like in a Pharmacist's Direct Patient Care Practice

The service can be described simply and in terms of what it can do for the patient

The service has an ethical and fiducial foundation

The service is based on standards of care so that it can be delivered consistently -- one practitioner to the next -- and from one patient to the next

The service integrates with the other providers on the health care team, using aligned and consistent terminology, philosophy, standardized care processes, and quality/outcome emphasis

The service generates measureable, reproducible results that demonstrate value to others

The service is paid for as other direct patient care is paid for (increasingly including emerging value-based payment models)

In the final analysis, “providers” must

…be fully accountable for the care and services they provide, particularly in terms of quality and outcomes;

…be committed to and focused on the patients/family who have given them permission to come into their lives;

…deliver care and services in the context of and alignment with national health policy goals and objectives (“quadruple aim”)

…**OWN and ACCOMPLISH THE WORK** that is the core of their particular expertise….while not adding work to the other clinicians on the care team.

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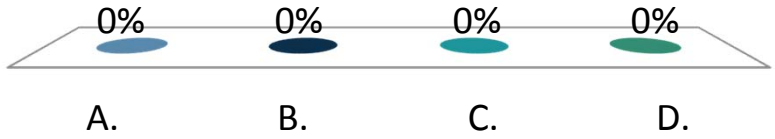

Get The Medications Right!

Questions?

Supplemental Resources for Continuing Professional Development

- Kaiser Family Foundation (www.kff.org)
  - Excellent data source on Medicare policies, trends, expenditures
- National Committee on Quality Assurance (www.ncqa.org)
  - Key organization in health system quality metrics development and application by Medicare/private payers
- Health Affairs (www.healthaffairs.org)
  - Leading national health policy journal covering the widest range of health policy, delivery system, and payment issues.