Contact Information	Brian Myers, (509) 252-0196, brian@empirehealthfoundation.org Organizations Involved: Empire Health Foundation, Better Health Together, Washington State University College of Pharmacy, Alliance for Integrated Medication Management
Project Title	*Integrated Medication Management to Improve Community Health*

Rationale for the Project

Problem statement – why this project is needed

More than a quarter of all Americans—and 2/3 older Americans—are estimated to have at least two chronic physical or behavioral health problems. Treatment for people living with these multiple chronic conditions (MCC) currently accounts for an estimated 66% of the Nation's health care costs. As the U.S. population ages, the number of patients with MCC continues to grow. This mounting challenge has become a major public health issue that is linked to suboptimal health outcomes and rising health care costs. Additionally, the demographic change of baby boomers living longer is quickly outstripping the capacity of family caregivers, providers, and affordable Long Term Supportive Services. This is particularly pervasive in our ACH's region with rural and frontier communities underserved largely due to a shortage of health care providers and limited resources.

Numerous studies find very high error rates in prescription medication regimes following care transitions, such as hospitalizations, with errors affecting a staggering 60 – 100% of patients. 66% of adverse events following a hospital discharge are drug related, and over 60% of such events are preventable[1]. As the population with MCC is at high-risk for emergency services and hospitalizations, the key intervention being proposed is to **improve medication management through a national best-practice model** guided by the professionally distinguished Alliance for Integrated Medication Management (AIMM).[2]

Integrated Medication Management for Improved Community Health is needed because:

- 30% of the people who live in our ACH region account for 60 – 80% of the health care costs distributed across many payment sources. This 30% has multiple chronic health care conditions managed in part with medication. Said another way, 71 cents of every $1 in health care costs goes to treating people with multiple chronic conditions.

- 66% of the adult population in the U.S. uses prescription drugs. People with MCC have more prescriptions than those who do not. Compounding the problem, oftentimes different doctors describe different medications, resulting in their combined effect going unmonitored.

- During transitions in care, such as from a hospital, jail, foster care placements or skilled nursing facility, well over 60% of the prescriptions ordered, filled and used are incorrect due to a variety of reasons including medical errors, patient confusion or disconnect from the usual medical care team familiar with patient health history.

Supporting research (evidence-based and promising practices) for the value of the proposed project.[i]

According to the National Center for Biotechnology Information[3], an effective medication reconciliation and management network across care settings—where medications a patient is taking are compared to what is being ordered—has been found to reduce errors. Doing so will avoid errors of omission, drug-drug interactions, drug-

[1] http://www.ntocc.org/portals/0/pdf/resources/ntoccissuebriefs.pdf

[2] http://medsmatter.org

[3] http://www.ncbi.nlm.nih.gov/books/NBK2648/

disease interactions, and other discrepancies. A medication reconciliation process is a major component of safe patient care in any environment and is amplified when integrated into a community medication management network.

Relationship to federal objectives for Medicaid[ii] with particular attention to how this project benefits Medicaid beneficiaries.

Medication Management to Improve Community Health is specifically designed to:

- Promote integrity and objectives of Washington State's Medicaid program;
- Be transformative in support of the goals of the waiver;
- Build upon evidence to strengthen potential for measurable ROI;
- Be substantially different than other CMS funded initiatives while leveraging current regional, state and national activities underway to accelerate results;
- Addresses significant community health needs identified through BHT's collaborative planning process; and
- Impacts Medicaid beneficiaries in our region in a significant way with the potential for accelerated statewide implementation.

Project Description

Which Medicaid Transformation Goals are supported by this project/intervention?

Medication Management for Improved Community Health supports all four goals:

- ✓ Reduce avoidable use of intensive services
- ✓ Improve population health, focused on prevention
- ✓ Accelerate transition to value-based payment
- ✓ Ensure Medicaid per-capita growth is below national trends

Which Transformation Project Domain(s) are involved?

Medication Management for Improved Community Health involves all three domains to some level:

- ✓ Health Systems Capacity Building
- ✓ Care Delivery Redesign
- ✓ Population Health improvement – prevention activities

Description

Medication Management to Improve Community Health project provides a model of care for Medicaid beneficiaries with multiple chronic conditions that supports medication optimization through:

1. Access to services within an integrated medication management community network. Patients will be able to access their pharmacist for consultation on their complete medication profile beyond medication reconciliation.
2. A medical care team that integrates community pharmacists and the College of Pharmacy for medication review during care transitions to address the large percentage of medication errors that occur during transitions. This is a key anchor strategy to sustain connections to a patient's Managed Care Organization (MCO) or Behavioral Health Organization (BHO) regardless of transitions in care settings.
3. 3. Specialized consultation, (in-person, phone or tele-med) for psychotropic and pain medication prescriptions, multi-medication reconciliation and ongoing management in primary care and palliative care settings.

It is very difficult for fragmented medical, pharmaceutical and community supportive services to self organize into a regional, highly functioning network accountable for results. In part this is because of the combined barriers of fee for service payment silos and the lack of an organizing entity to formalize the collaborative planning, inter-operational integration and shared savings among separately owned and managed resources across multiple sectors. Therefore, this project will not happen without our new ACH, Better Health Together, playing a catalytic role to achieve this transformation. In addition to collective impact backbone functions, this includes:

- Drawing on expertise of BHT member organizations and leaders;

- Creating readiness for delivery system and payment changes through practice support services; and
- Building formal clinical and community linkages and referral processes that support health and recovery of the whole person.

Region(s) and sub-population(s) impacted by the project. Include a description of the target population (e.g., persons discharged from local jail facilities with serious mental illness and or substance use disorders).

This project, aimed to begin in our ACH region will start small, but has high potential for accelerated scalability statewide. Our initial population will thread through multiple sub-populations annually, including:

- 500 adults with chronic conditions transitioning from medical care settings;
- 250 adults transitioning from jail and mental health facilities;
- 250 children and youth in foster care transitions; and
- 3,000 adults and children receiving long-term supportive services (LTSS).

While the number of people served is low, the impact on utilization and cost will be significant.

Relationship to Washington's Medicaid Transformation goals.[iii]

- *Reduction in avoidable use of intensive services* – Through medication management, chronic conditions are brought to, or kept at, goal levels, reducing risk for use of intensive services.
- *Improve population health, focused on prevention* – Medication reconciliation will allow for a network of preventive interactions through care coordination and community pharmacists focused on improving the health of the population. This incorporates the initial priority areas of the Prevention Framework of prevention and management of chronic disease and behavioral health issues, which will help lead the region and the state to the 2019 objectives of a healthier Washington for all.
- *Accelerate transition to value-based payment* – Many national examples look to manage health and cost of care through medication reconciliation and management. Providing a region wide network of medication reconciliation, integrated with current best-practice and evidence-based programs such as Health Homes, 3026 Care Transitions, EHF's Rural Aging Program and others that are designed to operate under a per member, per month system, will accelerate the successful transition to value-based payment.
- *Ensure Medicaid per-capita growth is below national trends* – Reductions in medication errors and improving chronic conditions through medication management will be a key element to controlling Medicaid (and other payment systems) cost.

Project goals, interventions and outcomes expected during the Demonstration, including relationship to improving health equity /reducing health disparities.

- Annually, 2,000 – 4,000 people, primarily Medicaid beneficiaries, with one or more chronic conditions will be served. Spokane Regional Health District's publication on health equity in Spokane County, *Odds Against Tomorrow*[4], repeatedly states those living with the greatest health disparities, especially the low-income population, are more likely to have multiple chronic diseases and will benefit from the outcomes of the project.

The population focused on, primarily Medicaid, low-income, and experiencing an adverse health/life event, does not currently have access to coordinated services including integrated medication management. This often underserved population, especially those transitioning as noted above, will experience improved health outcomes.

Links to complementary transformation initiatives - those funded through other local, state or federal authorities (such as the health home program and Early Adopter/Behavioral Health Organization regional purchasing) and/or Medicaid Transformation initiatives # 2 and 3.

[4] http://www.srhd.org/documents/PublicHealthData/HealthInequities-2012.pdf

Medication Management provides multiple positive outcomes, including delay or avoidance of more intensive long-term services and supports; creation of better linkages within the health care system; and
is a beneficial Targeted Support for Older Adults (TSOA). Additionally, Medication Management is a key component in other Transformation initiatives such as Health Homes and 3026 Care Transitions.

Potential partners, systems, and organizations needed to be engaged to achieve the results of the proposed project.

Program Leadership: Governed by a steering committee convened and staffed by the ACH Better Health Together, Network operations will be managed by Washington State University (WSU) College of Pharmacy, Philanthropy in Action (PIA) and the Alliance for Integrated Medication Management,
Provider Community – hospitals, FQHCs, primary care practices (including Spokane Teaching Health Center), nursing homes, home health agencies, social service agencies, Area Agency on Aging and family-centered supportive housing programs,
Payer Community – MCOs, BHOs, other Medicaid payers, CMS, QIN, child welfare, employers,
Pharmacist Community – WSU School of Pharmacy instructors, students and residents, 340 B pharmacies, health system pharmacies, community pharmacists, specialty pharmacists, and pharmacy technicians.

Core Investment Components

Description
Proposed activities and cost estimates ("order of magnitude") for the project.

Refine our ACH's regional vision and models for community integrated medication management and enroll action teams through Better Health Together

Establish a performance-based network design

Select and recruit pharmacy sites to participate in network

Identify patients who would benefit from medication profile optimization

Train community pharmacist and partners on network services and referral management

Develop and implement project region wide with a statewide roll out plan in future years

Manage rapid cycle development and practice improvement among network partners.

***Best cost estimates*:**
- Management design, training, implementation, data analysis and evaluation – $400,000
- Initial rural network site participation for costs not currently billable - $100,000
- Urban network site participation for costs not currently billable - $250,000
- Total annual cost estimates for ACH region - $750,000

How long it will take to fully implement the project within a region where you expect it will have to be phased in? 18-24 months

The financial return on investment (ROI) opportunity, including estimated amounts and associated ROI timeline.
An estimated annual savings per patient engaged in medication therapy management averages $350.
With a goal of 4,000 lives reached = $1,400,000 in savings.

Start-up: January through June 2016 (initial project funding provided by EHF; cost estimates are to take program to scale region wide)
Implementation: July 2016 through December 2017
Savings should be noticed within the first 12 months of operation (beginning in July 2016)

The state will monitor implementation of transformation projects at a regional and statewide level with process and outcome measures. Each project will require clearly defined outcomes that relate to the goals and specific process steps.

Key process and outcome measures assumed applicable to this project based on the Washington State Common Set of Measures and the Medicaid Measure Set.[iv]

- Diabetes: Focusing on bringing population that is above 7% A1C to that level or below.
- COPD: Reduction in hospital admissions for COPD patients involved in Medication Management. Evidence suggests these hospital admissions could be avoided through high quality outpatient care, or the condition would be less severe if treated early and appropriately. Proper outpatient treatment and adherence to care may reduce the rate of occurrence for this event, and thus of hospital admissions.
- Well child visits + immunizations (community pharmacists): Community pharmacists, under Washington State law[5], may prescribe legend drugs and vaccines in accordance with a collaborative drug therapy protocol.
- Medication – adherence, education & safety, management, and generic prescribing: Through this program, the Medication Management team will develop and implement interventions that will improve adherence, education & safety, management and generic prescribing.

If no specific benchmark performance data are currently available, what efforts will be undertaken to establish benchmark performance ahead of any proposed project implementation?

Data elements that will be needed for project measurement and how any gaps in data can be addressed.
Data needed will include hospital, provider group, health plan and service agency data for individuals with chronic conditions not at goal (especially diabetes and COPD); notification of transitions in care settings (including jail, hospital, SNF, foster care).

[i] The Washington's State Institute for Public Policy, http://www.wsipp.gov, has identified "evidence-based" policies that can lead to better outcomes.

[ii] Medicaid objectives as stated in GAO report 15-239, April 2015, http://www.gao.gov/products/GAO-15-239:

- Increase and strengthen coverage of low income individuals.
- Increase access to, stabilize, and strengthen provider networks available to serve Medicaid and low-income populations.
- Improve health outcomes for Medicaid and low-income populations.
- Increase the efficiency and quality of care for Medicaid and other low-income populations through initiatives to transform service delivery networks.
- Criteria established for specific demonstrations described through an informational bulletin or State Medicaid Director's Letter – available at: http://www.medicaid.gov/federal-policy-guidance/federal-policy-guidance.html.

[iii] Transformation goals as stated in Washington's Medicaid Transformation waiver, http://www.hca.wa.gov/hw/Documents/waiverappl.pdf:

- Reduce avoidable use of intensive services and settings such as acute care hospitals, nursing facilities, psychiatric hospitals, traditional LTSS and jails.
- Improve population health, with a focus on prevention and management of diabetes, cardiovascular disease, pediatric obesity, smoking, mental illness, substance use disorders and oral health; that is coordinated and whole-person centered.
- Accelerate the transition to value-based payment, while ensuring that access to specialty and community services outside the Indian Health system are maintained for Washington's tribal members.
- Ensure that Medicaid per-capita cost growth is two percentage points below national trends.

[5] RCW 18.64.011(11) WAC 246-863-100 RCW 69.41.030

[iv] An overview of the development of measures that reflect state priorities is included in the Waiver application http://www.hca.wa.gov/hw/Documents/waiverappl.pdf pages 46-47. This references the Statewide common measure set: http://www.hca.wa.gov/hw/Documents/pmcc_final_core_measure_set_approved_121714.pdf and includes the 2016 Medicaid contract common performance metrics.