INNOVATIONS in Medication Therapy Management

Effective Practices for Diabetes Care and Other Chronic Conditions

December 2013

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Innovations in Medication Therapy Management

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This publication is the latest in a series of AHIP Innovations reports highlighting trends in health care. Previous volumes include:

- Innovations in Medicaid Managed Care
- Health Literacy and America’s Health Insurance Plans: Laying the Foundation and Beyond
- Health Insurance Plans’ Innovative Initiatives to Combat Cardiovascular Disease
- Reducing and Preventing Childhood Obesity: Health Insurance Plans Partnering in Communities
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- Innovations in Reducing Preventable Hospital Admissions, Readmissions, and Emergency Room Use
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- Innovations in Prevention and Wellness
- Trends and Innovations in Health Information Technology
- Trends and Innovations in Chronic Disease Prevention & Treatment
- Innovations in Chronic Care
- Innovations in Health Information Technology
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Overview

Expanding the Horizons of Medication Therapy Management in a Changing Health Care System

Key Trends and Best Practices
In this report, we describe trends in the medication therapy management (MTM) programs being conducted by America’s health insurance plans, and we provide details about 16 companies’ MTM initiatives for a variety of patient populations.

The report is divided into two chapters:
The first chapter describes the three common themes that emerged in our review of health plans’ MTM initiatives:

- Advanced IT systems are enabling new strategies for care improvement and cost savings;
- MTM is helping achieve the goals of new care delivery models (accountable care organizations (ACOs) and patient-centered medical homes (PCMHs)); and
- Pharmacists’ roles are expanding in new and innovative ways to deliver effective, evidence-based care.

The second chapter is a company-by-company compendium of MTM programs in operation today. We have included results of these programs whenever available, as well as contact information for health plan professionals who can answer questions about the programs.

Medication-Related Challenges and the Need for MTM
At a time when people are living longer than ever with chronic conditions and it is not unusual for patients to have several doctors and take multiple medications, complex medication regimens are creating major challenges for patients, caregivers, health care practitioners, and the health care system as a whole. Care plans that call for several medications at different times of the day often lead to confusion and missed doses. The high cost of some medications may lead some patients to stop taking them.

The Agency for Healthcare Research and Quality (AHRQ) reports that 20 to 30 percent of prescriptions are never filled and that, on average, 50 percent of medications for chronic disease are not taken as prescribed. These problems have tremendous costs. According to AHRQ, nonadherence, or not taking medications as prescribed, has been estimated to cost the U.S. health care system between $100 billion and $289 billion annually.

People who have been hospitalized face additional challenges. Patients often receive new medications in the hospital, and when they leave, they may not know how their new medications relate to the ones they were taking before, which drugs do the same thing but have different names, which ones they should continue taking, and which ones should be eliminated to avoid duplication or adverse reactions. Primary care doctors may not know about the new drugs their patients were prescribed in the hospital, so potential safety issues may go unrecognized. Patients sometimes have cognitive difficulties, and many are simply exhausted after being in the hospital and do not fully remember or understand complex prescription instructions. As a result, medication-related challenges often lead to medical complications, as well as

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Overview

Expanding the Horizons of Medication Therapy Management in a Changing Health Care System (continued)

preventable emergencies, hospital admissions, and readmissions.

MTM in Medicare and Beyond

Medicare’s Comprehensive Medication Reviews. Congress recognized the significant health and financial implications of medication-related errors, omissions, and complications when it established MTM requirements as part of the Medicare Part D program in 2003.3 Under MTM rules issued by the Centers for Medicare & Medicaid Services (CMS),4 Medicare Advantage health plans and stand-alone prescription drug plans (PDPs) must offer beneficiaries who have multiple chronic conditions, take multiple prescription drugs, and are likely to have annual drug expenses over a specified level ($3,144 in 2013; $3,017 in 2014) the opportunity to have detailed, one-on-one medication consultations, called comprehensive medication reviews (CMRs), with pharmacists at least once a year.5,6,7

During a CMR, the pharmacist goes over all of the prescription and non-prescription drugs that the patient is taking; identifies any medication-related problems; develops a prioritized list of problems; and creates an action plan for working with the patient, caregiver, and prescribers to resolve these issues. The review must be conducted in real time, as an interactive consultation by phone, through telehealth technology, or in person between the pharmacist and patient or a patient’s representative. The purpose is to improve patients’ knowledge of their prescriptions and over-the-counter medications and supplements; identify and address patients’ problems or concerns; and empower patients to manage their medications and health conditions effectively.8

Following CMRs, Medicare Advantage plans and PDPs must give patients written summaries, which may include personal medication lists, along with action plans or recommendations. Medicare Advantage plans and PDPs also must reach out to beneficiaries’ physicians or other prescribers with suggested changes to resolve drug therapy problems and promote more effective care.9

On a quarterly basis, Medicare Advantage plans and PDPs are required to follow up with targeted medication reviews (TMRs) for each beneficiary, to go over medication use since the CMR and address any unresolved issues and/or new problems, as well as any medication issues associated with recent care transitions. Based on these reviews, additional action may be needed.10,11 Even if beneficiaries forego the option of having a CMR, Medicare Advantage plan and PDP pharmacists or other qualified providers must review patients’ medications on a quarterly basis and send prescribers their findings with recommendations.12

Innovative MTM Approaches to Address Critical

9 Centers for Medicare & Medicaid Services (November 2012).
11 Centers for Medicare & Medicaid Services (November 2012).
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**Overview**

Expanding the Horizons of Medication Therapy Management in a Changing Health Care System (continued)

**Health Care Priorities.** Many health plans are going beyond CMS’s MTM requirements and offer a wide range of MTM-related activities not only for Medicare beneficiaries, but also for patients with Medicaid and commercial coverage. MTM has become an essential part of strategies to address some of the nation’s highest priorities in health care: improving health outcomes and lowering costs for people with diabetes and other chronic illnesses; protecting patient safety; promoting effective care transitions; and reducing preventable hospital admissions and readmissions. As initiatives such as patient-centered medical homes and accountable care organizations are transforming the delivery system, MTM is an increasingly important part of strategies to achieve these initiatives’ goals of boosting health care quality, improving patients’ experiences with care, and lowering costs.

**New Roles for Pharmacists on Care Teams.** As the delivery system evolves, the role of pharmacists is changing significantly. In ACOs and PCMH programs, pharmacists are key members of care teams, working closely with doctors, nurses, care managers, and patients to proactively address the complex medication issues that often occur when patients are being treated with multiple medications prescribed by different health care providers. As they increasingly recognize the value that pharmacists’ expertise brings to care teams, doctors and nurses seek pharmacists’ advice and are collaborating with them to improve care. Under the collaborative practice agreements in place at some health plans, pharmacists have physician approval to help patients manage medications for specified health conditions, such as diabetes and high blood pressure. Pharmacists working under collaborative practice have a series of consultations with patients and may adjust their medication regimens and discuss lifestyle changes to improve health outcomes. Pharmacists also are playing important roles in health plans’ care transition, patient safety, and patient outreach initiatives.

**A Wide Variety of Programs.** In this report, we use the term MTM broadly, to include not only CMS-required MTM activities, but also a wide variety of innovative programs to address complex medication-related challenges for patients with chronic conditions such as diabetes, high blood pressure, heart failure, high cholesterol, asthma, and chronic obstructive pulmonary disease. As you will see in the pages that follow, MTM is not one-size-fits-all. Health plans are approaching MTM in many different ways, and individual health plans often have several different MTM activities underway at once. MTM continues to enter new territory, with pharmacists providing expert medication consults in senior centers, town hall-style meetings, and even the Minnesota State Fair. One health plan has a special hotline that Medicare beneficiaries eligible for MTM can call with medication-related questions.

It is our hope that this sharing of best practices will contribute to the next generation of innovative MTM programs, with lasting benefits for patients, caregivers, and health care practitioners throughout the country.
Chapter 1

Designing Many Creative Approaches to Improve Care

While health plans take many different approaches to medication therapy management (MTM), three major trends are notable in the design and implementation of MTM programs today:

- Health IT is being used with increasing sophistication to improve patient care;
- MTM is key to achieving the goals of new delivery system models such as accountable care organizations (ACOs) and patient-centered medical homes (PCMHs); and
- Pharmacists are taking on new and expanded roles in patient care.

This chapter offers a glimpse into how these trends are playing out in America’s health insurance plans, and Chapter 2 provides details on specific programs underway in 16 companies.

Health IT Can Play a Central Role

Health IT is an essential component of all health plans’ MTM activities, enabling health plans to find patients who could benefit from pharmacists’ support, identify potentially dangerous drug combinations, and track physicians’ generic prescribing rates. Health IT is being used in particularly innovative ways in MTM initiatives at Aetna, KelseyCare Advantage, the AmeriHealth Caritas Family of Companies, and Health Care Service Corporation, a Mutual Legal Reserve Company.

Aetna has created a personalized tool—a mobile app called CarePass—to help people reach health goals and self-manage their medications. People can use CarePass to create mobile medication lists with dosing instructions and set up reminders for each dose they need to take throughout the day. Patients can receive text messages when it’s time to take their medicine and record each dose taken. The app also enables people to locate doctors and find answers to simple medical questions.

KelseyCare Advantage’s MTM program for Medicare Advantage members takes electronic communication to a new level, with network physicians and pharmacists communicating regularly about medications through the electronic health record (EHR) system. Pharmacists send doctors summaries of each consultation they have with patients, including notes about potential drug interactions, side effects, dosing that could create safety risks, and opportunities to reduce costs with generic alternatives. Doctors review and respond to these notes, and they coordinate with pharmacists to adjust prescriptions as needed through the e-prescribing system.

Similarly, as part of the Drug Therapy Management program in the AmeriHealth Caritas Family of Companies, pharmacists communicate with care managers through the online care management system to address barriers to care for Medicaid members with diabetes who have not filled prescriptions as recommended. For example, care managers may collaborate with doctors and pharmacists if side effects or complex drug regimens are making it difficult for patients to follow care plans. Pharmacists can recommend alternative prescriptions and simplified dosing schedules. Drug Therapy Management software notifies pharmacists about potential drug interactions, duplicative therapies, and gaps in evidence-based care, and pharmacists contact physicians to resolve them.

As part of the Health Care Service Corporation’s Rx Health Advisor MTM program in four BlueCross Blue Shield plans, a pharmacist

1 The program operates in IL, TX, OK, and NM.
Innovations in Medication Therapy Management

Chapter 1

Designing Many Creative Approaches to Improve Care (continued)

serving as the Rx Health Advisor analyzes medical and lab records to identify health risks for patients taking multiple prescriptions. Based on these analyses, the pharmacist creates patient-specific Medication Action Plans to protect patient safety and improve health outcomes. These plans may include recommendations to add, discontinue, or modify prescriptions; change doses; simplify dosing schedules; and/or provide additional services to improve the effectiveness of care. The pharmacist sends Medication Action Plans through the EHR system to patients’ nurse case managers, and each week, the Rx Health Advisor and case managers hold conference calls to discuss the plans’ key findings. Care managers share the Advisor’s recommendations with physicians, who may adjust care plans accordingly.

MTM Helps Achieve the Goals of Accountable, Patient-Centered Care

In accountable care organizations and patient-centered medical homes around the country, MTM has become a key component of health plan and physician strategies to improve health outcomes, improve patients’ experiences with care, and reduce costs, not only for prescription drugs, but also for hospital inpatient and emergency room care.

In coordination with 18 ACOs, Aetna takes a population-based approach to MTM for patients with Medicare, Medicaid, and commercial health coverage. As a first step in engaging with an ACO, Aetna uses advanced IT tools to measure its performance on nationally recognized care standards—such as the proportion of patients with diabetes who are on ACE inhibitor and ARB medications,2 patients with congestive heart failure taking ACE inhibitors, and people with asthma who are taking inhaled corticosteroids—and it determines the rate of generic drug prescribing among ACO physicians. Based on this information, the health plan creates customized reports for each ACO that describe its performance in comparison to nationally recognized quality benchmarks and targets for generic prescribing. An Aetna medical director and pharmacist coordinate with each ACO’s clinical team to set mutual goals and initiate action plans to improve the quality and affordability of care.

Under Geisinger Health System’s ACO model, pharmacists specializing in disease management collaborate with doctors, nurses, and case managers in the care of patients who are at high risk of hospital admission and readmission. Pharmacists can help people start new medications, and they can work with physicians to simplify drug regimens and lower patients’ out-of-pocket costs. Pharmacists also coordinate with other care team members to ensure that patients with diabetes receive all of the treatments and reach the health benchmarks included in Geisinger’s evidence-based care “bundle.”³ Care teams are rewarded with bonus payments when patients reach nationally recognized clinical goals for health improvement.

As part of its agreements with seven newly formed ACOs throughout the state, Florida Blue’s

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2 ACE inhibitor is shorthand for angiotensin-converting enzyme inhibitor. ARBs are angiotensin II receptor blockers. Both medications are effective in treating high blood pressure and may be prescribed for patients with heart disease or diabetes.

3 The “bundle” of services for Geisinger patients with diabetes includes: annual flu shots; regular pneumonia vaccines; annual kidney function tests; documentation of smoking status and enrollment in smoking cessation programs; blood pressure levels below 130/80 mmHg; annual foot and retinal exams; treatment with recommended ACE inhibitor and ARB medications; as well as health care needed to attain HbA1c levels below 7 or 8 percent and blood pressure levels below 130/80 mmHg.
pharmacists partner with ACO physicians to set goals for evidence-based prescribing and cost savings. Each month, the health plan reports to the organizations’ medical leadership on generic drug prescribing rates and other metrics to track progress toward mutual objectives. As the ACOs develop further, pharmacists continue to add other medication-related goals to improve health outcomes and reduce the total cost of care. For example, in the Fall of 2013, health plan and ACO clinicians developed plans to address the effective use of proton-pump inhibitor medications, which sometimes duplicate other treatments and which can cause health problems if used over long time periods.

As part of capital District Physicians’ Health Plan’s (CDPHP’s) patient-centered medical home program, called the Enhanced Primary Care initiative, an MTM pharmacist regularly visits care teams and meets with patients. During these meetings, she provides advice to help them understand and streamline complex medication regimens, remove safety risks, avoid duplication, and identify opportunities for cost savings with generics. The pharmacist offers suggestions based on nationally recognized guidelines and standards for evidence-based care. She also provides condition-specific guidance, such as how to initiate and adjust insulin doses for patients newly diagnosed with diabetes.

Building on its past success with earlier versions of the PCMH model, Group Health Cooperative is pursuing Version 2.0, in which pharmacists’ work focuses on Medicare, Medicaid, and commercially insured patients with chronic conditions and other complex health care needs.

Pharmacists meet with these patients, in person or by phone, before their first appointments with primary care physicians. During these meetings, pharmacists review all of patients’ health conditions and medications; identify potential safety risks, and look for opportunities to promote evidence-based care, streamline drug regimens, improve health outcomes, and achieve cost savings with generics. Pharmacists document their findings in patients’ electronic health records and highlight issues for primary care physicians to address.

Pharmacists are on-site full-time at Kaiser Permanente’s PCMH practices in CO, OR, WA, and Riverside, CA to help patients understand, manage, and address complicated medication regimens. Pharmacists’ roles on care teams vary according to individual practices’ needs and priorities. For example, Kaiser’s PCMH practice in Riverside, CA is using clinically trained pharmacists to help reduce preventable hospital readmissions. The program focuses on people at risk of hospital readmission based on their health conditions, drug regimens, hospital lengths of stay, and emergency room visits in the past 12 months.

Pharmacists contact patients by phone to review and explain their medications; check whether they have filled all prescriptions; and identify any medication-related problems (such as omissions, difficulties with taking prescriptions, missing drug-related lab tests, duplication, and potential adverse interactions). Pharmacists then make recommendations to patients’ primary care physicians and connect patients with other care team members as needed to address challenges. As part of the process, case managers may help patients participate in programs for smoking cessation, weight loss, and disease management.
Chapter 1

Designing Many Creative Approaches to Improve Care (continued)

Independent Health is continuing to expand the pharmacy component of its PCMH model, called The Primary Connection, which covers about 30 percent of the health plan’s member population, or about 90,000 people with all types of health coverage. The program’s pharmacists attend monthly meetings of the health plan’s physician groups to talk about effective drug therapies (including ACE inhibitor and ARB medications for patients with diabetes, as well as recommended treatments for asthma and heart conditions), patient safety, and use of generic drugs to help lower the cost of care. In some cases, doctors ask pharmacists to consult directly with patients who have chronic conditions and complex care regimens.

Pharmacists’ Roles are Expanding to Enable More Far-Reaching and Effective MTM Activities

Pharmacists are taking on new and expanded roles in conjunction with health plans’ collaborative practice agreements, patient information programs, patient safety initiatives, care transition procedures, and special programs for patients with complex needs.

Collaborative Practice. Collaborative practice agreements—in which doctors authorize pharmacists to manage a specified set of medications (e.g., diabetes drugs, anticoagulants, blood pressure medications) for patients on an ongoing basis and make changes to improve health outcomes—represent the most mature model of MTM in practice today. Under these arrangements, patients receive a high level of support from pharmacists, as well as personalized information and tools to help them manage their conditions. Physicians also benefit from pharmacists’ expertise and insights.

KelseyCare Advantage has used collaborative practice agreements since 2004. Initially, the agreements covered five classes of drugs for which there were alternatives with the same therapeutic effect. In 2008, collaborative practice was expanded to allow pharmacists to adjust four additional types of medications based on analysis of lab data, dosing, and patient input. Pharmacists discuss recommended prescription changes with patients by phone and document modifications in EHRs. Pharmacists give patients their direct phone numbers to call if they have questions or concerns.

At Group Health Cooperative’s PCMH sites, pharmacists work under the collaborative practice model for patients with complex chronic conditions such as diabetes, high blood pressure, coronary artery disease, and cardiovascular disease. In 2014, the program is expanding to include patients with extensive health care needs who are taking specialty drugs for rheumatoid arthritis, hepatitis-C, multiple sclerosis, HIV, and oral oncology drugs. Pharmacists consult with patients by phone, e-mail, and in person for an average of four or five months to help them reach clinical goals such as reduced HbA1c, blood pressure, and LDL-cholesterol levels.

Under Geisinger Health System’s collaborative practice model, members with diabetes, high blood pressure, or high cholesterol who have not responded to treatment—as well as those taking anticoagulant medications, which require continuous monitoring to avoid bleeding and blood clots—are referred to pharmacists who

5 These include statins; ARBs; nasal steroids; bisphosphonates; and proton pump inhibitors.
6 These include certain serotonin re-uptake inhibitors (SSRIs) and insulin products, as well as expanded categories of ARBs and ACE inhibitors.
Chapter 1

Designing Many Creative Approaches to Improve Care (continued)

specialize in disease management.7 Pharmacists have a series of meetings with patients, by phone and in person, for a period which can range from weeks to months, depending on patients’ needs. During their initial visits, pharmacists engage in motivational interviewing, asking patients to identify life events (e.g., attending a grandson’s birthday party) or health-related goals (being able to walk a certain distance) that are important to them. They help patients understand how taking medications as prescribed, keeping appointments for recommended care, and making lifestyle changes will help them achieve their goals. In follow-up meetings, pharmacists collaborate with patients on action plans to reach these goals. They continue to adjust medications and dosing to find the combination that works best for each patient, and they coordinate with doctors, nurses, and case managers to connect patients with the resources and support services they need.

**Health Partners Medical Group**’s collaborative practice agreements cover a total of nine conditions and care processes.8 Pharmacists do thorough evaluations of patients’ health status and medications and may change prescriptions and doses to reduce side effects; improve the effectiveness of treatment; make it easier to follow care plans; and lower patients’ out-of-pocket costs. Physicians sign off on collaborative practice agreements once a year, and while the agreements are in place, pharmacists continue to confer with care teams by phone, e-mail, messages through the electronic health records system, and in person. Doctors have responded positively to collaborative practice and have continued to suggest additional conditions for pharmacists to manage under this model.

**Kaiser Permanente** began using collaborative practice agreements in the 1980s for managing anti-coagulation drugs and now has agreements covering additional outpatient medications for conditions such as diabetes; asthma; cancer; cardiovascular disease; post-heart attack care; and kidney disease. Under these agreements, pharmacists have the ability to initiate, adjust, and discontinue medications and order medication-related lab tests.

**New Venues for Patient Outreach.** Under several health plan initiatives, patients don’t have to go to the pharmacy for advice on medications. As part of **Highmark Health Services**’ Speaker Series, Medicare Advantage members with diabetes are invited to town hall-style meetings where a pharmacist, nurse health coach, and diabetes educator give presentations on effective diabetes care. After each presentation, beneficiaries can meet one-on-one with any of these professionals to ask questions and seek advice.

At **UCare**’s Ask-the-Pharmacist program, held once a week at the Minneapolis Skyway Senior Center, pharmacists answer people’s questions about medications and can provide information about specific health benefits. The pharmacist also can connect UCare members with case management and disease management programs to address ongoing needs. Each year, UCare staffs an Ask-the-Pharmacist booth offering the same type of service at the Minnesota State Fair.

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7 The program includes: patients with diabetes whose HbA1c levels measure above 9 or remain greater than 8 for more than a year; patients taking two or more medications for hypertension and whose blood pressure is above 130/80 mmHg; and patients whose LDL-cholesterol is above recommended levels ranging from 70-130 mg/dL and who have been prescribed statin medications for at least a year.

8 The conditions and processes covered under HealthPartners Medical Group’s collaborative practice agreements are: diabetes; hypertension; high cholesterol; asthma; chronic obstructive pulmonary disease; smoking cessation; transitioning from opioid treatment; transitioning from benzodiazepine treatment; and therapeutic interchange (which involves replacing one medication with an equivalent dose of another drug that is in the same therapeutic class and has a similar effect).
WellCare’s Medicare Advantage members who are eligible for MTM services can call the HealthLine Hotline for medication-related information and help. The hotline is staffed by full-time pharmacists and pharmacy technicians who answer questions, address problems with side effects, provide instructions on using medical equipment, discuss lifestyle issues such as diet and exercise, and connect members with other professionals who can help with ongoing needs such as nutrition or transportation.

Patient Safety. Kaiser Permanente’s pharmacists have been instrumental in the design, planning, implementation, and monitoring of the health plan’s Southern California Medical Group Outpatient Medication Safety Net initiative. Working with medical leadership in several specialties, pharmacists created physician alerts through the EHR system when patients face safety risks from: gaps in evidence-based care; potential drug interactions; use of drugs that are unsafe for elderly patients or that may worsen their health conditions; and missing lab tests or other monitoring procedures. Pharmacists identify safe and effective treatment options for each patient and collaborate with doctors and nurses to implement changes in medications, dosing, and/or monitoring to promote positive health outcomes.

Care Transitions. To help avoid medication-related problems associated with preventable hospital readmissions, pharmacists are playing key roles in health plans’ care transition programs. KelseyCare Advantage’s Medicare members who are discharged from hospitals following a heart attack or with any of three health conditions (pneumonia, chronic obstructive pulmonary disease (COPD), or congestive heart failure) receive phone calls from pharmacists within 72 hours. During these calls, pharmacists review patients’ medications, check for safety risks such as duplication, and ask about side effects and other challenges. If patients have symptoms that warrant further follow-up, pharmacists arrange for home visits by physician assistants, who conduct detailed evaluations and send findings to patients’ primary care doctors.

Pharmacists likewise reach out by phone to Excellus BlueCross BlueShield’s Medicare members who are discharged from hospitals with multiple medications for several chronic conditions. Pharmacists review patients’ medications, ask how they are feeling, and identify problems that could require medication changes or additional care. If they find that patients have unmet needs (e.g., if they are having side effects or can’t afford their prescriptions), pharmacists follow up with doctors and nurse case managers to find solutions. Pharmacists also talk with patients about diet and exercise, recommended preventive care, and other strategies to promote health and wellness.

Group Health Cooperative’s care transition program focuses on patients receiving care under the PCMH model who are discharged from hospitals with chronic conditions, complex care plans, and/or new drug regimens. Pharmacists contact patients in three to seven days of discharge to review and discuss their medications. Prior to each call, pharmacists compare medications listed on the hospital’s discharge summaries with the medication lists in their electronic health records. Based on this comparison, pharmacists identify potential problems (e.g., medication omissions, duplication, differences in dosing instructions, and potential for adverse drug interactions) and coordinate with care teams to develop an optimal drug regimen.
Chapter 1

Designing Many Creative Approaches to Improve Care (continued)

for each patient. In their conversations with patients, pharmacists explain the purpose and dosing instructions for each medication; explain any needed prescription changes to avoid adverse outcomes; and answer questions.

As part of Aetna’s Rx Home Success pilot program, people with chronic conditions who are taking multiple medications and whose health status is considered moderate- or high-risk receive phone calls from pharmacists within five days of hospital discharge. During these discussions, pharmacists review medications, answer questions, reconcile drugs prescribed in the hospital with those previously being taken, and identify barriers to care.

In one of the pilot locations, patients who are at high risk of complications and readmissions receive home visits from pharmacists within 48 hours of hospital discharge. Based on findings from their phone calls and home visits, pharmacists coordinate with Aetna’s nurse care managers and doctors to help patients access whatever they need to follow care plans and manage their conditions effectively.

Independent Health pharmacists contact patients with conditions such as asthma, chronic obstructive pulmonary disease, pneumonia, and heart failure following hospital discharge to review and explain medications. Pharmacists give patients their phone numbers to call if they have any questions. Some people have formed lasting bonds with pharmacists and continue to call them months or years later whenever they have concerns about their medicine.

A Resource for Care Teams Addressing Complex Needs. As part of UCare’s support program for people dually eligible for Medicare and Medicaid, nurse care managers send patients’ medication lists to pharmacists, who identify gaps in evidence-based care, potential risks to patient safety, and opportunities for cost savings with generics. Pharmacists collaborate with care managers and doctors in making any changes needed to improve care, and they participate in weekly conference calls with care teams to discuss challenges in care and offer recommendations.

Cigna-HealthSpring’s pharmacists consult with nurses and social workers on how to address medication-related challenges identified during post-discharge follow-up calls with Medicare Advantage members. For example, people often don’t know whether they should continue taking prescriptions they had been taking before being admitted to the hospital, or they may have trouble remembering to take multiple doses. If nurses determine during these conversations that members meet the requirements for the MTM process required by the Centers for Medicare & Medicaid Services, they connect the members with pharmacists to enroll in the MTM program and start the process of comprehensive medication review.
Aetna

Promoting High-Value Care with Health IT Tools and a Personal Touch

Overview

Aetna’s medication therapy management program uses a mix of high-tech and high-touch approaches, along with innovation in value-based insurance design, to promote effective care. In partnership with 18 accountable care organizations (ACOs) across the country, Aetna leverages the power of advanced health information technology (HIT) tools to promote evidence-based care and reduce prescription drug costs.

Aetna’s new mobile app, CarePass, enables individuals to work toward health-related goals and manage their medications. The generic drug kiosks placed in doctor’s offices in 15 metropolitan areas make it easy for doctors to find high-value medications to treat patients effectively.

Aetna’s new value-based insurance design initiative, Rx Healthy Outcomes, lowers the cost of cardiac drugs to give patients added incentive to stay on their medications so they can avoid repeat heart attacks. Additionally, Aetna’s care transition pilot program takes a personal approach, with pharmacists providing extra support to patients discharged from hospitals with complex medication regimens.

Leveraging Health Information Technology

Partnership with Accountable Care Organizations. In coordination with 18 ACOs, Aetna takes a population-based approach to medication therapy management (MTM) to improve care and lower costs for patients with Medicare, Medicaid, and commercial health coverage. As a first step in engaging with an ACO, Aetna uses advanced IT tools to measure its performance on nationally recognized care standards—such as the proportion of patients with diabetes who are on ACE inhibitor and ARB medications, patients with congestive heart failure taking ACE inhibitors, and people with asthma who are taking inhaled corticosteroids—and it determines the rate of generic drug prescribing among ACO physicians. Based on this information, the health plan creates customized reports for each ACO that describe its performance in comparison to nationally recognized quality benchmarks and targets for generic prescribing.

An Aetna medical director and pharmacist coordinate with each ACO’s clinical team to set mutual goals and initiate action plans to improve the quality and affordability of care. To help ACOs advance toward these goals, Aetna sends e-mails and pop-up alerts through electronic health record systems to their doctors and pharmacists, to identify gaps in evidence-based care, potential drug interactions for individual patients, options for effective treatment of selected health conditions, and effective generic alternatives when brand-name drugs are prescribed. Pharmacists in Aetna’s Rx Check unit review claims data every day to identify potentially serious drug-drug interactions and dosing problems. If they find imminent risks to patient safety, they call ACO doctors immediately.

A Mobile App to Help Patients Reach Personal Health Goals. Aetna’s mobile app, called CarePass, provides individuals support for pursuing health-related goals and managing medications. The app, which is available to the

Pharmacists in Aetna’s Rx Check unit review claims data every day to identify potentially serious drug-drug interactions and dosing problems. If they find imminent risks to patient safety, they call ACO doctors immediately.

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1 ACE inhibitor is shorthand for angiotensin-converting enzyme inhibitor. ARBs are angiotensin II receptor blockers. Both medications are effective in treating high blood pressure and may be prescribed for patients with heart disease or diabetes.

2 For example, the system would send an alert if a patient with congestive heart failure has not been prescribed ACE inhibitor or ARB medication.
Aetna

Promoting High-Value Care with Health IT Tools and a Personal Touch (continued)

Keeping Drug Costs Affordable

Generic Drug Kiosks. As part of its effort to increase generic prescribing, Aetna collaborates with a company that installs kiosks stocked with generic drug samples in physician practices. Currently, nearly 4,000 physician practices—including primary care physician offices and large, multi-specialty practices—in 15 metropolitan areas throughout the country are using the machines, each of which holds approximately 80 medications. The kiosks work like ATM machines, so that doctors enter patients’ medical and insurance information and, if effective generic drug options exist for patients’ conditions, machines dispense generic drug samples at no cost to patients. Aetna covers the entire cost of a one-month supply.

Results

■ In May 2013 (the most recent period for which results are available), the generic drug prescribing rate for physicians using generic drug kiosks was approximately 80 percent—a rate two to three percent above the averages for the markets where they are located.

No- and Low-Cost Cardiac Drugs. To make it easier for patients with heart conditions to take maintenance drugs as prescribed, Aetna introduced Rx Healthy Outcomes as an option for self-insured commercial coverage in 2011. Under the program, patients have reduced copays for brand-name cardiac drugs and no copays for generics following a heart attack or cardiac procedure (e.g., receiving a cardiac stent).

Within a week of discharge from the hospital after a heart attack, patients receive phone calls from pharmacists who explain their medications, reconcile new drugs prescribed in the hospital with others they were previously taking, answer questions, and identify any issues, such as side effects, that need follow-up. Pharmacists help patients connect with doctors, nurses, or other care team members to resolve these issues.

Results

■ A randomized controlled trial of a similar approach which did not include the pharmacist follow-up found that it significantly increased adherence to cardiac maintenance drugs, by rates ranging from 4.4 percentage points for beta-blockers to 6.2 percentage points for statins. Patients in the program had lower out-of-pocket costs and lower rates of stroke than those in the control group.3

Supporting Patients in Care Transitions

To further improve health outcomes following hospitalization, Aetna launched a care transition program called Aetna Rx Home Success on a pilot basis in Medicare Advantage and selected commercial plans in MD, Washington, D.C., and Northern VA in June 2013. The program is available to patients with at least two chronic conditions who are taking five or more medications and whose health status is determined to be moderate- or high-risk. Patients with moderate-risk health profiles receive phone calls from pharmacists within five days of hospital discharge to review medications, answer questions, reconcile drugs prescribed in the hospital with those previously being taken, and identify barriers to care. As with Rx Healthy Outcomes, pharmacists coordinate with nurse care managers and doctors to help patients access whatever they need (such as transportation or home delivery of medications) to follow care plans and manage their conditions effectively.

In MD, each patient who is at high risk of complications and readmissions receives a home visit from a pharmacist within 48 hours of hospital discharge. During these visits, pharmacists explain medications, reconcile old and new prescriptions, and identify medication-related challenges. Pharmacists communicate with Aetna’s nurse care managers about unmet needs, and care managers work with patients on an ongoing basis to address them. Additionally, pharmacists check patients’ electronic health records regularly for a 30-day period, and they contact patients who experience complications or other adverse events to provide medication-related information and support.

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AmeriHealth Caritas Pennsylvania and Keystone First

Reaching Out to Improve Care for Medicaid Members with Diabetes

Overview
The AmeriHealth Caritas Family of Companies—which includes Keystone First and AmeriHealth Caritas Pennsylvania health plans, as well as PerformRx, a pharmacy benefits manager—uses a combination of high-tech data analysis and personal outreach to improve care for Medicaid members with diabetes who are taking 15 or more medications. PerformRx’s drug therapy management (DTM) software alerts pharmacists when there are unfilled prescriptions, gaps in evidence-based care, duplicative and potentially dangerous drug combinations, or dosing errors. Pharmacists then coordinate with doctors, nurses, and social workers to help guide patients on a path to better health.

A Collaborative Approach

Helping Patients with Medication-Related Problems. Upon receiving alerts from the DTM software that patients have not refilled prescriptions, pharmacists contact the health plan’s nurses and social workers serving as care managers. Care managers work with patients to identify barriers to taking medications as prescribed. To help patients overcome these challenges, they may connect people with services such as no-cost transportation, publicly subsidized cell phone service, and home delivery of prescriptions. Care managers work with patients to identify barriers to taking medications as prescribed. To help patients overcome these challenges, they may connect people with services such as no-cost transportation, publicly subsidized cell phone service, and home delivery of prescriptions.

In their interactions with patients, care managers use motivational interviewing and health coaching to help patients pursue healthy lifestyles. For example, a care manager may find that a patient with diabetes is concerned that he might not be healthy enough to attend a granddaughter’s upcoming wedding. She can help him understand how changing his diet will enable him to reach that goal, and she can suggest small, manageable steps toward that end. She might say, “It sounds like you really want to go to your granddaughter’s wedding, but you’re concerned that you won’t be able to make it with all the trouble you’ve been having with your high blood sugars lately.” She then could explain how eating high-sugar, high-fat foods is affecting his blood sugar, and she may suggest adding two small, healthy snacks per day to help regulate hunger and reduce the urge to overeat during meals.

Working with Doctors to Promote Effective Care. When the DTM software alerts pharmacists to medication-related problems—such as potential drug interactions, duplicative therapy, sub-optimal dosing, or gaps in evidence-based care—pharmacists contact prescribers directly, typically by fax, to resolve them. In urgent situations involving imminent risk to patients’ health, pharmacists also contact prescribers by phone. Additionally, the software sends some alerts (e.g., those related to unfilled prescriptions) automatically to prescribers through the online provider portal.

Pharmacists and pharmacy technicians re-check patients’ electronic records within 90 days of the initial outreach to see if patients and physicians made the recommended changes. If so, pharmacists contact care managers through the online system and ask them to follow up with
AmeriHealth Caritas Pennsylvania and Keystone First

Reaching Out to Improve Care for Medicaid Members with Diabetes (continued)

patients to check on their progress and ask about side effects.

In one case, the DTM software identified a patient with chronic obstructive pulmonary disease who was over-using her rescue inhaler and had not been prescribed long-acting bronchodilator controller medication, which is nationally recognized as effective in preventing complications. The pharmacist contacted the physician to suggest prescribing the controller medication, and the care manager followed up with the patient after the prescription was filled. Upon learning that the patient was using the controller inhaler intermittently as a rescue medication—not on a regular basis as intended—the care manager explained how to use it correctly, and the patient has not since experienced further complications.

On a quarterly basis, PerformRx sends reports to prescribers listing instances when medications prescribed are not consistent with nationally recognized standards of care. For example, these may include drugs prescribed for seniors that have been identified as being high-risk for that age group, oral medications for diabetes that are less effective than insulin, and drug regimens for patients with diabetes and high blood pressure that do not include ACE inhibitor or ARB medications.

Results

- From 2010-2011, 744 Keystone First members and 286 AmeriHealth Caritas Pennsylvania members received services through the program. A study comparing health care use and costs during the measurement period (2010-2011) with those in the baseline period (2009-2010) to a control group of members with similar health status found that:
  - The number of hospital admissions per 1,000 patients among Keystone First health plan members included in the program declined by 10.4 percent, whereas hospital admissions among a similar group of members in a control group increased by 66 percent.
  - Pharmacy costs increased more among members in the control group (by 19.9 percent and 25 percent for Keystone First and AmeriHealth Caritas Pennsylvania, respectively) than among Keystone First (10.1 percent) and AmeriHealth Caritas Pennsylvania members (8.1 percent) included in the program.
  - Total medical and pharmacy costs were 47.8 percent lower among Keystone First members and 50.7 percent lower among AmeriHealth Caritas Pennsylvania members included in the program than among those in the control group.

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1 ACE inhibitor is shorthand for angiotensin-converting enzyme inhibitor. ARB is shorthand for angiotensin II receptor blocker. Both ACE inhibitor and ARB medications are effective in treating high blood pressure, and, according to national guidelines, should be prescribed for patients with diabetes and high blood pressure.
Capital District Physicians’ Health Plan, Inc. (CDPHP®)

Providing Personalized Support in Patient-Centered Medical Homes and Community Pharmacies

Overview

The medication therapy management (MTM) program at CDPHP is reaching doctors and patients with chronic illnesses in patient-centered medical homes (PCMHs) and in patients’ “pharmacy homes,” where they fill prescriptions most often. The PCMH program—which CDPHP calls the Enhanced Primary Care initiative (EPC)—includes more than 90 primary care physician practices, 27 of which are also part of a Centers for Medicare & Medicaid Services (CMS) demonstration. The pharmacy home initiative includes more than 30 community pharmacists in Upstate New York. Both programs are available to patients with Medicare, Medicaid, or commercial health coverage.

As part of both of these initiatives, pharmacists engage with patients and doctors to explain medications, promote effective care, address side effects, and simplify regimens so patients can afford their medications and take them correctly. This approach is improving the quality of care and reducing preventable hospital admissions and readmissions.

A Resource for PCMH Practices

Focusing on Patients with Chronic Conditions.

As part of EPC, a CDPHP pharmacist visits care teams and patients in two primary care practices four days a week, and on the fifth day, she evaluates medication issues among patients in 20 practices, whether or not they are part of the PCMH model. She spends about 65 percent of her time meeting with patients to conduct comprehensive medication reviews and provide drug information to prescribers and about 35 percent of her time identifying opportunities to promote evidence-based care and lower costs.

The pharmacist is available to consult with doctors in other practices by telephone, e-mail, or through the electronic health record system. Prior to meeting with care teams, the pharmacist reviews the electronic records of patients who have two or more chronic conditions and complex medication regimens.2 EPC practitioners and nurse case managers working in physician practices also refer patients taking multiple medications to the pharmacist for review.

During these reviews, the pharmacist looks for issues such as duplication; over- or under-dosing; potential for drug-drug and drug-disease interactions; patterns of not filling prescriptions or not taking them as recommended; and opportunities to adjust medications to promote evidence-based care, simplify medication regimens, and achieve cost savings by substituting generics for brand-name drugs.

Meeting with Patients. During meetings with patients, the pharmacist provides information about their health conditions and medications (including over-the-counter medications and dietary supplements) and asks about side effects, affordability, and any challenges to following care plans. Patients and pharmacists talk about potential prescription changes to address these challenges, simplify drug regimens, and promote more effective care. The pharmacist gives patients a complete list of their medications, emphasizes the importance of taking medications as directed, and may provide pill boxes or other

1 The CMS demo is called the Comprehensive Primary Care Initiative. Aetna, Empire Blue Cross, Hudson Health Plan, and MVP Health Care also participate. By 2014, more than 100 CDPHP practices, representing 30 percent of its membership (about 150,000 patients), will receive care through the model.

2 Patients meet the criteria for review if they: have two or more chronic illnesses that include diabetes, hypertension, depression, or congestive heart failure; are taking five or more medications; or have multiple prescribers and health conditions.
Providing Information and Support to Doctors. When visiting physician offices, the pharmacist gives doctors detailed reports with recommendations based on comprehensive medication reviews of individual patient records. In addition, she offers suggestions based on nationally recognized guidelines, evidence-based care standards, and the health plan’s formulary.

In some cases, the pharmacist offers condition-specific guidance. Examples include how to initiate and adjust insulin dosage for patients newly diagnosed with diabetes; treat acne effectively in primary care settings; transition effectively to ARBs\(^3\) to treat hypertension; and discuss alternatives to proton-pump inhibitor medications, which can be harmful if used for extended periods. The pharmacist also talks about issues such as effective management of chronic illness; medication dosing; antibiotic resistance; potential drug interactions; side effects; allergies; e-prescribing; and insurance coverage.

Helping Reduce Total Cost of Care. Under the EPC model, doctors receive bonuses for boosting rates of preventive care, improving health outcomes (such as lowering cholesterol, blood pressure, and blood sugar), and reducing preventable hospital admissions, readmissions, and emergency room visits. By working with patients to manage their conditions effectively and avoid complications, pharmacists are helping doctors achieve these goals. As a result, doctors increasingly are asking for the pharmacist’s input on the care of patients with complex conditions, and they are encouraging these patients to engage with the pharmacist. Some doctors have invited the pharmacist to accompany them on patient rounds, and some are considering hiring pharmacists as full-time staff members.

EPC Program Results

In 2012:

- The pharmacist working with EPC practices conducted more than 600 medication reviews for 450 patients with all types of health coverage and made referrals for follow-up with physicians, nurse case managers, and other nurses as needed.

- Both EPC practices scored higher than the national 90th percentile in targeted HEDIS\(^4\) measures for ACE inhibitor/ARB\(^5\) medication monitoring and diuretic medications for people with high blood pressure and/or heart disease, as well as for reducing potentially harmful drug-disease interactions in the elderly.

- One of the EPC practices also exceeded the HEDIS national 90th percentile rate for eye exams and kidney disease monitoring for patients with diabetes.

\(^3\) ARBs are angiotensin II receptor blockers.

\(^4\) HEDIS, which stands for Healthcare Effectiveness Data and Information Set, is a tool used by more than 90 percent of America’s health plans to measure performance on important dimensions of care and service. HEDIS measures address health issues such as asthma medication use, breast cancer screening, and antidepressant medication management.

\(^5\) ACE inhibitor is shorthand for angiotensin-converting enzyme inhibitor. ARBs are angiotensin II receptor blockers. Both ACE inhibitor and ARB medications are effective in treating high blood pressure and may be prescribed for patients with heart disease or diabetes.
Capital District Physicians’ Health Plan, Inc. (CDPHP®)

Providing Personalized Support in Patient-Centered Medical Homes and Community Pharmacies (continued)

- The other EPC practice exceeded the HEDIS national 90th percentile rate for asthma management and cholesterol screening among patients with diabetes.

Consultations in Community-Based Pharmacies

Detailed Medication Reviews. CDPHP patients who are not part of the EPC initiative but are taking five or more medications for chronic conditions, have multiple prescriptions from different doctors, and/or have been to the hospital or emergency room several times have the opportunity to meet one-on-one with specially trained pharmacists whom they know, in the pharmacies where they most often fill their prescriptions.

Patient Outreach. Patients in the program receive letters from these pharmacists offering to provide comprehensive medication reviews, including their prescription and over-the-counter drugs, either in person or by phone. Pharmacists analyze the records of patients who agree to participate, to identify gaps in evidence-based care; safety risks from drug-drug or drug-disease interactions; medications that can be dangerous for the elderly; and opportunities to simplify regimens or achieve savings from generic substitution.

Patients then have 15- or 30-minute appointments with pharmacists, depending on the issues involved. During these conversations, pharmacists explain patients’ medications, answer their questions, and ask about side effects or other difficulties they may be experiencing. They also talk about the progression of chronic disease, strategies to manage their conditions to stay healthy, and the importance of taking their medications, even if they are not experiencing symptoms. Pharmacists give patients printed lists of their prescriptions, drug-related educational materials, questions to ask their doctors, and their direct phone numbers so that patients can call with any questions.

Follow-Up with Doctors. Pharmacists mail each patient’s doctor a complete medication list, along with their observations and recommendations to improve patient outcomes, avoid dangerous drug combinations, simplify medication regimens, and reduce the total cost of care. In many cases, physicians previously were unaware of medications prescribed by others and the safety risks associated with certain combinations. If there are urgent issues involving patient safety, pharmacists call physicians directly.

Following their initial reviews, community pharmacists follow up each quarter with targeted medication reviews (TMRs) for each patient participating in the program to identify new prescriptions, challenges with taking medications, potential interactions, or other problems. After these reviews, pharmacists mail patients’ updated medication lists to their prescribers, and they call patients to address any challenges or medication problems.

Even if patients who meet the criteria for the program forego the one-on-one consultation, pharmacists review their prescription records as required for Medicare members under CMS rules. If they find potential safety issues or opportunities to improve care, they send letters to prescribers with documentation of the review and recommendations for action.

Community Pharmacy Results

In 2012:

- CDPHP referred more than 6,600 members for MTM services in community pharmacies.
Capital District Physicians’ Health Plan, Inc. (CDPHP®)

Providing Personalized Support in Patient-Centered Medical Homes and Community Pharmacies (continued)

Community pharmacists conducted 990 comprehensive medication reviews with patients and more than 12,000 follow-up TMRs for those who did not engage in one-on-one consultations.

- The program resulted in more than 9,000 interactions with prescribers and more than 2,000 documented changes in medication therapy to improve health care quality, health outcomes, and affordability.

Overall MTM Program Results

- The overall hospital admission rate for Medicare Advantage Part D members enrolled in the MTM program (including both the EPC and community pharmacy initiative) was 19 percent lower than for those who did not participate.

- The hospital readmission rate among Medicare Advantage Part D members enrolled in the MTM program was 27 percent lower than among those who did not participate (11.9 percent compared with 16.3 percent).

- CDPHP will measure the MTM program’s impact for Medicaid and commercial members in the coming months, and results will be available by late 2014.

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Cigna-HealthSpring

Helping Medicare Advantage Members Live Well with Chronic Conditions

Overview
Cigna-HealthSpring is providing Medicare Advantage members with chronic conditions the extra support they need to stay healthy. Pharmacists at LivingWell Centers\(^1\) meet with members before or after their doctor visits, to explain medications and address any challenges, and they can consult by phone if needed.

A Resource for Members at LivingWell Centers
When Medicare Advantage members eligible for medication therapy management (MTM) services\(^2\) visit their primary care physicians at any of Cigna-HealthSpring’s 15 LivingWell Centers, they have the opportunity to meet one-on-one with pharmacists. During these meetings—which typically last between 15 and 45 minutes depending on people’s needs—pharmacists and members discuss all of the members’ prescription and over-the-counter medications, as well as herbal and dietary supplements. Pharmacists explain each treatment in non-technical terms; ask people if they are having difficulties such as side effects or trouble with affordability; and answer questions. If in-person visits are not feasible or convenient for members, pharmacists conduct the reviews by phone.

As part of the process, pharmacists analyze members’ medications to identify gaps in evidence-based care, use of drugs with potential safety risks for the elderly, duplicative prescriptions, possible adverse drug interactions, opportunities to simplify regimens, and other issues. Pharmacists send letters to people’s doctors to address any identified issues. For example, pharmacists may suggest adding a drug that has proven effective for the person’s condition, and they can recommend alternatives to drugs that have caused problematic side effects. As required by CMS rules, pharmacists send doctors summaries of their reviews, along with recommendations.

Doctors, nurses, case managers and other care team members can refer any member to the program who they believe would benefit, even if the person is not required under CMS rules to receive MTM services. For example, people with complex health conditions, those not taking medications as recommended, and people having difficulty following care plans may be enrolled.

Help During Care Transitions
When Medicare beneficiaries are discharged from hospitals, they receive phone calls from nurses and social workers within a week to discuss challenges and concerns. Cigna-HealthSpring’s pharmacy team works closely with nurses during these transitions. For example, people often don’t know whether they should continue taking prescriptions they had been taking before being admitted to the hospital. They may have trouble remembering to take multiple doses. Nurses consult with pharmacists on ways to effectively address members’ medication-related concerns, and they may put pharmacists in touch with beneficiaries directly to answer questions and resolve problems.

\(^1\) LivingWell Centers are clinics owned by Cigna-HealthSpring that exclusively serve the health plan’s members.

\(^2\) Under MTM rules issued by the Centers for Medicare & Medicaid Services (CMS), Medicare Advantage health plans and stand-alone prescription drug plans must offer beneficiaries who have multiple chronic conditions, take multiple prescription drugs, and are likely to have annual drug expenses over a specified level ($3,144 in 2013; $3,017 in 2014) the opportunity to have detailed, one-on-one medication consultations, called comprehensive medication reviews, with pharmacists at least once a year.
Cigna-HealthSpring

Helping Medicare Advantage Members Live Well with Chronic Conditions (continued)

CMS (See page 3), they connect the members with pharmacists to enroll in the MTM program and start the process of comprehensive medication review.

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Excellus BlueCross BlueShield

Teaming Up to Ease Care Transitions and Overcome Medication Challenges

Overview
When complicated medication regimens present challenges for seniors leaving the hospital and for patients with ongoing and extensive health care needs, Excellus BlueCross BlueShield’s pharmacists reach out to provide insights, suggestions, and support.

Helping Seniors Transition Safely from Hospital to Home
Within a week of being discharged from the hospital, Medicare Advantage members who are taking multiple medications for several chronic conditions receive phone calls from nurses, who check on their health status and care needs and let them know that pharmacists will soon be in touch. During their phone calls, pharmacists review all of the prescription and over-the-counter medications patients are taking, explain their purpose and recommended dosing instructions, answer questions, and ask patients how they are feeling. Pharmacists discuss preventive care services recommended for patients’ health conditions (such as eye and foot exams for patients with diabetes), as well as lifestyle changes that can help maintain their health (e.g., quitting smoking, eating a healthy diet, increasing physical activity).

Excellus BlueCross BlueShield’s pharmacists also compare the medications patients were taking before and after being hospitalized and may contact doctors with suggested prescription changes to avoid problems such as duplication, adverse interactions, or incorrect dosing. If they find that patients have unmet needs (e.g., if they are having side effects or can’t afford their prescriptions), pharmacists follow up with doctors and nurse case managers to find solutions.

Providing Expertise and Advice on Complex Care
Nurses and social workers serving as case managers for patients with the most complicated health and social service needs consult regularly with Excellus BCBS pharmacists. When patients are struggling to take medications as recommended, pharmacists can offer suggestions for simplifying regimens. If nurses are concerned that patients’ current medications may not be working effectively, they can ask pharmacists for advice.

Pharmacists may call patients directly to answer questions and help resolve problems. For example, patients with multiple prescriptions may have questions about potential drug interactions. Pharmacists evaluate patients’ complete medication lists, contact physicians about any prescription changes needed to protect patient safety, and counsel patients on taking medications as recommended.

Pharmacists report findings of their patient consultations to doctors in follow-up letters and medication summaries. Doctors can send medication-related questions to pharmacists at any time via e-mail through the health plan’s Web site.

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Florida Blue

Partnering with Health Care Practitioners to Improve Care

Overview
Florida Blue is collaborating with doctors throughout the state in accountable care organizations (ACOs) and commercial health plans to promote effective care for patients with extensive health care needs. The health plan works closely with seven ACOs to coordinate health services, boost quality, and lower the total cost of care. Additionally, Florida Blue’s Guided Health initiative places actionable prescription information into the hands of physicians to improve health outcomes and reduce health costs for patients with chronic conditions.

Promoting Accountable Care
In 2013, Florida Blue partnered with seven integrated health systems’ ACOs to promote effective care and reduce the need for hospital admissions, readmissions, and emergency room visits. Two of the ACOs have special programs for people with certain types of cancer (breast, lung, reproductive system, respiratory, and blood cancers that have not metastasized), and the remaining five focus on improving overall health for patients with commercial health coverage.

Setting Mutual Goals for Medication Management. Besides helping patients access services, Florida Blue’s pharmacists work with health plan and ACO physicians to set mutual health-related goals to improve the quality of care and lower costs. ACO clinicians develop action plans to reach these goals, and each month, the health plan provides the organizations with data—such as generic prescribing rates for participating physicians—to track their progress.

As the ACOs develop further, Florida Blue’s pharmacy team continues to collaborate on additional pharmacy initiatives. For example, in the Fall of 2013, health plan pharmacists and ACO clinicians worked on strategies to promote the effective use of proton-pump inhibitor medications, which sometimes duplicate other treatments and which can be detrimental if used for long time periods.

Supporting Doctors and Patients
Throughout its Medicare and commercial health plan networks, Florida Blue is offering added support to doctors caring for patients with chronic conditions such as diabetes, high cholesterol, hypertension, epilepsy, and depression. Recognizing that these patients often take multiple medications prescribed by different doctors, in 2013 Florida Blue
Florida Blue

Partnering with Health Care Practitioners to Improve Care (continued)

launched the Guided Health campaign. As part of the program, health plan pharmacists analyze medical and pharmacy data to identify potential medication safety issues, duplicative prescriptions, underuse of recommended medications, and opportunities to achieve cost savings (e.g., through use of generics). Based on this analysis, Florida Blue sends doctors Guided Health packets that highlight potential medication-related problems and offer options for improving health outcomes and lowering costs for individual patients.

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Geisinger Health System

Providing a One-Stop Shop for Medication Management

Overview

Geisinger Health System pharmacists provide a one-stop shop to manage medications for patients with the most complex health conditions. Under a collaborative practice model of care, pharmacists specializing in disease management do whatever it takes to enable patients with diabetes, hypertension, high cholesterol, and those taking anticoagulation medicine to overcome medication-related challenges and reach nationally recognized health goals. Under Geisinger’s accountable care model, pharmacists work hand-in-hand with care teams to provide comprehensive medication therapy management and disease management support for patients with the greatest health risks.

Taking on the Toughest Challenges

Under Geisinger’s collaborative practice model, members with diabetes, high blood pressure, or high cholesterol who have not responded to treatment—as well as those taking anticoagulant medications, which require continuous monitoring to avoid bleeding and blood clots—are referred to pharmacists who specialize in disease management. As part of the program, which is available to members with Medicare, Medicaid, and commercial health coverage, pharmacists have a series of meetings with patients, by phone and in person, for a period which can range from weeks to months, depending on patients’ needs.

During the first meeting, pharmacists do motivational interviewing, asking patients to identify life events (e.g., attending a grandson’s birthday party) or health-related goals (being able to walk a certain distance) that are important to them. Pharmacists help patients understand how taking medications as prescribed, making lifestyle changes to improve health, and keeping appointments for recommended care will help them reach these goals. Pharmacists coordinate with patients on action plans to reach their goals, and they collaborate with care teams to help patients access the resources and support services they need.

In developing effective drug regimens, pharmacists take into account not only the nature of patients’ health conditions, but also their treatment preferences, education levels, and financial resources. If patients with diabetes will not take insulin injections, pharmacists prescribe oral medications. If patients can’t afford their medications, pharmacists work with doctors to find less costly alternatives and connect patients with financial assistance. If patients are having difficulty understanding or remembering medication instructions, pharmacists can streamline dosing and simplify instructions.

Pharmacists continue to adjust prescriptions and dosing to find the combination that works best for each patient, and they send doctors updates prior to patient appointments. Pharmacists manage medications for patients until they reach recommended clinical targets (e.g., HbA1c levels below 7 or 8 percent for patients with diabetes); patients then receive medication-related support as needed from doctors, nurses, and case managers. If at any time patients’ health conditions worsen and they need additional help managing medications, they can resume meetings with pharmacists.

1 The program includes: patients with diabetes whose HbA1c levels measure above 9 or remain greater than 8 for more than a year; patients taking two or more medications for hypertension and whose blood pressure is above 130/80 mmHg; and patients whose LDL-cholesterol is above recommended levels ranging from 70-130 mg/dL and who have been prescribed statin medications for at least a year.
Providing 360-Degree, Accountable Care

Under Geisinger’s accountable care model, which operates throughout the health system, pharmacists coordinate with doctors, nurses, and case managers to ensure that patients with all types of health coverage who are at high risk of hospital admissions and readmissions receive the support they need to manage their health conditions effectively. Pharmacists can help people start new medication regimens, providing explanations and instructions in non-technical terms, along with tools to help people remember to take recommended doses. They work with other care team members to ensure that patients with diabetes receive the evidence-based services and reach the health benchmarks included in Geisinger’s evidence-based care bundle. Depending on patients’ needs, pharmacists can work with physicians to simplify drug regimens and lower patients’ out-of-pocket costs. Care teams are rewarded with bonus payments when patients reach nationally recognized clinical goals for health improvement.

Results

- From December 2010-March 2012, among the nearly 3,000 patients with diabetes, hypertension, and high cholesterol who received medication management services under Geisinger’s collaborative practice model:
  - Eighty-four percent reduced HbA1c levels, and 64 percent reached their clinical goals (with HbA1c levels below 7 or 9 percent);  
  - Seventy percent achieved goals for reduced blood pressure (with levels below 140/90 or 130/80 mmHg);  
  - Seventy-two percent reached goals for reduced LDL-cholesterol (with levels below 100 or 70 mg/dL); and
  - Less than half as many patients receiving medication management services for treatment with anticoagulant medications under the collaborative practice model experienced bleeding (8 percent) as those not participating in the program (17 percent).

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2 These include: annual flu shots; regular pneumonia vaccines; HbA1c levels below 7 or 8 percent; annual kidney function tests; documentation of smoking status and enrollment in smoking cessation programs; blood pressure levels below 130/80 mmHg; annual foot and retinal exams; and treatment with recommended ACE inhibitor and ARB medications.
Group Health Cooperative

Taking Patient-Centered Care to the Next Level

Overview

Medication therapy management plays a central role in Group Health Cooperative’s patient-centered medical home (PCMH) model of care for patients with all types of health coverage. As Group Health builds on past success to pursue Version 2.0 of the model, pharmacists focus on medication needs of patients who are at the highest risk of hospital admission and readmission and/or have extensive health care needs. Pharmacists coordinate with patients, families, and care teams to promote positive health outcomes, improve patient experiences with care, and achieve cost savings. Through their involvement in medical onboarding, collaborative practice, and medication review following hospital discharge, pharmacists are helping bring patient-centered care to the next level.

PCMH Version 2.0

Medical Onboarding. People who have chronic conditions and other complex health care needs connect with pharmacists as soon as they join any of Group Health’s 26 PCMH clinics. These patients engage in a process of medical onboarding with pharmacists by phone or in person, before appointments with primary care physicians. As part of onboarding, pharmacists review patients’ health conditions and prescriptions to identify safety issues such as duplication, dosing errors, potential for adverse interactions, and use of medications that are high-risk for the elderly. They also look for opportunities to promote evidence-based care, streamline drug regimens, improve health outcomes, and achieve cost savings with generics.

Pharmacists document all of their findings in the electronic health record system and highlight issues for primary care physicians to address during patient visits. Pharmacists also ask patients whether they are experiencing problematic symptoms, side effects, challenges with access or affordability, or difficulty remembering to take medications. Depending on individual needs, pharmacists may suggest changes to drug regimens to improve health outcomes.

Transforming Disease Management with Collaborative Practice. Group Health’s collaborative practice model of care is transforming disease management for patients with complex health care needs who receive care at PCMH sites. Under collaborative practice agreements with doctors and physician assistants, more than 30 Group Health pharmacists can prescribe and change medications to manage chronic disease medications within specified parameters for patients with chronic conditions such as diabetes, high blood pressure, coronary artery disease, and cardiovascular disease. In 2014, the program is expanding to include patients with extensive health care needs who are taking specialty drugs for rheumatoid arthritis, hepatitis-C, multiple sclerosis, HIV, and oral oncology medications.

Pharmacists consult with patients by phone, e-mail, and in person for an average of four to five months. As a first step, pharmacists conduct comprehensive reviews of patients’ prescription, over-the-counter, and herbal medications. Then they collaborate with patients and care teams to set goals for treatment and health outcomes (such as having blood sugar, cholesterol, and

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Group Health Cooperative

Taking Patient-Centered Care to the Next Level (continued)

Pharmacists continually evaluate how well drug regimens are working, and they may modify treatment plans to make them more effective and affordable. Pharmacists continually evaluate how well drug regimens are working, and they may modify treatment plans to make them more effective and affordable. Pharmacists often coordinate with care team members to coach patients on making lifestyle changes (such as following a low-salt diet to reduce blood pressure) consistent with good health.

Pharmacists regularly participate in care team meetings and consultations—in person and online—with doctors, nurses, and case managers to prevent, identify, and resolve complex, medication-related care challenges. As part of these discussions, team members brainstorm on options to help patients progress toward clinical goals. Once patients achieve these goals, they transition out of the program.

Promoting Safe Care Transitions. Patients who are discharged from the hospital with chronic conditions, complex care plans, and/or new drug regimens often experience confusion that leads to medication-related errors, health complications, and readmissions. To help these patients transition safely to outpatient care, pharmacists on Group Health’s PCMH care teams contact patients in three to seven days of discharge to review and discuss their medications.

Prior to each call, pharmacists compare medications listed on the hospital’s discharge summaries with the medication lists in their electronic health records. Based on this comparison, pharmacists identify potential problems (e.g., medication omissions, duplication, differences in dosing instructions, and potential for adverse drug interactions) and coordinate with care teams to develop an optimal drug regimen for each patient. In their conversations with patients, pharmacists explain the purpose and dosing instructions for each medication; explain any needed prescription changes to avoid adverse outcomes; and answer questions.

Results

- A study of nearly 500 patients from 2009-2010 found that the rate of hospital readmission at seven days and 14 days following discharge was significantly lower among patients who received pharmacy record reviews and post-discharge phone calls from Group Health pharmacists (0.8 percent and 4 percent, respectively) than among those who did not (5 percent and 9 percent).

- In more than 80 percent of record reviews conducted for the study, pharmacists identified at least one medication-related issue (such as duplication, omission, and/or risk of adverse interaction) requiring follow-up with care teams, and in many cases, they addressed multiple issues for follow-up.

- Based on these results, Group Health expanded the program to all of its PCMH sites in 2010.

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Putting Medication Analysis Into Action for Patients with Complex Needs

Overview
Health Care Service Corporation’s (HCSC’s) Rx Health Advisor Medication Therapy Management (MTM) initiative provides expert medication analysis and actionable information to care teams supporting patients with extensive health needs. The program’s personalized Medication Action Plans serve as valuable roadmaps to prevent adverse events, improve health outcomes, and lower the cost of care.

The Rx Health Advisor
When patients with complex needs take multiple medications prescribed by different physicians, the potential for medication-related errors and health complications is an ongoing concern. To avoid these problems and improve care for patients with extensive health care needs, HCSC created the Rx Health Advisor MTM program.

As part of the program—available to approximately 130,000 nonelderly adults with commercial BlueCross BlueShield coverage in four states—a pharmacist serving as the Rx Health Advisor analyzes medical and lab records to identify health risks for patients taking multiple prescriptions. Based on these analyses, the pharmacist creates patient-specific Medication Action Plans to protect patient safety and improve health outcomes.

These plans may include recommendations to add, discontinue, or modify prescriptions; change doses; and/or simplify dosing schedules. Action plans often provide additional information and suggestions to improve the effectiveness of care. For example, the Rx Health Advisor may recommend testing or medication changes based on lab results; pinpoint gaps in evidence-based care; suggest follow-up doctor visits to assess problems; share findings from the latest medical research; and/or identify potential cost savings from effective generic, specialty pharmacy, or mail-order prescription options.

The pharmacist sends Medication Action Plans through the electronic health record (EHR) system to patients’ nurse case managers, and each week, the Rx Health Advisor and case managers hold conference calls to discuss the Plans’ key findings. During these calls, nurses may ask questions, discuss additional issues, and seek the pharmacist’s advice. For example, if a patient’s condition is not responding to treatment, they may discuss changes in dosing or prescriptions that could help.

Nurses share the Rx Health Advisor’s recommendations with physicians, who may adjust care plans accordingly. After each conference call, the Rx Health Advisor follows up with nurse care managers to address outstanding issues and continues to track additional changes in patients’ health status and care plans through the EHR system.

Results

- Since the program was launched in 2012, the Rx Health Advisor has generated over 2,100 Medication Action Plans with more than 4,200 recommendations to improve care and lower costs for over 7,500 patients.
- The program saved more than $700,000 in medication costs from 2012-2013.

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1 The program operates in IL, TX, NM, and OK.
HealthPartners

Pursuing Excellence in Medication Management through Accountable, Collaborative Care

Overview
Accountable care and collaborative practice are the way of life for HealthPartners patients and care teams who are managing complex conditions and drug regimens. HealthPartners members with extensive health care needs have the opportunity to meet one-on-one with pharmacists on an ongoing basis to pursue goals for better health, and pharmacists work closely with care teams to help patients overcome challenges in care. Doctors are rewarded with bonuses for improving patient health and meeting high standards for patient safety, preventive and maternity care, and patient satisfaction. Under HealthPartners’ accountable care contracts, physicians receive a share of the savings that result from more effective and efficient delivery of services.

A Comprehensive Approach to Medication Therapy Management
Since its inception in 2006, HealthPartners’ medication therapy management (MTM) program has expanded to cover all members who could benefit from extra medication-related support. These include Medicare Advantage members with chronic conditions who are taking multiple prescriptions, as well as people with Medicaid and commercial health coverage who are having difficulty following drug regimens and/or are at risk of hospital admission or readmission.

Pharmacists in HealthPartners Medical Group and retail pharmacies participating in the HealthPartners MTM network reach out regularly to offer these members the opportunity to participate in MTM. Doctors, nurses, and care managers also have the opportunity to refer patients to the program. Patients have the option of meeting with pharmacists in person, talking by phone, or having online video consultations.

Each patient participating in the program has an initial one-hour appointment with a pharmacist and may have a series of shorter follow-up consultations over an extended period. Among the patients receiving MTM services, about one-third has a single visit with a pharmacist; about a third meets regularly with pharmacists for three to six months; and a third continues to consult with pharmacists for a year or more.

During these meetings, pharmacists review and explain all of patients’ medications, answer questions, and address any concerns. Pharmacists assess whether medications are working as intended; whether they are causing or have the potential to cause adverse effects; and whether patients are able to take their prescriptions as recommended. If patients aren’t reaching their health care goals, can’t afford their medicine or are confused by complex drug regimens, pharmacists help find solutions.

Pharmacists, doctors, and patients collaborate to set workable treatment goals and develop care plans to achieve these goals. Each patient receives a personalized medication plan that accounts for his or her needs and preferences. In developing these plans, pharmacists take into account all of the social, financial, and behavioral health issues that can affect patients’ ability to follow treatment recommendations, and they may also work with HealthPartners’ case managers and disease management nurses to help patients overcome challenges in care.

Pharmacists help arrange for the clinical and lab tests to track patients’ progress in improving their health, and care teams revise treatment plans as needed to reach patients’ goals. More than 140 pharmacists in physician-based clinics and retail pharmacies in MN and Northwest WI participate in the program.

“For the first time since being diagnosed, all goals have been met, my diabetes is well-controlled, and all blood work—cholesterol, liver, kidney, A1c, and BP—were excellent. The [medication therapy management] program was instrumental in doing that!”

—A patient who received HealthPartners’ MTM services
HealthPartners

Pursuing Excellence in Medication Management through Accountable, Collaborative Care (continued)

The care team continues to monitor important indicators of patient health (such as blood pressure, cholesterol levels, weight, HbA1c, as well as kidney and liver function), evaluate the effectiveness of drug regimens, and work with patients to modify treatments. Patients transition out of the MTM program once they have met all of their medication-related goals, but they can continue to contact MTM pharmacists at any time for additional support.

An Evolving Model of Accountable Care

As accountable care organizations proliferate throughout the country, HealthPartners continues to refine the tools it has used for many years to promote accountability among health care teams. Approximately 85 percent of HealthPartners’ health plan members receive care from clinics covered by shared savings agreements, which provide care teams with a portion of savings achieved through strategies such as increasing the use of generic drugs; streamlining office operations; and improving the coordination of services to avoid preventable hospital admissions, readmissions, and emergency room visits. Additionally, the health plan provides bonuses to physicians for achieving national and regional quality goals for treatment of diabetes and hypertension; reducing health disparities; and meeting high standards for preventive care, maternity services, patient satisfaction, and patient safety.

A Team-Based Model of Collaborative Practice

Within HealthPartners Medical Group, pharmacists help patients manage a total of nine health conditions and care processes under collaborative practice agreements with physicians. Doctors, nurses, and other care team members refer patients with any of these conditions or treatment plans to pharmacists, who help them develop effective and workable drug regimens. Pharmacists meet with patients in person or by phone to evaluate their prescriptions and over-the-counter medications and help them achieve positive health outcomes. As part of the process, pharmacists can change prescriptions and dosing as needed to make it easier for patients to follow care plans; reduce side effects; improve the effectiveness of treatment; and lower patients’ out-of-pocket costs.

Physicians sign off on collaborative practice agreements once a year. While the agreements are in place, pharmacists continue to confer with care teams by phone, e-mail, messages in the electronic health record system, and in person. Doctors have responded positively to collaborative practice and have continued to suggest additional conditions for pharmacists to manage under this model.

Results

- Approximately 4,000 patients with all types of health coverage participate in HealthPartners’ MTM program each year.
- An 18-month randomized controlled clinical trial of 450 adults, described in the July 2013 issue of JAMA, found that:
  - The proportion of people with hypertension who reduced blood pressure to recommended levels was significantly higher among HealthPartners Medical Group patients who received MTM and

1 The conditions and processes covered under HealthPartners Medical Group’s collaborative practice agreements are: diabetes; hypertension; high cholesterol; asthma; chronic obstructive pulmonary disease; smoking cessation; transitioning from opioid treatment; transitioning from benzodiazepine treatment; and therapeutic interchange (which involves replacing one medication with an equivalent dose of another drug that is in the same therapeutic class and has a similar effect).

Innovations in Medication Therapy Management

CHAPTER 2
Advancing Best Practices in Medication Therapy Management: A Compendium of Health Plan Initiatives

HealthPartners

Pursuing Excellence in Medication Management through Accountable, Collaborative Care (continued)

“...the clinical pharmacist is working with me to find medications that work well together without side effects and...found ways to use medications that can be taken at a time of day when I won’t forget to take them. As a result, I’m taking them all, pretty regularly, for the first time since my diagnosis.”

—A patient receiving HealthPartners’ MTM services

telemonitoring services under collaborative practice as part of the study than among those in a control group. These differences were found after six months (72 percent versus 45 percent), 12 months (71 percent versus 53 percent), and 18 months (72 percent versus 57 percent).

According to a study of more than 650 commercially insured patients with Type 1 and Type 2 diabetes from 2007-present:

- Sixty percent of those participating in HealthPartners’ MTM program achieved the five measures of effective diabetes control established by a statewide quality improvement initiative, whereas 39 percent of similar patients in a control group met the standards.

- Ninety-seven percent of HealthPartners members surveyed in the study said they had made lifestyle changes to improve health. Seventy-four percent said they were able to keep blood sugar at optimal levels. Ninety-two percent said they always or usually followed care recommendations, and 88 percent said they took medications as recommended 100 percent of the time.

- A 2008-2009 analysis found that the total cost of care was 19 percent lower among patients with an MTM benefit who participated in the MTM program than among a matched group of patients without an MTM benefit.

- Medication costs were the same in the two groups; cost differences were attributed to reduced rates of hospital admissions and emergency room visits among patients receiving MTM services.

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—a2008-2009analysisfoundthatthetotalcostofcarewas19percentloweramongpatientswithanMTMbeneftwhoparticipatedintheMTMprogramthanamongamatchedgroupofpatientswithoutanMTMbeneft.

3MeasuresweredevelopedbyMinnesotaCommunityMeasurement,anonnprofitorganizationthatcollectsandreportspersonalperformanceofhealth careorganizationsthroughoutthestateinmeetingstandardsforhealth carequality,cost,andpatientexperiencewithcare.Thefive measureforoptimalcontrolofdiabetesare:HbA1Clevelsbellow8 percent;bloodpressurebelow140/90mmHg;LDL-cholesterolbelow100mg/ dL;nocigarettesmoking;andadailydoseofaspirinfolloweddorentendedtomaintainpatients’health.
Highmark Health Services

From Town Hall to Home: Finding New Ways to Help Members Achieve Better Health

Overview
Highmark Health Services’ town hall-style meetings for Medicare Advantage members with diabetes and team-based health coaching for people with extensive health care needs not only are changing the way patients interact with health care teams but also are providing new ways to help patients understand and take their medications and avoid complications that can lead to hospital admissions, readmissions, and emergency room use.

The Speaker Series
Recognizing the challenges facing Medicare beneficiaries with diabetes who have complex medication regimens, Highmark Health Services decided to try a new approach. The health plan’s town hall-style Speaker Series launched in 2011 provides hands-on, practical information and one-on-one support from a team of health professionals with expertise in diabetes care. The Speaker Series has been conducted in three metropolitan areas across Pennsylvania (Erie, Hershey, and Pittsburgh). Members with diabetes receive personalized invitations to attend information sessions with pharmacists, nurse health coaches, and diabetes health educators.

During each session, the doctor or diabetes educator explains how diabetes progresses over time and discusses effective ways to manage the disease and avoid complications. The nurse health coach describes the coaching program and offers suggestions for following diabetes treatment plans successfully. The pharmacist provides an update on diabetes medications, explains how they work, discusses potential drug interactions to watch for, and emphasizes the importance of having regular flu, pneumonia, and Hepatitis B shots. Following the presentations, audience members can ask questions, and after the group question-and-answer session, Medicare members have the opportunity to meet one-on-one with the health professionals to ask questions specific to their needs. The events typically last about two hours, and a variety of healthy, low-sugar snacks are served.

Health Coaching Teams for Patients with Complex Needs
When Medicare Advantage members and those with commercial health coverage are admitted to the hospital or when Highmark Health Services’ clinical data suggests that members are at risk of medical complications or hospitalization, nurse health coaches reach out by phone to offer personalized assistance. People receive health coaching to reduce health risks if: they have not received services according to national standards for evidence-based care; they are taking several different medications with the potential for adverse interactions; they are elderly and have been prescribed medicine identified as high-risk for seniors; they are not filling prescriptions or not taking medication as prescribed; their medication dosing raises safety concerns; or they have serious health problems that are likely to worsen without additional support.

Helping People Reach Their Goals. Coaches help people understand and manage their health conditions, identify life goals related to their health (such as feeling well enough to play baseball with their grandchildren), and make the lifestyle and medication-related changes to reach those goals. When people need help making doctor’s appointments, finding transportation, and accessing prescriptions, coaches provide support. They also can help coordinate care.
Highmark Health Services

From Town Hall to Home: Finding New Ways to Help Members Achieve Better Health (continued)

for members receiving treatment from multiple physicians. The duration and frequency of coaching vary depending on patients’ needs.

Providing Extra Support from Pharmacists. Because patients often struggle with complex medication regimens, nurse health coaches work hand-in-hand with pharmacists to provide information and support. Pharmacists and nurses do three-way conference calls with patients as needed. For example, conference calls may focus on finding workable strategies to help patients remember to take medications or effective alternatives to drugs that are causing side effects. When patients are taking multiple medications prescribed by different doctors, pharmacists can make suggestions for streamlining treatment plans. Pharmacists play an active role on care teams, offering expertise and medication-related suggestions, and they participate in clinical case rounds and case reviews to address challenges in care.

Results

Since 2011:

- Nearly 300 Medicare Advantage members with diabetes have attended information sessions as part of Highmark Health Services’ Speaker Series.

- Approximately 300,000 Medicare Advantage members and 3.8 million people with commercial health coverage have been eligible to receive health coaching from nurses and/or pharmacists to address complex needs.

- Highmark Health Services is measuring the health coaching program’s impact on hospital admissions for chronic and ambulatory care sensitive conditions, as well as use of recommended preventive and other evidence-based services. Preliminary results will be available in 2014.

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1 The Agency for Healthcare Research and Quality defines ambulatory care sensitive conditions as conditions for which good outpatient care can potentially prevent the need for hospitalization, or for which early intervention can prevent complications or more severe disease. (See Department of Health and Human Services. Agency for Healthcare Research and Quality (2001). Guide to Prevention Quality Indicators: Hospital Admission for Ambulatory Sensitive Conditions. ARHQ Pub. No. 02-R0203. Rockville, MD: Author. Available at: http://1.usa.gov/1biH70w.)
Independent Health

Sharing Medication Expertise to Enhance Patient-Centered Care

Overview
As more and more patients with complex needs receive care through Independent Health’s patient-centered medical home (PCMH) initiative, primary care doctors are finding it helpful to meet regularly with pharmacists to discuss effective medication management. Pharmacists also are reaching out to patients with chronic conditions to address medication challenges following hospital discharge.

Helping Transform Primary Care
As Independent Health expanded its patient-centered medical home initiative—called The Primary Connection—to cover about 30 percent of its patient population (about 90,000 members with Medicare, Medicaid, and commercial health coverage), it became clear that primary care physicians (PCPs) needed ongoing support to manage patients medications effectively. Beginning in 2012, the health plan added pharmacists to PCMH care teams.

Three of the health plan’s PCP practices have their own pharmacists on-site, and two pharmacists travel among remaining PCMH groups for meetings with doctors and patients. During monthly meetings with physicians, pharmacists talk about effective drugs for congestive heart failure and diabetes (particularly use of ACE inhibitors and ARB medications for people with diabetes and high blood pressure); use of inhaled corticosteroids for people with asthma; medications that are unsafe for elderly patients; and use of generic drugs to help lower the cost of care.

Pharmacists also conduct comprehensive medication reviews for patients with Medicare, Medicaid, and commercial coverage who are taking multiple medications and/or are having difficulty following drug regimens as prescribed. During these reviews, pharmacists identify potential drug interactions, duplication, dosing errors, other safety risks, as well as opportunities to achieve cost savings with generics. Pharmacists collaborate with doctors, nurses, and physician assistants to develop optimal drug regimens for individual patients.

Doctors often ask for pharmacists’ advice on medication regimens for patients with extensive health care needs. Physicians also have pharmacists call patients directly to resolve medication-related problems such as side effects and confusion over dosing instructions. If patients are having trouble taking medications as directed, pharmacists may do motivational interviewing to help people identify health-related goals and understand how taking recommended medications will help them reach these goals.

Easing Care Transitions
Within three days of leaving the hospital, patients with conditions such as asthma, chronic obstructive pulmonary disease, pneumonia, and heart failure receive phone calls from nurses to assess needs and review medications. Nurses send patients’ medication lists to Independent Health pharmacists, who compare the prescriptions that have been filled to those that have been prescribed and check for gaps in care, duplication, over- and under-dosing, potential for adverse interactions, and other safety issues (such as seniors’ use of drugs that have been identified as high-risk for the elderly). Pharmacists follow up with patients to review

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1 ACE inhibitor is shorthand for angiotensin-converting enzyme inhibitor. ARBs are angiotensin II receptor blockers. Both ACE inhibitor and ARB medications are effective in treating high blood pressure, and, according to national guidelines, should be prescribed for patients with diabetes and high blood pressure.

2 Inhaled corticosteroids are nationally recognized as the most effective medication for long-term management of persistent asthma.
Independent Health

Sharing Medication Expertise to Enhance Patient-Centered Care (continued)

and explain medications and answer questions. Pharmacists also contact doctors to resolve any problems related to safety, side effects, or dosing.

Pharmacists give patients their phone numbers to call if they have questions. Some patients have developed strong bonds with pharmacists and continue to contact them months or years later whenever they have medication-related concerns.

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Kaiser Permanente

Coming Together to Promote Patient Safety and Health

Overview
Collaboration is central to Kaiser Permanente’s approach to medication management. Through the health plan’s collaborative practice agreements, Outpatient Medication Safety Net program, and patient-centered medical home (PCMH) initiatives, pharmacists work closely with patient care teams to prevent drug-related health complications and improve members’ well-being.

Maximizing Opportunities for Collaborative Practice
Collaboration is a defining feature of all Kaiser Permanente pharmacy programs. Under collaborative practice agreements—first implemented in the 1980s and expanded over time—doctors, nurse practitioners, and physician assistants refer patients with chronic conditions to pharmacists for ongoing medication management. Under collaborative practice agreements, pharmacists can initiate, adjust, and discontinue medications and order medication-related lab tests. Pharmacists confer regularly by phone with patients to help them work toward specific health goals, typically over a period of several months. All medication changes are documented in the electronic health record (EHR) system so that doctors can review updated drug information before patient visits. The program is available to patients with Medicare, Medicaid, and commercial health coverage.

Kaiser’s first collaborative practice agreements covered management of anticoagulation drugs, and the health plan now has agreements covering additional outpatient medications for conditions such as diabetes; asthma; cancer; cardiovascular disease; post-heart attack care; and kidney disease.

Leading the Way to Medication Safety
Coordination among care teams is key to the success of Kaiser Permanente’s Southern California Medical Group Outpatient Medication Safety Net program, launched in 2009. Pharmacists worked with specialists in family practice medicine, pulmonology, cardiology, geriatrics, and endocrinology to design the program, which alerts doctors through the EHR system if gaps in care or prescribed drug regimens create potential risks to patient health. Pharmacists and licensed vocational nurses created registries to identify and track safety risks and document actions taken to avoid adverse health consequences. The pharmacist and medical director who lead the program developed information materials about the initiative for patients and health care practitioners, as well as a continuing education program for physicians.

As part of the program, doctors receive alerts in the following situations: patients are taking medication for irregular heartbeat and have not had the regular testing and monitoring needed to avoid adverse outcomes; people over age 65 are prescribed high doses of digoxin, which may cause toxic reactions; elderly members with multiple diagnoses are prescribed medications that could worsen one of their conditions; patients with diabetes and hypertension have not been prescribed recommended ACE inhibitor or ARB medications; and/or patients are prescribed two cholesterol drugs with the potential to interact and cause kidney damage. The program has the flexibility to expand as additional safety

1 ACE inhibitor is shorthand for angiotensin-converting enzyme inhibitor. ARBs are angiotensin II receptor blockers. Both ACE inhibitor and ARB medications are effective in treating high blood pressure, and, according to national guidelines, should be prescribed for patients with diabetes and high blood pressure.
Kaiser Permanente

Coming Together to Promote Patient Safety and Health (continued)

issues and corrective strategies are identified. In the messages that accompany physician alerts, pharmacists identify safe and effective treatment alternatives and encourage doctors to contact them with any questions or concerns. Pharmacists collaborate with doctors and nurses to implement changes in medications, dosing, and/or monitoring to promote positive health outcomes.

Teaming Up to Manage Complex Needs in Patient-Centered Medical Homes

Pharmacists likewise work closely with care teams to improve health outcomes for patients with complex needs at PCMH practices in CO, OR, WA, and Riverside, CA. Pharmacists are on-site full-time in these practices to help patients understand, manage, and address complicated medication regimens. Pharmacists’ roles on care teams vary according to medical groups’ needs and priorities. Kaiser’s PCMH practice in Riverside, CA is using clinically trained pharmacists to help reduce preventable hospital readmissions. The program focuses on people at risk of hospital readmission based on their health conditions, drug regimens, hospital lengths of stay, and emergency room visits in the past 12 months.

Pharmacists contact patients by phone to review and explain their medications; check whether they have filled all prescriptions; and identify any medication-related problems (such as omissions, difficulties with taking prescriptions, missing drug-related lab tests, duplication, and potential adverse interactions). Pharmacists then make recommendations to patients’ primary care physicians and connect patients with other care team members as needed to address challenges. As part of the process, case managers may help patients participate in programs for smoking cessation, weight loss, and disease management.

Pharmacists use the EHR system to share information with care teams about patient needs, medication changes, and follow-up care. In some cases, primary care physicians ask pharmacists to contact patients after doctor visits to review medication instructions and address questions or concerns.

Results

Patient Safety

Since the Southern California Medical Group Outpatient Safety Net program was launched in 2009, Kaiser Permanente’s health care teams have adjusted treatment regimens to avoid adverse health events for more than 18,000 patients. As a result of these activities:

- From 2010-2013, as part of the initiative to prevent thyroid, liver, kidney and/or lung damage among patients taking heart arrhythmia drugs:
  - Over 3,200 patients whose tests showed abnormal results had prescriptions for the arrhythmia drug adjusted or discontinued and switched to effective alternatives.
  - More than 1,800 patients taking a statin drug with the potential to interact with the arrhythmia medication switched to safer alternatives.
  - More than 5,800 patients who previously were missing lab tests had the recommended procedures completed.
  - For every dollar spent on safety monitoring, the program saved an estimated $2.14 in hospital and emergency room costs.
Kaiser Permanente

Coming Together to Promote Patient Safety and Health (continued)

- In 2011:
  - More than 2,000 patients with diabetes and hypertension began taking recommended ACE inhibitor or ARB medications.
  - More than 1,500 patients at risk of harmful drug-disease interactions were prescribed safer alternatives.

- In 2012:
  - Drug regimens were changed to avoid adverse reactions for nearly 2,500 patients at risk of dangerous interaction between two cholesterol medications.

- In 2013:
  - More than 1,500 elderly patients had doses of digoxin medication reduced to prevent toxic reactions.

**Patient-Centered Medical Home**

- From 2010-2012, pharmacists working in Kaiser’s Riverside, CA PCMH site made nearly 3,500 medication-related recommendations. These included actions to address care gaps; schedule lab tests; help patients overcome difficulties taking medications; and avoid adverse reactions, duplication, and use of drugs that are high-risk for elderly patients. PCMH care teams implemented approximately 83 percent of suggested changes.

- From 2010-2011, the 30-day readmission rate among patients in Kaiser’s Riverside PCMH site was 44 percent lower than that of similar patients in a control group not receiving care at PCMH sites.

The average score for patient satisfaction with the Riverside PCMH model was 4.6 on a scale of 1 to 5.

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Overview

Getting medications right is at the top of the agenda for patient care teams at KelseyCare Advantage. Under the health plan’s collaborative practice agreements with physicians, pharmacists work hand-in-hand with doctors to adjust patients’ medications and arrange for needed follow-up. Pharmacists reach out to beneficiaries with chronic conditions following hospital discharge, and they coordinate with care teams to make sure patients have everything they need for successful recovery. When Medicare members with chronic conditions are not filling prescriptions as recommended, pharmacists check in to uncover underlying problems and connect patients with doctors, nurses, and social workers to find solutions. The health plan’s advanced IT systems enable real-time electronic communication among team members to promote timely and effective care.

Collaborating for Better Health

KelseyCare Advantage pharmacists work closely with physicians under collaborative practice agreements to find the medications and dosing schedules that work best for Medicare beneficiaries. The health plan has used collaborative practice agreements since 2004. Initially, the agreements covered five classes of drugs for which there were alternatives with the same therapeutic effect. In 2008, collaborative practice was expanded to allow pharmacists to adjust four additional types of medications based on analysis of lab data, dosing, and patient input. Pharmacists discuss recommended prescription changes with patients by phone and document modifications in electronic health records (EHRs). Patients are advised to schedule follow-up visits with primary care physicians to assess the effectiveness of prescription changes, which typically are intended to reduce side effects, avoid duplication, simplify dosing, and improve health outcomes. Pharmacists give patients their direct phone numbers to call if they have questions or concerns.

Leveraging Health IT Tools

Pharmacists communicate regularly with doctors about medication issues through the electronic health record system, avoiding the need for faxing and other paper-based communication. Pharmacists send doctors summaries of each consultation they have with patients, including notes about potential drug interactions, contraindications, side effects, dosing that could create safety risks, and opportunities to reduce costs with generic alternatives. Doctors review and respond to these notes, and they coordinate with pharmacists to adjust prescriptions as needed through the e-prescribing system.

The pharmacy team has incorporated important patient safety notifications into the EHR system, which automatically sends best-practice alerts to doctors when: beneficiaries are due for flu or pneumonia vaccines; seniors have been prescribed medications that are high-risk for the elderly; people receive prescriptions for narcotics from multiple doctors; and/or there are gaps in evidence-based care. Best-practice alerts often include suggested adjustments to treatment regimens to improve patients’ health and well-being.
KelseyCare Advantage

Putting Medication Management at the Hub of Collaborative Care
(continued)

Leading the Way to Successful Care Transitions

When Medicare members are discharged from hospitals following heart attack, chronic obstructive pulmonary disease, pneumonia, or congestive heart failure, pharmacists reach out by phone within 72 hours. During their calls with patients, pharmacists review all medications sent home from the hospital, compare them to prescriptions filled before and after being hospitalized, and check for duplication, potential for adverse interactions, and dosing errors. They ask patients about side effects, difficulties with taking and affording medications, and unmet needs.

Pharmacists then collaborate with the health plan’s doctors, nurses, social workers, and physician assistants to arrange for follow-up care, prescription changes, financial assistance, and/or social services. If patients are continuing to experience problematic symptoms, pharmacists arrange for home visits with physician assistants (PAs). PAs perform detailed evaluations and send findings to patients’ primary care doctors for follow-up. If patients need help with activities of daily living, pharmacists coordinate with social workers to set up home care services. Pharmacists also can help patients access transportation to doctor’s appointments and enroll in disease management programs.

Mobilizing Care Teams to Help Patients Take Their Medicine

If patients with diabetes, high cholesterol, and hypertension do not fill or refill prescriptions within a week of the prescribing date or refill due date, pharmacy technicians contact them by phone to assess the reasons and address underlying problems. If forgetfulness is the only reason, pharmacy staff suggest tools such as smartphone reminders, pill boxes, and pharmacies’ automated refill systems. If patients are experiencing side effects, can’t afford their prescriptions, do not understand the instructions, or are facing other barriers to care, pharmacists mobilize care teams for rapid response. Pharmacists create alerts in the electronic health record system, and they coordinate with doctors, nurses, and others to help patients access effective treatments and follow care plans. For example, social workers may help members apply for financial assistance to pay for medications. Pharmacists may work with doctors to simplify medication regimens, and they may arrange for home delivery of prescriptions.

Results

From 2012-2013:

- The proportion of members taking recommended diabetes medications grew from 76 percent to 83 percent.
- The proportion of Medicare beneficiaries taking statins for high cholesterol as recommended rose from 71 percent to 82 percent.
- The proportion of beneficiaries taking drugs for high blood pressure as prescribed increased from 77 percent to 86 percent.
- The use of effective generic drug alternatives to brand-name drugs rose from 86 percent to 89 percent.

In 2012, prescription changes made as a result of KelseyCare Advantage’s collaborative practice agreements saved members a total $340,000 in out-of-pocket costs.
Putting Medication Management at the Hub of Collaborative Care (continued)

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Innovations in Medication Therapy Management

CHAPTER 2
Advancing Best Practices in Medication Therapy Management: A Compendium of Health Plan Initiatives

Reaching Beyond Traditional Boundaries to Provide Medication-Related Help

Overview
From partnering with independent pharmacies in Somali and Hmong neighborhoods to setting up an Ask-the-Pharmacist booth at the Minnesota State Fair and a senior center, UCare is finding a range of new ways to help people understand their medications and manage them effectively. By reaching out to many groups of people with unmet needs to provide information and support, UCare is seeking to improve the health not only of members, but also of the communities it serves.

Pharmacies as Community Centers
The two independent pharmacies in UCare’s network that operate in Somali and Hmong neighborhoods are community gathering places, where people catch up with their friends and consult with pharmacists who live in their neighborhoods, speak their languages, and share their cultural traditions. With many customers having concerns about use of Western medicines, pharmacists offer reassurance and advice. Pharmacists also can translate prescription labels and explain medication instructions. People who previously avoided going to the doctor for immunizations feel comfortable having flu shots at these pharmacies.

Ask-the-Pharmacist
Since UCare launched its Ask-the-Pharmacist program in 2011, people don’t even have to go into a pharmacy to get information about medications. Once a week, a UCare pharmacist visits the Minneapolis Skyway Senior Center and stays as long as it takes to answer people’s questions about their prescriptions and over-the-counter treatments. The pharmacist also can provide UCare members with information about specific health benefits and help them access the health plan’s case management and disease management programs to address ongoing needs.

Each year, UCare staffs an Ask-the-Pharmacist booth offering the same type of service at the Minnesota State Fair. Pharmacists are also on hand to answer questions about pharmacy needs during annual meetings for Medicare members in October.

Support for Dual Eligibles
Upon joining UCare, beneficiaries covered by Medicare and Medicaid (dual eligibles)—who often have unmet needs that go beyond healthcare—are paired with nurse care coordinators to help them access a broad range of medical, social, financial, and nutrition-related services. Care coordinators mobilize care teams that provide everything beneficiaries need to maintain their independence at home. Care teams include pharmacists, nurses, doctors, social workers, meal and transportation providers, home care workers, and others.1

Care coordinators contact dual eligibles as soon as they join UCare to assess their health conditions and determine all of the prescription and over-the-counter medications they are taking. Nurses send patients’ complete medication lists to pharmacists, who analyze their medication regimens to identify gaps in evidence-based care, potential for adverse interactions and other safety risks, duplication, incorrect dosing, and potential cost savings. Based on their analyses, pharmacists make recommendations that may include changes to increase adherence to evidence-based care.

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Once a week, a UCare pharmacist visits the Minneapolis Skyway Senior Center and stays as long as it takes to answer people’s questions about their prescriptions and over-the-counter treatments.

UCare

Reaching Beyond Traditional Boundaries to Provide Medication-Related Help (continued)

standards, simplify medication regimens, and achieve cost savings.

Pharmacists may consult with physicians to ask why certain medications have been prescribed or recommend alternatives that have proven effective in treating certain conditions. Pharmacists also participate in care conferences with doctors and nurses to help solve complex care challenges. They follow up with other care team members to see whether recommended medication changes were made and if additional adjustments are needed to improve patients’ well-being.

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Empowering Patients and Doctors with Pharmacy Information and Support

Overview
Through its HealthLine Hotline and physician outreach program, WellCare is finding new ways to provide actionable pharmacy information and support to Medicare Advantage members and doctors throughout the country.

Providing a Help Line for Patients
Medicare beneficiaries with multiple chronic conditions who are taking several medications often have questions and concerns about their prescriptions and don’t know where to turn. WellCare’s HealthLine Hotline gives patients eligible for the health plan’s medication therapy management (MTM) services (about 9 percent of WellCare’s Medicare Advantage members) an easy way to resolve challenges related to their care. Patients can call anytime during business hours and speak to pharmacy professionals.

Some patients call with concerns about pain control. Others need step-by-step instructions on how to use glucose monitors. Some are experiencing side effects from medications and are unsure what to do next. Others are struggling to understand new prescriptions and follow complicated dosing schedules.

HealthLine Hotline’s full-time pharmacists and pharmacy technicians help patients address a wide range of issues. They explain medications in simple, non-technical terms and offer tips for following treatment plans. They coordinate with WellCare’s doctors and nurses to help patients avoid problematic side effects and simplify dosing regimens.

Depending on patients’ needs, pharmacy staff may talk about changes to diet and exercise that can improve health, and they can help patients enroll in disease management and other support programs. Pharmacists can connect patients with care team members who can help make doctor’s appointments and arrange transportation. Often, patients just need a one-time consultation; in other cases, it may take several conversations to resolve an issue. Some patients form lasting bonds with Hotline pharmacists and call regularly for medication-related advice.

Reaching Out to Doctors
Besides working with patients on an ongoing basis, WellCare’s pharmacists travel to communities throughout the country to give doctors serving Medicare Advantage and Medicaid beneficiaries the information they need to effectively manage patients’ medications. WellCare pharmacists conduct in-person meetings in solo and group practices, with independent practice association (IPA) leadership teams, and in community health centers.

The program focuses on practices with large numbers of patients who could benefit from treatment changes consistent with nationally recognized quality standards. These include: prescribing ACE inhibitor, ARB, or direct renin inhibitor medications for people with diabetes and hypertension; adjusting drug regimens to prevent adverse interactions; avoiding medications that have been identified as high-risk for seniors; and ensuring that children taking medication for attention deficit hyperactivity disorder have recommended follow-up visits with doctors.

Results:
- In 2012, nearly 9,500 Medicare beneficiaries (an average of 788/month) contacted the

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1 ACE inhibitor is shorthand for angiotensin-converting enzyme inhibitor. ARBs are angiotensin II receptor blockers.
WellCare Health Plans, Inc.

Empowering Patients and Doctors with Pharmacy Information and Support (continued)

HealthLine Hotline for medication-related support.

- As of August 2013, the HealthLine Hotline was receiving an average of 1,417 calls/month.
- Collectively, WellCare pharmacists conduct on average 200 in-person meetings per month to share pharmacy best practices and tools with individual doctors, group practices, IPA leaders, and community health center staff throughout the country.

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