Primary Care and the Community Pharmacist – Creating Value and Opportunity in the New World of Health Care

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Disclosure

Bryan Ziegler declares no conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.
Learning Objectives

• Discuss team based care models in which the pharmacist can collaborate with a primary care provider.

• Utilize resources for implementing new collaborative services with primary care providers.

• Outline strategies to identify physician practice targets for collaboration.

The Times They Are A-Changin’

Come gather 'round people Wherever you roam
And admit that the waters Around you have grown
And accept it that soon You'll be drenched to the bone
If your time to you is worth savin’ Then you better start swimmin' or you'll sink like a stone
For the times they are a-changin’

- Bob Dylan “The Times They Are A-Changin’”
Fee for Service

• Provides payment for professional services in which the practitioner is paid for the specific service rendered, rather than receiving a salary.

  o Payment is dependent on the quantity of care, rather than quality of care.
  o Payment is established based on Evaluation and Management (E&M) codes
  o Adverse incentive to drive volume, more services = more money.

Fee For Service Model

Quantity Driven Model
Fee For Service Model

Quantity Driven Model

Pay for Performance

• Provides financial incentives to clinicians for achieving patient-focused high value health outcomes based upon evidence-based defined measures such as:
  
  o Clinical outcomes
    • A1c to control
    • Lowering blood pressure
    • Smoking cessation
  
  o Select care processes
    • Testing A1c
    • Measuring blood pressure
    • Mammograms
Shared Savings

• Payment strategy providing incentives for clinicians to reduce health care spending for a defined patient population by offering them a percentage of net savings resulting from their efforts.
  - Based on comparison with a control group.
  - For reducing potentially avoidable complications (PAC) associated with treating a chronic condition.
    • Hospital Admissions
    • ED Visits

Bundled Payments

• Bundled payment is a single payment to providers or health care facilities (or jointly to both) for all services to treat a given condition or provide a given treatment.
  - Providers to assume financial risk for the cost of services for a particular treatment or condition, as well as costs associated with preventable complications.
    • Coronary Bypass
    • Joint Replacement
    • Care Coordination
    • Chronic Care Management
  - Ambulatory Care Pilots
Fee For Value Model

Quality Driven Model

Percentage of Traditional Medicare Payment Tied to Quality or Value, and Goals for the Future

Exhibit 3. Percentage of Traditional Medicare Payment Tied to Quality or Value, and Goals for the Future

How do we determine value?

What you receive

QUALITY

COST

= Value

What you pay
So…How do we measure Quality?

Medicare Star Ratings

Five-Star Quality Rating by CMS
### Medicare Part D – 2016 Average Rates for PQA-endorsed Measures

<table>
<thead>
<tr>
<th>Part D Plan Rating</th>
<th>MA-FD</th>
<th>PDP</th>
</tr>
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<tbody>
<tr>
<td>PDC – Diabetes</td>
<td>77%</td>
<td>80%</td>
</tr>
<tr>
<td>PDC – Hypertension</td>
<td>79%</td>
<td>82%</td>
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<tr>
<td>PDC – Cholesterol</td>
<td>75%</td>
<td>78%</td>
</tr>
<tr>
<td>CMR Completion Rate</td>
<td>30.9%</td>
<td>15.4%</td>
</tr>
<tr>
<td>High-Risk Medications</td>
<td>7.4%</td>
<td>10.9%</td>
</tr>
</tbody>
</table>

PDC = Proportion of Days Covered; the rate indicates the percent of persons on the target drugs who are highly adherent to the drug regimen.

http://pqaalliance.org/measures/cms.asp

### Pharmacy Quality Reporting

Pharmacy Report

<table>
<thead>
<tr>
<th>Measure</th>
<th>Trend</th>
<th>Pharmacy</th>
<th>Versus Goal</th>
<th>Versus Others</th>
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<tr>
<td>Cholesterol PDC</td>
<td></td>
<td>87.1%</td>
<td>79%</td>
<td>83.7%</td>
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<td>Diabetes PDC</td>
<td></td>
<td>84.1%</td>
<td>82%</td>
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<tr>
<td>Drug Drug Interactions</td>
<td></td>
<td>8.3%</td>
<td>21%</td>
<td>6.2%</td>
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<tr>
<td>High-risk Medications</td>
<td></td>
<td>2.5%</td>
<td>6%</td>
<td>6%</td>
</tr>
<tr>
<td>Blood Pressure</td>
<td></td>
<td>85.4%</td>
<td>81%</td>
<td>85.6%</td>
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<td>High BP</td>
<td></td>
<td>63.5%</td>
<td>76.8%</td>
<td>68%</td>
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</tbody>
</table>

Source: [www.equipp.org](http://www.equipp.org)
Physician Quality Measures

• Medicare Part B –
  • Physician Quality Reporting System (PQRS)
  • Meaningful Use
• Medicare Part C & D STAR ratings
• Medicare ACO Measures
• NCQA (HEDIS) Measures - (PCMH)
  • Commercial payers primarily HEDIS focused

Chronic Disease

• Accounts for 7 of 10 deaths in US

• treating people with chronic diseases accounts for 86% of our nation’s health care costs.

  • >20% spending on diabetes alone

http://www.cdc.gov/chronicdisease/
PCP Shortage

Currently 65 million people live in areas of PCP shortage

By 2020, estimated physician shortage to rise to 91,000 (split between PCP & Specialists)

Recent Studies and Reports on Physician Shortages in the US

October 2012

Center for Workforce Studies
Association of American Medical Colleges

Reference: www.kff.org, Medicaid and the Uninsured. March 2011

Challenges/Opportunities

• Today, the average primary care visit with a physician lasts 11 minutes.

• Appointments are typically scheduled in 15 minute increments, with double appointments sometime scheduled to allow for no-shows.

PCP Role Change

Health Care Reform Aims

The Triple Aim

- Improving the patient experience of care
  - Access
  - Satisfaction
- Improving the health of populations
  - Outcomes
  - Quality
- Reducing the per capita cost of health care

Institute for Healthcare Improvement (IHI)
More Key Stats…

Nearly Five Million US Adults Aged 65 And Older Are Not Taking Blood Pressure Medication Properly, CDC Says.

The CBS News (9/13, Weiten) website reports that nearly five million adults in the US aged 65 and older are not taking their blood pressure medication properly, putting them at risk for severe health complications, including heart disease, stroke, kidney disease, and early death. The findings of a “Vital Signs” report from the Centers for Disease Control and Prevention reveal.

After analyzing data from more than 16.5 million people enrolled in Medicare Advantage or Original Medicare with Medicare Part D prescription drug coverage during 2014, the CDC found that “only half of the 73 percent of American adults 65 and older with hypertension ‘manage to keep their blood pressure under control.’

HealthDay (9/13, Thompson) quotes CDC Director Tom Frieden, MD, MPH, who said the study’s findings are “particularly troubling, because other research indicates that up to 25 percent of new prescriptions for blood pressure medication are never picked up.”

Dr. Frieden added, “Of those prescribed those regimens, maybe a quarter of the people don’t continue them.” The Connecticut Post (9/13, Costa) also covers.

More Key Stats…

Patients who don’t take their medication properly cost the overall health-care system

$290 billion annually

Source: New England Healthcare Institute, 2009
Impact of Medication-Related Problems

Medication Non-adherence = $290 Billion

- ↑ costs to health care system
- ↑ costs to employers and payers
- ↑ premiums and co-pays to patients and ↓ health outcomes

More Key Stats...

Loading the News

Healthcare Spending To Top $10,000 Per Person This Year.

In a report published in the journal Health Affairs, the Centers for Medicare and Medicaid Services forecasts that for the first time, national health spending “will average more than $10,000 a person” this year, the New York Times (7/13). Peril, Subscription Publication reports. The Times adds that the “milestone heralds somewhat faster growth in health spending after several years of exceptionally growth.” HHS predicts that by 2026, “health care will represent 20 percent of the total economy, up from 17.8 percent last year.” and it “the pace of health spending will pick up in the coming decade, driven by improvements in the economy, higher medical prices and aging of the people born from 1946 to 1964.”

The Wall Street Journal (7/13, Armour, Subscription Publication) says that while healthcare spending will continue to increase in the next decade, it will be at a slower pace than during the 23-year period before the recession.

The AP (7/13, Alonso-Zaldivar) says the “new peak” in healthcare spending means the Administration “will pass the problem of health care costs on to its successor.”

Reuters (7/13, Pearson) says the report said health spending rose 2.9 percent in 2013, “versus 5.3 percent in 2014, and is expected to have risen 5.5 percent in 2015.” It predicts the annual growth of health expenditures between 2015 and 2025 will be 1.3 percentage points faster than growth in gross domestic product.” However, Koocher acknowledged, “There’s uncertainty in a lot of our estimates, especially on prescription drug spending.”
More Key Stats…

Analysis Shows Employers Shifting More Healthcare Costs To Workers.

The New York Times (9/14, B2, Abelson, Subscription Publication) reports that Affordable Care Act exchanges “are in turmoil,” but “the employer market — where the majority of Americans still get their coverage — seems like a bastion of stability.” Data from an analysis conducted by the Kaiser Family Foundation found that the share of employers offering coverage in 2016 remained largely unchanged, while the premiums held steady for the most part. Meanwhile, “workers continue to pay an ever-greater share of their medical bills, a trend for several years now.”

Similarly, the Washington Post (9/14, Johnson) reports that while lawmakers “have been embroiled in a fiery debate over the ACA, a quiet but profound shift is fundamentally reshaping how health insurance works for the roughly 155 million Americans who receive coverage through their employers.” Data indicate “four out of five workers had a deductible as part of their individual coverage.

Some Measures You Could Influence (TODAY)

- Vaccines: pneumococcal, influenza
- Med adherence (examples):
  - ACEI/ARB in DM & CHF, PVD
  - ASA in DM, CAD
  - Statin in DM, CAD, CVA, PVD
  - BB in PVD
- Help control Med Costs
- High Risk Meds (want FEWER obviously)
- Encourage annual visit w/ PCP(specifically!)
  - NOTE: IF IT ISN’T in MD’s CHART, usually DOESN’T COUNT
How do your current pharmacy services align with primary care quality measures?
What do you do with this information?

NOTE: IF IT ISN’T in MD’s CHART, usually DOESN’T COUNT for Quality Metrics
Med Wreck or Med Rec?

What do you do with this information?

SYNCHRONIZE

Comprehensive Medication Review
Medication Synchronization

- Do you promote this service to physicians?
- Do you target patients with chronic disease?
- Do you keep track of the impact on patients?

Medication Synchronization

- Do you make phone calls to patients with this service?
  - What questions do you ask?
  - Do you find any medication problems?
  - What do you do about these problems?
  - Do you document any information?
  - Where does this documentation reside?

Hold this thought for a few minutes....
Medication Cost Management

- Improving adherence to drug therapy will **INCREASE** the Drug Cost

- Drug Cost is a part of Total Health Care Cost

- Improved adherence to **APPROPRIATE** drug therapy typically improves health outcomes (particularly for Chronic Diseases) and **REDUCES** Total Net Health Care Costs.

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Spend a little, save a lot

- Congestive Heart Failure: Increase in Rx Spend: $1,058, Reduction in Medical Spend: $8,881
- Diabetes: Increase in Rx Spend: $656, Reduction in Medical Spend: $4,413
- High Blood Pressure: Increase in Rx Spend: $429, Reduction in Medical Spend: $4,337
- High Cholesterol: Increase in Rx Spend: $601, Reduction in Medical Spend: $1,860

Medication Cost Management

• Are pharmaceutical patient assistance/coupon programs good or bad?

This practice DECREASES Patient Out-of-Pocket Expense But........

INCREASES DRUG COST and TOTAL COST OF CARE for Patient

POTENTIAL NEGATIVE IMPACT IN HEALTH CARE REFORM!!!!
Collaborative Working Relationships

- Individual characteristics
- Contextual factors
- Exchange characteristics

Commitment to the relationship
Relationship expansion
Exploration and trial
Professional recognition
Professional awareness

McDonough & Doucette Model
Journal American Pharmaceutical Association, 44(3), 358-365

Various Models of Pharmacist – Primary Care Collaboration

• **Pharmacist Integrated into Physician Office**
  - Pharmacist employee model
  - Pharmacist contractor model (Hourly vs. Billed Services)
  - Full-time vs Part-time Pharmacist Model
  - Shared Pharmacist Model
  - “Hybrid” Pharmacist Model

• **“Remote” Pharmacist Partnership**
  - Community Pharmacy Based Model
  - Central Medical Office/Call Center Model
Service Revenue Opportunities

• Pharmacy/Pharmacist
  • MTM
  • Medicare Star Rating “Bonus” (coming 2017)

• Team-Based Care Model
  • MD billing for Pharmacist Services
  • Shared Performance Bonus with MD
  • Direct payment from MD

Chronic Care Management (CCM)

CPT Code 99490

Non-face-to-face service provided to Medicare beneficiaries

Medicare Learning Network – Chronic Care Management Services
Key Definitions

**Auxiliary Personnel** means any individual who is acting under the supervision of a physician (or other practitioner), regardless of whether the individual is an employee, leased employee, or independent contractor of the physician (or other practitioner) or of the same entity that employs or contracts with the physician (or other practitioner).

Source: 42 CFR 410.26(a)(1)

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**Key Definitions**

**General Supervision** - means the procedure is furnished under the physician’s overall direction and control, but the physician’s presence is not required...

**Direct Supervision** in the office setting means the physician must be present in the office suite and immediately available to furnish assistance and direction throughout the performance of the procedure. It does not mean that the physician must be present in the room when the procedure is performed.

**Personal Supervision** – means a physician must be in attendance in the room during the performance of the procedure.

Source: 42 CFR 410.32(b)(3)(i)-(iii)
CCM

**Supervision**

CMS provided an exception under Medicare’s “incident to” rules that permits clinical staff to provide the CCM service incident to the services of the billing physician (or other appropriate practitioner) under the general supervision (rather than direct supervision) of a physician (or other appropriate practitioner).

“general supervision” means the definition specified at 42 CFR 410.32(b)(3)(i), that is, the procedure or service is furnished under the physician's overall direction and control, but the physician's presence is not required during the performance of the procedure.

Currently, however, clinical staff providing these services for RHC and FQHC patients are subject to direct supervision, i.e., they must be physically present in the same suite of offices as a physician or non-physician practitioner who is available to provide assistance.

Medicare Learning Network – Chronic Care Management Services

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Practitioner Eligibility

Physicians and the following non-physician practitioners may bill the new CCM service:

- Certified Nurse Midwives;
- Clinical Nurse Specialists;
- Nurse Practitioners; and
- Physician Assistants.

**NOTE:** Eligible practitioners must act within their State licensure, scope of practice, and Medicare statutory benefit. The CCM service may be billed most frequently by primary care physicians, although specialty physicians who meet all of the billing requirements may bill the service. The CCM service is not within the scope of practice of limited license physicians and practitioners such as clinical psychologists, podiatrists, or dentists, therefore these practitioners cannot furnish or bill the service. However, CMS expects referral to or consultation with such physicians and practitioners by the billing practitioner to coordinate and manage care.

Medicare Learning Network – Chronic Care Management Services
CCM

**CMS requires** the billing practitioner to furnish a comprehensive evaluation and management (E/M) visit, Annual Wellness Visit, or Initial Preventive Physical Examination (IPPE) to the patient prior to billing the CCM service, and to initiate the CCM service as part of this visit/exam.

Although patient cost-sharing applies to the CCM service, CCM may help avoid the need for more costly face-to-face services in the future by proactively managing patient health, rather than only treating disease and illness.

**CCM – Scope of Service Elements**

- **Structured Data Recording** – Demographics, Problems, Medications, Allergies, etc
- **Comprehensive Care Plan**
- **Access to Care/Continuity to Care**
- **Manage Care** – (ongoing assessment, med reconciliation, etc)

Medicare Learning Network – Chronic Care Management Services
Chronic Care Management and Other New CPT Codes. Family Practice Management. January/February 2015

PATIENT-CENTERED CARE PLAN

Patient name: ___________________________ Date: ___________________________

Provider name: ___________________________

Complete the next four sections prior to your visit:

Top concerns and barriers
The main things I would like to fix or improve about my health are:

- 
- 
- 

The main things preventing me from improving my health are:

- 
- 
- 

Symptom management
The main symptoms I wish to reduce or eliminate are:

- 
- 
- 

To treat these, your provider will help you complete the "Summary of things I need to do," next page, at your appointment.

Health care providers
List any other providers you see regularly for health care (for example, ophthalmologists, cardiologists, therapists):

- 
- 

Resources and supports
Who could you turn to for help for health-related problems (for example, family members, friends, a spiritual leader)?

- 
- 

Complete the remaining sections with your provider at your appointment:

My medications:

☐ I agree to do the following
  • Discuss concerns I have about taking any of my medications with my primary care provider (PCP) and/or pharmacist,
  • Advise my PCP if I choose to stop my medications, including my reasons for stopping, and discuss potential alternatives,
  • Advise my PCP of bothersome side effects from my medications.
  ☐ I have reviewed the current medication list you gave and confirm that it is accurate.

My allergies:

- 
- 

My conditions:

- 
- 

Treatment goals/targets
These are mutually agreed upon, measurable goals to help me improve or control my medical conditions or manage their symptoms (for example: LDL cholesterol <100, BP <130/80; weight of 150 pounds; 7 hours of uninterrupted sleep; average pain level of 3; ability to walk to my mailbox daily):

- 
- 

Chronic Care Management and Other New CPT Codes. Family Practice Management. January/February 2015
Chronic Care Management and Other New CPT Codes. *Family Practice Management*. January/February 2015

Summary of things I need to do
List action needed and time frame for each item. If not applicable, indicate N/A or none:

- Tasks to complete
- Other health professionals to see
- Community resources to use
- Medication changes to make
- Other treatments to get
- Health-related education to pursue
- Short-term activities to do
- Lifestyle changes to make (for example, quit smoking, lose 10 pounds, buy a pedometer and walk 3,000 steps per day; SMART goals: specific, measurable, achievable, realistic, time-bound— are recommended)
- Diet
- Exercise
- Stress management
- Safety
- Smoking
- Other habits
- Frequency of planned future appointments here: _______ per year

Care manager
If I need help arranging care outside this office or have questions or concerns about any of the things I need to do (above), I can contact:

- Name: ____________________________
- Phone/Mobile: ____________________
- Address: __________________________

☐ I will ask other providers to send a summary of their care to this office.

Expected outcomes/prognosis
If I follow the treatment/action plan above, I can expect the following to happen:

- ...

- ...

Patient signature: ____________________________
Provider signature: ____________________________

* Data for these sections may be imported from the patient record when this form is used as the basis for an electronic health record template. The following elements should also be incorporated: date created, patient name and identifiers, and provider name.

Chronic Care Management and Other New CPT Codes. *Family Practice Management*. January/February 2015
Payment - CCM

CPT Code 99490
- Per Member Per Month (PMPM) bundled payment
- ~$42


CCM – What’s on the horizon?

CPT Code 99487  Proposed CMS Physician Fee Code 2017

Complex Chronic Care Management Services
- 2+chronic conditions lasting at least 12 months
- Conditions w/ significant risk of death, acute exacerbation/decomposition, or functional decline
- Establishment or substantial revision of care plan
- Moderate or high complexity medical decision making
- 60 minutes of clinical staff time per calendar month

Proposed 2017 Non-Facility Payment = $92.66
CCM – What’s on the horizon?

CPT Code 99489

• Each additional 30 minutes of clinical staff time per calendar month

Proposed 2017 Non-Facility Payment
= $46.87

CCM – What’s on the horizon?

Proposed CMS Physician Fee Code 2017

CMS now proposes to amend the regulations concerning RHCs and FQHCs, changing the direct supervision requirement to a general supervision requirement. This change will afford these rural and safety net providers greater flexibility in providing CCM services for their eligible patients.
Why are we talking about CCM?

**TODAY**

- Service focuses on patient being adherent to product

**NEAR FUTURE**

- Service focuses on:
  - Adherence
  - Appropriateness/Safety
  - Effectiveness
  - Care Plan (outcomes)

Develop Collaborative Relationship with PCP

+ Medication Management

CCM Billing by MD

+ Documentation

Med Sync + Med Management

- Clinical evaluation of drug therapy
  - Is the drug therapy appropriate?
  - Is it safe?
  - Is it effective?

- Conversation with patient goes beyond patient having the meds available and focuses on:
  - Drug therapy management and education,
  - Follow up & monitoring for safety/effectiveness,
  - Updated med rec
  - Achieving desired therapeutic outcomes

- Documentation & Communication with Healthcare Team
Collaborative Working Relationships

Individual characteristics
Contextual factors
Exchange characteristics

Commitment to the relationship
Relationship expansion
Exploration and trial
Professional recognition
Professional awareness

• Key Points:

- Pharmacists are not billing for many of these services DIRECTLY unless the payer recognizes them as a provider.

- Instead, Physicians are billing for pharmacist services provided as part of collaborative, team-based care.
Additional Key Items Needed

- Verify the Pharmacist Scope of Practice
  - Does it allow the pharmacist to perform the duties needed for billing purposes?

- Are Collaborative Practice Agreements allowed?

- Which practitioners can delegate medical acts to pharmacists?

Finding a Collaborative Partner

- Shared patients with the pharmacy
- Providers shifting into new payment models
  - Search insurance list of providers
- Proximity to pharmacy
- Payer mix/Disease mix
- Interest in Collaborative relationship/Team-based care
- Who owns the practice?
Collaborative Working Relationships

- Individual characteristics
- Contextual factors
- Exchange characteristics

- Commitment to the relationship
- Relationship expansion
- Exploration and trial
- Professional recognition
- Professional awareness

McDonough & Doucette Model
Journal American Pharmaceutical Association, 44(3), 358-365

Formalizing the Collaborative Relationship
Collaborative Practice Agreements (CPAs)

A formal agreement in which a licensed provider makes a diagnosis, supervises patient care, and refers patients to a pharmacist under a protocol that allows the pharmacist to perform specific patient care functions.

Source: Collaborative Practice Agreements and Pharmacists’ Patient Care Services. CDC.
Challenges to Implementing a Pharmacist Collaborative Relationship with PCP

- Finding a PCP that is a Pharmacy Champion
- Education of PCP on roles/duties of Pharmacist
  - Staff too!
- Determining the financial model to support the Pharmacist
- Overcoming the conservative mindset of the Compliance/Billing department
- Access to medical records
  - Documentation
- Billing/Coding for the pharmacist services
- Gaining patient referrals
  - Workflow and Scheduling
- Tracking clinical and financial outcomes

Example (Transformation in Progress)
Example (Cont)

Step 1
- Introduced Med Sync
- Added Med Rec into routine

Step 2
- Comprehensive Review IDs Problems
- Started Addressing the Problems w/MD(s)

Step 3
- Continues to foster relationship with key local MD
- Care (Meds) Coordination leads to EHR access
- Documenting at pharmacy + EHR

Example (cont)

Next Steps
- Collaborative Practice Agreement with MD
- Explore opportunity to document for CCM/revenue generation
- Continuous tracking and reporting of outcomes
Wayne Gretzky

“I skate to where the puck is going to be, not where it has been.”

Where’s the puck going?
Randy McDonough, PharmD
Co-Owner, Towncrest Pharmacy
Iowa City, IA

Pharmacy Saves Payer $2.4 Million by Making Clinical Interventions a Priority

Published Online: Friday, January 29, 2016

- Total health care cost savings produced over 1 year for 600 patients
- Towncrest adjusted their dispensing process to focus on 3 points:
  1. Has the patient achieved intended therapeutic outcomes?
  2. Is the drug therapy effective?
  3. Is the medication regimen safe?
- 2,000-3,000 clinical interventions per month!
### Pharmacy Quality Reporting

**XYZ Health Plan**

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<tr>
<th>Pharmacy A</th>
<th>Target</th>
<th>Current</th>
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<tr>
<td><strong>Diabetes Care</strong></td>
<td></td>
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</tr>
<tr>
<td>% poor control (&lt;9.0%)</td>
<td>&gt;85%</td>
<td>73%</td>
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<tr>
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<td>% control for select population (&lt;7.0%)</td>
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<td><strong>Cholesterol Mgt</strong></td>
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<td>≥65%</td>
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<td>47%</td>
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<td>% &lt; 140/90 mm Hg</td>
<td>≥70%</td>
<td>72%</td>
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<tr>
<td>% &lt; 100 mg/dL</td>
<td>≥60%</td>
<td>72%</td>
</tr>
</tbody>
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**Where’s the puck going?**

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**The Wall Street Journal**

*Health Insurers Push to Tie Drug Prices to Outcomes*

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*UnitedHealth’s OptumRx Seeks Refunds When Expensive Drugs Fail*
Where’s the puck going?

Stages of CPESN Launch

October 2016

Slide used with permission from Ashley Branham, PharmD

Questions?

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