illion Hearts™

Medication Therapy Management Fishbowl

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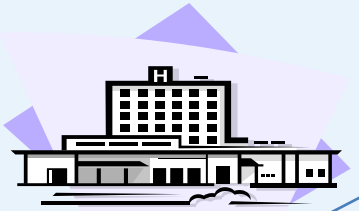
American Health Care

Scaling and Spreading Innovation
Strategies to Improve Cardiovascular Health
April 19, 2012

CDC Centers for Disease Control and Prevention
AHRQ
AHRQ HEALTH CARE INNOVATIONS EXCHANGE
Center for Medicare & Medicaid INNOVATION
Department of Health & Human Services USA
American Heart Association® Learn and Live

Description of Innovation

Asheville Model



Employers

Reduced Rx Copayment

Patient w Chronic Condition

Patient Keeps Dr. Visits

Physician

Meets every 1-3 months (between doctor visits)

Fee for Service

Communicates summary of session & makes recommendations

Pharmacist/Educator

-Electronic Record
-Integrated Patient Data
-Gaps in Care Identified
-Plan of Care Reinforced
-Outcome Reports Generated

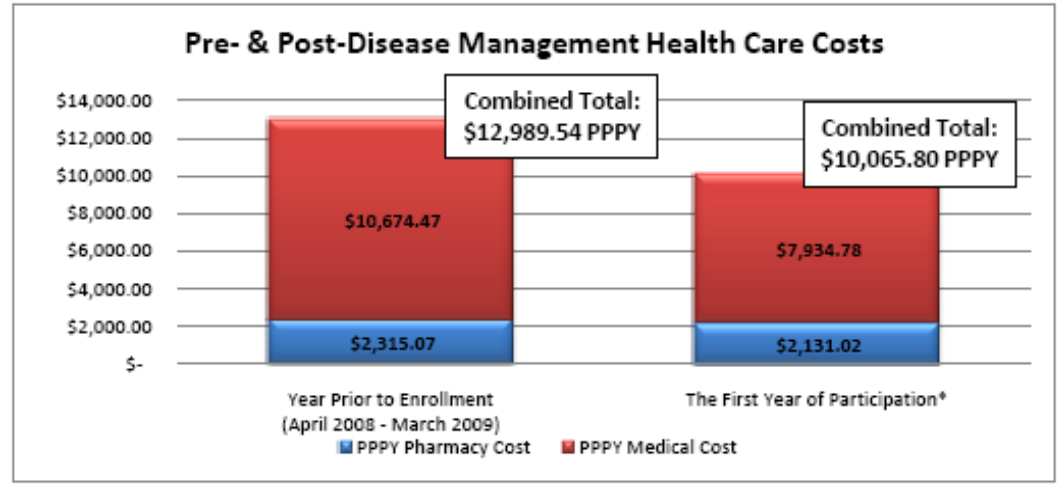
Business Case, Cost-Benefit, Return on Investment

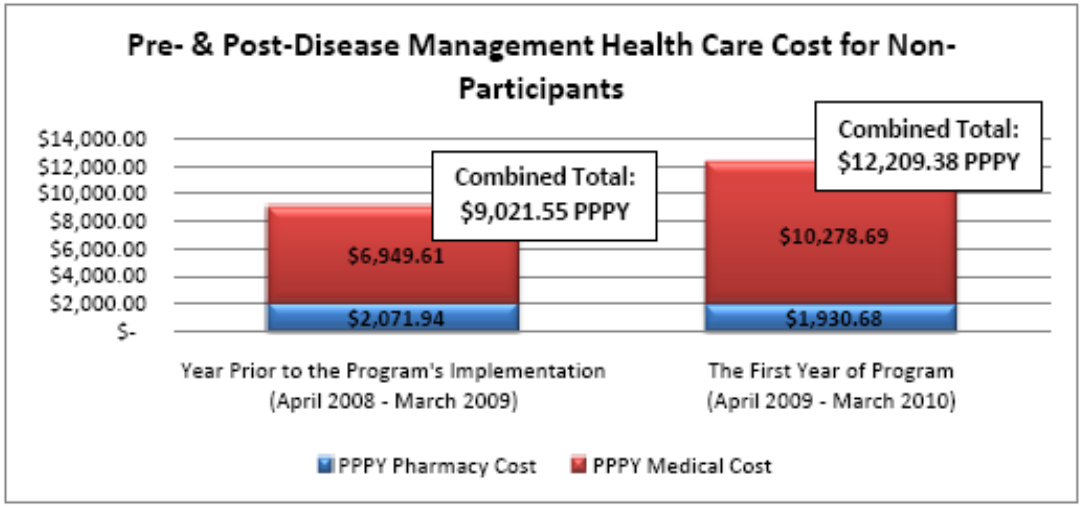
Financial Outcomes:

	Year 1		Year 2			
Program	**PPPY Savings**	**Total Savings**	**PPPY Savings**	**Total Savings**	**Total Program Savings**	**Cumulative ROI**
Diabetes	$137.07	$4,022.20	$1,111.53	$24,453.37	$28,475.57	4.0:1
Hyperlipidemia	$20.01	$780.24	$522.84	$6,325.42	$7,105.66	1.86:1
Hypertension	$23.11	$1,317.30	$81.01	$1,863.31	$3,180.61	(0:1)
Totals	**$180.19**	**$16,119.74**	**$1,715.38**	**$32,642.10**	**$38,761.84**	**2.14:1**
		Combined Total Program Savings:			**$38,761.84**	**2.14:1**

*Red Number indicates a negative savings

Business Case, Cost-Benefit, Return on Investment





Lessons Learned/Spread Issues

- Is possible to decrease cardiovascular events & lower health care costs for patients with cardiovascular risk with a preventive care approach

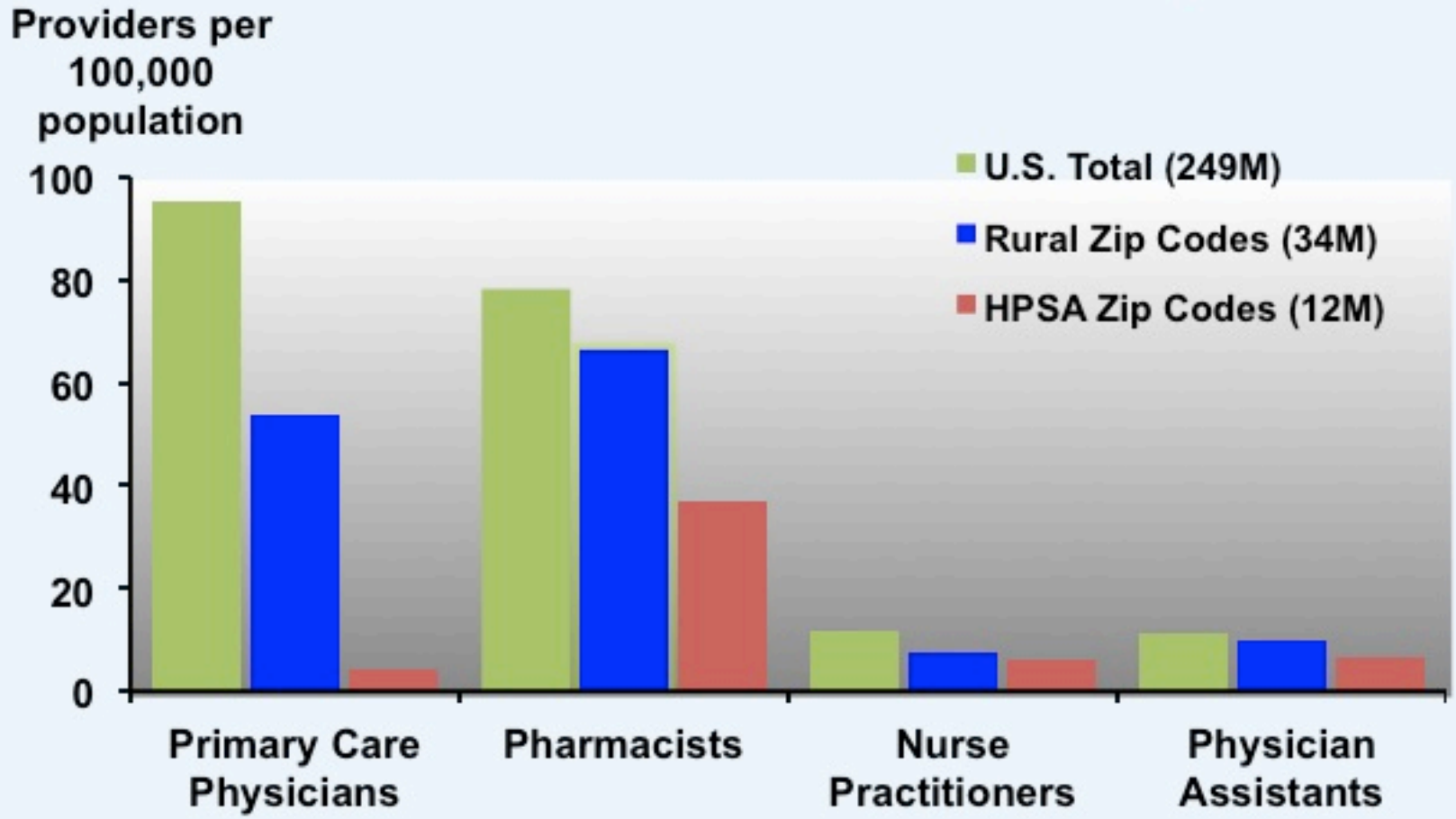
  (*The Asheville Project: Clinical & Economic Outcomes of a Community-Based LongTerm Medication Therapy Management Program for Hypertension & Dyslipidemia J Am Pharm Assoc. 2008;48:23-31.)*

- Pushback from physicians has been minimal & should not be a significant barrier to spread
  - Plan is to emphasize how the program helps physicians improve their "report card", without significantly increasing their time investment
  - Plan is to emphasize the physician remains the decision maker, but is able to make some important decisions in a more informed manner
- Skepticism from payers continues to be a barrier to spread ("burned" on programs that didn't work)
  - Plan is to use the growing amount of objective data showing financial/clinical benefit of the model to overcome skepticism
  - Plan is to use the employer's own data to expose their problem areas (speaks more strongly than "national" data)
  - Plan is to use the simplest of financial outcome measures as benchmark of success, "Does the program save more than it costs?"

Lessons Learned/Spread Issues

- There continues to be a barrier of competing models (telephonic vs. face-to-face, wellness approach vs. chronic disease focus)
  - Plan is to focus on individuals with chronic conditions taking chronic medications
- Patient engagement continues to be a barrier to program participation
  - Plan is to emphasize the effectiveness of financial incentives (reduced Rx co-payments, premium incentives)
- The skill set of pharmacists matches very well with individuals with cardiovascular risk, for whom medications are frequently a fundamental risk reduction strategy
  - Plan is to advocate the use of pharmacist's clinical skills to improve therapy
- Pharmacists are very accessible, but not all pharmacists are available to provide the service
  - Plan is to develop networks of qualified pharmacists who have time to provide service
  - Plan is to take advantage of pharmacy's large national footprint (both an opportunity and a challenge)

The Opportunity National Distribution of Provider Groups



Source: JAPhA 1999; 39:127-35.

* HPSA: Health Provider Shortage Area

Disclaimer

The findings and conclusions in this presentation are those of the author(s) and do not necessarily represent the official position of the Centers for Disease Control and Prevention or the Agency for Healthcare Research and Quality.