Delivering and Documenting Value-Based Care

CPESN Networks Working Directly with Medical-Side Payers

By Jay Williams and Ashley Branham, Pharm.D.

Community-based pharmacies have long believed that they provide the best care for their patients. Many pharmacists boast about their high-touch approach to patient care or their ability to influence a patient's medication therapy regimen. Unfortunately (for the pharmacy community), pharmacists have long been simply telling themselves. The greater healthcare team has largely been unaware of the value of local, community-based pharmacy care. Until now.

A number of pharmacy providers have organized to provide a systematic approach to patient care and care plan documentation to demonstrate the results that community-based pharmacies can deliver. As a clinically integrated network, pharmacies in the Community Pharmacy Enhanced Services Network (CPESN USA) have found they can bypass the pharmacy benefit manager (and get out of the pharmacy silo) and work directly with the medical-side payer to lower costs and improve health outcomes.

CPESN pharmacies connect with their high-risk patient population 35 times a year, compared to just 3.5 annual visits to their primary care provider.[1] That access is valuable to medical-side payers. Additionally, CPESN pharmacies collaborate with the extended patient care team—physicians, in-home care team, etc.—to coordinate care. Data show that 98 percent of CPESN patients felt their care was coordinated amongst their various care team members. Again, valuable to a true payer. Combine these with the long reported, but under promoted, data around community-based pharmacies' No. 1 ranking in three different patient/customer satisfaction surveys (J.D. Power, Consumer Reports, and Boehringer Ingleheim Customer Satisfaction PULSE) and you have a trifecta worthy of betting upon.

What's even more exciting is the documented improvement in patient care metrics that matter to the medical-side payer. CPESN pharmacies in North Carolina delivered 5 percent to 20 percent higher medication adherence rates than non-CPESN pharmacies. Additionally, CPESN pharmacies in Pennsylvania (Pennsylvania Pharmacist Care Network) were able to reduce HgA1c by 0.5% and reduce high blood pressure (3.7 mmHG avg. systolic reduction and 2.1 mmHg average diastolic reduction) in a six-month analysis of care they provided to patients of a Medicaid MCO. And, a hospital patient discharge study—which included contributions from several CPESN Hawaii participating pharmacies—showed a 46 percent lower hospitalization rate or an annualized cost of avoided admissions of $6.6 million. These are real numbers that are turning heads with medical directors and chief medical officers.

There is still work to be done. Payers want ready-made networks. They don't want to engage networks that aren't ready, or are sitting still and "waiting for a payer." This isn't a "which came first, the chicken or the egg?" scenario. The networks must come first. Community-based pharmacies must organize. They must be clinically integrated. They must start documenting the care that they are providing. They must rally other like-minded, patient-focused pharmacies to have enough pharmacies to take care of the payer's patients. When that occurs, great things are happening in those state-wide markets.

In areas where pharmacies aren't organizing, aren't documenting care, and aren't developing a strong coverage area, it seems that community-based pharmacist will just continue to brag amongst themselves.

Branham speaks at the 2019 TPA Conference & Expo.

Reference

[1] Gaskins RE. "Innovating Medicaid: The North Carolina Experience." North Carolina Medical Journal. January-February 2017;78(1): 20-24.