

Prescription Drug Benefit Cost and Plan Design Report Supplement

A SUPPLEMENT TO AMERICAN HEALTH & DRUG BENEFITS

JULY/AUGUST 2010

PART 4 OF 4

The Importance of Collaboration in Managing Chronic Conditions

By Jeffrey D. Dunn, PharmD, MBA

The current economic impact of chronic conditions in the United States is devastating, with 75% of healthcare spending (\$1.7 trillion) going toward the treatment of patients with chronic conditions.¹ As the US population continues to age, coupled with the rising rate of obesity, the prevalence of chronic conditions is expected to have a greater impact on our healthcare system.^{2,3}

As a result, stakeholders across the continuum of care are being constantly challenged to develop population-management strategies that improve clinical outcomes and reduce healthcare utilization and costs. Payers, in particular, are expected to navigate the complex and ever-evolving healthcare system and provide their customers—employers, providers, and patients—with innovative solutions that bring prolonged change. However, organizational structures, system inertia, limited data and information integration, and lack of shared values can often inhibit or prevent change.

Improving outcomes for populations with chronic conditions requires collaboration among the various stakeholders. Collaborative initiatives by the government, payers, and employers have been driven by the need to improve the delivery of cost-effective quality care. Historically, these efforts have been multidisciplinary in scope, involving patients, physicians, pharmacists, and other ancillary healthcare providers (eg, hospitals) to varying degrees. Some of these collaborations include the eHealth Initiative, the Integrated Healthcare Association in California, the Iowa Chronic Care Consortium, the Michigan Quality Improvement Consortium, and the Wisconsin Pharmacy Quality Collaborative (see page 3). Through its numerous demonstration projects, the Centers for Medicare and Medicaid Services has been working with diverse groups to enhance the quality of care for the elderly and indigent populations. For employers, Pitney Bowes has served as a model of how employers and employees can work together to improve employee health and productivity.



The overall success of these programs required a sustained effort to improve the delivery, quality, and affordability of healthcare—a significant challenge that payers face today. One approach that has shown promise to advance the delivery of healthcare is the chronic care model. This model is an excellent example of how stakeholders can work together to enhance the management and treatment of chronic conditions. This model calls for comprehensive system changes by patients, providers, the community, and the health system to improve outcomes (Figure, page 2).⁴ Preliminary data suggest that implementing system-wide change through the chronic care model may improve care processes and outcomes in patients with select chronic conditions.

Outcomes results to date have been mixed.⁵ However, in a review of 82 articles on chronic care model interventions, Coleman and colleagues noted that compared with patients in a control group, individuals enrolled in chronic care models for congestive heart failure (CHF), diabetes,

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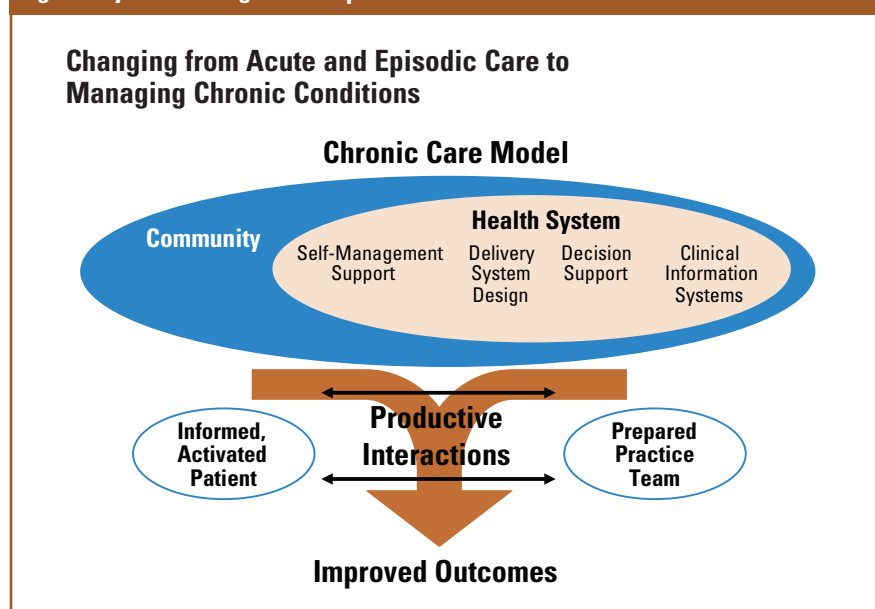
Dear Colleague,

Welcome to the fourth issue of a supplement to our annual *Prescription Drug Benefit Cost and Plan Design Report*. This publication provides quarterly updates to the annual study findings. We also feature real-world case study examples to show how managed care organizations and payer organizations are working to improve the delivery of drug benefits.

PBMI gratefully acknowledges the support of Takeda Pharmaceuticals North America (TPNA), Inc., for the provision of a grant to cover costs incurred in the production of this publication. TPNA has no access to the individual responses or raw data gathered, nor do any other third parties. This protects the confidentiality of the survey respondents and ensures the independence and objectivity of the research findings.

If you have a case study to share or questions, please contact PBMI President Dana H. Felthouse, MBA, at dfelthouse@pbmi.com.

Figure. System Changes for Improved Outcomes under the Chronic Care Model



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and asthma showed improvement in outcomes.⁵ For patients with CHF, those in the chronic care model were more knowledgeable about this disease and adherent to their angiotensin-converting enzyme therapy, resulting in fewer emergency department visits and 35% fewer hospital days.⁵ Furthermore, diabetic patients receiving chronic care showed improvements in hemoglobin A_{1c} levels, with some patients showing a decreased risk of cardiovascular disease or heart disease.⁵ Similarly, evidence regarding the cost-effectiveness of chronic care models and the benefits to payers, providers, and patients is limited.⁵ Although further research is needed, studies to date suggest that chronic care models have the potential to improve the quality of care and outcomes for chronic conditions.⁵

SelectHealth deeply values collaboration among all its healthcare stakeholders. Multidisciplinary work groups have been established for many chronic disease states. These groups are charged with providing evidence-based guidelines and education based on the needs of all participants within our system. Furthermore, data projects are ongoing to facilitate the improved dissemination of information to coordinate care at all points of interaction within the system. It is important that those in charge of

pharmacy, medical, quality, and case/disease management work together to improve quality and manage costs. These efforts have resulted in new benefit designs, improved electronic prescribing, better communication between medical and pharmacy, improved patient satisfaction, and improved outcomes.

With the rising prevalence of chronic conditions and their associated costs, the need for collaboration among all stakeholders is essential to drive meaningful, sustainable change to our healthcare system. Payers in particular need information and tools to address key challenges and support the efforts of providers, employers, and patients to effectively manage chronic conditions.

The Chronic Care Collaborative

As a stakeholder in the healthcare arena and an emerging leader in the pharmaceutical industry, the Managed Markets team at Takeda Pharmaceuticals North America, Inc, has developed The Chronic Care Collaborative (CCC) in an effort to meet the needs of payers across the continuum.

The CCC is a non-product-specific compilation of evidence and resources designed to support payer objectives. Developed by Takeda in collaboration

with managed care leaders, the CCC is intended to help payers implement innovations that improve the management of populations with chronic conditions.

The CCC provides information sets and practical tools to help stakeholders assess and address various population management levers. The information sets provided are evidence-based resources designed to allow managed care decision makers to assess key issues and determine how they can be addressed. The tools provided are designed to assist plans in communicating their goals to employers, providers, and patients.

The CCC offers many opportunities through which plans can receive valuable and timely information. Forums include, but are not limited to, live meetings/symposia, topical e-Zines, journal articles published in peer-reviewed journals, and research reports. The CCC portal (www.thechroniccarecollaborative.com) is an easy-to-navigate clearinghouse, offering a myriad of downloadable resources.

The CCC will provide tools that assist managed care organizations in managing their populations with chronic conditions and supporting stakeholders to improve the quality and cost-effective delivery of care.

Conclusion

In our ever-changing healthcare environment, it is important that plans have access to new and relevant information that can assist in the cost-effective delivery of care. Stakeholders have many different needs and challenges. The Chronic Care Collaborative is an easy-to-use, up-to-date resource that can provide concepts and tools to help plans coordinate the appropriate delivery of healthcare.

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Case Study

Payers, Providers Collaborate to Improve Pharmacy Care

By Maggie Bruce

The Wisconsin Pharmacy Quality Collaborative (WPQC) is a payer–pharmacist collaboration that aligns incentives to improve medication use and safety, reduces healthcare costs for payers and patients, and increases professional recognition and compensation for pharmacist-provided services.

Access to affordable medications, adherence to prescribed therapies, and safe use of drugs are essential for improving health and containing healthcare costs. Payers of drug benefit programs and providers are continually challenged to help plan members manage medications effectively, especially medications for chronic conditions. Community pharmacists have the knowledge and skills to be a valuable resource in meeting this challenge, yet product-based pharmacy reimbursement is a disincentive. As reimbursement has decreased over time, pharmacies have had to make it up in volume by dispensing more prescriptions per pharmacist. The end result is less time to spend with patients.

Although Wisconsin pharmacists have had opportunities to be compensated for cognitive services, lack of standardization among existing reimbursement models has limited participation. In 2006, the Pharmacy Society of Wisconsin convened a group of payer organizations and community pharma-

cists to develop a standardized program to achieve shared goals through collaboration. The newly created WPQC sought to restructure the payer–pharmacy financial relationship in a way that (1) reimburses professional services separately from dispensing, (2) establishes and raises quality standards, and (3) engages community pharmacies in keeping the drug benefit affordable.

Unity Health Plans Insurance Corporation, a regional network model health maintenance organization (HMO) providing prescription drug coverage for 42,000 individuals, played an integral role in advancing the initiative. In addition to participating in the developmental stages, Unity Health was the first payer to contract for value-added pharmacy services through WPQC.

“As a provider-owned HMO with pharmacy and medical risk, we’ve always understood how quality on the pharmacy side impacts medical outcomes and cost,” says Patrick Cory, PharmD, Pharmacy Director, Unity Health. “The health plan pays claims for patients to see a physician, have appropriate tests to diagnose a condition, and obtain medication proven to improve outcomes for that condition. Too often when we check on those patients later, particularly in the case of chronic conditions, they’re not at the therapeutic goal. They’re not taking

the medication properly, or not taking it at all. We’ve made a large investment up front, and we’re not realizing a return.”

Pharmacies Earn Credentials

WPQC developed a quality credentialing process for pharmacies, a training program and a standardized professional services reimbursement schedule. Participating pharmacies must implement changes within their practice sites to meet 12 best-practice quality-based requirements, including a medication error continuous quality improvement process.

“The quality measures are process-oriented, much like the National Committee on Quality Assurance administrative standards,” Dr Cory said. “Meeting the measures requires a significant commitment from pharmacies.” Participating pharmacists complete training on the WPQC quality requirements and reimbursable services and methods for integrating both into the workflow. Pharmacies that meet the requirements are eligible for reimbursement for providing value-added professional services to the payers’ members.

There are 2 levels of service. Level 1 includes primarily point-of-care services, including in-depth medication device teaching, and interventions for cost-effectiveness, adherence, therapeutic

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About the Lead Article Author

Jeffrey D. Dunn, PharmD, MBA, is the Formulary and Contract Manager for SelectHealth (formerly Intermountain Health Care Health Plans) in Salt Lake City, Utah, an integrated health system comprising 22 hospitals, 68 physician clinics and surgery centers, and more than 450 employed community-based physicians.

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Payers, Providers Collaborate to Improve Pharmacy Care

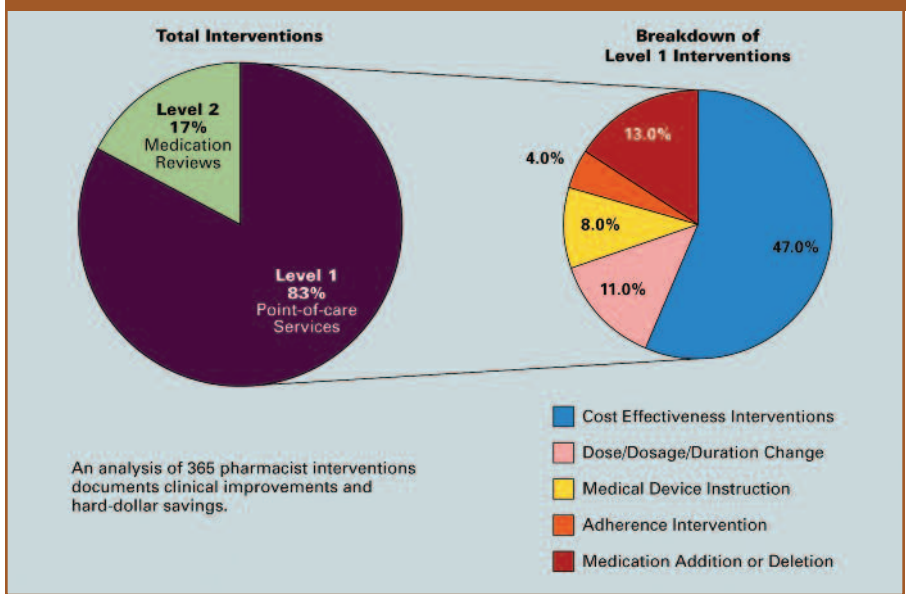
duplication, dosing adjustments, and medication additions or deletions based on clinical or safety guidelines. Level 2 services are appointment-based, comprehensive medication reviews for patients with complex conditions and medication needs. Communication with the patient's primary care physician is a requirement for all reimbursed services. A web-based technology platform custom-designed for standardized documentation and billing supports the program.

Pilot Shows ROI

In the first 18 months of the program pilot, 365 paid interventions were made on behalf of Unity Health members with an annualized, calculated return on investment (ROI) of 2.5 to 1. Of the total interventions, 304 were level 1 services and 61 were level 2. Level 1 interventions varied, with 47% falling into the cost-effectiveness category (Figure).

"When calculating the ROI, we included savings solely from cost-effectiveness interventions, without regard to possible additional ROI from other types of interventions more difficult to quantify, but we included the costs of all services covered in the program," said Dr Cory. "The cost-effectiveness interventions alone have paid for the entire program, and then some."

Figure. Unity Health Reimburses for Multiple Interventions



Source: Data supplied by Unity Health Plans Insurance Corporation.

In its pilot phase, WPQC also served as 1 of 5 phase-1 demonstration projects testing quality measures developed by the Pharmacy Quality Alliance (PQA). Although WPQC best-practice requirements are process-oriented, PQA measures focus on the clinical quality of pharmacy services. WPQC recently was chosen as a phase-2 PQA demonstration project. To date, 54 community pharmacies and more than 100 pharmacists are participating in WPQC. More than 120 pharmacists, 6 pharmacy technicians, and 45 fourth-year University of Wisconsin-Madison School of Pharmacy students completing clerkships at WPQC pharmacies have been trained.

Unity Health launched the program in May 2008. A second payer joined the program in June 2008, bringing the number of members eligible for services to 70,000. Two additional payers with a combined total of 1.8 million lives are expected to join WPQC in 2010. This will substantially increase the scale of the program, including the volume of patients using value-added services of participating pharmacies.

WPQC is continuing to focus on physician engagement and increasing physician referral of patients for WPQC pharmacist services. One of the lessons learned from the pilot program is that patients who can benefit from a compre-

hensive medication review and action plan are hesitant to take advantage of the service. Another focus will be on additional pharmacist training for medication adherence interventions.

Disclosure Statement

Unity Health Plan Insurance Corporation and WPQC have not received any funding from Takeda Pharmaceuticals North America, Inc, or any other pharmaceutical manufacturer. The McKesson Corporation developed the software application used by participating WPQC pharmacies and provided financial support to the Pharmacy Society of Wisconsin for ongoing project development.

National Group Focuses on Pharmacy-Level Metrics

The Pharmacy Quality Alliance (PQA), launched in 2006, is a consensus-based alliance with more than 50 member organizations focused on developing, testing, and implementing quality measures in the practice of pharmacy. The PQA's vision is to provide pharmacy-level quality data much like hospital and physician datasets used for contracting purposes. Learn more at www.pqaalliance.org.

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This publication further provides benefit design decision makers the integrated industry information they require to devise formularies and benefit designs that stand up to today's special healthcare delivery and business needs.

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