



Pharmacy and the Medicaid Accountable Care Organization

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COLORADO
Department of Public
Health & Environment

CDC Grant

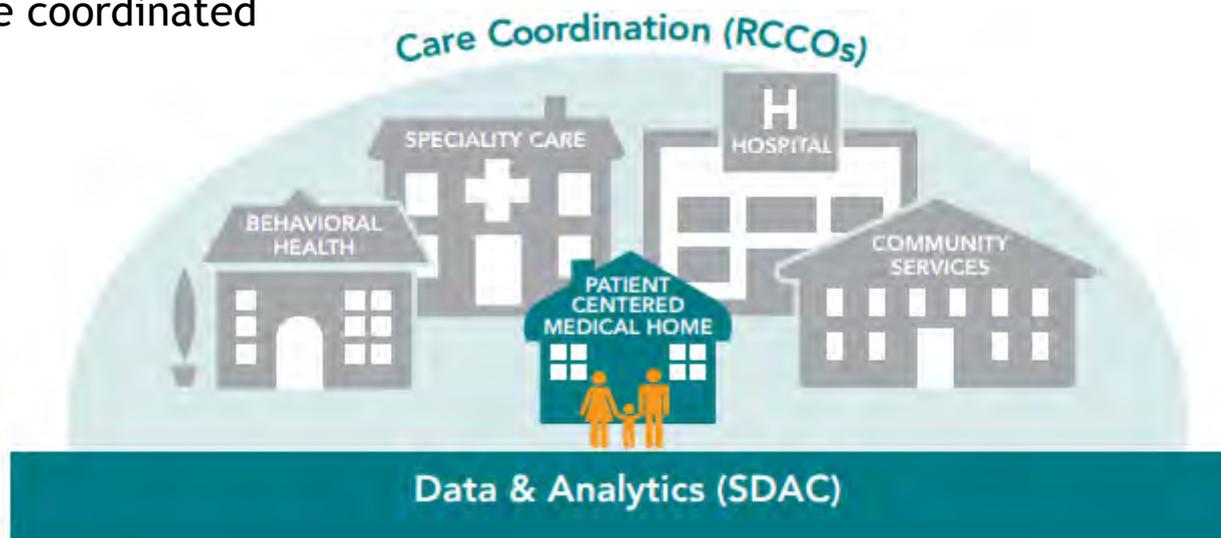
- Increase engagement of non-physician team members (ie., pharmacists) in Hypertension (HTN) and Diabetes Mellitus (DM) management in health care systems;
- Increase the proportion of community pharmacists that promote medication-/self-management;
- Increase the proportion of adults with diabetes and high blood pressure in adherence to medication regimens; and
- Increase the proportion of adults who have achieved blood pressure and/or diabetes control.



The Accountable Care Organization

Centers for Medicare and Medicaid Services:

Accountable Care Organizations (ACOs) are groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to the ... patients they serve.



<https://www.colorado.gov/pacific/sites/default/files/Accountable%20Care%20Collaborative%202014%20Annual%20Report.pdf>



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The ACO System in Colorado

Design: Primary care medical providers contract with Regional Care Collaborative Organizations (RCCOs) to help provide medical homes to Medicaid enrollees.

Primary Care Medical Providers (PCMPs) serve as a Medical Home that:

- Is member/family centered
- Is whole person oriented
- Is coordinated
- Promotes client self-management
- Provides care in a culturally sensitive and linguistically sensitive manner
- Is accessible

RCCOs achieve financial and health outcomes and ensuring comprehensive care coordination and a Medical Home level of care for every Member through:

- Network Development/Management
- Provider Support
- Medical Management and Care Coordination
- Accountability/Reporting



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The ACO System in Colorado, continued

Currently:

- Regional Care Collaborative Organizations (RCCOs) receive \$9 per member, per month (PMPM) payment.

In the future:

- After a RCCO operates on a cost neutral basis, they are eligible to draw from a quarterly incentive payment pool.
- To receive incentive payment, they must meet specific performance goals:
 - reduce ER visits
 - reduce hospital re-admissions
 - and address utilization of medical imaging.



The ACO System in Colorado, continued

Was it not ideal for a RCCO to:

- consider being the intermediary for integrating pharmacy
- provide reimbursement using their PMPM to contract with community pharmacists and
- to focus on adherence

...toward the goal of increasing control of HTN and DM just like CDC had asked us to do?



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Why Now?

1. Pharmacy engagement
2. Conversations with Health Care Policy and Financing (state Medicaid)
3. Provider shortage focus
4. Centers for Disease Control and Prevention focus and grant
5. Existing diabetes management clinics through University of Colorado (CU)

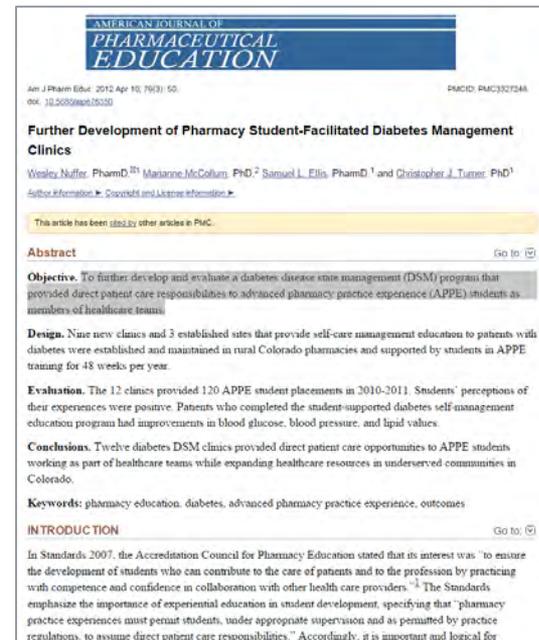


University of Colorado Disease State Management Clinics

12 diabetes disease management clinics in rural pharmacies across the state

Purpose: To further develop and evaluate a diabetes disease state management (DSM) program that provided direct patient care responsibilities to advanced pharmacy practice experience (APPE) students as members of healthcare teams.

<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3327248/>



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**PHARMACEUTICAL
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PUBID: PMC3327248

Further Development of Pharmacy Student-Facilitated Diabetes Management Clinics

Wesley Nuffer, PharmD,^{1,2} Marianne McCollum, PhD,² Samuel L. Ellis, PharmD,¹ and Christopher J. Turner, PhD¹
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This article has been cited by other articles in PMC.

Abstract Go to:

Objective. To further develop and evaluate a diabetes disease state management (DSM) program that provided direct patient care responsibilities to advanced pharmacy practice experience (APPE) students as members of healthcare teams.

Design. Nine new clinics and 3 established sites that provide self-care management education to patients with diabetes were established and maintained in rural Colorado pharmacies and supported by students in APPE training for 48 weeks per year.

Evaluation. The 12 clinics provided 120 APPE student placements in 2010-2011. Students' perceptions of their experiences were positive. Patients who completed the student-supported diabetes self-management education program had improvements in blood glucose, blood pressure, and lipid values.

Conclusions. Twelve diabetes DSM clinics provided direct patient care opportunities to APPE students working as part of healthcare teams while expanding healthcare resources in underserved communities in Colorado.

Keywords: pharmacy education, diabetes, advanced pharmacy practice experience, outcomes

INTRODUCTION Go to:

In Standards 2007, the Accreditation Council for Pharmacy Education stated that its interest was "to ensure the development of students who can contribute to the care of patients and to the profession by practicing with competence and confidence in collaboration with other health care providers."⁴ The Standards emphasize the importance of experiential education in student development, specifying that "pharmacy practice experiences must permit students, under appropriate supervision and as permitted by practice regulations, to assume direct patient care responsibilities." Accordingly, it is important and logical for



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RCCO Pilot Elements

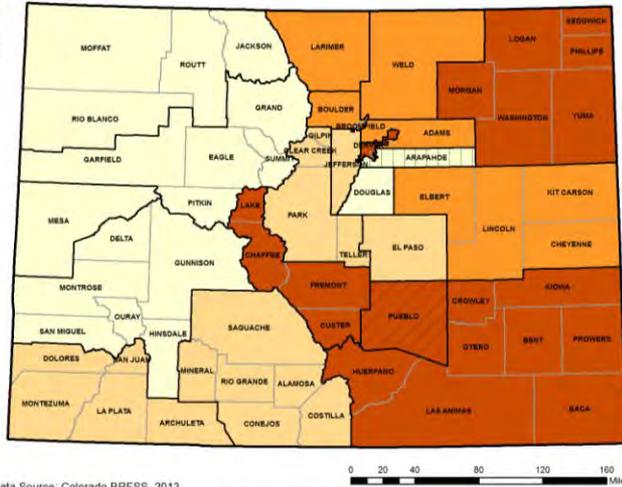
1. Strong relationships between RCCO clinics/providers and pharmacists/pharmacies
2. Utilization of claims data to identify clients who could benefit from adherence and disease management services, with specific attention to hypertension and/or diabetes
3. Enrollment of a distinct number of clients in a program
4. Use of multiple pharmacies
5. Specific program offered by pharmacy students
6. Fourth year pharmacy students provide services at no cost



Prevalence of Cardiovascular Disease in Adults By Health Statistics Region, 2013



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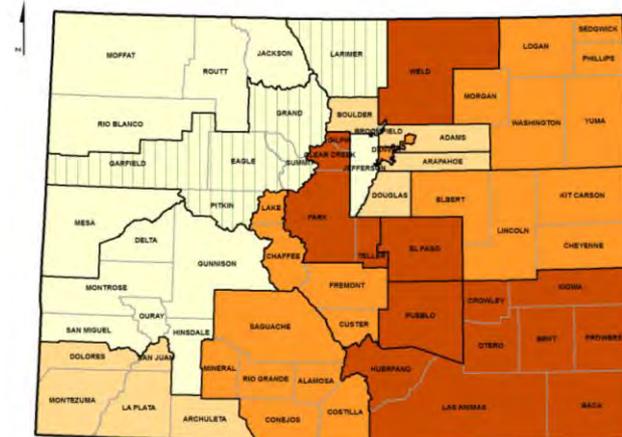
Data Source: Colorado BRFSS, 2013
Percent of Adults Age 18+ Years with Cardiovascular Disease (Estimated)



Prevalence of Hypertension in Adults By Health Statistics Region, 2013



Colorado Department
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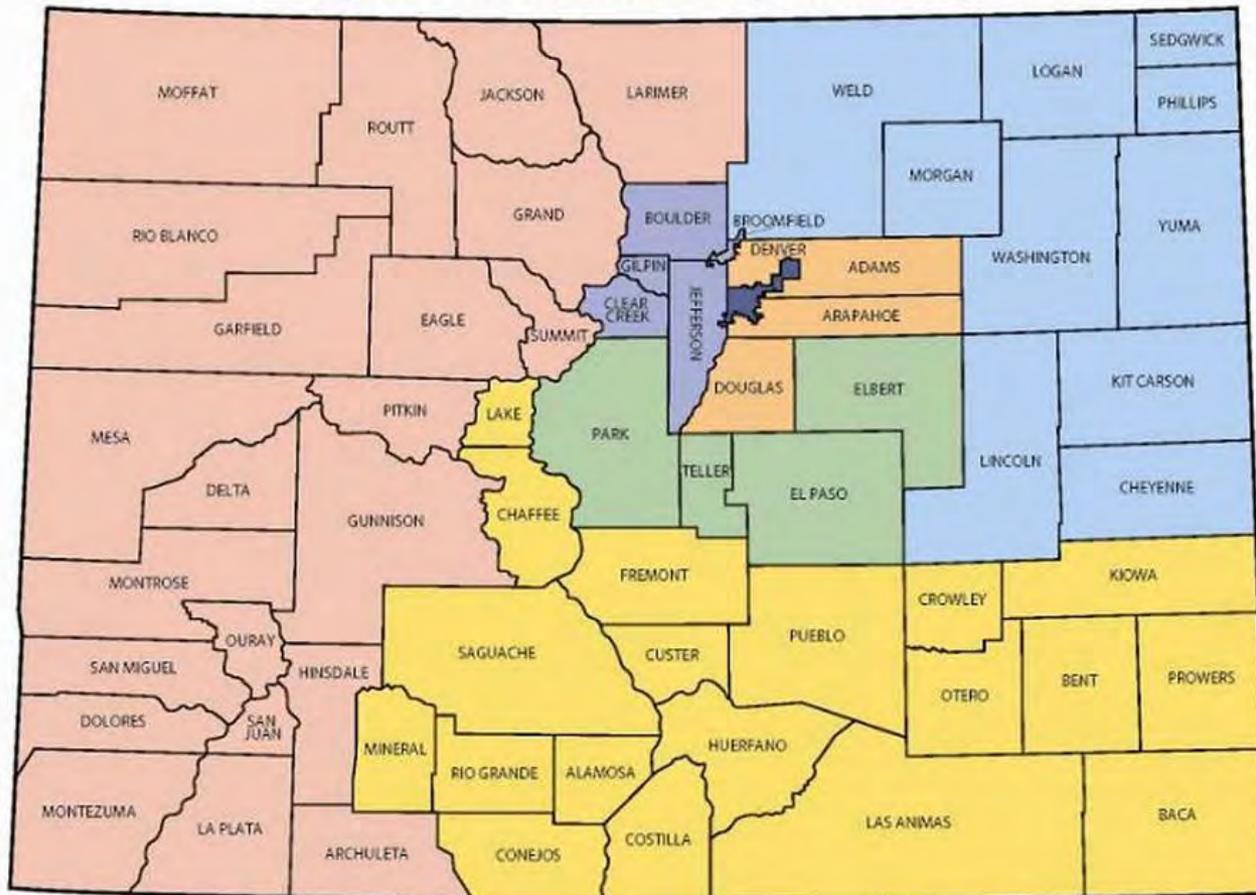


Data Source: Colorado BRFSS, 2013
Percent of Adults Age 18+ Years with Hypertension (Estimated)



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Colorado's Accountable Care Collaborative Regional Care Collaborative Organization Map



Region 4:
Integrated
Community
Health
Partners



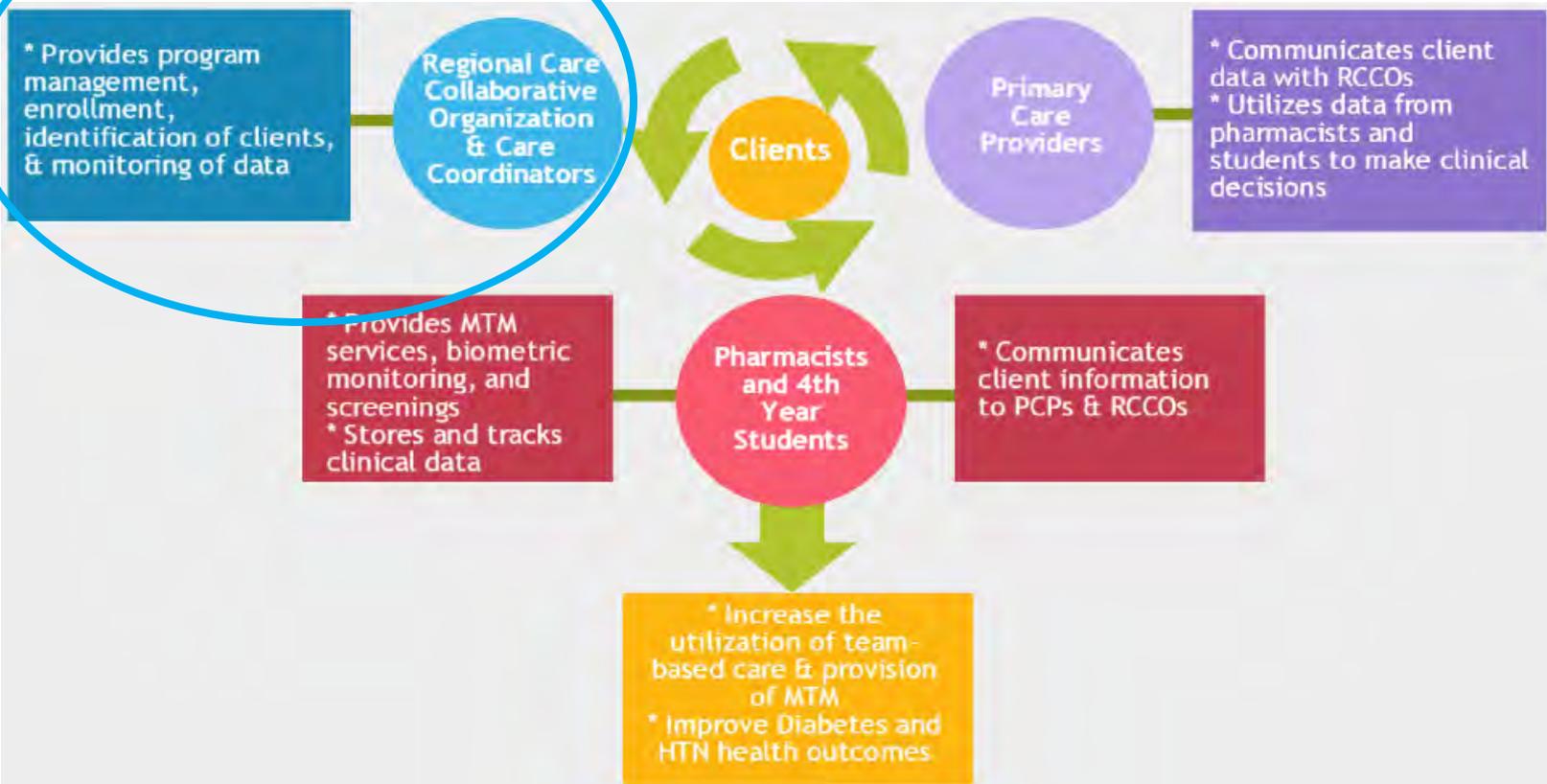
Pilot Sites



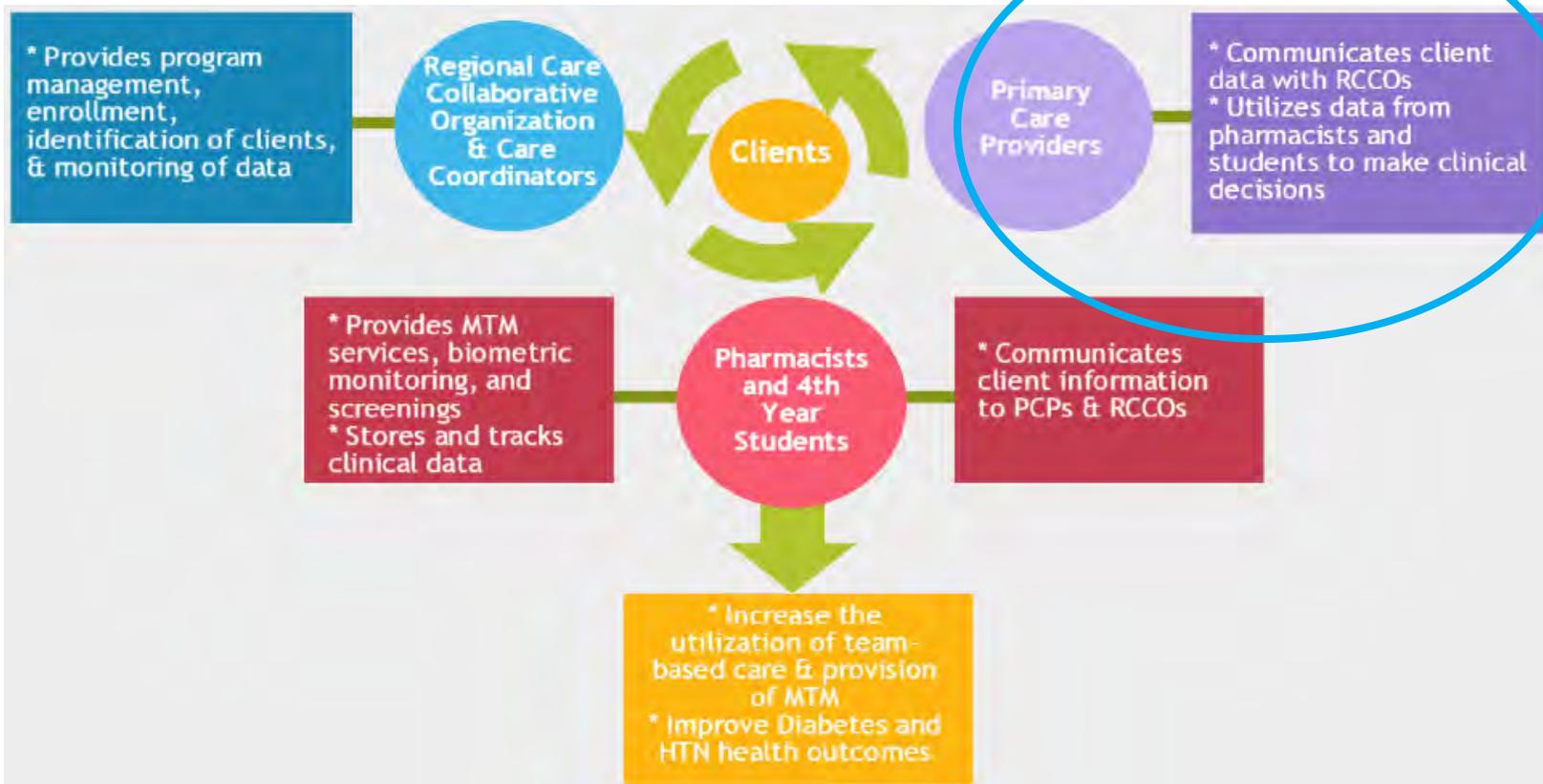
Overall Project Design



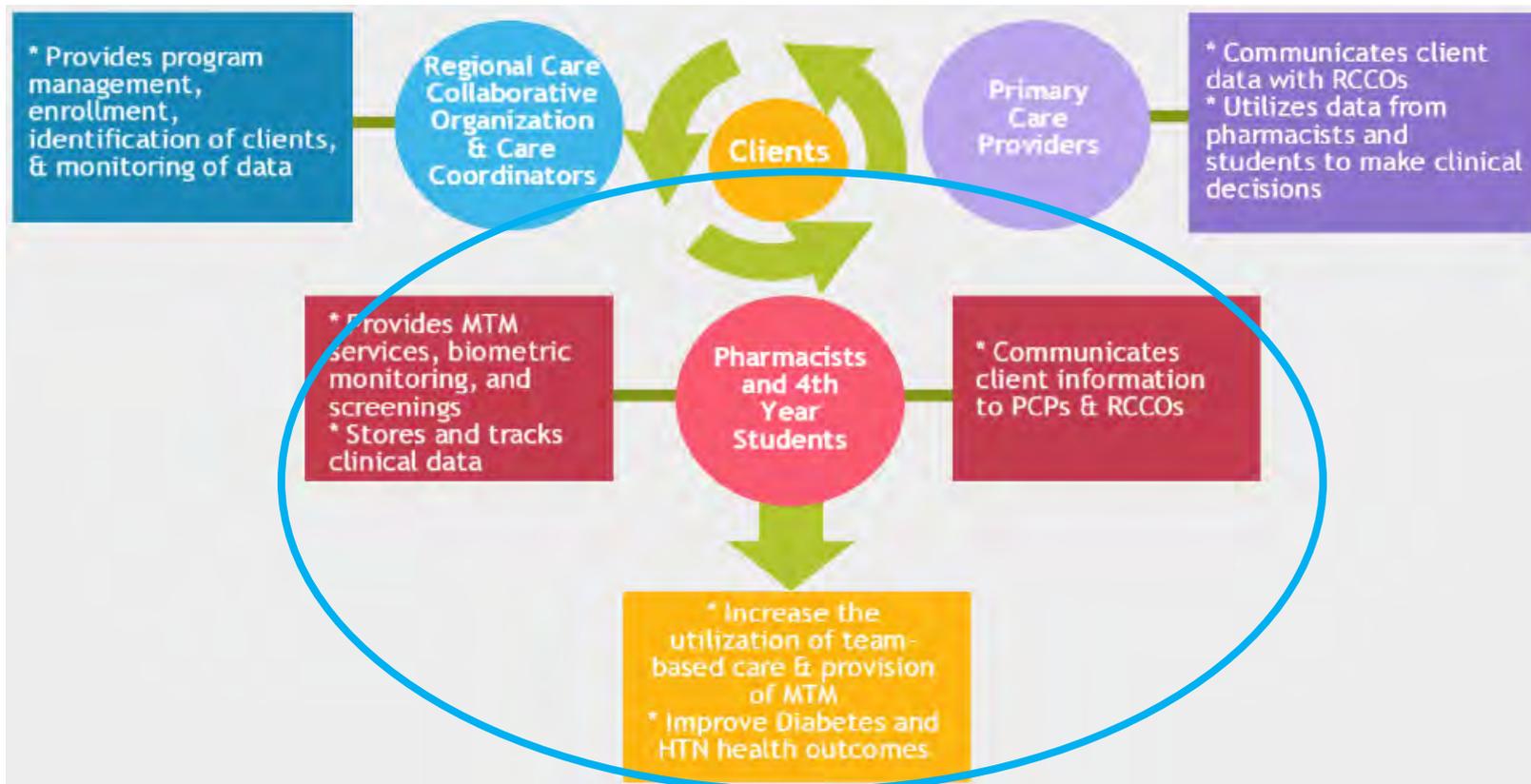
Overall Project Design



Overall Project Design



Overall Project Design



Pharmacy Program Components Relative to Defined MTM

- ✓ Performing or obtaining necessary assessments of the patient's health status;
- Formulating a medication treatment plan;
- Selecting, initiating, modifying, or administering medication therapy;
- ✓ Monitoring and evaluating patient's response to therapy;
- Performing a comprehensive medication review;
- ✓ Documenting care delivered and communicating essential information to patient's PCPs;
- ✓ Providing verbal education/training to enhance patient use of his/her medications;
- ✓ Providing supports/resources to enhance patient adherence with therapeutic regimens;
- ✓ Integrating MTM services with patient's broader health care-management services



Diabetes management curriculum

Current diabetes management program follows the nationally recognized Diabetes Self-Management Education (DSME) program

Components include:

- What is diabetes?
- Cardiovascular risks of diabetes
- Exercise benefits with diabetes
- Hypoglycemia and diabetes
- Diabetes medications
- Long-term complications of diabetes
- Medication Nutrition Therapy with diabetes
- Insulin
- Injection technique/Pen devices
- Pre-diabetes
- Sick day management
- Smoking cessation
- Weight loss
- Gestational diabetes
- Advanced nutrition
- Complementary/alt medicine and diabetes
- Glucose monitor training
- Travel and diabetes



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Cardiovascular/HTN disease management curriculum

Current CVD management program includes:

- What is high blood pressure?
- How to monitor your blood pressure
- OTC meds and blood pressure
- Prescription blood pressure medications
- Diet and nutrition and cardiovascular disease
- What is high cholesterol?
- Prescription cholesterol medications
- CV Complications- heart attacks and strokes
- OTC/herbal/CAM and CV disease
- Smoking cessation
- Exercise and activity and CV disease
- Patient resources

<http://millionhearts.hhs.gov/resources/teamuppressuredown.html>



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Data measurement design

Clinical Outcomes/Descriptors:

- How many clients accessed services; what kinds of insurance, demographics
- What kinds of services were most accessed and most useful, consultation, self-management plans, lifestyle tools
- Total Cholesterol, LDL-C, HDL-C, Triglycerides, Systolic BP, Diastolic BP, A1C, height, weight, Waist circumference
- If obtained: Blood glucose, Highest SMBG read, Lowest SMBG read, Average SMBG glucose, Serum creatinine, Urine creatinine, BUN, Microalbumin

Educational Outcomes/Descriptors:

- How many students are in the field?
- Student's knowledge gain of team-based care, readiness to work in care teams

Systems Outcomes/Descriptors:

- Facilitators and barriers of implementation of component



Pillars of Support

<h2>Education & Training</h2>	<h2>Disease Management</h2>	<h2>Clinical Transformation</h2>	<h2>Sustainability</h2>
 <p>Increase knowledge of disease management, medication management and team-based care to improve practice among pharmacists & clinical team members.</p>	 <p>Increase access to disease management services for clients.</p>	 <p>Improve practice-based processes to ensure clients can access adherence support from pharmacy partners as members of the care team.</p>	 <p>Increase long-term support for systemic utilization of pharmacists practicing at the top of their licensure.</p>
<h2>Interventions</h2> <ul style="list-style-type: none"> • Motivational Interviewing training among pharmacy students • Provide Disease Management (diabetes and hypertension) rotation for pharmacy students • Engage in team-based care approach for clinics • Implement coordinated care approach through regional care collaborative 	<h2>Interventions</h2> <ul style="list-style-type: none"> • Create curriculum for people with diabetes and/or hypertension that can be delivered by a pharmacist. • Create a database for tracking client visit data including metrics and plans. 	<h2>Interventions</h2> <ul style="list-style-type: none"> • Create Med Adherence/Pharmacy Practice Improvement Toolkit • Support 10-15 practices through Med Adherence/Pharmacy improvement initiatives 	<h2>Interventions</h2> <ul style="list-style-type: none"> • Develop a replicable model system of pharmacy integration at the regional care level • Analyze financial benefit for utilization of pharmacists at the regional care level
<h2>Key Players</h2> <ul style="list-style-type: none"> • Skaggs School of Pharmacy and participating pharmacies • Regis University and participating pharmacies • Integrated Community Health Partners and participating clinics • Medicaid 	<h2>Key Players</h2> <ul style="list-style-type: none"> • Skaggs School of Pharmacy and participating pharmacies • Regis University and participating pharmacies • Integrated Community Health Partners and participating clinics • Clients 	<h2>Key Players</h2> <ul style="list-style-type: none"> • Skaggs School of Pharmacy • Project Extension for Community Healthcare Outcomes (ECHO) • Colorado Department of Public Health & Environment Clinical Quality Improvement Project and participating clinics • Evidence Now Initiative and participating clinics 	<h2>Key Players</h2> <ul style="list-style-type: none"> • Skaggs School of Pharmacy and pharmacies • Regis University and participating pharmacies • Integrated Community Health Partners and clinics • Clients



Pillars of Support: Clinical Transformation

- Overall Clinical Quality Improvement
- Clinical Quality Improvement to take 10-20 practices through integration with pharmacy
- Medication Adherence Pharmacy Practice Toolkit



Key Partners:

Skaggs and Regis Schools of Pharmacy, Project Extension for Community Healthcare Outcomes (Project ECHO), State Clinical Quality Improvement team, Evidence Now (AHRQ grant)



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Pillars of Support: Sustainability

- Replicable model of integration at RCCO level
- ROI, value statement for community pharmacy integration



Key Partners:

Skaggs and Regis Schools of Pharmacy, Integrated Community Health Partners, clients



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Next Steps

- Diabetes self management reimbursement
- Connectivity
- Provider Status
- Other sites, other RCCOs, Other Programs





Thank you!

<https://www.colorado.gov/cdphe/community-pharmacist-integration>

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Questions?

<https://www.colorado.gov/cdphe/community-pharmacist-integration>

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