

Best Practices Service Level Expectations

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Welcome back from break. And it is quite an honor and a privilege to stand before you here today. And that's because in January of last year, 2011, I was fortunate to be invited to take a six-month sabbatical in the Drug Benefit and C&D Data Group to assist in studying improvements in the MTM Program. Subsequently, I was invited back to the CMS Innovation Center to help achieve our medication safety aims of the Partnership for Patients. But the reason I was attracted to the Part D Benefit Group is germane to today's presentation. And the reason I was drawn to this group is because of work that was started shortly after program inception to measure quality in the MTM Program.

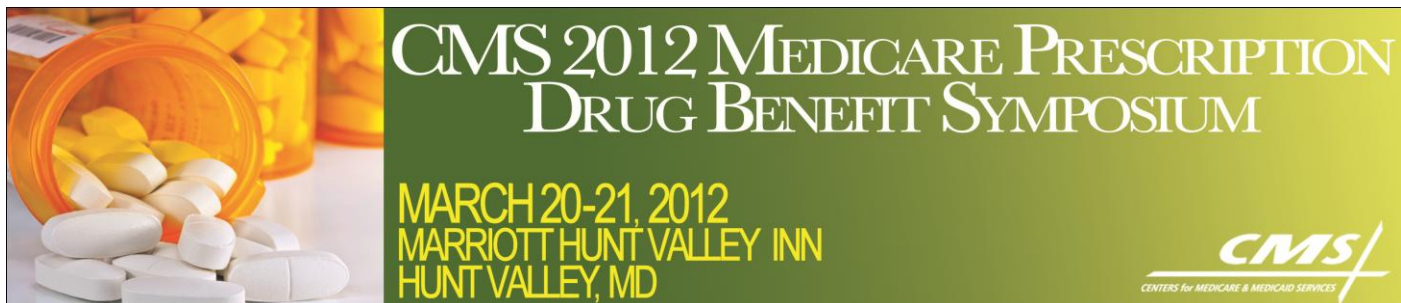
In 2006, I was speaking on an MTM Program in Baltimore. One of the other speakers was a CMS Drug Benefit Representative here today, Michelle Ketcham. And in her presentation, Michelle talked about improving the MTM benefit and measuring quality. Quite frankly, I was amazed. Just think about it for a moment – 2006. Here we were at the height of Cynthia Tudor's slide on the chaos and confusion; and on top of that, we're working with a payment system that was uniquely designed to come out of administrative fees paid to the health plans and our strict limitations on who can receive a comprehensive medication review. And on top of all that in 2006, here we had an individual from CMS who was talking about improving the program and measuring quality. Talk about looking at the glass as half full rather than half empty.

And I really want to take this opportunity to thank all of my colleagues at the Drug Benefit and C&D Data Group for the work we did together. They really treated me on a first-class basis. And it was interesting because they gave me last June three going-away parties. I think they were sending me a message.

All right, so these are our primary objectives, but I want to do much more than that today in the 22½ minutes we have together. And I want to look at the big picture, kind of what Jonathan Blum talked about -- *How are the efforts of our drug benefit and the Medication Therapy Management Program helping us to redesign our nation's medication use system?* And then take that down to the grassroots level. What does that mean to our beneficiaries? What are we conveying and saying to the public about a comprehensive medication review? And that will take us to the value proposition, which John Blum talked about -- *How can we use the Part D Benefit to strategically improve the program?*

And what's dawned on me as I was putting this together was that we have – some of the issues we're addressing today follow the key questions in the 2011 MTM Fact Sheet. And here we're actually going to be addressing 6 of the 11 key questions. We won't answer all of them today, but we certainly will be addressing them. And our Workshop Session agenda -- I want to talk about the national quality strategy - the aims for safer health care, improved transitions and reduced health risks – so we can put this Part D Program into the context of our national efforts; overview of medication management initiatives and interagency external stakeholder groups; the importance of a comprehensive medication review in designing a rational medication use system; analysis of CMR process of care indicators; beneficiary service level expectations; and then program improvements based on beneficiary engagement.

We start with the National Quality Strategy Report to Congress, the Affordable Care Act was passed, and nearly one year of effort was put together to get to this “roadmap” that I like to call it to set our priorities. We have four engines for redesigning health delivery and financing: our interagency partners. When I



was invited back to the Innovations Center August 1st, our very first meeting every Wednesday across from the HHS building in downtown Washington D.C., every government agency involved in health care is in the same room at the same time coordinating our initiatives and programs. How awesome is that? And then that's tied with our national -- the Quality Forum, who convenes our stakeholders. We have our contracts, programs, projects, and then our payment policies.

So we're talking about creating safer systems. Adverse drug events are one-third of the hospital-acquired conditions in the Partnership for Patients. In terms of that, we have the care transitions piece. We're discovering drug-related readmissions -- as you can imagine, an important component to our care transitions; improved effectiveness and prevention, starting with cardiovascular risks -- the Million Hearts initiative. And I want to say a few remarks about our colleagues at the Centers for Disease Control and Prevention, who really have put a lot of time, effort and resources into Pharmacy Outreach project, community transformation grants, and the National Prevention strategy.

So we have as medication managements many programs -- the thousands of Innovation Challenge grants came -- there's some in there. AHRQ has done a wonderful job. Health Resources and Services Administration have our PSPC communities. I've talked briefly about our MTM Fact Sheet. Three of the 17 Beacon Communities are focusing on the IT piece of our care coordination. And then our over 600 area agencies on aging are partnering on the medication use through our Care Transitions program.

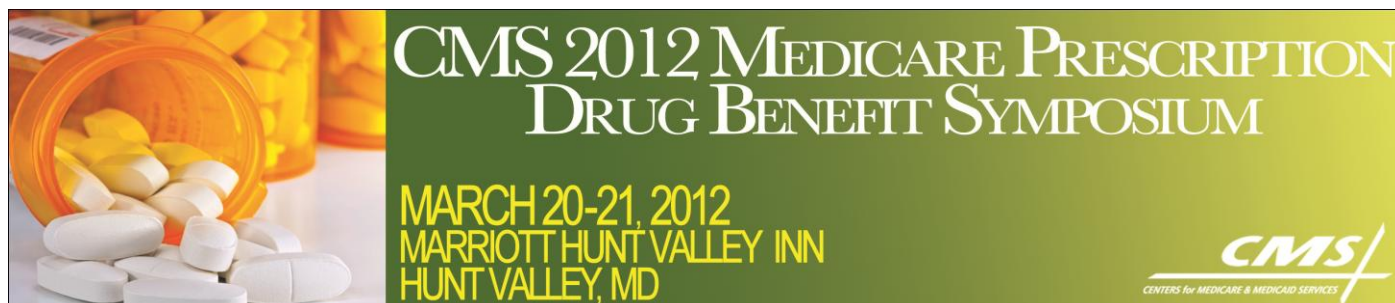
You've probably seen these very bold aims that we're working very hard to achieve. I think what's interesting is we've decreased hospital-acquired conditions from 137 per 1,000 to 111 per 1,000 patients. Remember, a third of those are the adverse drug events, which takes us down to 125. So these are a significant number of lives and dollars that will be saved.

These are the ten core areas, or the market basket of harm, that we're addressing. I highlight four of the ones that are prominently affected by drugs.

This is -- I know it's a busy slide, but it talks about our 26 hospital engagement networks. When I returned to the Innovations Center, they asked me to serve as a Contract Officer Representative; and I took the training, and I'm overseeing four of these particular networks.

Layered on top of our hospital engagement networks are a series of affinity groups -- subject matter experts -- that are intended to help our hospital engagement networks achieve their goals across OB health, patient engagement, rural health, transitions of care, and we have one called the Medication Safety and Pharmacist Engagement Group, which I serve as one of the co-leads on the interagency side. And what we're really looking to do is to work with the medication advisory groups that are embedded in all the hospital engagement networks to get us closer to the sharp end of care. And what that means is to look at quality improvement, using Deming's statistical process controls to do run charts, if you will, on anticoagulation safety, hypoglycemia safety, opioid safety, and what have you.

Now, this slide here -- in the lower left-hand corner -- I include the Part D MTM Program because this is a network of networks. It does not stand alone. And what's nice about the fact that I'm in the Innovations Center, I can bring the experiences and the information to bear in coordinating across the AB and C&D programs. I talk briefly about the Community-based Care Transitions Program. Any folks in this room -- show of hands, please -- have submitted an application in this program? Involved in any or are about to? Know anyone who is? Okay, wait, I've got a couple.



This is a big deal. We have the first 7, plus 23 more were recently announced. I give some of the information about it. But I just want to highlight -- four of the first seven awardees described medication needs assessment root cause readmission components to their applications.

Okay, we transition. Picture yourself on either side of this table. What should happen next? This is a reality, guys. I'll just give you a quick -- you're probably wondering what the retail cost of the drugs on this table are. It's \$92,000. But this is a reality. Someone has to take care of patients. We have to meet this need, and let's talk about what that is.

In the Innovations Center, we have a Signature Style. I'm going to have to truncate it today because of the six and a half minutes we have left. And it's the story of self, the story of us, and the story of now. How many individuals here today have heard about a care innovation initiative that's improving medication safety or effectiveness? Please participate; raise your hands. Come on. All right. Who is working on a team or initiative of any kind that can impact adverse drug events or drug-related readmissions? And finally, how many individuals are working to improve the beneficiary's comprehensive medication review experience? Good, good, good, good, oh beautiful. If we had more time, we'd actually engage in a think/pair/share, but we will not be able to do that at this time.

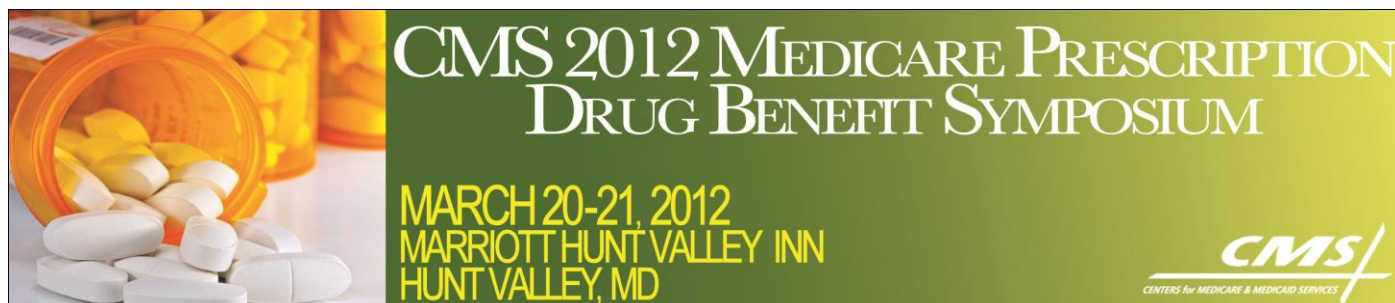
Okay, how can we use a comprehensive medication review to help us build a medication use system? We don't have a scientific medication use system in place. When drugs are approved for marketing, we abandon all scientific principles. This manifests as drug-related morbidity and mortality, the root causes of which have been described as "drug therapy problems." So I pose the rhetorical question, *Will we be able to build a system in which every drug in use in America is assessed for intended medical use, effectiveness, safety and ability to be taken by the patient?*

These are the seven categories of drug therapy problems, which really through thousands and thousands of encounters, fall out in a distribution similar to this. Now, to build a comprehensive medication management system, it would be desirable if every drug in use in America were assessed for intended use, effectiveness, safety and ability to be taken by the patient. It's focused on the "linchpin" I call this of patient-specific goals of therapy, and it's embedded in team-based care, from cradle to grave, across the care continuum.

In describing medication therapy management or medication management, there are a number of key references that are available. And I think what's significant and what I want to convey today is that we may debate what a comprehensive medication review is and medication therapy management services. And that's okay. It happens in every profession. Physicians may say, "Well, wait, that's a left-handed surgery technique, instead of this." But the patient, it just means one thing to them -- they fix the problem. And the problem here is that the patient's not achieving their goals of therapy. So think about it from the beneficiary's perspective, is where I want to take us today.

So we have process of care indicators. We have a technical or scientific component, assessing all the patient's drug-related needs to make therapeutic determinations. There is a social behavioral or art of caring component, establishing a therapeutic relationship. Then we follow on assessment, systematic review of the patient's needs; design a care plan to responsibilities for achieving goals of therapy and resolving drug therapy problems; and follow-up evaluation.

Now, concurrent with the work of the Medicare Part D Drug Program is the work of the American Medical Association's CPT Editorial Panel. I happen to be on the national coalition that worked to approach or submit a code proposal to the CPT Editorial Panel to describe medication therapy management services.



And these have been really articulated and the service articulated; but, however, once again we had a unique situation where they were assigned time-based codes rather than the tiered intensity or resource-based relative values scale.

So let's take a moment to compare the Part D Comprehensive Medication Review with the CPT Medication Therapy Management Services. We have person-to-person compared to face-to-face. Now, person-to-person, as we know, can be telephonic, can be face-to-face. We see use of virtual visits, where the patient may go in a rural area to a nearby clinic; use of the Skype camera; and beginning to see a little bit of – well, I would like to see an iPhone app to help the patients with medication management. But we'll talk about that here in a little bit.

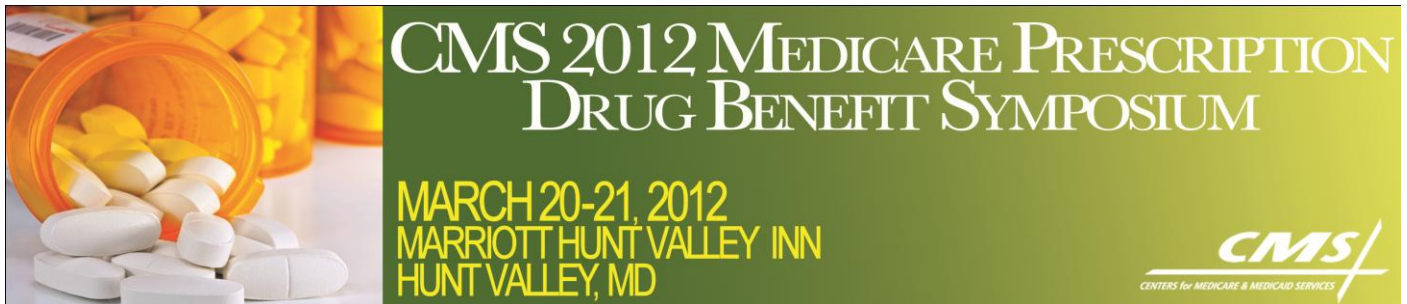
There are possible differences in the ability to establish a therapeutic relationship and resolve drug therapy problems. This is more, I'll say, "anecdotal evidence" from some of the plans and vendors; but it does make intuitive sense. If I'm on a phone from New Jersey calling a patient in Wyoming, it might be tough to establish a therapeutic relationship; but it still can be done. However, there is wider – actually, there is wider access through person-to-person. This is intriguing because maybe there is no one close to them -- that patient/beneficiary in Wyoming. That only contact is for the individual on the telephone.

Now, so some of the challenges or concerns are integration into the patient-centered health homes. I'm going to talk about the most important concern that patients or beneficiaries have related to the integration of the service with their primary care. Integration with this team-based medication management would be ideal. And ability to measure patient and family engagement through patient activation measures is an exciting development.

So we'll use an example from Minnesota, one of the areas I've done some research with. They have 7 hospitals, 42 clinics. They are currently a Level 2 accountable care organization. Level 1 is very little risk sharing. Level 3 is total risk sharing. And this Level 2 is two-way. Pharmacists have been integrated in the primary care for about 13 years. And what's interesting is 50% of the physicians' compensation is based on outcomes. And the way they converted all their clinics is that they took their physicians off the RVUs. And you guys all know what that means. I don't have to explain it to you. And they told these teams to work together and do what's right for the patient. And they had some shared savings through commercial payers. And the description is that all members help set patient-specific goals of therapy. There's a standard assessment. When the patient's not achieving goals of therapy, everybody on the team knows it and can work more effectively and efficiently together. Coordination of care is actually the ambulatory pharmacists are reverse mentoring and teaching this care process to the hospital pharmacists. And everybody on the health team works together to define high-risk patients. It's not a checklist; it's that we know that this person's going to have a high chance for being readmitted.

So some of the results that have been published that relate to the goals of therapy achieved -- return on investment, the number of drug therapy problems resolved. One study we did with them was to actually evaluate quality of the interaction. And I'm going to talk a little specifically about that actually using the Rand methodology used at CMS for physician care. Looked at patients with diabetes who were in these team-based practices with pharmacists embedded. 40% of patients were achieving all five benchmarks, which is A1C, LDL, blood pressure, aspirin use when appropriate, and smoking cessation. And evidence of decreased readmissions—more importantly, in these innovation clinics the cost increases were limited to 3.4% increases while the usual care of the other clinics was at the traditional 14%.

So this one kind of goes through measuring quality of a CMR. I talked about this structured implicit review that we used in Minnesota where we actually had – there's four individuals, two physicians and



two MTM practitioners, who actually then rate the therapeutic determinations of randomly-selected cases. And that was – the results were outstanding. They agree with 92.4% of all the therapeutic determinations made by pharmacists practicing in this way. We did a program evaluation of the Minnesota Medicaid MTM law in 2007. They actually used a resource-based relative value scale – or tiered intensity reimbursement system. And interesting, 36% were under billed. Pharmacists were too kind. Maybe that's just Minnesota. But recently, they just did – the Department of Health and Human Services for Minnesota actually did their own audit – one of the nation's first audits of MTM over some 200 chart reviews. And there were a handful of folks that had to pay money back because they weren't documented; but again, 20% were under billed. And the biggest default was -- the need or improvement was to justify the drug therapy problems that were found.

So for the researchers in the audience, I ask you to bear with me. My methodology was what I'll call an "ethnographic observation." I just said, "*What happens if a person outside health care wants to know what a comprehensive medication review feels like – what goes on? What are we telling the public?*" So I did a systematic review of publically-available descriptions of comprehensive medication review – even joined the linked in medication management chat room, LISTSERVs, contacted a convenient sample of health plans and MTM vendors to obtain copies of letters and solicitations, reviewed copies of beneficiary communications, and then we actually talked to consumers and individuals who have received a comprehensive medication review. And the results generally are health plan and vendor MTM programs typically are limited to broad statements about optimizing response to medications. Pre-service letters provide more context to the interaction in terms of empowering them to take control of their health. Post-service letters get closer to service level indicators of intended medical use, goals of therapy and safety parameters.

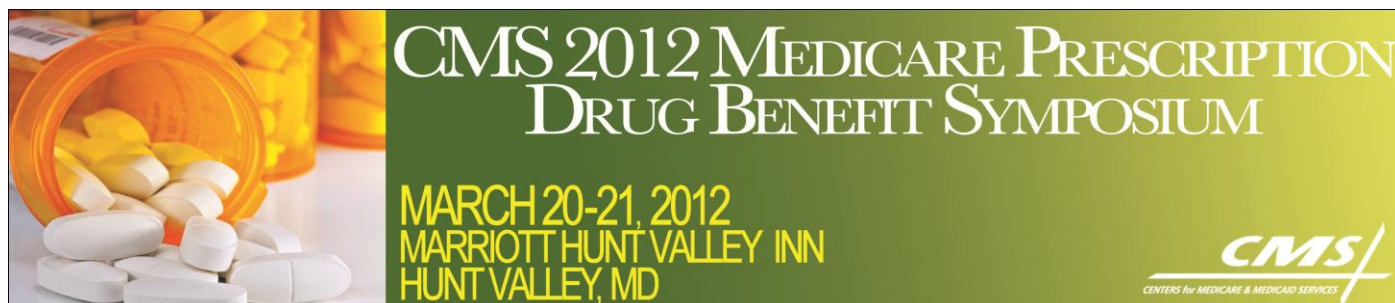
Consumer focus groups – I was just finishing a study before I came to CMS funded by the Community Pharmacy Foundation, where we actually had consumer focus groups help us design a consumer-generated medication therapy management marketing plan.

And then I also want to speak a little bit about the Standard Formats project engaged here at CMS to really look at – hear what the beneficiaries have to say; and then as the beneficiaries talk about what's important to them in the Standard Formats, it really gets us closer to what they're looking for as a service-level expectation – goals of therapy, intended medical use that we've talked about here.

And the new horizons are – you've heard a little bit about the 2012 Medicare and You Handbook will include a description of a comprehensive medication review, including the Star Ratings initiative. There is also on the Complaint Tracking Module, we've done some work so that the CSRs – help me with this – consumer service representatives, is that the correct term? – Okay, that they understand what medication therapy management is so that they can more accurately classify the complaints that come in so we can respond to them more effectively.

Okay, CMR polling – you don't have to get your clicker out yet. But you must answer this question. You must answer one of the three. *How many individuals here today have witnessed a comprehensive medication review?* Okay, *how many individuals here have not witnessed a comprehensive medication review?* Okay, and *who did not vote?* Oh, come on. I think that's important because this is a brand new service. Really before 2005, it wasn't defined; it wasn't articulated. Nobody had seen it. So we have some work yet left to do.

So here's a vignette that was adapted from our CPT Panel Code Proposal. And when I came to the Part D Program, I said, "You know, what? I wonder if I brought a simulated case – vignette – and actually



used by colleagues to play this out, would that help them understand what a CMR is – but more importantly, help us to improve what the Standard Formats look like? And so here's a market basket, a case; and we used some of our colleagues to serve as the patient, to actually walk through what it feels like to experience a comprehensive medication review – that initial therapeutic relationship -- and then the assessment of all the medications, the review of systems, and the summary of findings.

And then this takes us to the high point, the patient and family engagement in transforming health care. We know that activated patients have the skills, knowledge and motivation to be effective members of the health team; that when they are engaged, it's there – improved health status, lessened symptom burden and it reduces errors. Patient activation measure is a valid, highly-reliable tool to use. The Pioneer ACO Program and the Partnership for Patients are seeking patient engagement in sharing decision-making processes. Measuring and reporting patients' health care experiences is central to the CAP Survey, Star Ratings, [HEDUS] and others, and patient-centered medical care focusing on redesigning care. From the end user's perspective, it's something that I think we are really making great strides at.

So, patient empowerment in comprehensive medication management -- this is, I think, the next frontier where we can get to. If patients are involved – and really the thought that I've had for many years is, *Why not teach the patients how to conduct their own rudimentary comprehensive medication review?* Just think about how engaged they would be. And to do this, really a patient only needs to answer three questions: 1) What is the intended medical use of all my prescriptions, supplements, over the counter drugs? 2) What are the goals of therapy? I call that the linchpin – the goals of therapy; 3) And finally, what are the unique safety parameters that are specific to their needs and concerns? I think we can get there. And so that they make the patients partners in stewardship over their own medication management care plan, and we enhance the information technologies.

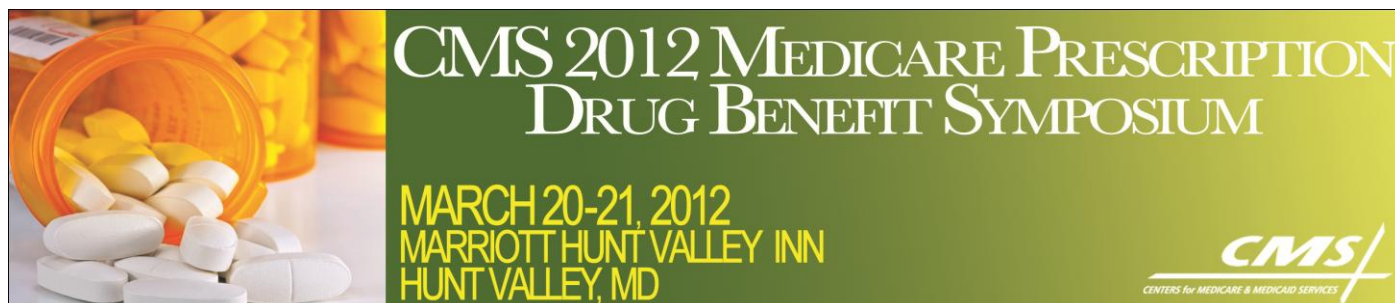
We've seen the Blue Button campaign. I talked a little bit about the Smartphone applications and Kindle references, so that we can tie that patient in so that they feel in control of managing their medications instead of the other way around.

Okay, this was part of the Innovation Signature Style, which we have to bypass for the moment, since we abandoned that. But I do want to get to a discussion of the key questions addressed today. What information and data are useful to enhancing beneficiary awareness of Medication Therapy Management's programs and services? What effect does a comprehensive medication review have on beneficiary engagement, activation and satisfaction? Which beneficiaries will derive the greatest benefit from a CMR? What are the best methods for delivering a CMR? And what are the effects of CMRs on achieving improved care for individuals, better health for populations, and at lower per-capita expenditures?

Okay, so now we get to our assessment questions. I brought my clicker up here because I need Continuing Education credit too.

Excuse me for just one moment. There were some concerns that the response cards were not working. And I just wanted to let everybody know that during the last break, they were all checked out and everything has been recorded for everyone who has been here. So they are working. As long as your green light is going on, your response is being recorded, okay? You can change your response as many times as you'd like while the poll is still open, and your last response will be recorded. Okay, thank you.

Stacy, could I request music please?



Could you request--?

Request music, -- yes, please.

Sir, you can request music, all right?

All right, so let's go to our questions. Now, this one I changed a couple of words in here from what's in your distribution materials. *Which of the following is not a widely-used approach to conduct a person-to-person CMR?* I'll repeat that. *Which of the following is not a widely-used approach to conduct a person-to-person CMR?*

Music please – can you sing?

Oh, no.

So I have them vote now?

Yes.

Okay, you may begin.

[MUSIC]

Okay, judges. This was a little bit of a trick question. We talked about Skype and that; but technically, the iPhone's a telephone, right? Now, it's interesting when I'm back at the University of Minnesota, I have a technique with students; and I let them negotiate the answers to the test. You laugh. So what happens is if they can convince 50% or more of their colleagues that their answer was more correct than theirs, then we can give them credit. In academia, we can do that kind of stuff. At CMS, you've got to keep a little more low-key.

Okay, let's go the next question. *The highest service level intensity of a CMR is... disease state management, target medication review, targeted medication review using high-risk disease state comorbidities, or a systematic assessment of drug-related needs and medications in use?*

Music, please, judges.

[MUSIC]

Okay, the answers. Interesting. "4" is the correct answer, but we can also negotiate the answers during the Question & Answer Session.