



Value-Based Care and the Medical Home: Implications for Pharmacists

NABP/AACP

November 6, 2014

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About Me...



- Practicing internist and ID physician for 28 years
- Worked in Massachusetts 2002-2011
- Recruited back to Clinic in 2011 to develop and execute healthcare reform strategy
- I support reform... and medical education
- No disclosures

Outline

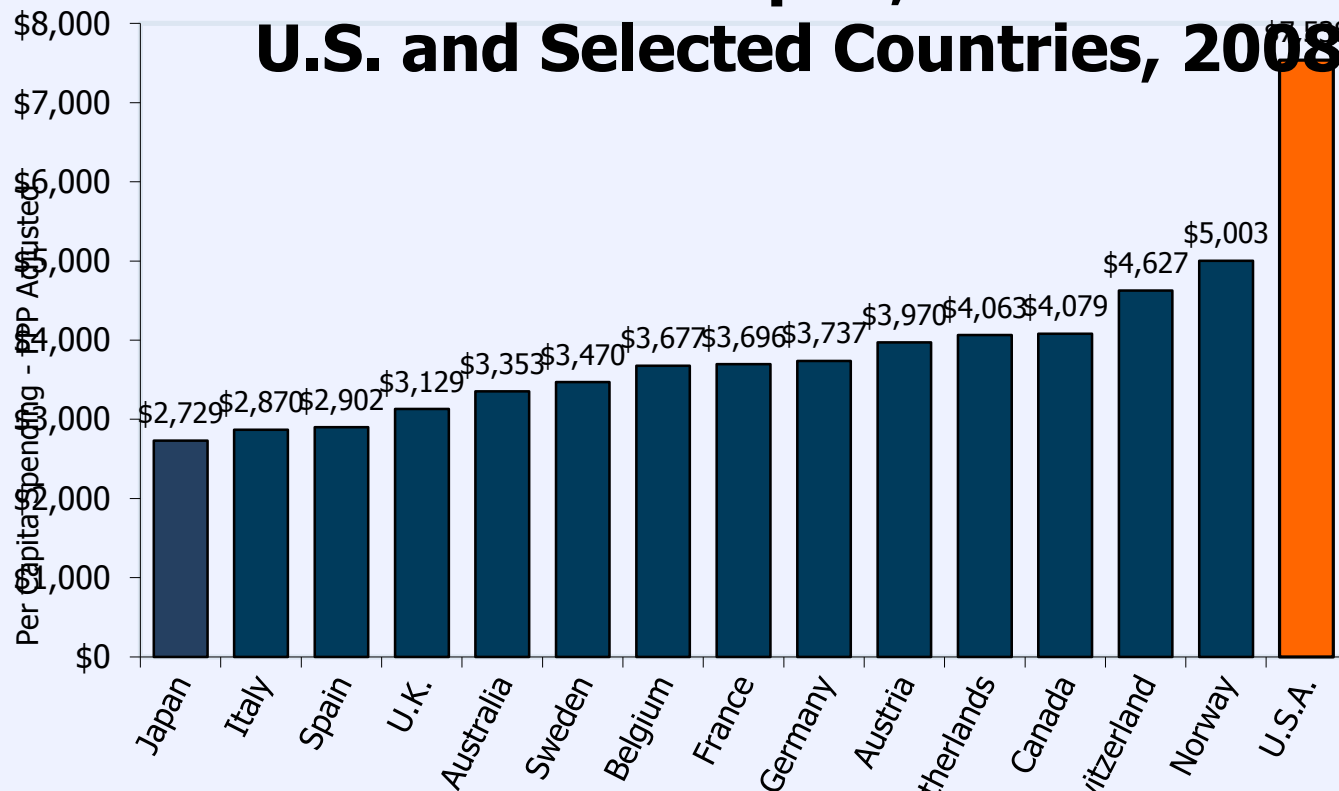
- **The Case for Reform**
- **Patient Centered Medical Homes and Accountable Care**
- **Our Strategy**
- **Population Management at Cleveland Clinic**
- **The Implications for Pharmacy**

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Health Care Spending Per Capita in the USA Exceeds Other Nations

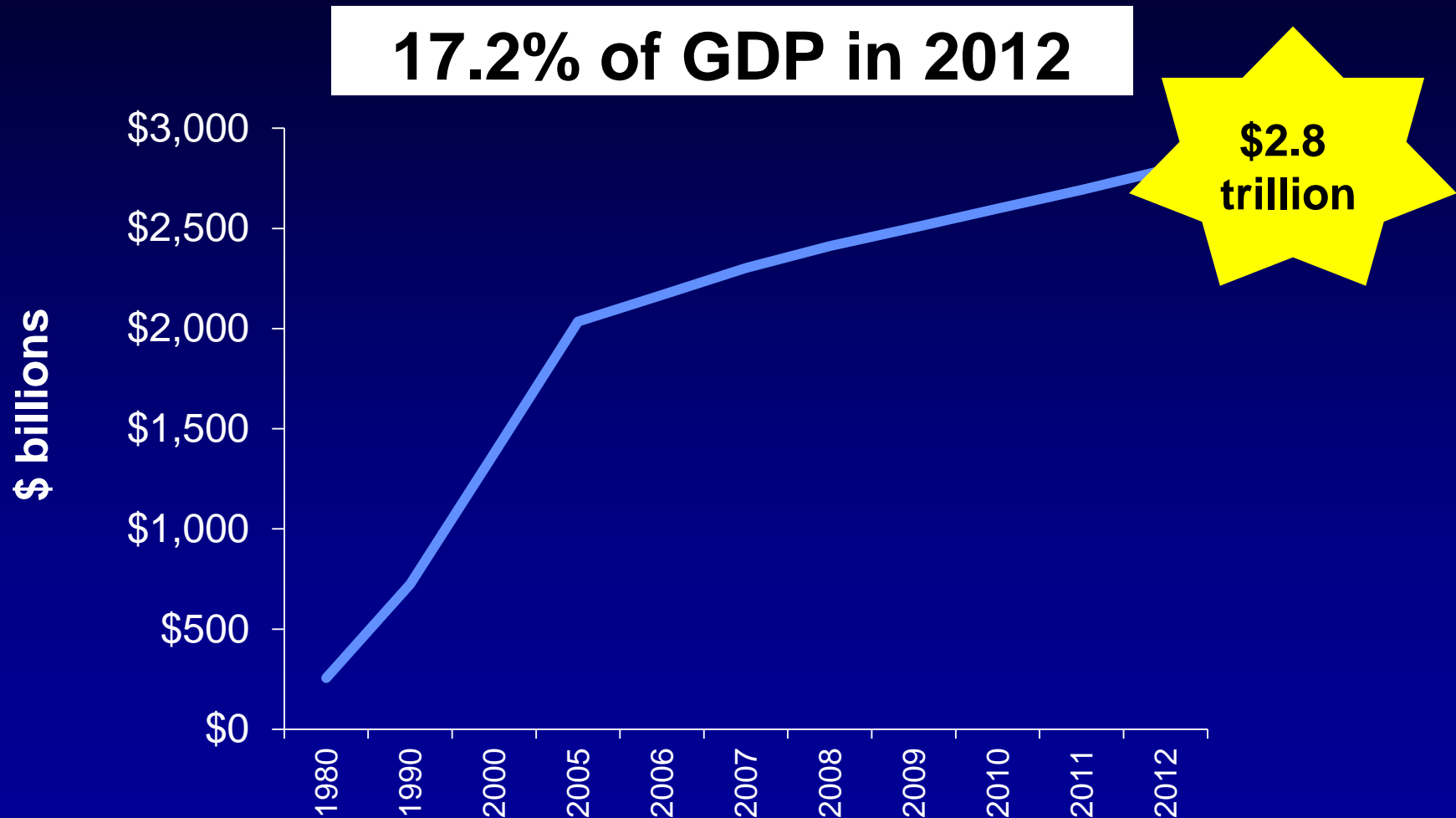
Total Health Expenditure per Capita, U.S. and Selected Countries, 2008



Source: Organization for Economic Co-operation and Development (2010), "OECD Health Data", *OECD Health Statistics* (database). [doi: 10.1787/data-00350-en](https://doi.org/10.1787/data-00350-en) (Accessed on 14 February 2011).

Notes: Data from Australia and Japan are 2007 data. Figures for Belgium, Canada, Netherlands, Norway and Switzerland, are OECD estimates. Numbers are PPP adjusted.

National health spending continues to rise, but growth has slowed for 4 years



Costlier Care is Often Worse Care

Overall Ranking

Country Rankings	
	1.00–2.33
	2.34–4.66
	4.67–7.00



AUS CAN GER NETH NZ UK US

OVERALL RANKING (2010)

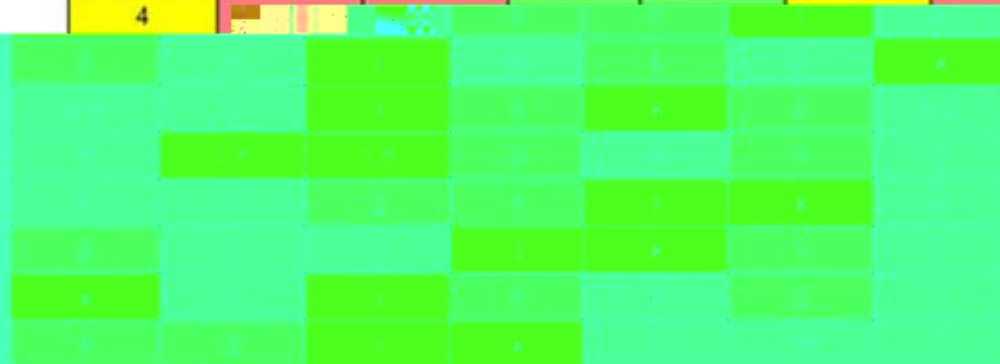
Quality Care

Effective Care

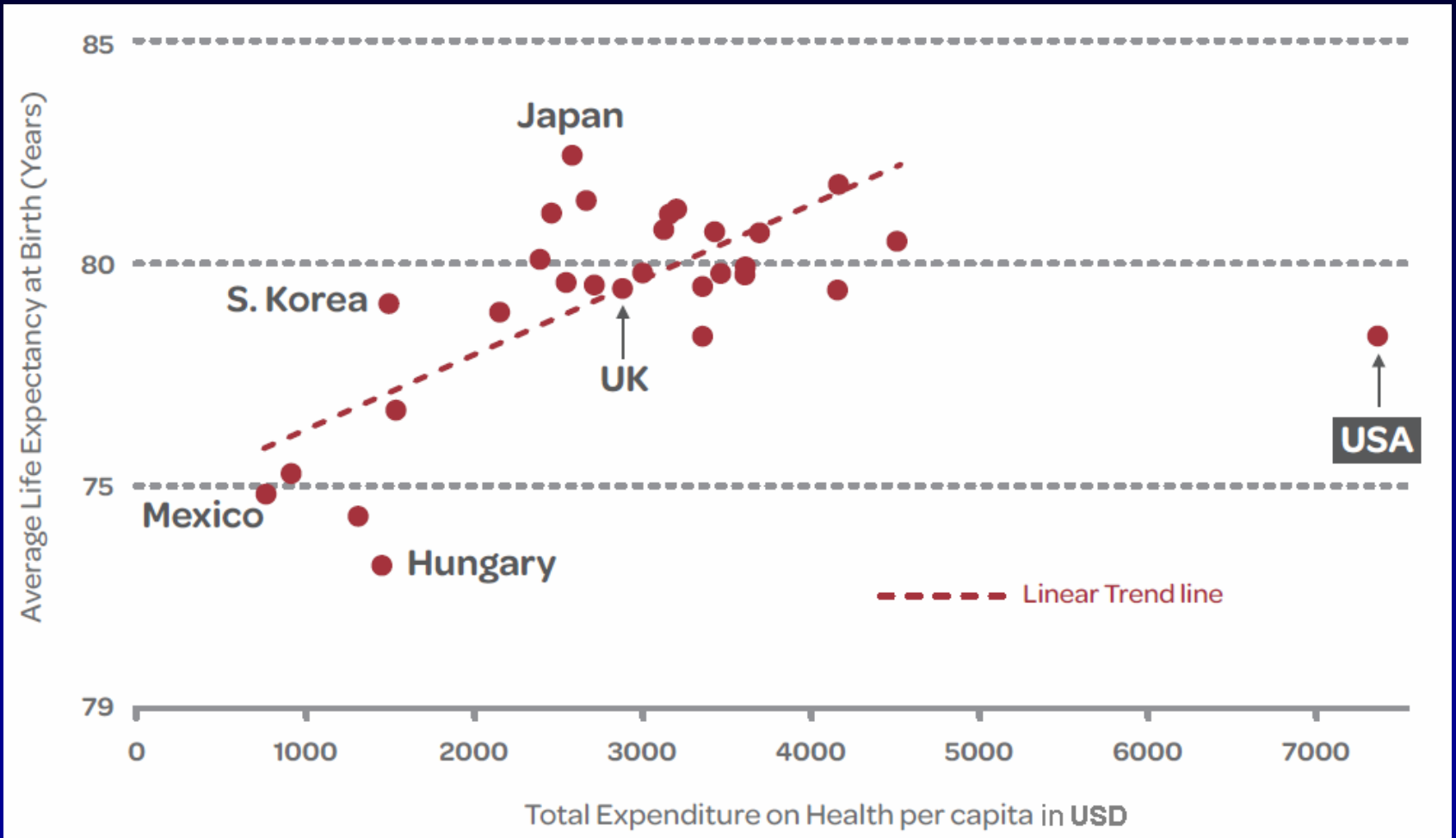
Safe Care

Coordinated Care

3	6	4	1	5	2	7
4	7	5	2	1	3	6
2	7	6	3	5	1	4
6	5	3	1	4	2	7
4	7	4	1	2	1	6



Where's the Value?



Today Care is Fragmented, Variable and Discontinuous

Community-Based Care

Acute Care



Hospital



IRF



SNF



Outpatient Rehab



HC

Recovery and Rehab

Wellness / Fitness Center



Retail Pharmacy

Surgery Center



Urgent Care



Home



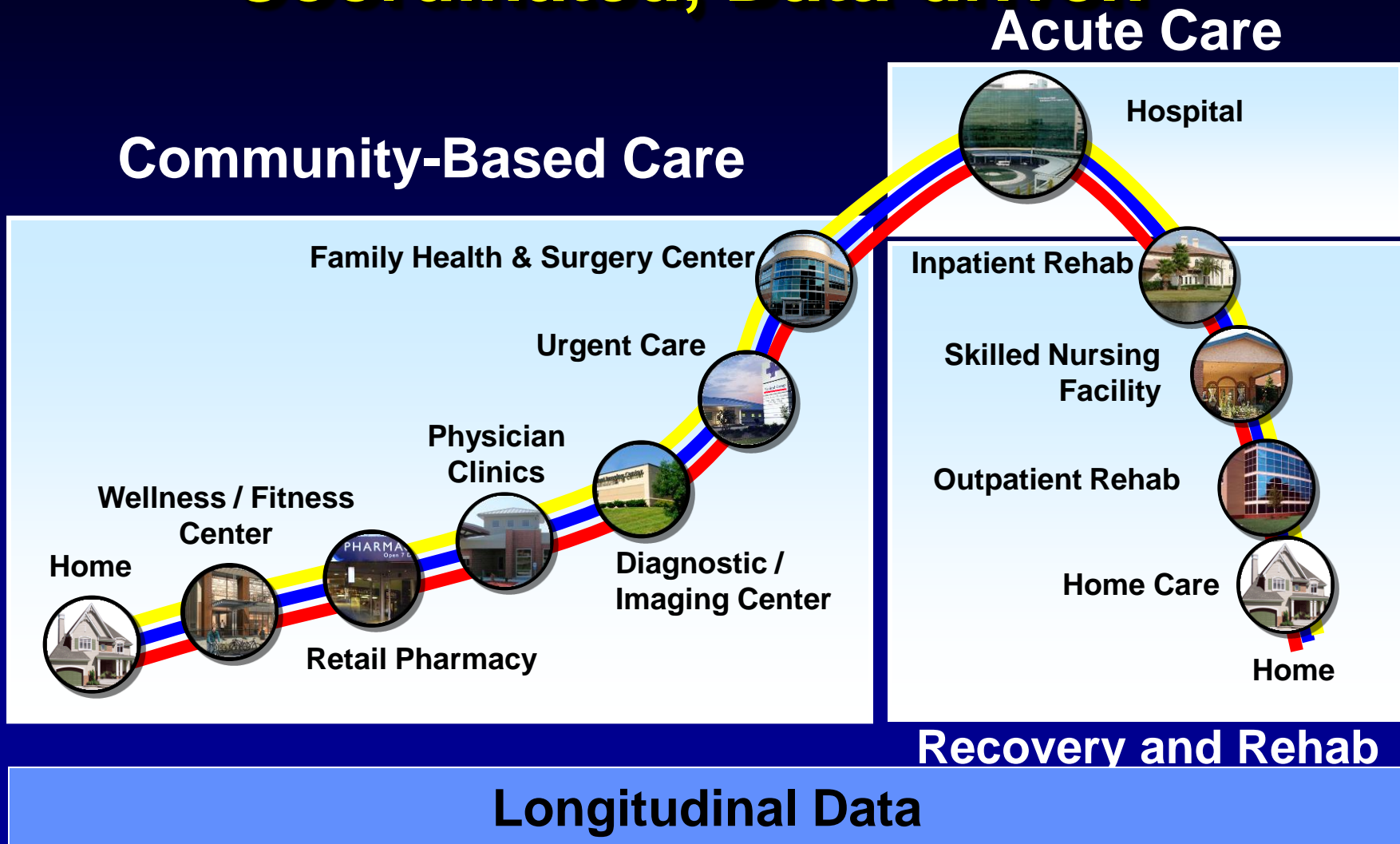
Physician Clinics

Diagnostic / Imaging Center



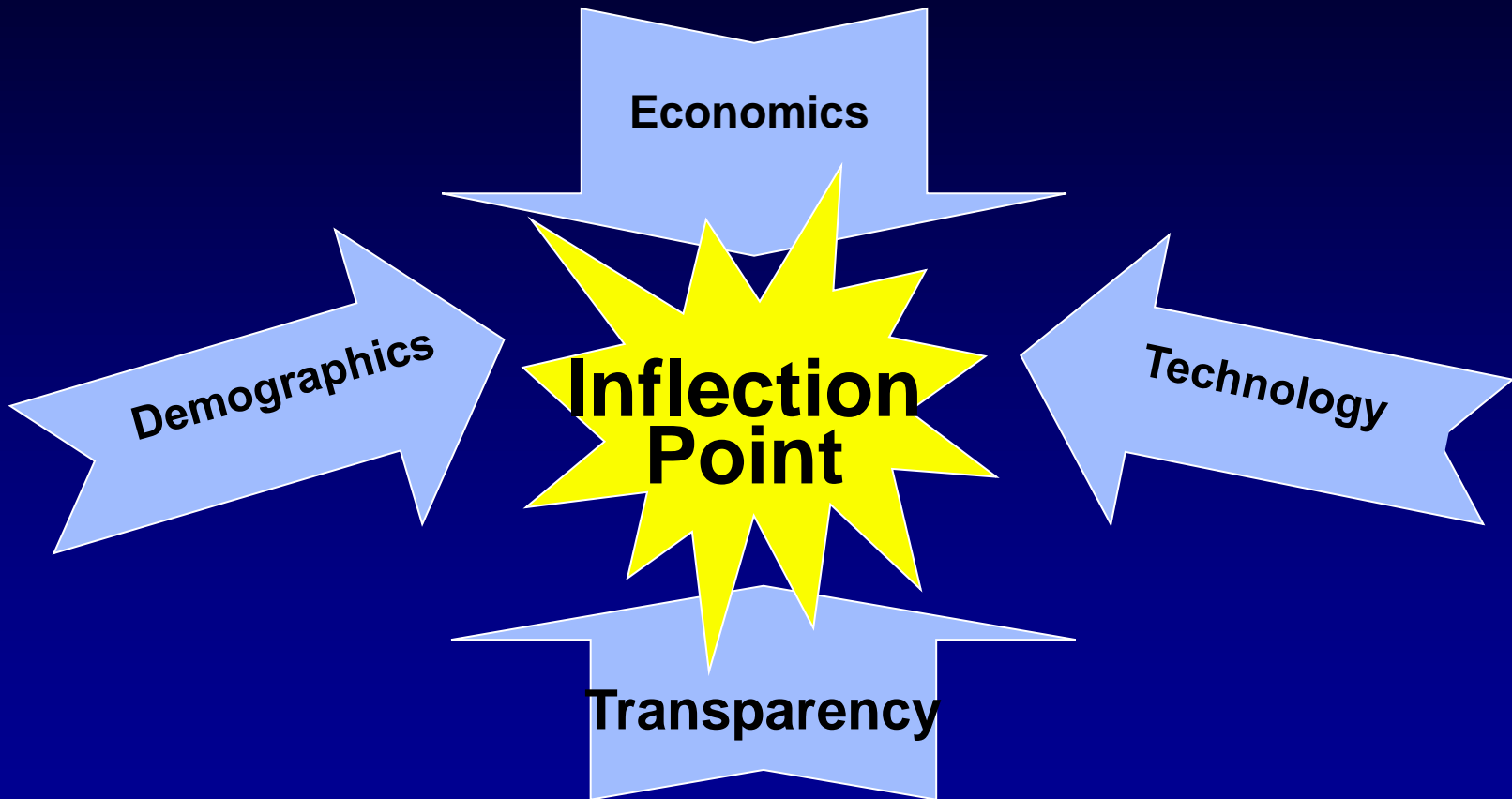
- It is our obligation to coordinate care for our patients
- We must tighten up the care continuum

Tomorrow Care Must be Integrated, Coordinated, Data-driven



Care paths and outcomes 
Distance Health Infrastructure 
Cost and value analysis 

U.S. Healthcare is Undergoing Dramatic Change



“Plan or be Planned For”

The Shift

Volume-Based



Value-Based

Payment	Fee-for-Service	Outcomes Based
Focus	Acute Episodes	Bundles & Populations
Role of the Provider	Single Episodes	Care Continuum
Information	Retrospective	Real-time & Predictive

Fundamentally new orientation & capabilities

Our Burning Platform

- **Costs too high**
- **Prices too high**
- **Outcomes variable**
- **Transparency outs us**
- **Growth strategy**



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Patient-Centered Medical Home: Definition

“Patient-centered medical home (PCMH) is a model of care where patients have a direct relationship with a provider who coordinates a cooperative team of healthcare professionals, takes collective responsibility for the care provided to the patient and arranges for appropriate care with other qualified providers as needed.”

NCQA

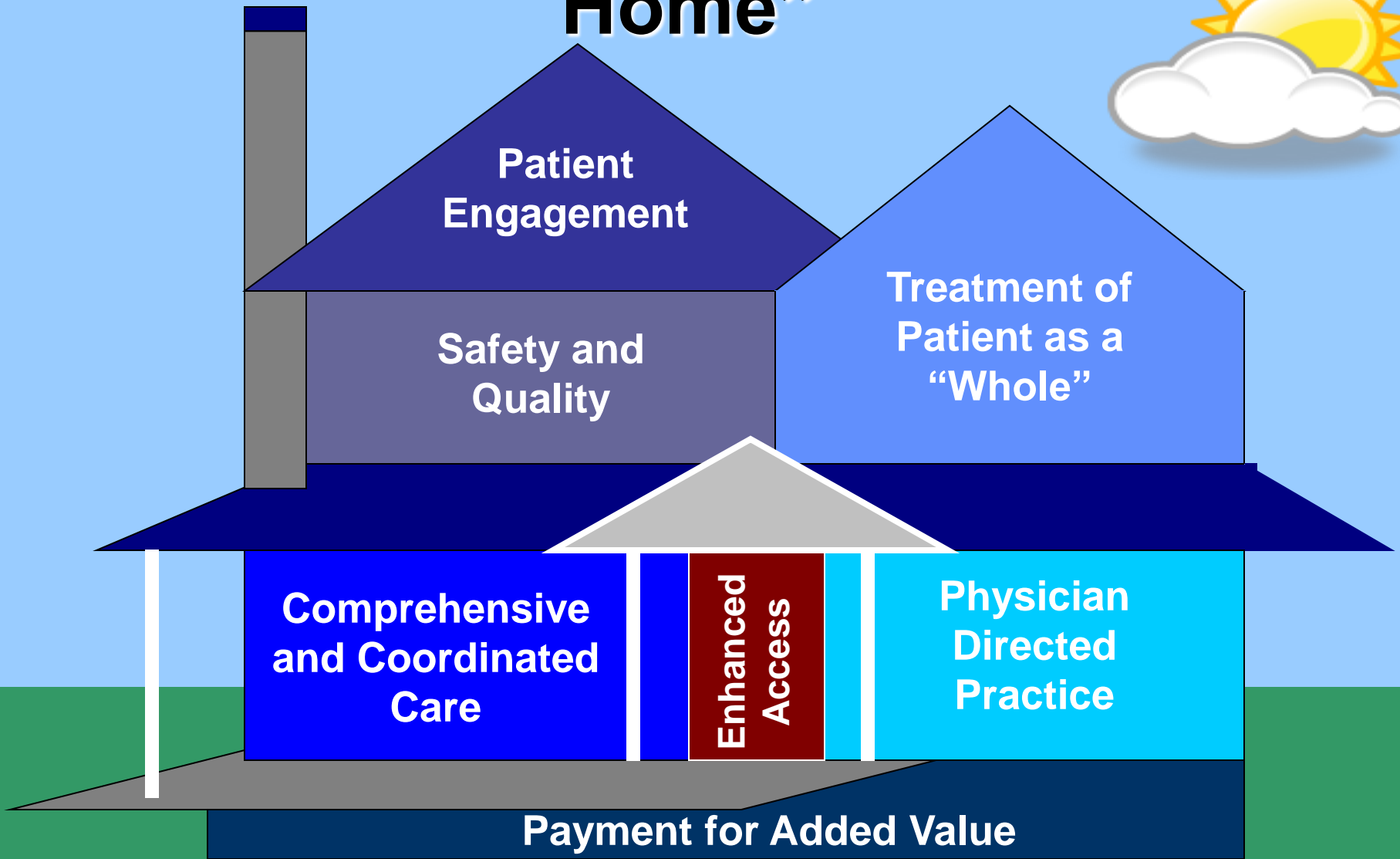
Patient-Centered Medical Home: History

- 1967** First proposed by American Academy of Pediatrics
- 2002** Future of Family Medicine Project endorsed concept
- 2005** American College of Physicians called for “Advanced Medical Homes”
- 2006** IBM et al created Patient-Centered Primary Care Collaborative
- 2008** NCQA released its PCMH recognition program, >1500 practices qualified
- 2011** NCQA revised required elements
- 2013** JCAHO certification program

Patient-Centered Medical Home: Core Competencies

- Identify and manage populations
- Enhanced access and continuity
- Plan, manage, track, and coordinate care
- Provide self-care support and community resources
- Measure and improve performance

There's No Place Like a "Medical Home"



“Care Transformation” is Critical

- **Transform** the clinical operations
- **Assemble** the right care team
- **Reward** added value with sustainable payment models
- **Support** with the correct Analytics



Step 1: Transform Clinical Operations

Patient follow-up & engagement post visit



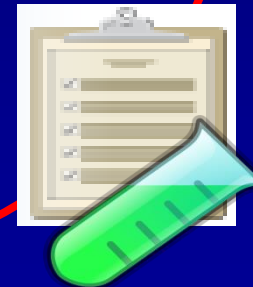
Proactive, targeted outreach

Engage specialists & other providers

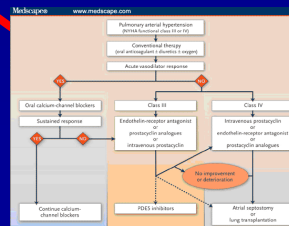


Enhanced access

Focus on chronic care

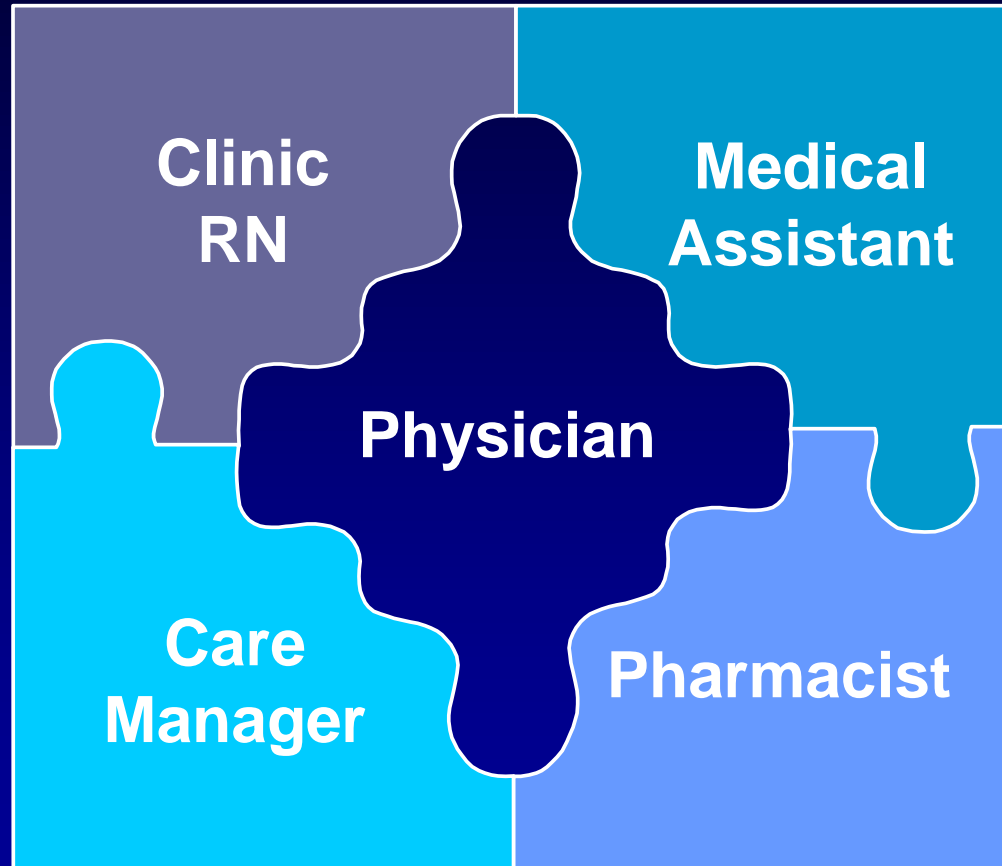


Visit planning

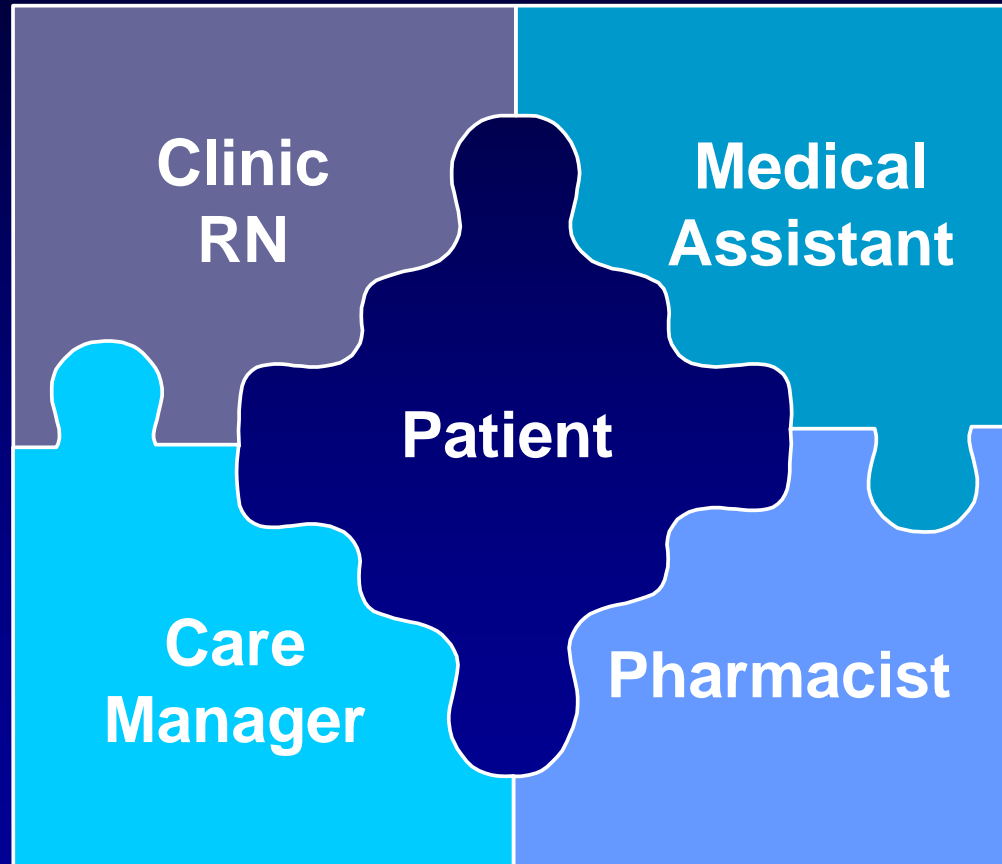


Standardized Care Paths

Step 2 : Assemble the Right Team



Step 2 : Assemble the Right Team



Step 3: Reward added Value with Sustainable Payment Models

Evaluate a variety of payment options and pursue a multipronged approach with the payers

**Enhanced
fee-for-
service**

- Recognizes additional billing codes for services

**Additional
PMPM**

- Recognizes additional care provided for each patient

**Global
payment**

- Covers all patient primary care need for a set period of time

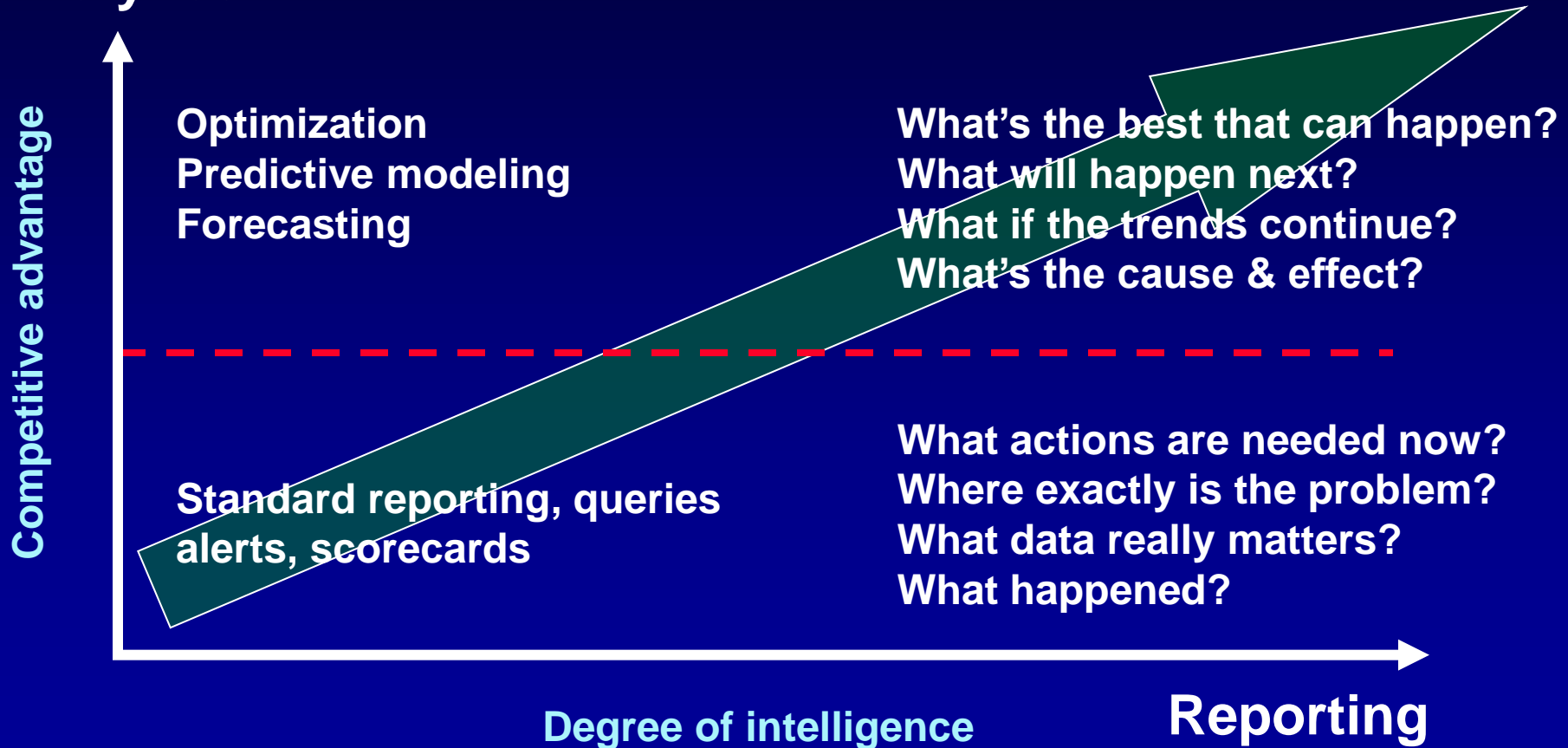
**Pay-for-
performance
/ Gainsharing**

- Rewards high quality / low cost care with bonuses

Step 4: Support with Correct Analytics

Skill Development Curve

Analytics



Patient-Centered Medical Homes: Do They Deliver on the Promise?

- Tested in Integrated Delivery System Models, Private Payer Sponsored Initiatives, Medicaid Sponsored Initiatives and other programs
- Quality improvement in selected domains
- Cost reductions through reduced admissions, ER visits, skilled nursing facility days and pharmacy costs in some studies

... but results are mixed

Why are Patient-Centered Medical Homes Important?

Accountable Care Organizations: The Three-Part Aim

- **Better care for individuals**
- **Better health for populations**
- **Lower growth in expenditures**

Managing Population Health: The Rapidly Emerging Driver

**Today:
The FFS model**

Care of the individual

**Payment for any
service we provide**

Predictability!

**The New Today:
The Value-Based
model**

Care of a population

**Payment based on our
quality and efficiency
performance**

Uncertainty and risk!

What Does 'Value' Really Mean?

$$\text{Value} = \frac{\text{Outcomes}}{\text{Cost}}$$

Outcomes

Quality

Health Status

Process

Experience

Cost

Event

Episode

Per Capita

The move to Accountable Care is all about a move to value...



- Elliot Fisher coined the term in 2006
- Builds on the Three Part Aim
- Legislated via the PPACA
- >300 CMS ACOs, many more commercials

Accountable Care Organization

The CMS Operational Definition

CMS defines an ACO as *a legal entity* recognized and authorized under applicable state law and composed of certified Medicare providers or suppliers. These participants work together to *manage and coordinate care for a defined population* of Medicare fee-for-service beneficiaries and have established a mechanism.....

Accountable Care Organization

The CMS Operational Definition

...for *shared governance* that provides appropriate proportionate control over the ACO's decision-making process. ACOs that meet *specified quality performance standards are eligible to receive payments for shared savings if they can reduce spending growth below target amounts.*

Accountable Care Organization

The Seven Core Competencies

- 1. Ability to alter physician practice patterns**
- 2. Widely respected brand**
- 3. Adequate financial capital**
- 4. Ability to aggregate lives**
- 5. Ability to manage risk**
- 6. A geographic footprint**
- 7. Collaborative intelligence (i.e. instinct to align incentives that may require compromise)**

Michael Leavitt

**Former Governor of Utah and
Secretary DHHS**

Accountable Care Organization

The Seven Key Building Blocks

- 1. *Network of Patient-Centered Medical Homes***
- 2. IT systems and technology**
- 3. Analytical capabilities**
- 4. Critical mass of covered lives and services including key partnerships**
- 5. Clinical integration**
- 6. Supporting organizational structure**
- 7. Business model**

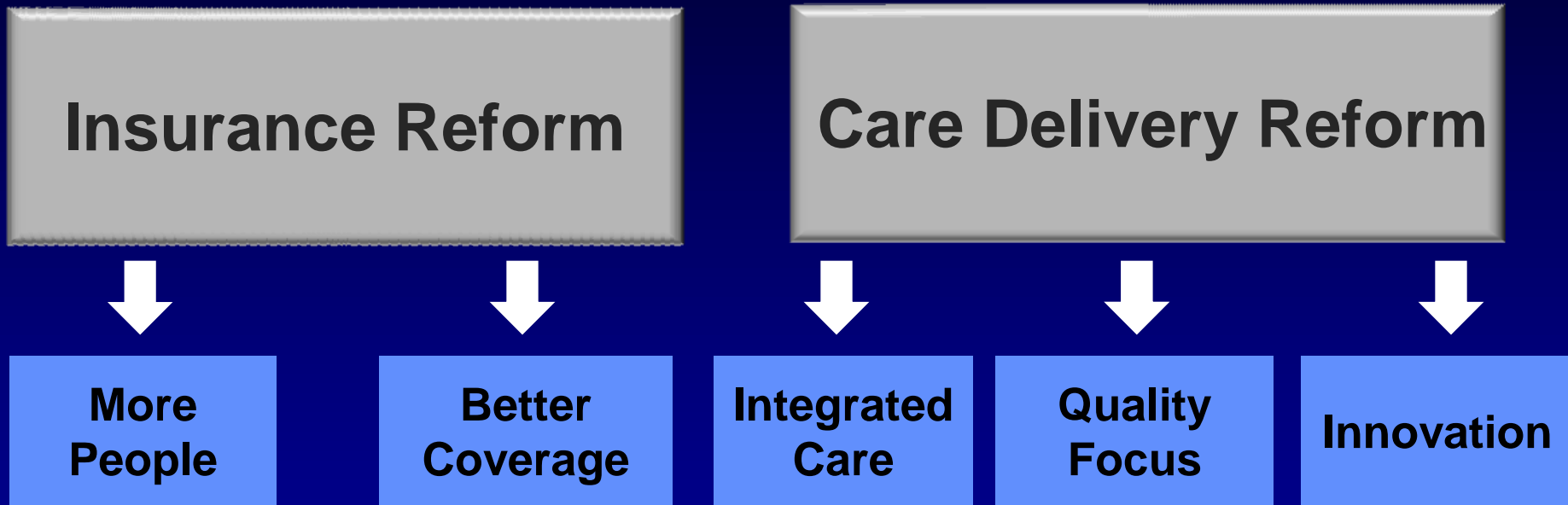
Accountable Care Organization Implications for Care Delivery

- **PCMHs and care coordination become vitally important**
- **An adequate PCP base is essential**
- **Hospitals are cost centers rather than profit centers**
- **Resource allocation will change with more emphasis on wellness, prevention, chronic care and disease management, prevention of hospitalization and recidivism**

Patient Protection and Affordable Care Act (PPACA)

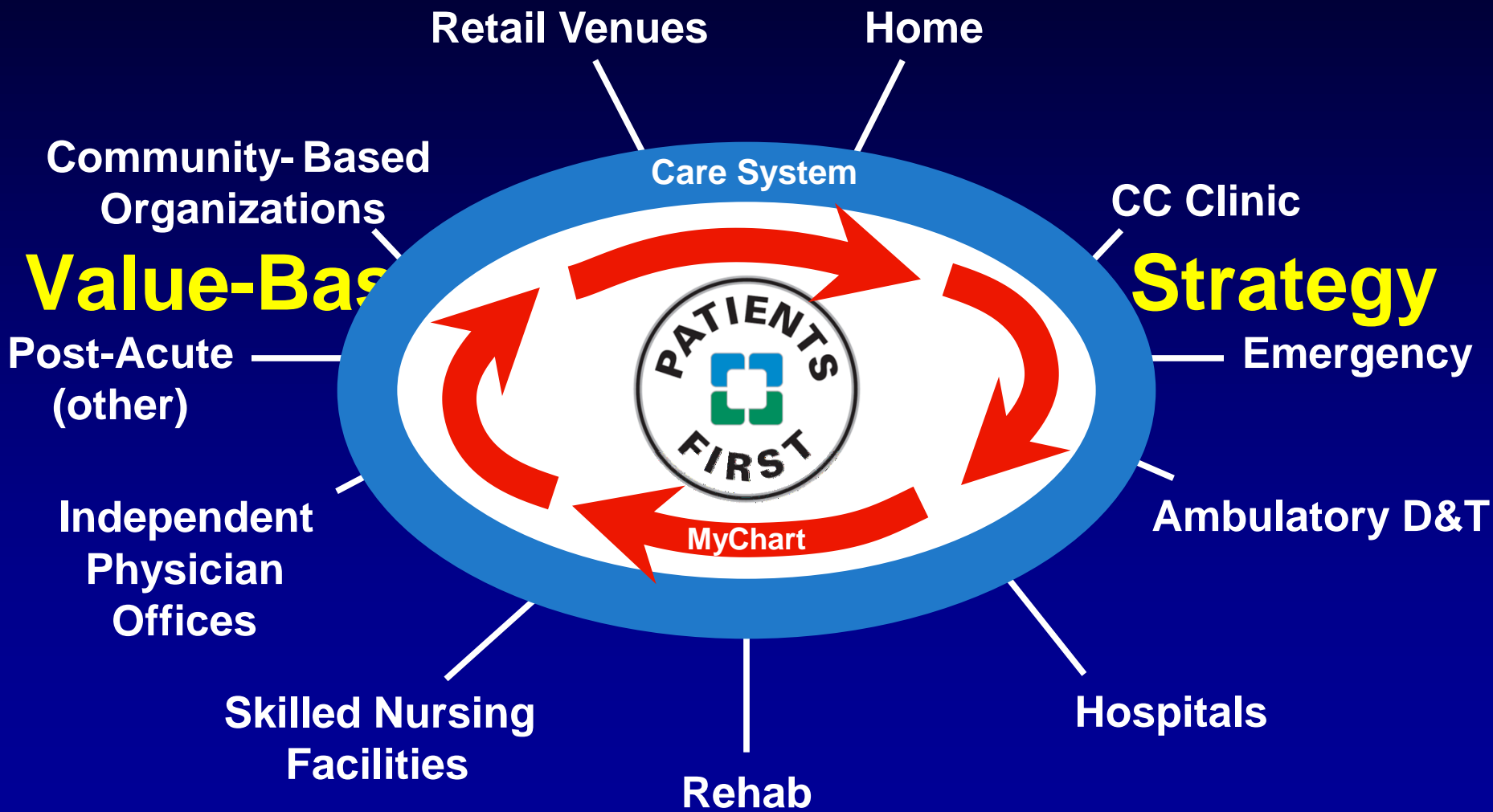


Structure of Healthcare Reform



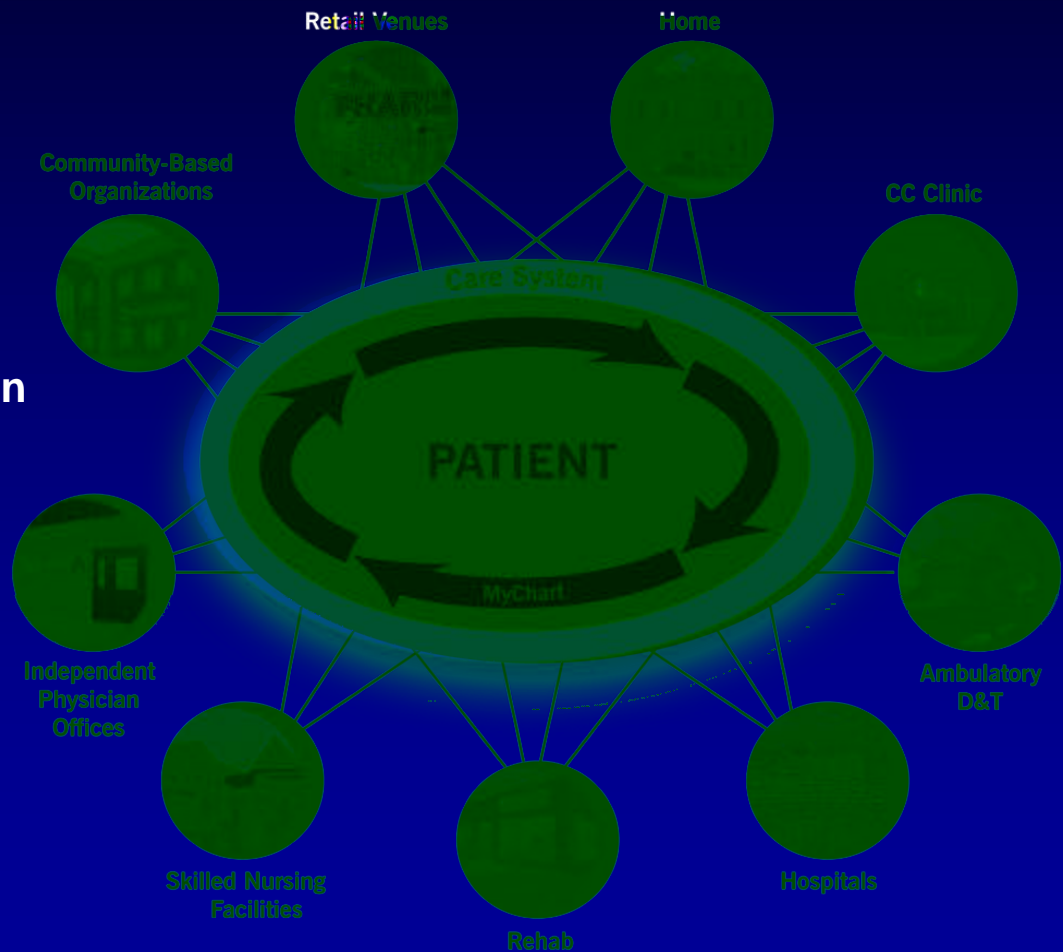
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Cleveland Clinic Integrated Care Model: A Value-Based Patient-Centered Model of Care

- Personalized
- Patient-focused
- Integrated
- Continuous
- Transcends time, physical location
- Right care, right place, right time
- *Primary care and Specialty Care*



Elements of the CCICM

- Care Paths
- Care Coordination
- People and Teams
- Access and Flow
- Enabling Capabilities

***We must take cost out of the system
and manage risk***

What is a Care Path?

- An established¹ multidisciplinary care plan used to optimize the value² of patient care by reducing unnecessary practice variation
 - Some of what we do will never fall on a Care Path
- Used to optimize care across the CC Integrated Care Model
- 68 built in 2013

¹ May or may not be evidence-based; established plan may be based upon commonly accepted practice for which there is not currently an evidence-based guideline.

² Where 'value' = outcomes/cost, and value is therefore optimized by improving outcomes while reducing cost

Care Coordination

- **Network of nurses and other care team members who coordinate care across the continuum**
 - Venues: primary care, specialty, transitional
- **Goal is to drive value: improve outcomes while reducing utilization (cost)**
- **Focus is on managing high risk patients**
 - **Patients at high risk for poor outcomes and high utilization**
 - **Eliminate care gaps, ensure compliance**

Our Strategy is Evolving

The New Drivers

- **The Market**
 - **Patients**
 - **Payers and Employers**
 - Risk-based contracting
 - Episodes (CMMS, SIM, Commercial)
- **Quality, safety, patient experience**
- **Affordability and cost of care**
- **Sustainability of our financial health**

***We are focusing and prioritizing
our care transformation work
around these new drivers...***

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Taking Risk

Assets in Place

- JCAHO certified PCMHs at Main Campus, 18 Family Health Centers, 39 practices at 29 sites
- Uniform IT platform, best of breed
- Large cadre of employed and aligned high-quality PCPs
- Growing experience with population management and care coordination of high risk patients

Taking Risk

Assets in Place

- **Good to excellent quality metrics in most domains**
in those patients we touch
- **Mature hospitalist and post-acute programs at 5 hospitals**
- **Sophisticated QPSI, finance, contracting support**
- **Committed senior leadership**

Population Management Implementation

- **Practice transformation at all FHCs completed 3.1.2014**
 - **Embedded care coordinators and pharmacists**
 - **50 care coordinators trained**
 - **230 PCPs, 300,000 lives**
- **Epic Registry tool in place**
- **126 IM residents moved to Team Care model at G10**
- **Risk-based contracts 2015, 380,000 lives**

Results

Utilization Management

ED Visits and Admission Rate w/in 30 Days of CC Intervention

	Q1 2014	Q2 2014	Change
ED Rate	19.3%	13.5%	-5.8
Admit rate	19.0%	15.5%	-3.5

More great work!

Patients with multiple care coordination interventions are counted for each intervention. Assigned to quarter by start of care coordination.

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Pharmacists have an important role to play in the Value Era

- Education, coaching, adherence
- Flagging opportunities around cost, drug interactions, appropriateness, duplication of therapy
- Transitions of care
- Gaps in care

Pharmacists have an important role to play in the Value Era

- Prescriptive authority
- Formulary management
- Medication management of complex high risk patients

Pharmacists are partners in care

Early Outcomes of Pharmacy Intervention at CC

1st and 2nd Q 2014

- HTN referrals seen by pharmacist (n=45)
 - Mean change in SBP: -15mmHg
 - Mean change in DBP: -9mmHg
 - Mean last BP on file: 140/78 mmHg
 - % of patients with BP <140/90 increased from 11% to 47%

Early Outcomes of Pharmacy Intervention at CC

1st and 2nd Q 2014

- DM referrals seen by pharmacist (n=27)
 - % patients with A1c <9% nearly doubled from 33% to 63%
 - Mean change in A1c = - 0.9%
 - Mean f/u time frame of 5 months from first pharm visit to last A1c on file

What are the Implications as Educators in Clinical Pharmacy?

- **Changing roles and responsibilities**
- **New competencies required**
- **Curricular development to teach these**
- **Faculty development**

The New Competencies

The Future

- Leadership
- Team skills
- Human resource management
- Innovation
- Change management
- Emotional intelligence
- Empathy
- Coaching

The New Competencies

The Future

- Patient engagement and activation
- Cultural competency
- Organizational intelligence
- Business and public policy intelligence
- Knowledge management

... and we must teach these

“The future belongs to those who believe in the beauty of their dreams”

Eleanor Roosevelt

***... and the future is all about the
young people***





Cleveland Clinic

Every life deserves world class care.