Value-Based Care: What Providers Wish Pharmacists Knew

Adam Chesler, PharmD, MBA

Financial Disclosure

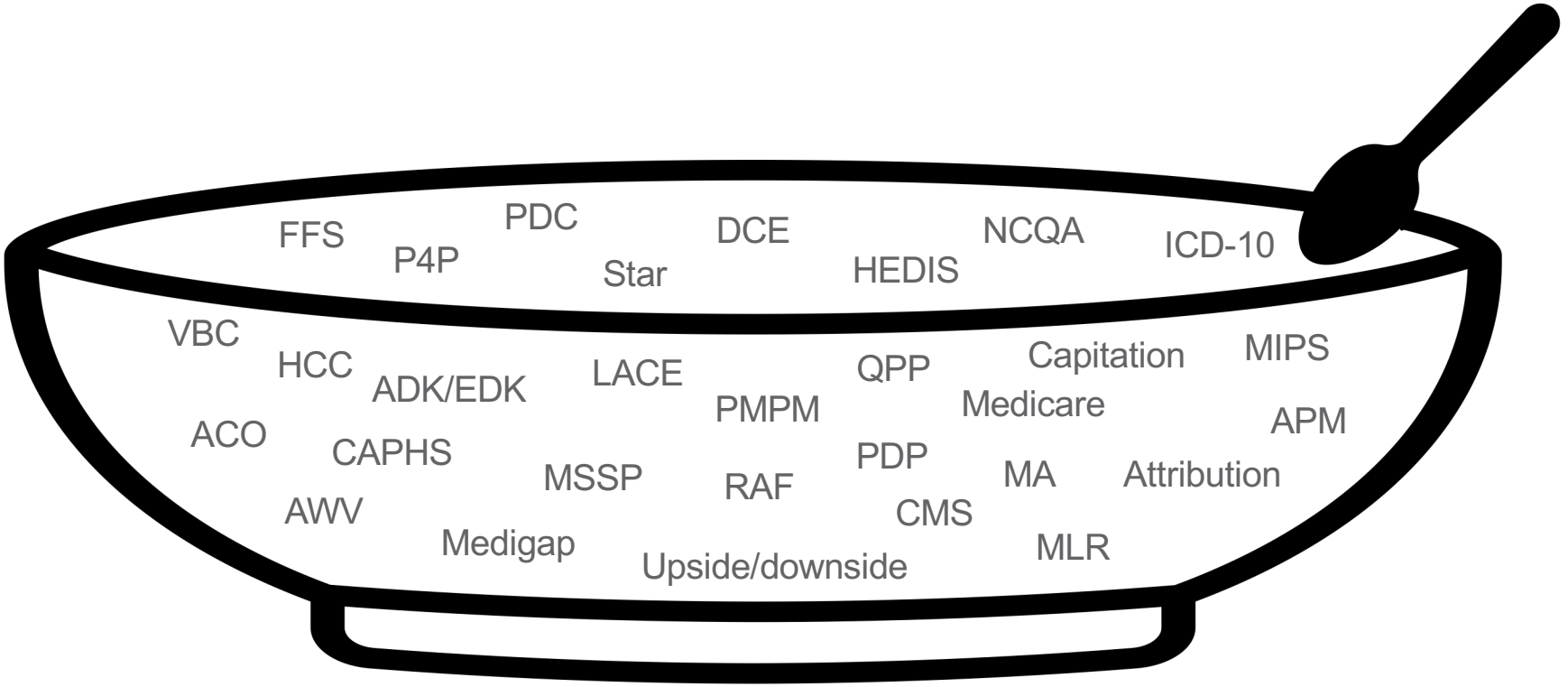
Adam Chesler declares that he has a current affiliation or financial arrangement with an ineligible company as an employee of VillageMD.

All relevant financial relationships have been mitigated.

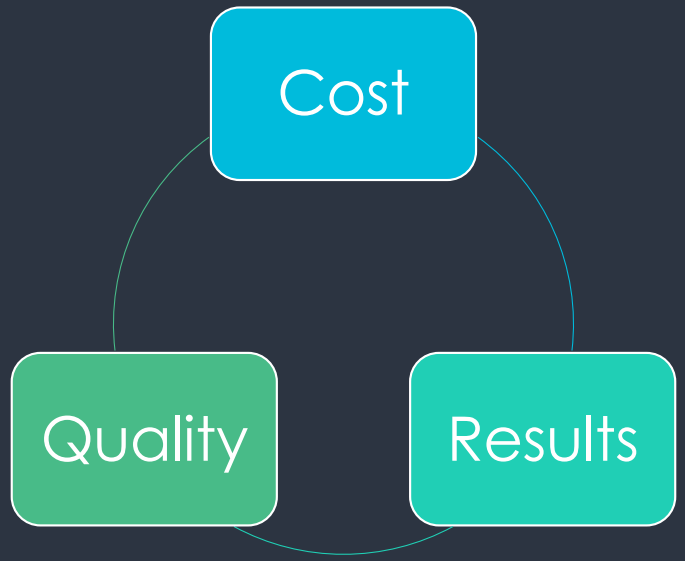
Objectives

Define	Define key terms and acronyms for understanding value-based care
Explain	Explain how value-based care (VBC) plays into each aspect of the patient journey
Recognize	Recognize the star measures related to pharmacy practice
Identify	Identify how pharmacists and technicians can impact value-based care
Apply	Explain how to apply learnings to pharmacy practice

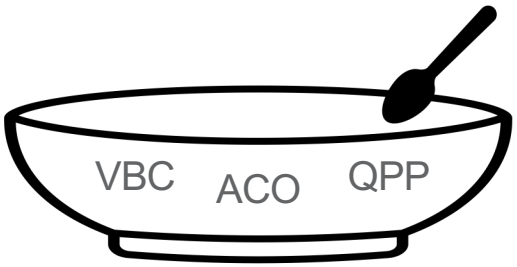
The Alphabet Soup of Value-Based Care



Value-Based Care History and Terminology



Value-Based Care (VBC) Explained



VBC programs

- Episode based payment
- Accountable care organizations (ACO)
- Reduce hospital acquired conditions
- Value-based purchasing

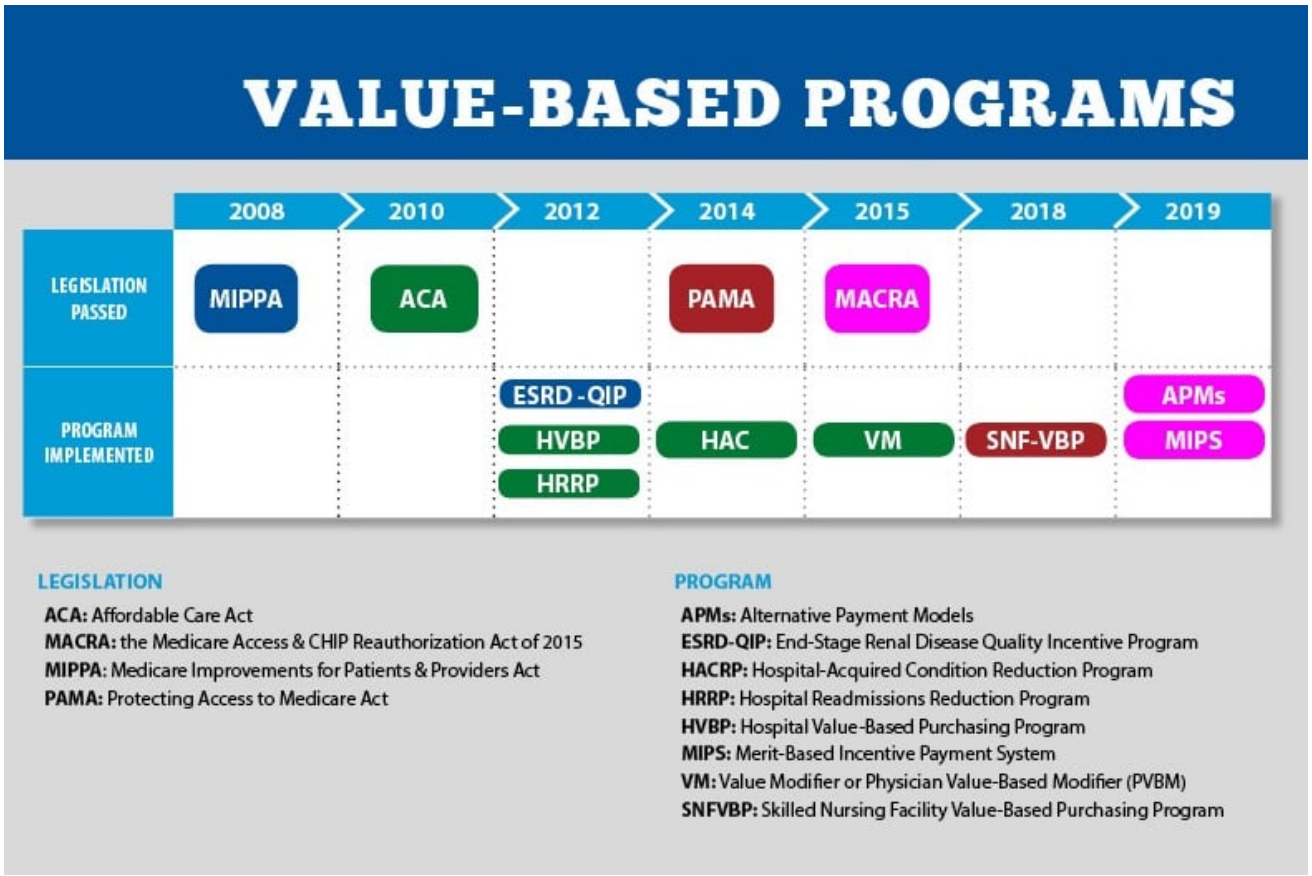
Accountable care organization (ACO) models

- Eligibility guidelines
- Provides structure and tools to ACO

Quality payment models

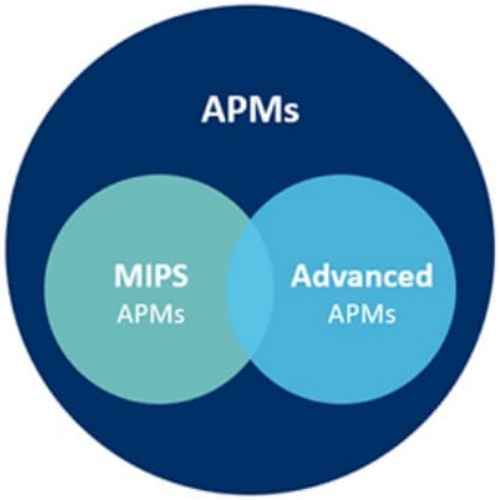
- Pay for performance guidelines

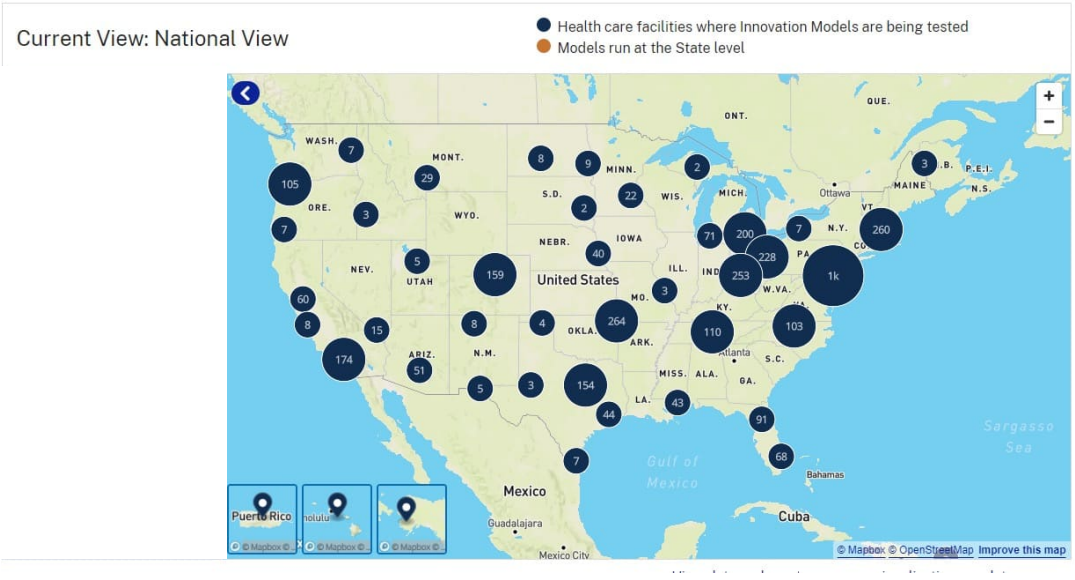
Value-Based Care and Legislation



Centers for Medicare and Medicaid (CMS) Innovation Models

- Develops and tests new healthcare payment and service delivery models
- Alternative payment models (APMs) to reward quality of care provided
  - Merit-based incentive payment system (MIPS) and Advanced APMs





Health Care Providers and Value-Based Reimbursement: Best Practices for Success. [Internet]. Health Management Associates. Available from: https://www.healthmanagement.com/wp-content/uploads/Health-Care-Providers-and-Value-Based-Reimbursement.pdf [Accessed March 10, 2024].

Forming an Accountable Care Organization

ACO professionals: Physician, physician assistant, nurse practitioner, clinical nurse specialist

Networks for individual practices of ACO professionals

Partnerships or joint ventures agreements between hospitals and ACO professionals

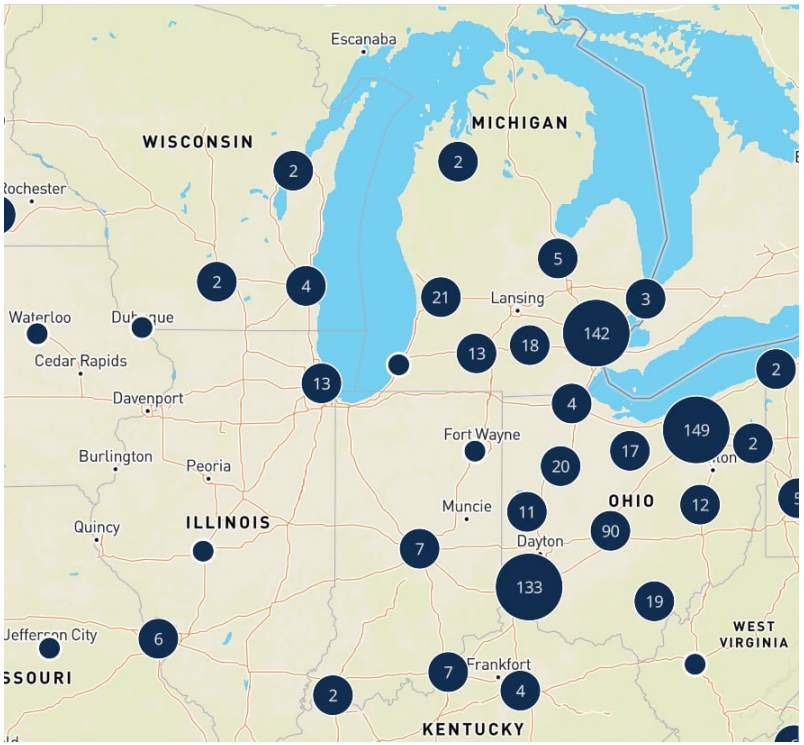
Hospitals employing ACO professionals

Qualifying critical access hospitals

Federally qualified health centers

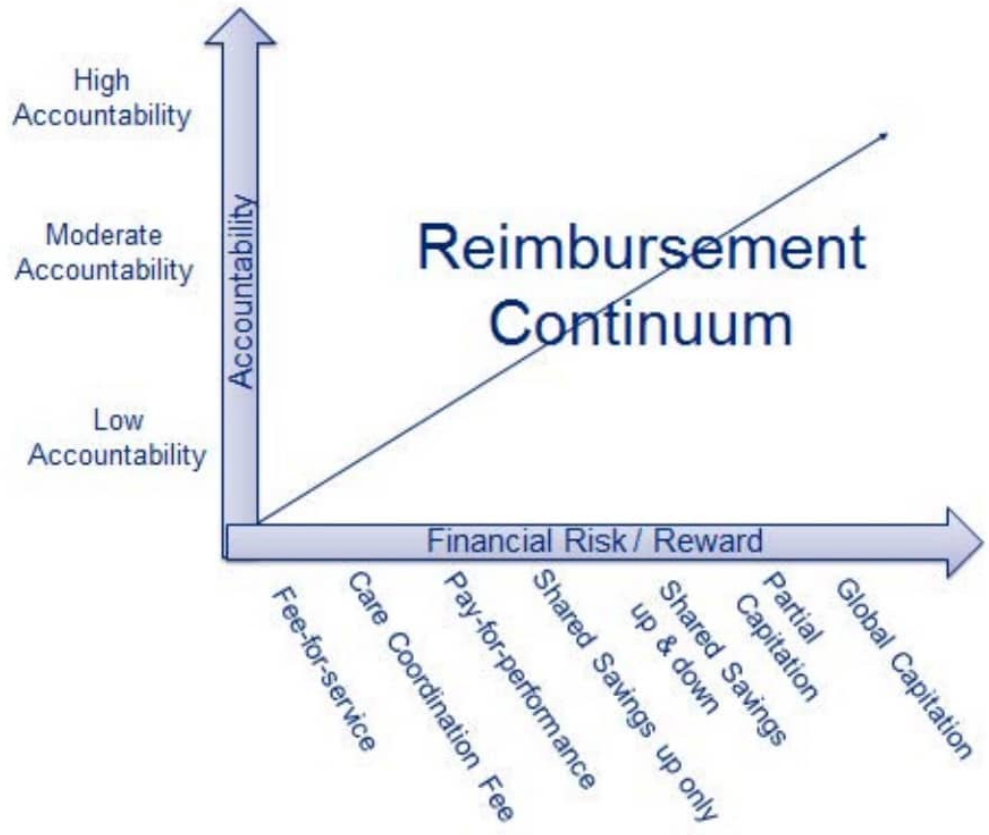
Rural health clinics

Qualifying teaching hospitals



Payment Models Overview

Figure 1: Reimbursement Continuum



Fee-for-service (FFS)

- Traditional payment model with billing codes sent from a facility to an insurance company

Direct contracting entity (DCE)

- P4P = pay for performance
- Shared savings
- Capitation models

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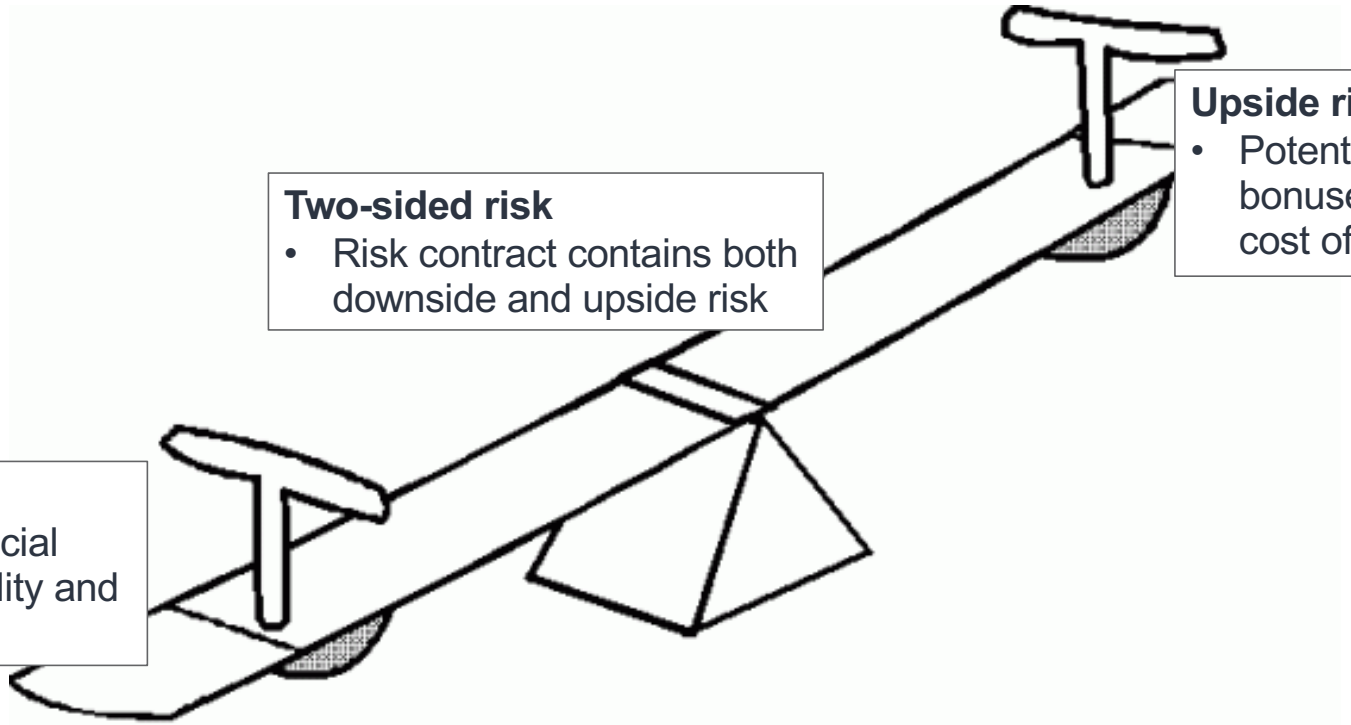
Shared Risk Contract Arrangements



Upside risk
- Potential for financial bonuses for quality and cost of care

Two-sided risk
- Risk contract contains both downside and upside risk

Downside risk
- Potential financial losses for quality and cost of care

Capitation Model

- **Per member per month (PMPM) and per member per year (PMPY)**
- The cost of healthcare spend per person averaged per month or per year
- PMPM costs are calculated based on multiple factors including patient enrollment, local costs, average utilization of services, and patient diagnoses
- Often, a portion of the payment is held, and organization must meet quality standards to receive the rest of the payment

Member risk	Capitation PMPM	Patient population	Patient average spend	Payment to organization	Net benefit
≤1.0	$50	100 patients	$55	$5,000	-$500
>1.0	$100	100 patients	$98	$10,000	+$200

Medical Loss Ratio

- **MLR** calculates portion of dollars spent on administrative, marketing, and non-direct patient care costs compared to portion spent on direct patient care
- In shared savings, the goal is the have the actual MLR come in less than the target MLR

Table 2: Example of Medicare Earnings or Deficits driven by an Upside/Downside or Partial Risk Arrangement, *Membership = 3,000; PMPM Premium = $900; shared savings split = 50%*

Target MLR		82%	83%	84%	85%
Actual MLR	80%	$324,000	$486,000	$648,000	$810,000
	81%	$162,000	$324,000	$486,000	$648,000
	82%	$0	$162,000	$324,000	$486,000
	83%	-$162,000	$0	$162,000	$324,000
	84%	-$324,000	-$162,000	$0	$162,000
	85%	-$486,000	-$324,000	-$162,000	$0
	86%	-$648,000	-$486,000	-$324,000	-$162,000
	87%	-$810,000	-$648,000	-$486,000	-$324,000
	88%	-$972,000	-$810,000	-$648,000	-$486,000
	89%	-$1,134,000	-$972,000	-$810,000	-$648,000
	90%	-$1,296,000	-$1,134,000	-$972,000	-$810,000
	91%	-$1,458,000	-$1,296,000	-$1,134,000	-$972,000

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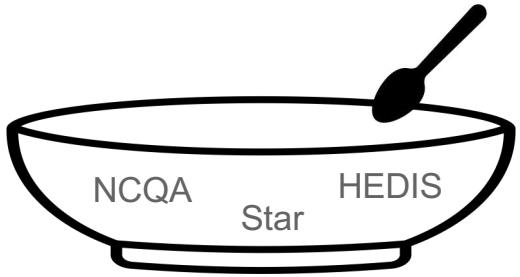
Value-Based Care Terminology and Acronyms

National committee for quality assurance (NCQA)
- The organization that sets HEDIS measure standards
- Also, they do health plan and patient-centered medical home accreditation

Healthcare effectiveness data and information set (HEDIS)
- Quality performance tool used in all healthcare spaces

Star ratings
- A rating given to MA and PDP plans to grade the quality of health and drug services received by members



HEDIS Measures

Includes over 90 measures across 6 categories

Effectiveness of care***
- Breast cancer screening
- Controlling high blood pressure

Access of care
- Prenatal and postnatal care

Experience of care
- CAHPS survey

Utilization
- Readmissions

Health plan descriptive information
- Enrollment

Measures reported using electronic clinical data systems
- Depression screenings and follow-up

Quality of Care Measurement

Organizations are measured on all the factors we discussed, and more
All measured organizations aim for a five-star rating

Star Measures

Medicare Advantage with prescription drug plans (MA-PD)

- Rated on up to 38 quality and performance measures

Medicare Advantage only plans (MA)

- Rated on up to 28 measures

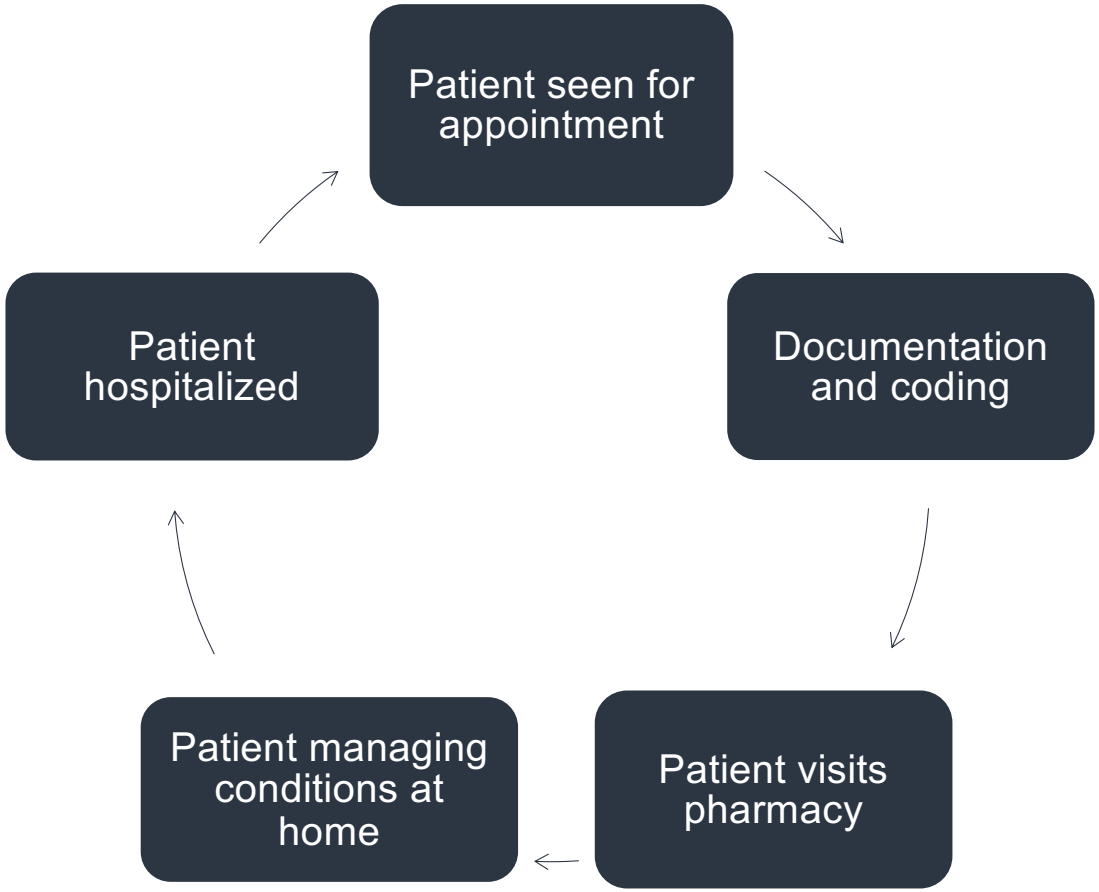
Stand-alone Part D plans (PDP)

- Rated on up to 12 measures

Measure Examples
Statin therapy for patients with diabetes
Care for older adults- medication reviews
Diabetes- blood sugar controlled
Medication adherence
Getting needed prescription drugs
Medication reconciliation post-discharge
Customer service

The Patient Journey

The Cyclical Patient Journey

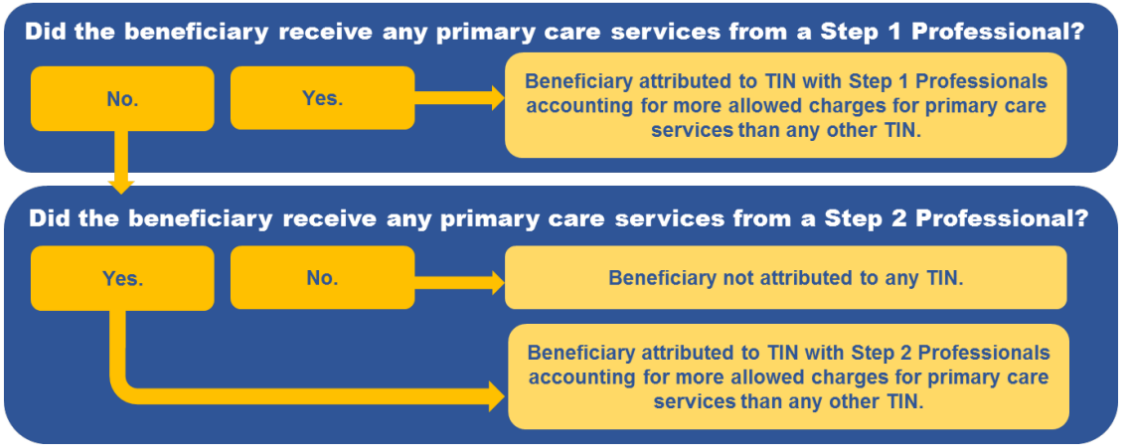


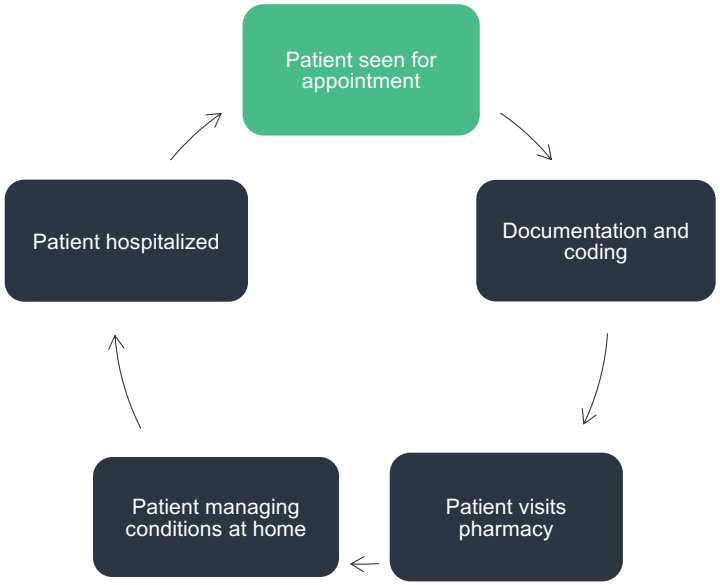
Patient Registration

Attribution is a foundation component of value-based care models

- Formal assigning of responsibility of a patient to a provider
- Patient is assigned to a taxpayer identification number (TIN)
- Patients can self-attribute by filling out a voluntary attribution form

Figure 1. Two-step attribution methodology





Attribution in the Medicare Physician Value-Based Payment Modifier Program: Factsheet. [Internet]. Centers for Medicare & Medicaid Services. Available from: https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2016-03-25-Attribution-Fact-Sheet.pdf [Accessed November 1, 2023].

Documentation and Coding

Documentation must support coding

- Timely
- Accurate
- Specific

International classification of disease (ICD-10)

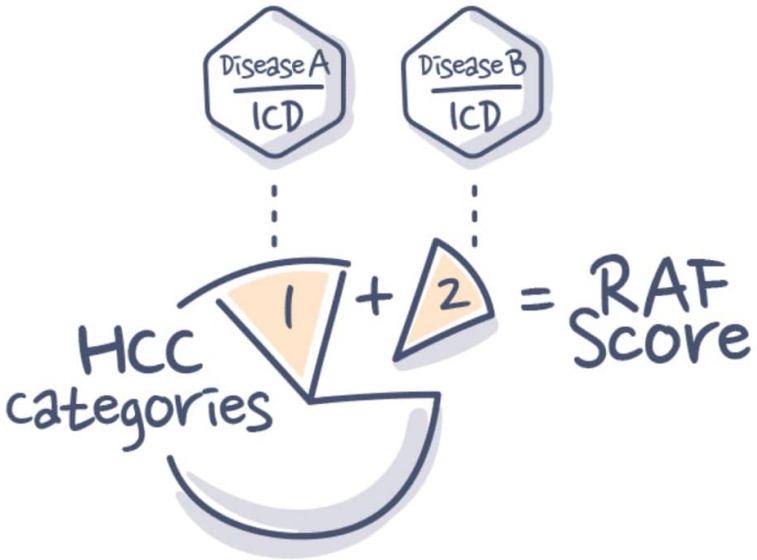
- Codes are used to classify and code both diagnoses and complications

Hierarchical condition category (HCC)

- Groups related medical diagnoses based on resource use and cost

Risk adjustment factor (RAF)

- Numerical value assigned to a patient to help with determination of financial reimbursement for that patient



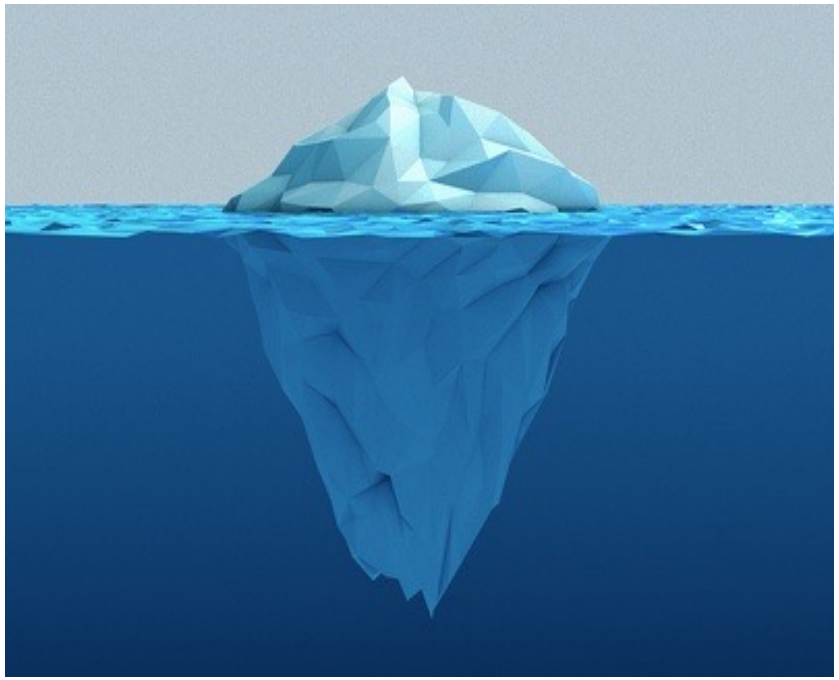
ForeSeeMed. Medicare Risk Adjustment. Available from: https://www.foreseemed.com/medicare-risk-adjustment#:~:text=A%20Medicare%20Advantage%20beneficiary's%20RAF,like%20a%20skilled%20nursing%20facility. Accessed March 27, 2024.

Coding Examples

ICD-10	Description	RAF
	Patient demographics	0.323
E11.9	Type 2 diabetes mellitus without complications	0.105
I10	Essential primary hypertension	0.00
N18.9	Chronic kidney disease	0.00
Z68.38	BMI 38.0-38.9, adult	0.00
Total RAF = 0.428 **Expenditure denominator = $1,000** **Expected annual expenditure = $428**		

ICD-10	Description	RAF
	Patient demographics	0.323
E11.9	Type 2 diabetes mellitus with polyneuropathy	0.302
I10	Essential primary hypertension	0.00
I12.9 & N18.4	Hypertensive chronic kidney disease with stage III CKD	0.224
Z68.38	BMI 38.0-38.9, adult	0.00
Total RAF = 0.849 **Expenditure denominator = $1,000** **Expected annual expenditure = $849**		

Additional Primary Care Provider Activities

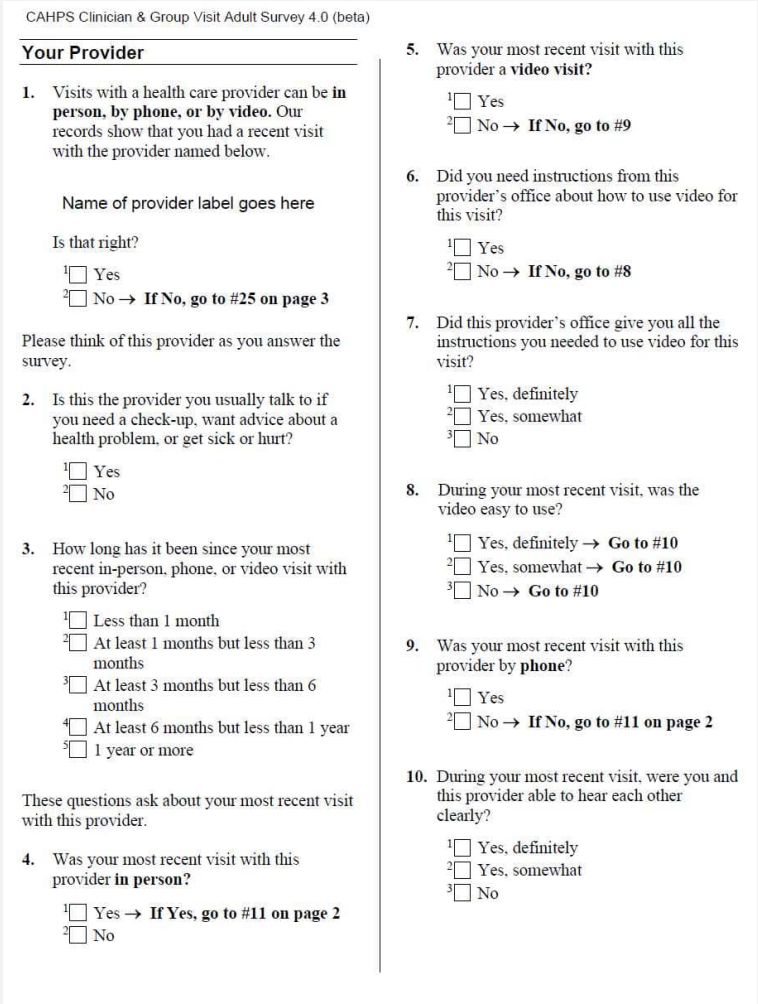


Seeing the patient in office is the tip of the iceberg for daily activities

- Authorizing refills
- Reviewing and acting on lab and imaging results
- Reviewing hospital and outside records
- Answering patient questions
- Answering inbox messages
- Completing prior authorizations for medications and referrals
- Completing peer-to-peer calls with insurance companies for overrides
- Discussing patients with specialists or ER providers/hospitalists
- Attending practice meetings, leadership meetings, conferences

CAHPS Clinical and Group Survey

- Consumer Assessment of Healthcare Providers and Systems (CAHPS)
- Survey given directly to patients to report on their **experiences**
- Questions fall under four categories:
  1. Accessibility
  2. Communication
  3. Care coordination
  4. Interactions
- Scores are reported publicly



CAHPS Clinician & Group Visit Adult Survey 4.0 (beta)

Your Provider

1. Visits with a health care provider can be **in person, by phone, or by video.** Our records show that you had a recent visit with the provider named below.

Name of provider label goes here

Is that right?

[1] ☐ Yes
[2] ☐ No → **If No, go to #25 on page 3**

Please think of this provider as you answer the survey.

2. Is this the provider you usually talk to if you need a check-up, want advice about a health problem, or get sick or hurt?

[1] ☐ Yes
[2] ☐ No

3. How long has it been since your most recent in-person, phone, or video visit with this provider?

[1] ☐ Less than 1 month
[2] ☐ At least 1 months but less than 3 months
[3] ☐ At least 3 months but less than 6 months
[4] ☐ At least 6 months but less than 1 year
[5] ☐ 1 year or more

These questions ask about your most recent visit with this provider.

4. Was your most recent visit with this provider **in person?**

[1] ☐ Yes → **If Yes, go to #11 on page 2**
[2] ☐ No

5. Was your most recent visit with this provider a **video visit?**

[1] ☐ Yes
[2] ☐ No → **If No, go to #9**

6. Did you need instructions from this provider's office about how to use video for this visit?

[1] ☐ Yes
[2] ☐ No → **If No, go to #8**

7. Did this provider's office give you all the instructions you needed to use video for this visit?

[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

8. During your most recent visit, was the video easy to use?

[1] ☐ Yes, definitely → **Go to #10**
[2] ☐ Yes, somewhat → **Go to #10**
[3] ☐ No → **Go to #10**

9. Was your most recent visit with this provider by **phone**?

[1] ☐ Yes
[2] ☐ No → **If No, go to #11 on page 2**

10. During your most recent visit, were you and this provider able to hear each other clearly?

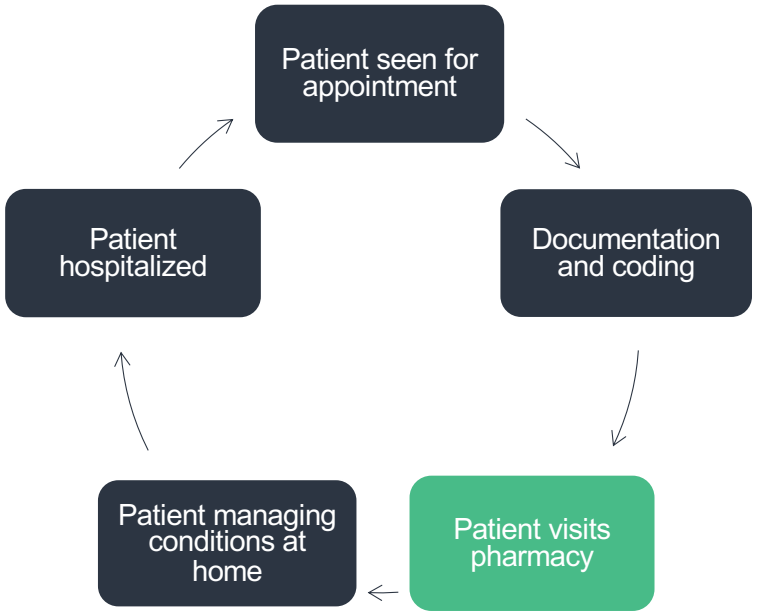
[1] ☐ Yes, definitely
[2] ☐ Yes, somewhat
[3] ☐ No

Agency for Healthcare Research and Quality (AHRQ). CAHPS Surveys & Guidance. Available from: https://www.ahrq.gov/cahps/surveys-guidance/index.html. Accessed March 27, 2024.

Patient Visits Pharmacy

Tools implemented into electronic medical records to help PCPs with prescriptions:

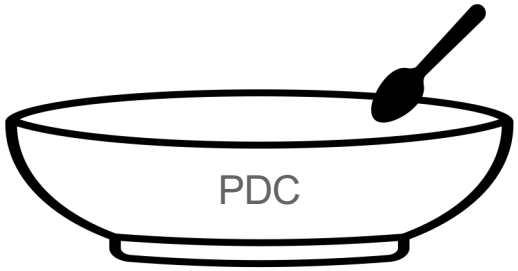
- Insurance formulary look up
- Prior authorization notifications
- Copay cost estimations
- Fill histories
- Delegation authority to team members



Adherence Star Measures

Proportion of days covered (PDC)

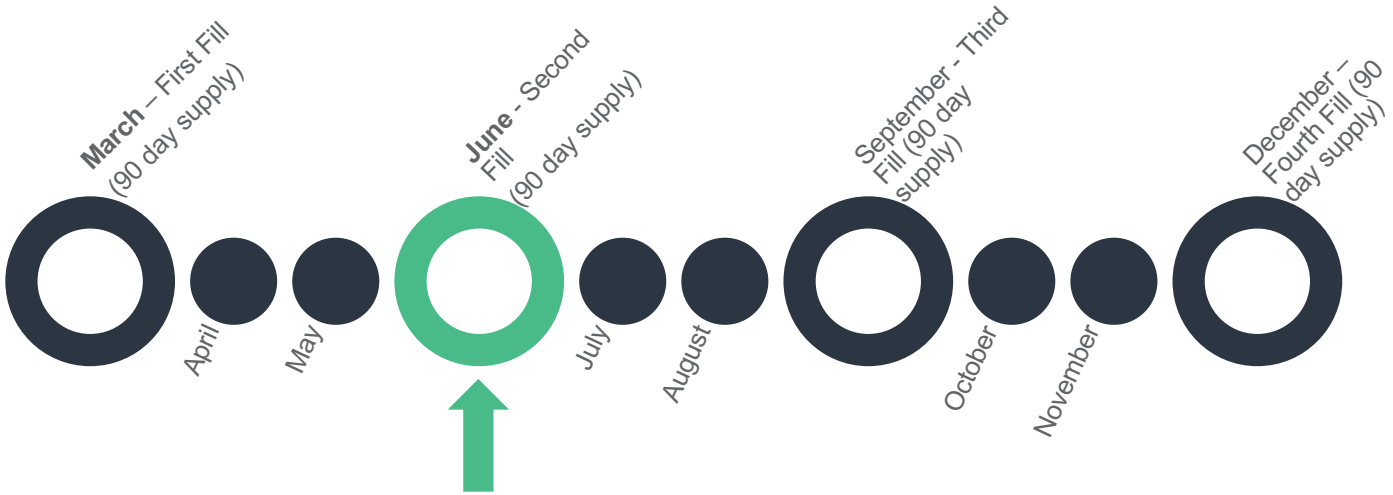
- A method to measure medication adherence by Medicare
- A triple weighted measure for star rating
- Measured by prescription fill claims data
- **Goal: PDC 80%**



Medication Adherence for **Cholesterol**	Medication Adherence for **Diabetes**	Medication Adherence for **Hypertension**
• Statins	• Non-insulin antidiabetic medications	• RAS Antagonists

Adherence – Qualifying for the Measure

$$PDC = \left(\frac{\text{Days covered in observation period}}{\text{Number of days in observation period}} \right) X\ 100$$



Second Fill = Patient Qualifies for Adherence Measure

Denominator Days – March – December (330 days)

Adherence Star Measures Weighting

- Star measures can be single-weighted or triple-weighted
- Each measure impacts the overall star score for an organization

Medicare Advantage Measures	Payer Contract Weight	% Impact to Payer Contract Aggregated STAR Score	2 STAR	3 STAR	4 STAR	5 STAR	(5-5-5 STAR) Payer Contract EOY Rate	(4-4-4 STAR) Payer Contract EOY Rate	(4-4-3 STAR) Payer Contract EOY Rate	(4-3-3 STAR) Payer Contract EOY Rate	(3-3-3 STAR) Payer Contract EOY Rate
Screening											
Breast Cancer Screening	1	4%	58%	68%	74%	81%	5	5	5	5	5
Colorectal Cancer Screening	1	4%	56%	67%	75%	82%	5	5	5	5	5
Care for Older Adults – Medication Review			77%	88%	95%	98%	5	5	5	5	5
Care for Older Adults – Pain Assessment			78%	88%	93%	96%	5	5	5	5	5
Osteoporosis Mgmt in Women who had a Fracture	1	4%	33%	46%	61%	75%	3	3	3	3	3
Chronic Condition Management											
Diabetes Care – Eye Exam	1	4%	54%	67%	75%	83%	5	5	5	5	5
Diabetes Care – Blood Sugar Controlled	3	11%	64%	76%	84%	90%	5	5	5	5	5
Kidney Health Evaluation for Patients with Diabetes (Part C)	1	4%	44%	51%	58%	77%	5	5	5	5	5
Controlling High Blood Pressure	3	11%	62%	70%	76%	84%	5	5	5	5	5
Medication Adherence for Diabetes Medications	3	11%	82%	86%	90%	93%	5	4	4	4	3
Medication Adherence for Hypertension (RAS)	3	11%	84%	88%	91%	93%	5	4	4	3	3
Medication Adherence for Cholesterol (Statins)	3	11%	84%	88%	90%	93%	5	4	3	3	3
Statin Use in Persons with Diabetes (SUPD)	1	4%	87%	90%	92%	96%	5	5	5	5	5
Statin Therapy for Patients with CV Disease	1	4%	83%	86%	88%	92%	5	5	5	5	5
Transitional Care											
Transitions of Care	1	4%	44%	56%	68%	82%	3	3	3	3	3
Medication Reconciliation Post-Discharge	1	4%	44%	58%	70%	84%	3	3	3	3	3
F/U after ED Visit for People w Mult High-Risk CC	1	4%	48%	57%	64%	72%	3	3	3	3	3
Plan All-Cause Readmissions	**3**	**11%**	13%	11%	8%	6%	3	3	3	3	3
CAHPS/Patient Experience											
Patient Experience (Payer Program Design)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maximum Aggregated STAR Score Potential							**4.32**	**4.18**	**4.07**	**3.96**	**3.86**

Adherence Star Measures Performance Standards

- Thresholds for 2-, 3-, 4-, and 5-star performance are set by Medicare

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Plan All-Cause Readmissions	**3**	**11%**	13%	11%	8%	6%	3	3	3	3	3
CAHPS/Patient Experience											
Patient Experience (Payer Program Design)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maximum Aggregated STAR Score Potential							**4.32**	**4.18**	**4.07**	**3.96**	**3.86**

Adherence Star Measures Impact on Aggregated Score

- The total aggregate score determines payment
- Medication adherence makes a major impact on total aggregated score

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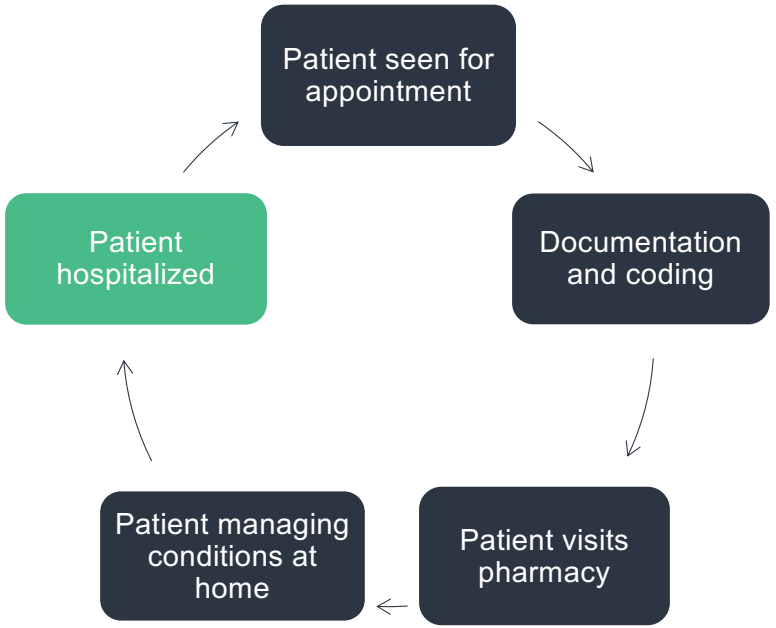
Breast Cancer Screening	1	4%	58%	68%	74%	81%	5	5	5	5	5
Colorectal Cancer Screening	1	4%	56%	67%	75%	82%	5	5	5	5	5
Care for Older Adults – Medication Review			77%	88%	95%	98%	5	5	5	5	5
Care for Older Adults – Pain Assessment			78%	88%	93%	96%	5	5	5	5	5
Osteoporosis Mgmt in Women who had a Fracture	1	4%	33%	46%	61%	75%	3	3	3	3	3
Chronic Condition Management											
Diabetes Care – Eye Exam	1	4%	54%	67%	75%	83%	5	5	5	5	5
Diabetes Care – Blood Sugar Controlled	3	11%	64%	76%	84%	90%	5	5	5	5	5
Kidney Health Evaluation for Patients with Diabetes (Part C)	1	4%	44%	51%	58%	77%	5	5	5	5	5
Controlling High Blood Pressure	3	11%	62%	70%	76%	84%	5	5	5	5	5
Medication Adherence for Diabetes Medications	3	11%	82%	86%	90%	93%	5	4	4	4	3
Medication Adherence for Hypertension (RAS)	3	11%	84%	88%	91%	93%	5	4	4	3	3
Medication Adherence for Cholesterol (Statins)	3	11%	84%	88%	90%	93%	5	4	3	3	3
Statin Use in Persons with Diabetes (SUPD)	1	4%	87%	90%	92%	96%	5	5	5	5	5
Statin Therapy for Patients with CV Disease	1	4%	83%	86%	88%	92%	5	5	5	5	5
Transitional Care											
Transitions of Care	1	4%	44%	56%	68%	82%	3	3	3	3	3
Medication Reconciliation Post-Discharge	1	4%	44%	58%	70%	84%	3	3	3	3	3
F/U after ED Visit for People w Mult High-Risk CC	1	4%	48%	57%	64%	72%	3	3	3	3	3
Plan All-Cause Readmissions	**3**	**11%**	13%	11%	8%	6%	3	3	3	3	3
CAHPS/Patient Experience											
Patient Experience (Payer Program Design)	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA	NA
Maximum Aggregated STAR Score Potential							**4.32**	**4.18**	**4.07**	**3.96**	**3.86**

Hospital and Emergency Room Utilization Measurements

Admissions per thousand (ADK)
Emergency room visits per thousand (EDK)

- A calculation that allows for direct comparison between organizations
- Allows for national comparison regardless of the size of the organization
- Number of visits x 1000/Number of people lives



Reducing Hospitalizations in a VBC Organization

A patient was being readmitted to the hospital every two weeks. The patient was deemed a high utilizer and flagged for a care management program.

A care manager started following the patient via telephone and in person after every discharge.

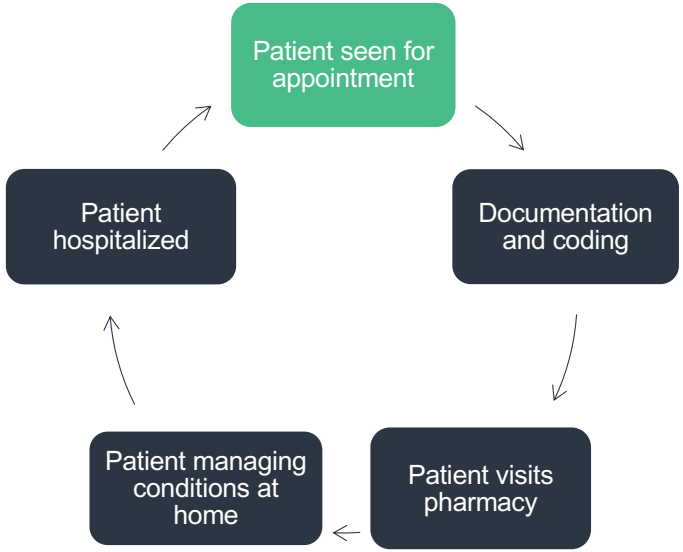
The care manager discovered the patient was going to the hospital because he did not have food to eat at home.

The organization arranged for delivery of groceries to the patient's home every two weeks. After this, patient stopped being admitted to the hospital.

Transitional Care Management

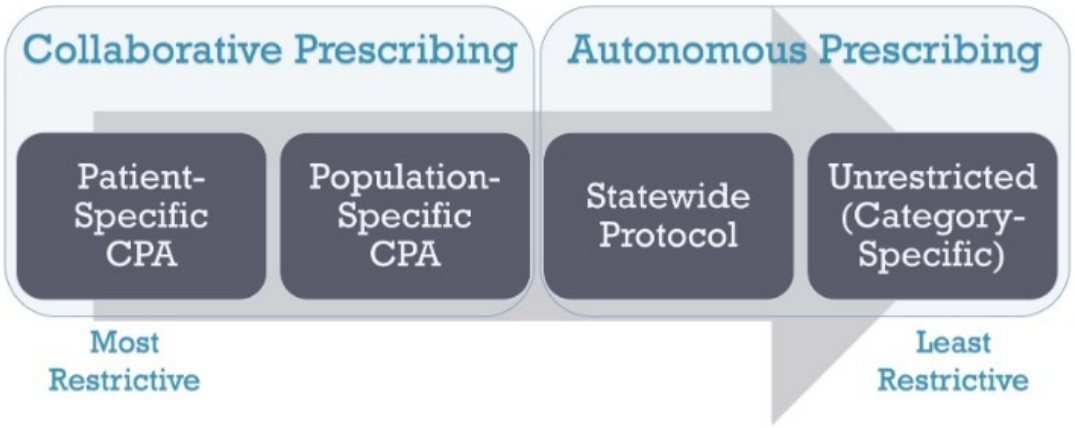
Transitional care management (TCM) key to preventing hospital readmissions. Both hospitals and primary care are held responsible for readmissions within 30 days of discharge.

Time since discharge	Details
Within 48 hours	Contact with the patient must occur. This can be telephone, electronic, or in-person
Within 7 days	TCM appointment with provider for a high complexity patient
Within 14 days	TCM appointment with provider for a moderate complexity patient
Within 30 days	The latest date a TCM appointment can be completed to qualify for TCM



Implementation and Pharmacist Impact

Pharmacist Scope of Practice

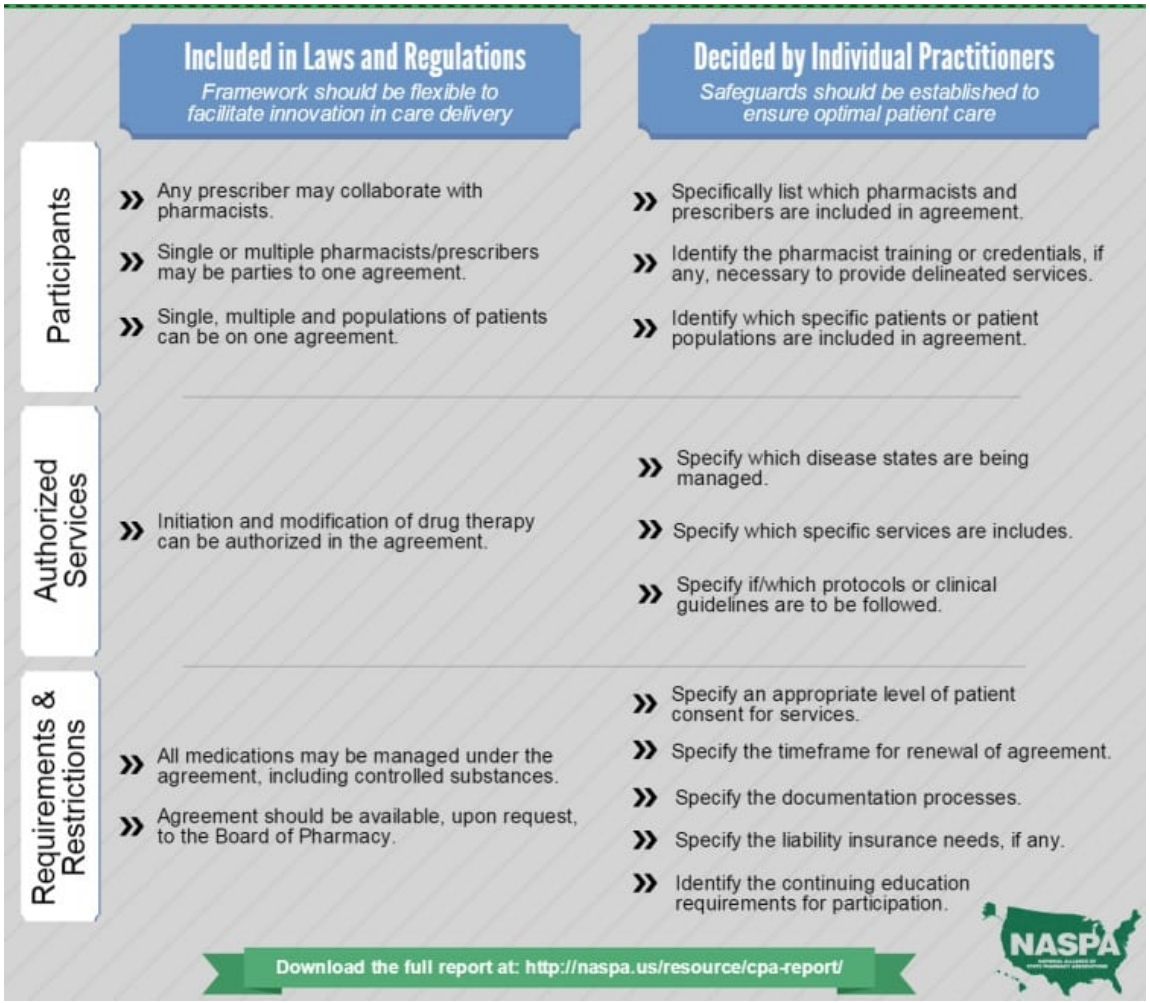


The following statewide protocols are available in various states:

1. Vaccines
2. Naloxone
3. Hormonal contraception
4. Statins
5. Epinephrine
6. Smoking cessation
7. HIV prophylaxis
8. Paxlovid
9. Therapeutic substitution

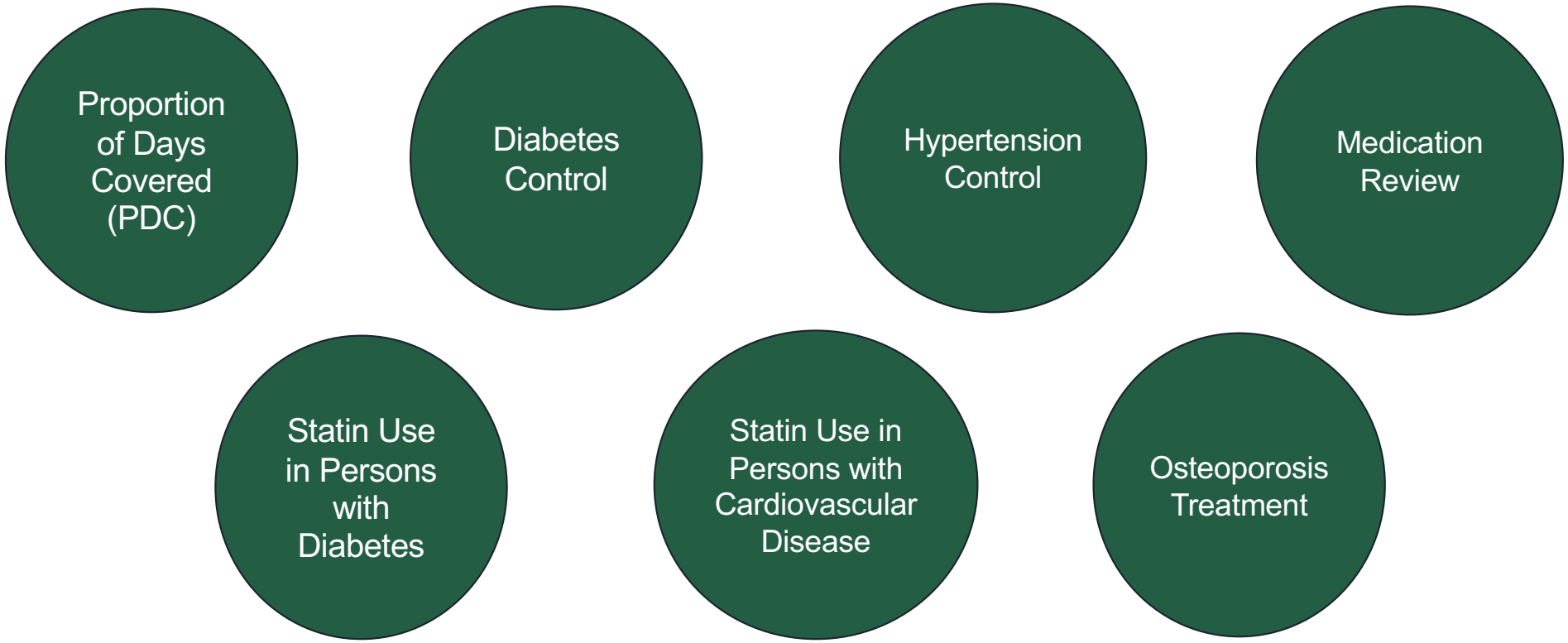
Adams AJ, Weaver KK. The Continuum of Pharmacist Prescriptive Authority. *Annals of Pharmacotherapy*. 2016;50(9):778-784.

National Alliance of State Pharmacy Associations Collaborative Practice Agreement Regulation Recommendations



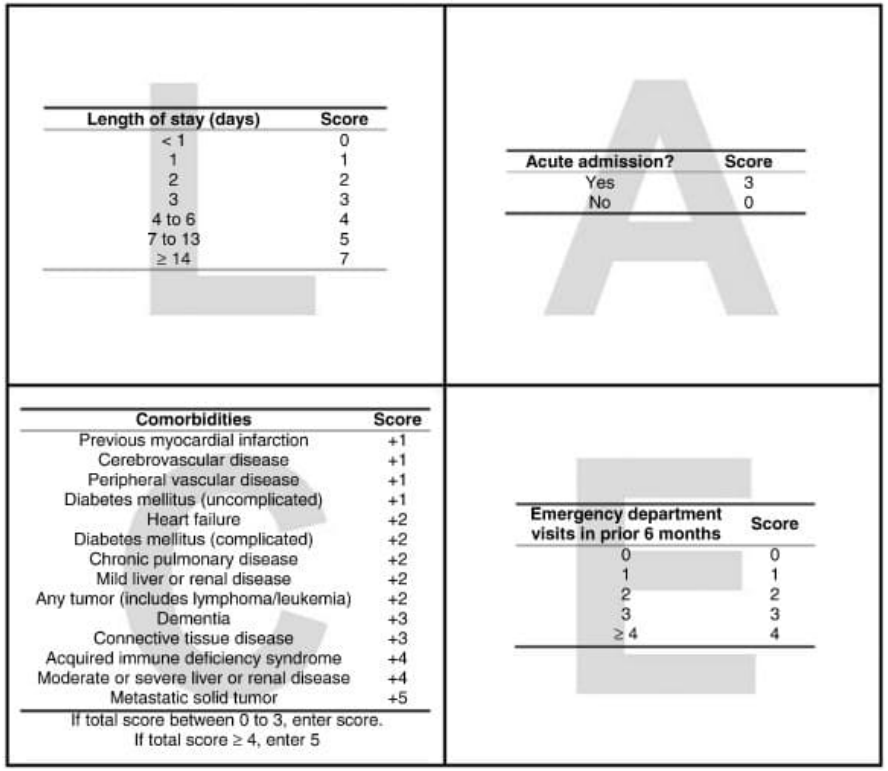
Start Your Implementation

Star Measures Related to Pharmacy and Pharmacy Services



Medication Review Star Measure Program Example

- Start a TCM medication reconciliation program
  - Focus on the highest risk populations
- Prioritize counseling on post-discharge medications
- Help to coordinate and reiterate importance of seeing PCP for TCM appointment



Length of stay (days)	Score
< 1	0
1	1
2	2
3	3
4 to 6	4
7 to 13	5
≥ 14	7

Acute admission?	Score
Yes	3
No	0

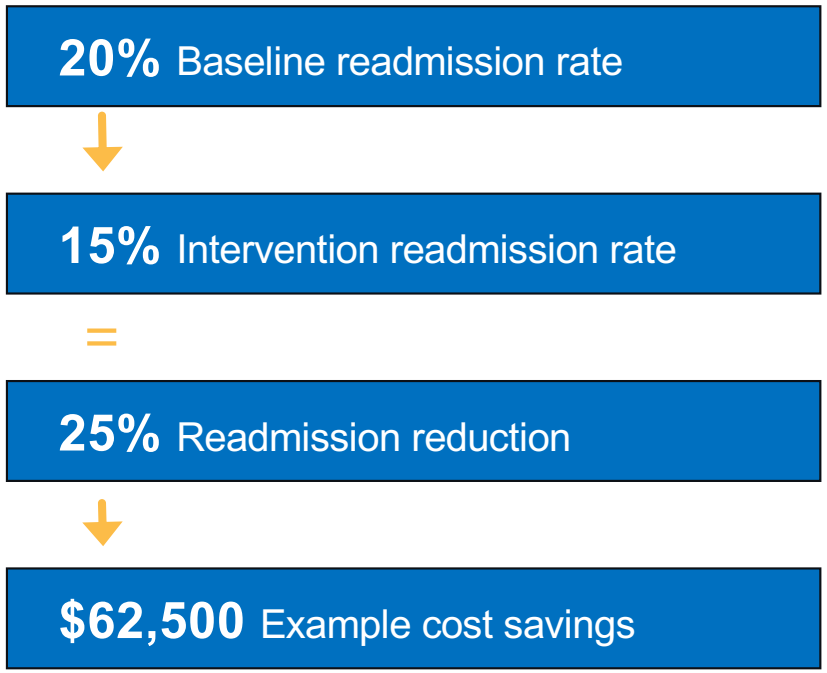
Comorbidities	Score
Previous myocardial infarction	+1
Cerebrovascular disease	+1
Peripheral vascular disease	+1
Diabetes mellitus (uncomplicated)	+1
Heart failure	+2
Diabetes mellitus (complicated)	+2
Chronic pulmonary disease	+2
Mild liver or renal disease	+2
Any tumor (includes lymphoma/leukemia)	+2
Dementia	+3
Connective tissue disease	+3
Acquired immune deficiency syndrome	+4
Moderate or severe liver or renal disease	+4
Metastatic solid tumor	+5
If total score between 0 to 3, enter score. If total score ≥ 4, enter 5	

Emergency department visits in prior 6 months	Score
0	0
1	1
2	2
3	3
≥ 4	4

Yazdan-Ashoori P, Lee SF, Ibrahim Q, Van Spall HGC. Utility of the LACE index at the bedside in predicting 30-day readmission or death in patients hospitalized with heart failure. *American Heart Journal*. 2016;179:51-58. https://www.sciencedirect.com/science/article/abs/pii/S0002870316300941?via%3Dihub. Accessed November 2023.

Example of Health Cost Reduction of TCM Program

100 high-risk patients



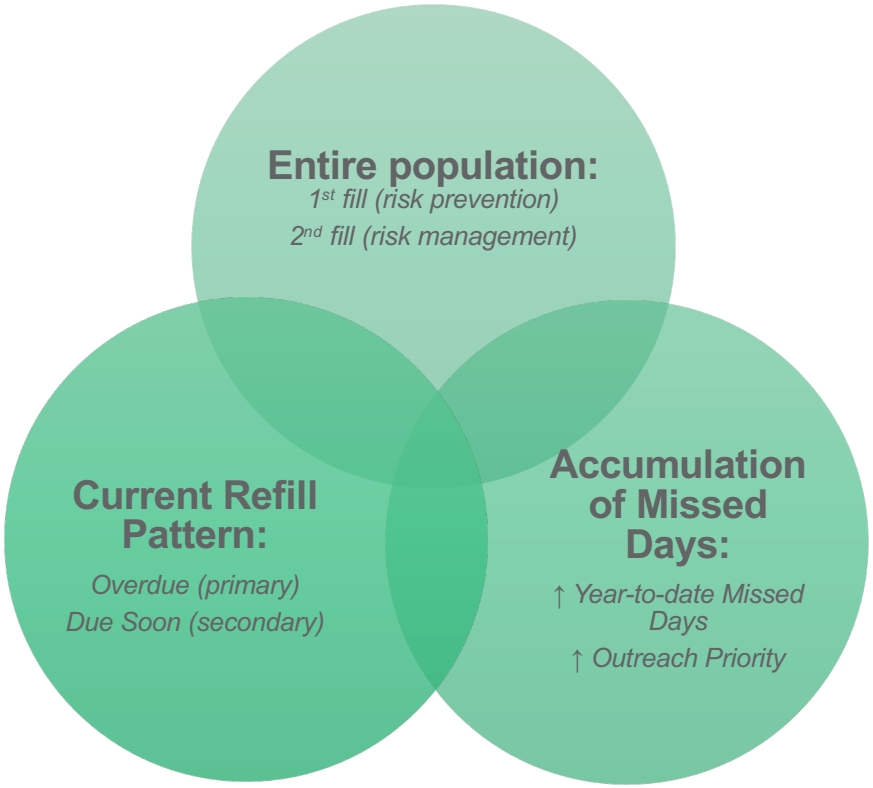
Without intervention: **20 readmissions**

With intervention: **15 readmissions**

Readmissions avoided: **5**

Approximately **$12,500 per readmission**

Adherence Star Measure Program Example



Create a central workflow:

- ✓ Regular feed of medication fill data
- ✓ Risk prioritization and monitoring
- ✓ Coordinated patient outreach
- ✓ Escalation and resolution of barriers
- ✓ PCP feedback through EMR

Additional Ways to Help With PDC

1

Ask for new prescriptions when directions have changed

2

Encourage 90-day and 100-day supplies

3

If samples are needed, encourage them to be given at the beginning of the calendar year

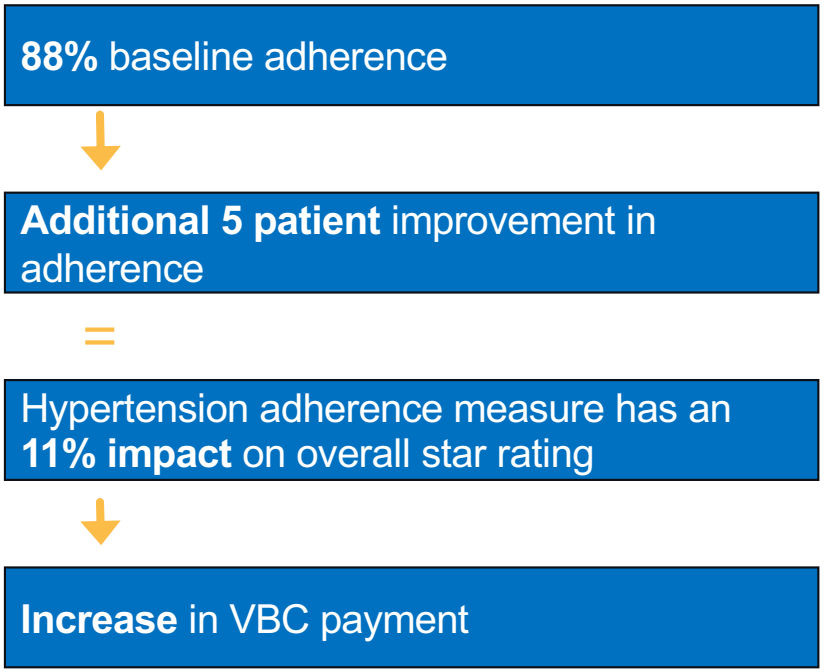
4

Discuss tools that aid in adherence

- Medication fill synchronization
- Auto refills
- Delivery services
- Educate on insurance plan benefits

Example of the Impact of an Adherence Program

100 patients in hypertension adherence measure



88% associated with a 3-star rating

93% associated with a 5-star rating

+0.21 improvement in overall star rating

Shared savings based on contracts

Star Measures and Chronic Disease Management

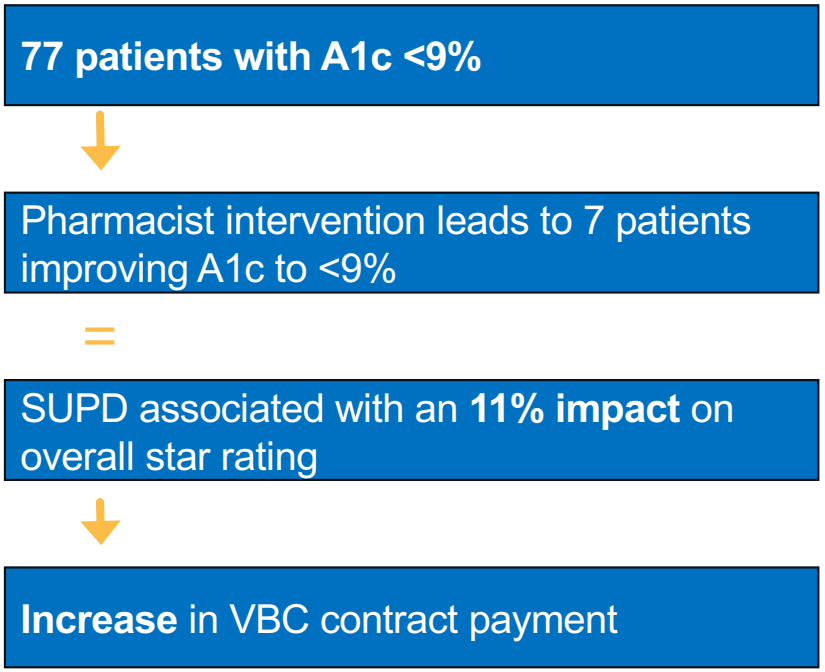
Triple-weighted measures

Pharmacists improve chronic disease state control, especially under collaborative practice agreement

- Learn your state laws pertaining to collaborative practice agreement (CPA)
  - Management of chronic disease states
- Use analytics tools identify patient populations
  - Reporting tools through electronic medical record systems
- Develop protocols
- Stay up to date with guideline driven medical treatment

Example of the Impact of a Diabetes Control Program

100 patients with type 2 diabetes diagnosis



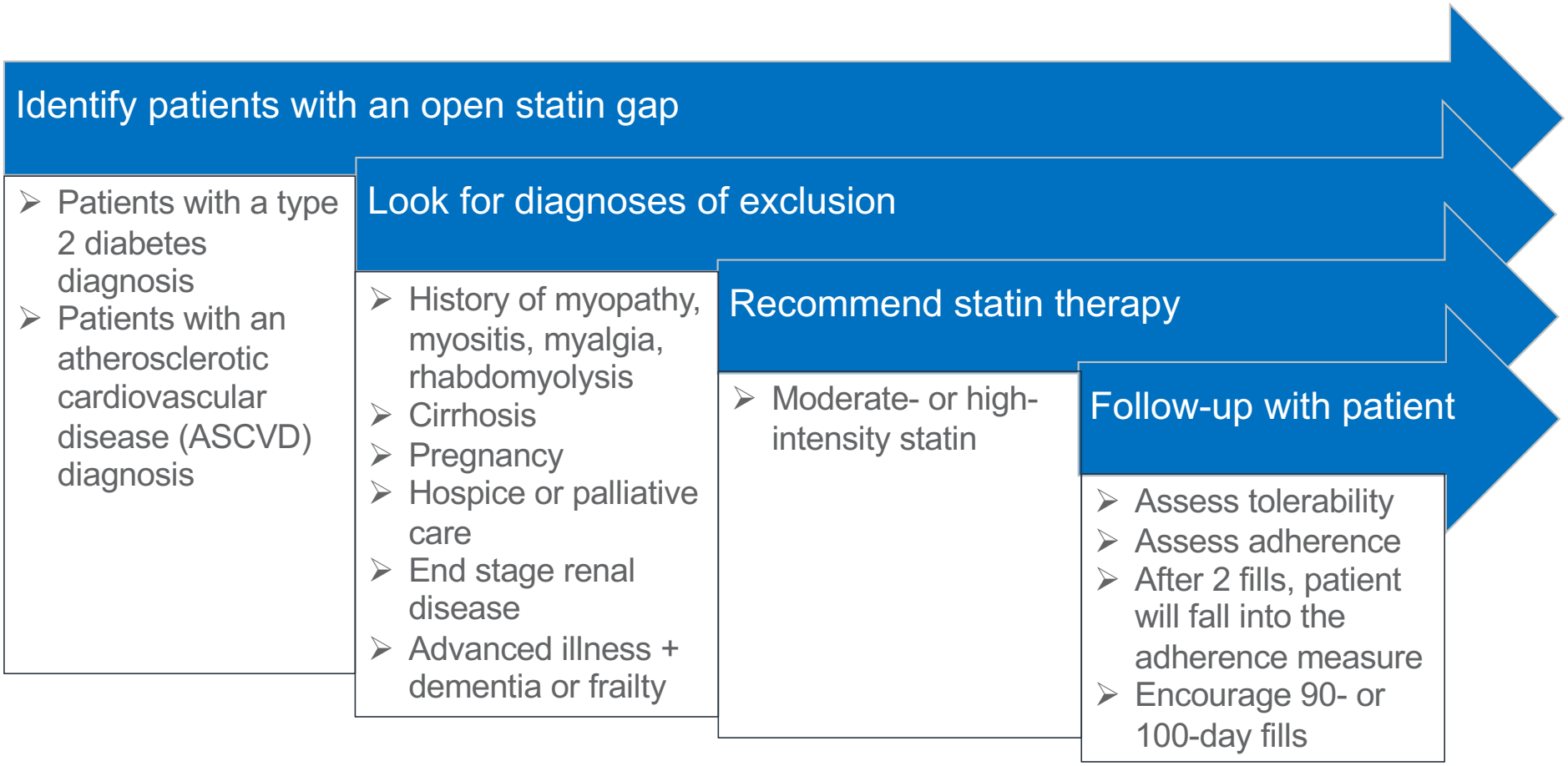
77% associated to a 3-star rating

84% associated to a 4-star rating

+0.22 improvement in star rating

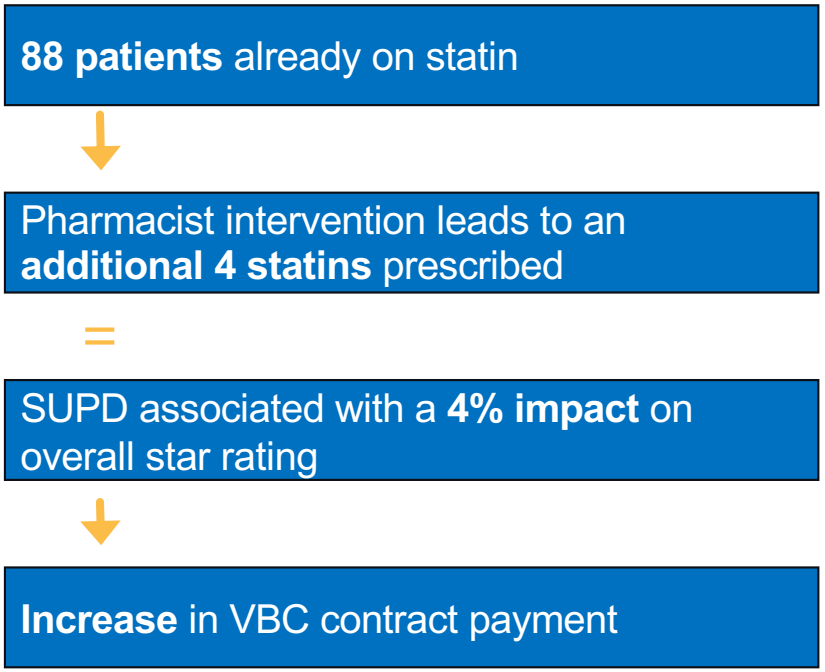
Shared savings based on contracts

Statin Use Program Implementation



Example of the Impact of a Statin Use Program

100 patients eligible for statin therapy due to type 2 diabetes diagnosis



88% associated to a 2-star rating

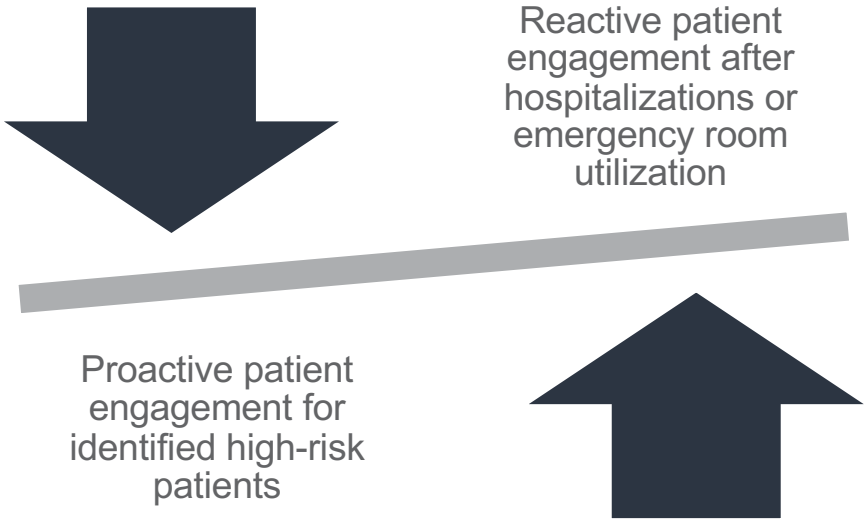
92% associated to a 4-star rating

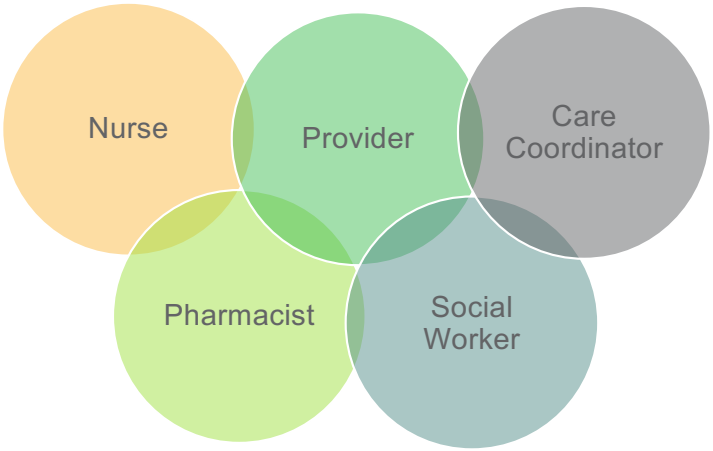
+0.07 improvement in star rating

Shared savings based on contracts

Collaborative Care

- Patient care extends beyond the exam room
- Multidisciplinary patient care leads to improved patient support and outcomes





Preventative Services

- Vaccines
  - Recommend and administer
- Medicare Annual Wellness Visits
  - Pharmacists are eligible healthcare professionals to conduct AWVs
- Point-of-Care Testing and blood pressure checks
  - Send results to primary care provider or document in patient's chart
- Lab orders and preventative screenings
  - As part of CPA or standing orders

Medicare Annual Wellness Visits Required Components

Physical measurements

- Weight, height, and blood pressure

Screeners

- Health risk assessment questionnaire, depression, and fall risk

Preventative Measures

- Mammogram, colon cancer screening, lung cancer screening, DEXA scan, lab work for screening purposes, immunizations

Education

- Patient must be given education about items they screen positive
- Patient must be provided with a preventative screenings schedule

Pharmacists Completing AWVs

Pharmacists are eligible healthcare professionals to provide an AWV

- Pharmacists are unable to submit HCC codes
  - Often the AWV is when a provider submits yearly HCC codes
- Pharmacists must have supervision
  - Incident-to billing

Service provided	Diagnosis code	Billing code	National average reimbursement
Medicare AWV, initial	V70.0	G0438	$166.39
Medicare AWV, subsequent	V70.0	G0439	$130.13

Health Information Technology Integration

Establish shared electronic medical record

- Pharmacist with access to patient charts on EMR
- Real-time access to records
- Comprehensive medication education and review
- Reduce gaps in communication and care plans

Common communication platform

- Connect messaging and phone system between pharmacist and clinic
- Faster communication
- Allows virtual support
- Establish regular touch points about high-risk patients

Value-Based Care Education in Pharmacy School Curriculum

- The Accreditation Council for Pharmacy Education (ACPE) standards emphasize the importance of student pharmacists understanding various healthcare delivery models.

University of Illinois Chicago College of Pharmacy

Pharmacy & The U.S. Healthcare System

Pharmacoeconomics & Payment

Concordia University Wisconsin School of Pharmacy

Pharmacy and the Health Care System

Conclusions

Pharmacists and technicians must understand the elements of value-based care

- Terminology
- Payment structure
- Outcomes measurements

Pharmacists and technicians play a role in value-based care

- Chronic disease state management
- Medication adherence
- Star measure performance improvement

State laws and pharmacy curriculum are needed to support VBC

- Collaborative practice agreements
- Standing orders
- Vaccinations
- Pharmacy education

Question 1

1. Which of the following defines the type of shared savings risk that could result in financial losses for quality of care?
   a. Downside risk
   b. Fee-for-service
   c. Two-sided risk
   d. Upside risk

Question 2

2. Which of the following classes of medications qualifies a patient for the medication adherence measure?

a. Angiotensin receptor blocker
b. Anticoagulant
c. Inhaled corticosteroid
d. Insulin

Question 3

3. Which of the following is an initiative that could improve medication adherence?
    a. Blood pressure screening campaign
    b. 100-day supply campaign
    c. Flu shot campaign
    d. Medication deprescribing campaign

Question 4

4. What impact do the medication adherence measures have on the overall star score?
    a. 4%
    b. 12%
    c. 25%
    d. 33%

Question 5

5. A pharmacist is considered an accountable care organization (ACO) professional
    a. True
    b. False

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Questions?

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