Medication Management: Where do we go from here?

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How did we get here?

- Pharmaceutical Care concept introduced in mid 1990’s
- Medication Therapy Management (MTM) as part of Medicare Part D
- Expansion of MTM to Commercial plans
- Medication Reconciliation is adopted by JCAHO in 2005
- Med Rec Standard definition continues to expand to multiple points of care
- The Healthcare reimbursement landscape evolves to put providers at risk for readmissions and cost
- MTM transitions to medication Management Management-Transitions of Care
Where do we go from here?

- Barriers
  - Financial
  - Technical
  - Business

- What does Nirvana look like?
  - Medication Management as part of a team approach

- Where do we start?

- What is feasible today?
Barriers

- Financial
  - What is the business model for Medication Management?
  - Who pays? Who accrues value?
  - Is a pharmacist Medication Management model sustainable?
    - Payer pays $1 to $2 per minute for Medication Therapy Management (MTM) and a pharmacist can’t bill out 8 hours of MTM in an 8 hour work day
    - Average margin for a prescription is about $15. A pharmacist can be responsible for 125 to 150 filled prescriptions per day
  - Cost of technology and data
Barriers

- Technical
  - What are the sources of Medication History?
  - What is the latency?
  - What about other clinical information (e.g., labs, Medical History, etc.)?
  - How do you get Medication History into workflow?
  - Does the application make use of all the data provided?
  - Does the application turn data into information?

At the end of the day, a digital Medication History still needs a clinician to verify authenticity with the patient!!!
Barriers

▪ Data sources
  – Doing business with the data sources or the application provider
  – BAAs with a Covered Entity

▪ Data rights
  – Is the data being utilized within the contractual data rights provided by the data source?

▪ Consent mechanism
  – How and when is consent given, and to whom? How is it stored?

▪ Security and Privacy Concerns
  – HIPPA
  – Local and State laws
  – Security and Privacy P&Ps
What does Nirvana look like?

- Patient Centric Medical Home
  - Medications
  - Diet
  - Exercise
  - Vital Signs
  - Additional Therapy
  - Follow up visits with Care Managers, Home Health and Primary Care
Where do we start?
What is feasible today?
What do you have an appetite for?
Pharm2Pharm

- A Medication Management Program funded by CMS
- Looked at Hospital Discharge Medication Reconciliation
- Measured changes in Healthcare cost for ED visits and readmission
PHARMACIST ROLE:
- Dispense medications
- Answer clinician questions
- Manage formulary

ADDED PHARMACIST ROLE:
- Identify patients at risk
- Medication reconciliation
- Patient education
- Hand-off to community pharmacist
- Readmission reviews

“Pharm2Pharm” MODEL for HIGH RISK PATIENTS

ADDED PHARMACIST ROLE:
- Medication management across prescribers and pharmacies for 1 year

PHARMACIST ROLE:
- Dispense medications
- Answer patient questions

PCPs & Specialists

DISCHARGED TO HOME

Community Pharmacies
Pharm2Pharm Patient Timeline

**Discharge**
- Hospital Consulting Pharmacist
  - Screen/enroll
  - Medication reconciliation
  - Patient engagement
  - Formal handoff
  - Review readmissions

**End of One Year**
- Community Consulting Pharmacist
  - 12 medication management visits
  - Identify & resolve drug therapy problems
  - Quarterly updates to prescribers
- Goal
  - Better health
  - Prevent ED visits
  - Prevent re-admissions
  - Lower total cost of care
MEDICATION MEASURES THROUGH MARCH 2014...

81% of patients’ medications were reconciled by the Community Pharmacist within 30 days post discharge
1,833 drug therapy problems were identified
44% of drug therapy problems identified were resolved by the next patient visit
In 8% of visits with the Community Pharmacist, the patient reported medication access problems
40% of medication access problems were resolved by the Community Pharmacist
TOTAL Acute Care Costs (hospital, observation, ER)
Pre/Post Pharm2Pharm Enrollment/Hand-off

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<thead>
<tr>
<th>Duration</th>
<th>PRE</th>
<th>POST</th>
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<tr>
<td>240-day pre/post</td>
<td>$1,622,785</td>
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<td>(pts enrolled through April 2013, n=60)</td>
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<td>210-day pre/post</td>
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<td>120-day pre/post</td>
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<td>(pts enrolled through November 2013, n=658)</td>
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Can we focus on …

- ... a hospital discharge medication reconciliation program for high risk patients?
- Why?
  - Discharge from a hospital creates a medication conundrum.
    - What are the discharge medications?
    - What medications are sitting at home?
    - What has been added, deleted or changed?
    - Does the patient understand this?
Opportunity to highlight Medication Management as a critical Step 1 process!

- Decrease Discharge Adverse Drug Events
- Decrease readmission to the hospital
- Decrease ED visits
- Increase the ability of a high risk patient to understand what they have to do to manage their chronic condition
Next Steps

- Discussion
- New and better ideas
- Workgroup formation
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