

COMMUNITY-BASED APPROACH TO PERSONALIZED HEALTH CARE: HEALTHMAPRX™

A Patient Self-Management Program Utilizing Community-Based Pharmacists
Summary Document

Authors:

William M. Ellis, RPh, MS, Executive Director and CEO, The American Pharmacists Association Foundation

Toni Fera, Pharm.D., Senior Director, Patient Self-Management Programs, The American Pharmacists Association Foundation

Jamie Kirkwood, BS Marketing and Sales Representative

Benjamin Bluml, RPh, Vice President, Research, The American Pharmacists Association Foundation

Program Overview

HealthMapRx™ is a service of the American Pharmacists Association (APhA) Foundation. The service has evolved from the previous decade of research by the Foundation, including the “Asheville Project®,” a community pharmacy-based program that began in 1996 and continues today. (1) The success of this model has helped business leaders to recognize that health care can be an investment in well-being rather than an expense for sickness.

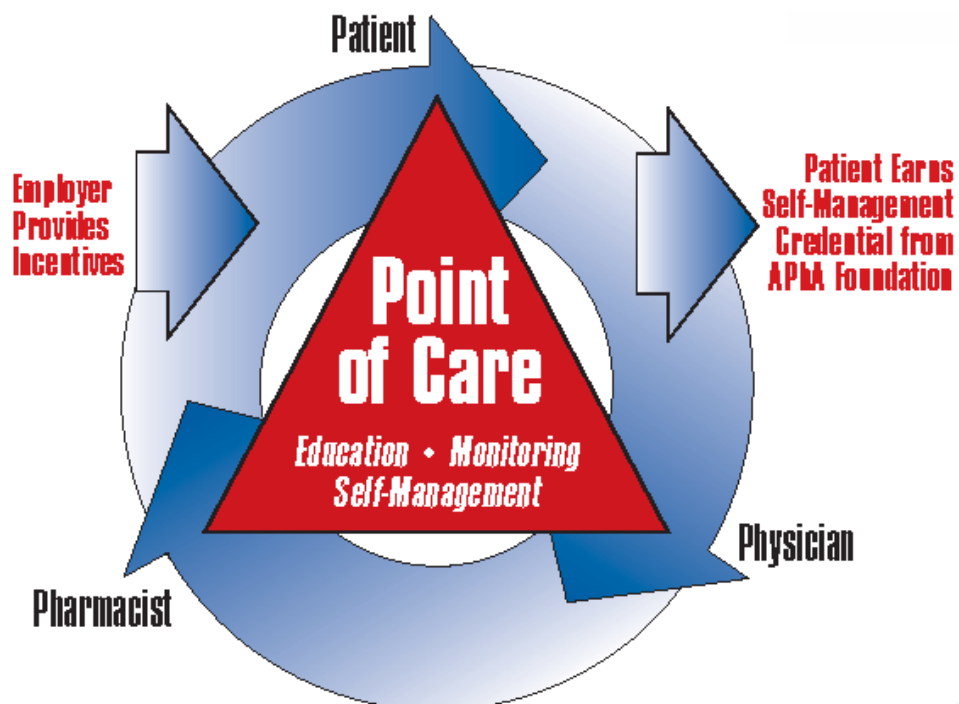
HealthMapRx™ is a patient-focused collaboration between employers, their covered health plan beneficiaries, and specially trained community pharmacists who provide, face-to-face counseling sessions where participants learn how to better manage their chronic conditions (such as diabetes, high blood pressure, hyperlipidemia) and reduce associated health risks.

Local networks of pharmacists are established to provide the self-management services to the patients. The program is collaborative and designed to *complement and reinforce* existing health care team provider roles, including the patient’s primary care physician. In addition, the program establishes a benefit model that aligns incentives for employers, patients, and providers.

What the Program Does: The Value Proposition

- The **HealthMapRx™** program creates a collaborative team of employers, employees, pharmacists, physicians and diabetes educators — and aligns incentives — to focus on wellness, patient self-management and workplace cost savings.
- **Educates and supports employees** with information and guidance to become active participants in managing chronic diseases, such as diabetes, based on a proven model and demonstrated research outcomes.
- **Employer waives co-pays on medications** or provides other incentives to encourage active engagement in self-care.
- **Employee (or dependent beneficiary) meets regularly with pharmacist** to discuss their care and learn new ways to monitor and control their disease.
- **Centers care around the patient** and positions pharmacists as accessible, valuable resources in helping patients understand and control chronic disease.
- **Reduces unscheduled absenteeism** in the workplace and associated costs.
- **Improves health outcomes** as measured by key indicators.
- **Saves health care dollars** by investing in patient well-being — keeping people healthy rather than paying for care when they become seriously ill.

How the Program Works



- **Specially trained community pharmacists** “coach” participants on how to manage their chronic disease, including setting goals, using medications properly, and tracking their condition consistently with recognized clinical indicators such as cholesterol tests, blood pressure, foot exams and eye exams.
- **Collaborative care teams** – including pharmacists, diabetes educators and physicians – are assembled in the community, educated about the program and are compensated for their involvement. Team members communicate regularly to optimize patient care.
- **Employees choose to participate** through a voluntary benefit offered by their employer that aligns employee benefit incentives to encourage success.
- **Success is measured** with the following indicators:
 - improvement in A1C concentrations (blood sugar control)
 - body mass index
 - blood pressure control
 - lipid control
 - increased patient satisfaction with pharmacy services
 - decreased costs of medical care

The Model

Employers/Payers

The practice model implemented for HealthMapRx™ is designed as a collaborative care model that emphasizes the roles of the employer, physician, pharmacist and patient. The employer/health plan agrees to invest in incentives for patients and pharmacist providers. At a minimum, these incentives include waived co-pays for medications and certain supplies. Some employers add other incentives as a way to integrate the program into their existing plan offerings. Other incentives have included counting participation toward wellness points, waiving co-pays for education classes and/or laboratory test co-pays. Most employers participating in the program are self-insured employers.

Employers work closely with their Third Party Administrators (TPA) and Prescription Benefit Managers (PBM) in order to establish a process to implement incentives (such as waived co-pays) and to provide basic claims data information on an annual basis to allow for program economic performance review. In some situations, the TPA or PBM can assist the employer with other aspects of program implementation, such as sending announcement letters to potential participants or managing enrollments.

Participants/Patients

Enrollment is voluntary; the employer educates eligible beneficiaries about the program through various announcement methods, including direct mailings, e-mail, newsletters and live orientation sessions. All participants are required to complete enrollment materials and a participant agreement. Enrolled participants are matched with a pharmacist “coach” and/or location from a local pharmacy network directory.

Pharmacists

Patient assignments are coordinated by a local pharmacy network coordinator. Services may be provided in a local pharmacy or at the participant’s workplace. During regularly scheduled visits, pharmacists apply a prescribed process of care that focuses on clinical assessments and progress toward clinical goals, establish self-management goals specific to each patient, and work with other health care providers and may recommend adjustments in the patients’ treatment plans. Pharmacists who participate in the program are required to complete an ACPE-accredited training program in the relevant clinical area (such as diabetes or hypertension), or are otherwise certified. They generally follow national treatment guidelines unless otherwise specified by the physician. Pharmacists collect subjective and objective assessment information and enter it into a web-based documentation system for outcomes reporting. Pharmacists are reimbursed by employers for patient visits according to fee schedules negotiated by the local pharmacy network.

Physicians and other Providers

Physicians are informed of participant enrollment and are encouraged to share their care plan with the pharmacists, who reinforce that plan with the participants. Pharmacists communicate with physicians after every visit, as necessary, and refer patients as needed to their physician (for follow-up visits, laboratory tests or resolution of medication-related problems), or other providers, such as a dietician (for intensive nutrition education) or diabetes education centers (for additional education support).

Program Experience

The HealthMapRx™ Program evolved from early published works in Asheville, North Carolina and the APhA Foundation’s Project ImPACT Hyperlipidemia (1, 2, 3, 4). Since that time, the APhA Foundation has conducted projects in a variety of sites throughout the country to assess the replicability of the model in diverse settings. Results from the initial pilot site replications were published in 2005 (See Appendix A) (5). These results demonstrated positive clinical, economic and patient satisfaction improvements for participants enrolled in the program. In order to test the scalability of the program, the APhA Foundation launched the *Diabetes Ten City Challenge* at the end of 2005. The interim clinical results were published in March, 2008 (6). Currently, the program is implemented under the

brand name, HealthMapRx™. The program has now been implemented by more than 80 employers in 20 states, with more than 3,000 active participants. Several employers are continuing the program into multiple years.

The majority of employers implementing the program have been self-insured and include private companies, school districts, city and county municipalities, and health systems. Program design has core elements that are required to ensure the integrity of the model, but there is significant opportunity to tailor the program and its implementation at the local level. The HealthMapRx™ team provides implementation consultation for employers, as well as templates for announcing the program and for managing enrollment.

Success Factors

There are key qualities that seem to drive successful program implementations:

- An Employer/Payer that will invest in incentives for patients and providers to improve health and lower costs
- Employers who are more involved in the program implementation, and have an open culture with their employees tend to have faster and higher percentage of enrollments of eligible beneficiaries
- Receptiveness of health care providers who support community-based collaborative care
- A local network of pharmacists that have the motivation, training and time to help patients manage their care
- Accessibility to pharmacist services
- Following the HealthMapRx established process for employer implementation, patient care, and documentation
- Willingness of TPA/PBM to provide claims data for analysis

Challenges

The program is implemented at the local level and developed to address needs, resources, cultural and political issues within the employer's community. Thus, challenges may occur at the local level. Although some employers have unique challenges, there are some challenges that appear to occur more frequently. For example, an employer "champion" usually drives the initial approval and implementation of the program. If there is a change in staff or lack of a true "champion," this is challenging and may even jeopardize continuation of the program. Without strong employer support and a plan for consistent and clear communication about the program benefit design for participants, the full enrollment potential (and therefore, results) may not be realized.

On the pharmacist network side, since this is a relatively new practice model for community-based pharmacists, it is important to balance participant access with network capacity. In addition, there needs to be adequate resources to support

network services, coordination, and management. The pharmacist provider shortage, particularly in rural areas can also be a challenge.

Employer Profile

In order to implement the program, employers should have the following characteristics:

- Willingness to invest in employees' health to enhance quality of life, reduce sick days and lower hospitalization costs;
- Willingness to promote the program, orient and enroll patients;
- Capability to (or use a PBM) provide reduced/waived co-pay prescription cards or other incentives;
- Ability to provide access to data from TPA to track total health care costs for enrollees; and
- Willingness to provide payment to pharmacist providers/the provider network.

Patient Profile

When employees enter the program, they are asked to sign a participant agreement, which outlines consistent requirements for their patients who participate. Generally, the program is introduced as a voluntary benefit for employees and/or dependents who agree to meet with a qualified pharmacist on an ongoing basis for education, monitoring and set personal goals for diabetes self-management. The patient agrees to work with pharmacist coaches to set goals and monitor their progress. Participants must agree to meet at least quarterly with a qualified pharmacist to set self-management goals, have scheduled assessments and procedures to monitor performance.

Pharmacist Provider Profile

Specially trained pharmacists or those willing to complete the required training are recruited to pharmacy networks as providers for the program. Providing medication therapy management services, including identifying and preventing drug-related problems is a key component of the pharmacist's role. In addition, pharmacist providers have received additional training in chronic care and the program processes of care. Examples of requirements include:

- Pharmacists must have designated certification or completed a comprehensive ACPE-accredited program in diabetes or other disease state as specified (such as a CDE, BCPS certified or APhA Diabetes program certification).
- A private consultation area must be available for patient education.

- Self-management coaching to patients in relevant lifestyle areas, such as smoking cessation, diet, exercise and nutrition must be provided.
- There must be collaboration with local health care providers, including primary care physicians and refer, or recommend for referral, participants to existing resources.
- Outcomes documentation must be maintained.

Other Health Care Providers

It is important to stress that, in this program, physicians will remain responsible for overall care of patient and changes in therapy. Physicians will receive summary reports after each patient's session with the pharmacist as applicable, and will be notified about the program when patients enroll. Physicians are still responsible as required to make therapy changes or referrals as required. Data from the early projects indicate that physician outpatient and diabetes education center visits increase.

Summary

A collaborative practice model utilizing community-based pharmacists to provide coaching and self-management education to patients, that aligns incentives for participants, sponsoring employers and health care providers has been successfully implemented in a variety of settings. An investment in "well care" has led to lower costs, improved employee satisfaction, and better outcomes for patients with chronic disease.

APPENDIX A

HISTORY OF HEALTHMAPRx™

The following milestones and research have paved the way for HealthMapRx™

- 1996** The APhA Foundation creates **Project ImPACT: Hyperlipidemia™**, the first collaborative care program designed to show how pharmacists, physicians and patients with high cholesterol can work together to make lifestyle changes and improve medication adherence to achieve cardiovascular goals. (4) Over a three-year period, nearly 400 people with high cholesterol in 12 states, working together with 26 pharmacies, participated in this landmark program.
- The results, published in the *Journal of the American Pharmacists Association* in 2000, showed that more than 90 percent of patients stayed on their medications and 67.5 percent reached the National Cholesterol Education Program (NCEP) treatment goals.
- 1997** The diabetes management program, the **Asheville Project**, is first offered to employees, dependents and retirees in the City of Asheville, North Carolina, in partnership with the North Carolina Center for Pharmaceutical Care. The program starts with 47 initial participants.
- 1998** Mission-St. Joseph's Hospitals and the Blue Ridge Paper Company add the diabetes management program for beneficiaries in their health plans. It grows to more than 300 people with diabetes over the next three years.
- 2003** Long-term results of the Asheville Project, published in the *Journal of the American Pharmacists Association*, showed that patients improved A1C levels (key diabetes indicator), employers had lower total health care costs, employees had fewer sick days and increased satisfaction with pharmacist services, and pharmacists developed thriving patient care services. (1) Asheville Project results also appeared in *Business Insurance* and *The Washington Post*.
- 2003** The APhA Foundation begins follow-up research based on the Asheville Project and **Project ImPACT: Hyperlipidemia™** to assess the feasibility of expanding the model to multiple employer types and geographic locations. A pilot program, "**Patient Self-Management Program™ for Diabetes**," is initiated in four states at five employer sites with more than 300 patients.
- 2004** The APhA Foundation completes development of "**The Patient Self-Management Program™ Diabetes Credential**," the first and only credential for education in diabetes that can be awarded to individual patients for completing study in diabetes and its management as part of the Patient Self-Management: Diabetes™ program research.

- 2005 Patient Self Management Program™ for Diabetes** program results are published with compelling findings that indicate the ability to replicate and expand the scale of the Asheville model in diverse settings (5):
- Participants dramatically improved in key indicators of diabetes control, including reducing average A1C values from 7.9 to 7.1 percent, using the goal set by the American Diabetes Association
 - More patients kept up to date with key indicators of diabetes care, including influenza vaccinations, foot and eye exams, recorded blood pressure, and lipid profiles (average increase of more than 40 percent)
 - Employers realized a \$918 net cost savings per employee

2005 Diabetes Ten City Challenge™ is announced in October, inviting participation from employer groups that want to seize the opportunities for improved patient health and cost savings demonstrated in the Asheville Project and Patient Self-Management Program™ for Diabetes. The Pittsburgh Business Group on Health and the Northwest Georgia Healthcare Partnership are the first employer groups selected to participate.

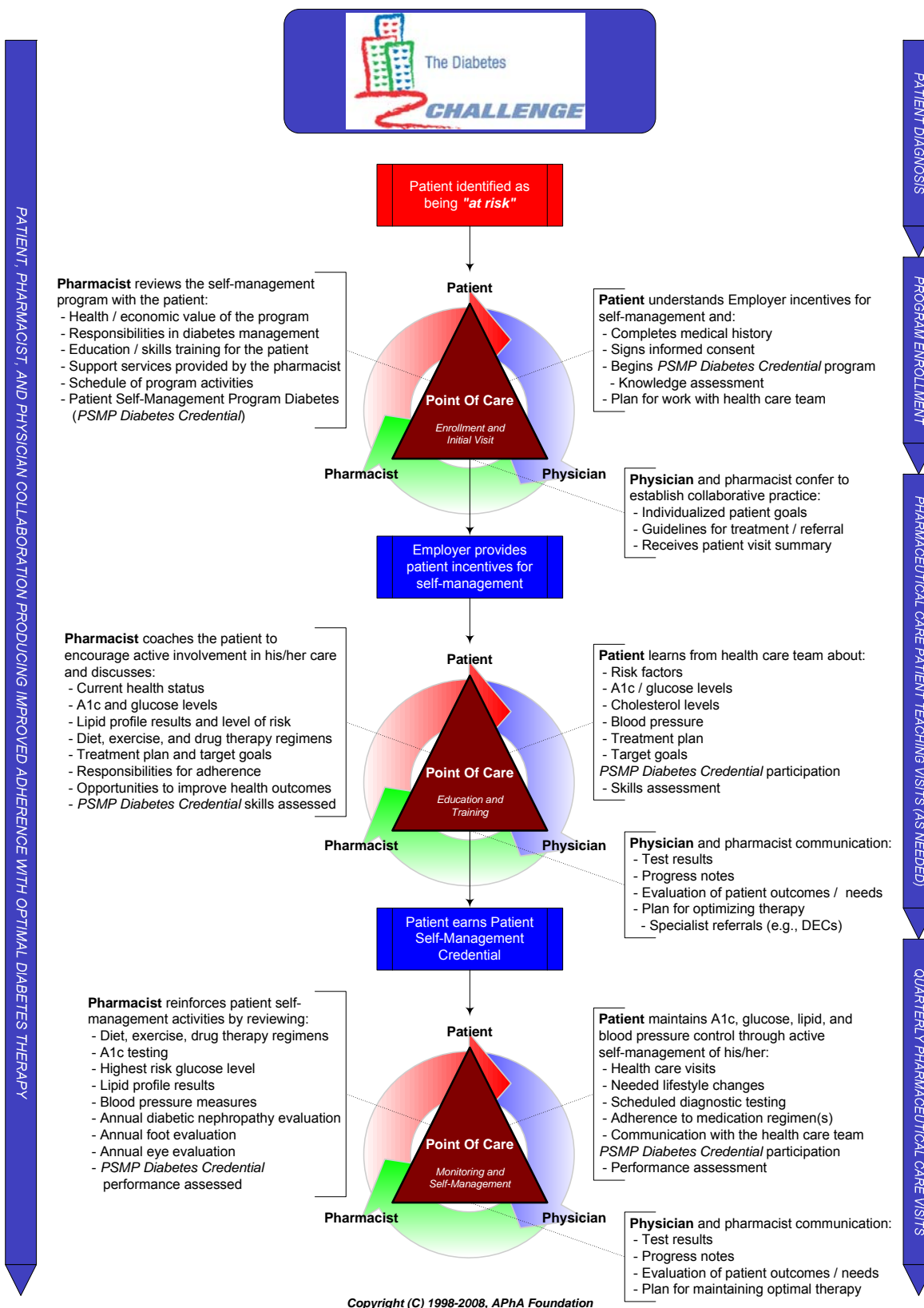
2006 HealthMapRx™ is established.

2008 The Interim Results of the Diabetes Ten City Challenge are published in JAPhA (6)

The report released analyzed aggregate data on 914 DTCC participants who were in the program at least three months as of September 30, 2007. It documented clinical improvements in all the recognized standards for diabetes care, including:

- Decreases in laboratory measures (mean) for hemoglobin A1C (a laboratory test showing the patient's average blood sugar control over the previous two to three months), LDL cholesterol and blood pressure over the initial year of the program
- Increases in the number of participants with current influenza vaccinations, foot examinations and eye examinations
- 21% increase in the number of participants achieving the American Diabetes Association goal of A1c level <7.0
- Increase from 43.8% to 57.7% in participants achieving nationally recognized National Cholesterol Education Program goals for LDL cholesterol
- 15.7% increase in the number of people achieving recognized goals for systolic blood pressure
- The number of DTCC participants who felt their overall diabetes care was "very good to excellent" increased from 39% to 87%
- More than 97% of participants reported being "very satisfied" or "satisfied" with diabetes care provided by DTCC pharmacists
- The number of participants setting self-management goals to control their diabetes also increased significantly: those with nutrition goals increased from 22% to 66%; those with weight goals increased from 23% to 64%; and the number of participants setting exercise goals increased from 24% to 72%

Community-based Personalized Health Care The HealthMapRx™ Patient Self-Management Program



HealthMapRx™ Testimonials

Pharmacist Testimonial:

Society and even families don't realize how bad this disease is. They often don't know that uncontrolled diabetes can lead to blindness, amputation, end-stage kidney disease, and cardiovascular complications such as stroke or heart attack. It's important that patients can access a coach on a regular basis to help them through the ups and downs and help them control their diabetes as best they can. You can't just show someone how to use a glucometer and send them on their way – it takes constant education, encouragement, and support to empower the patient to self manage. Our participation in this pharmacist directed wellness program gives us a chance to give back to the community by providing much-needed diabetes patient education and make a difference in the health outcomes of people with diabetes. Pharmacists have the ability to apply their scientific knowledge in making therapeutic decisions that will affect health outcomes.

In the first three months of the program we ideally like to see the patient once a month to understand their health history, set goals, and go over basics like nutrition, exercise, and how to use a glucometer. We see what patients need in terms of education and make sure they understand what each medication does and how to take it.

Employer Testimonial:

This program enables people to understand what they need to do in order to become healthy or stay healthy. The more that people take advantage of it, the healthier our employees will be, which can be a win for everybody. Improving health means improving energy and attitude, and there is less down time from lost workdays.

Everyone I have talked with who is involved in the program has been pleased with their results, whose personal encouragement helped recruit employees to the program. They tell me they have learned more about diabetes than ever before.

Patient Testimonial:

The program is a good support to help you stay on track, and an excellent resource for information. Having an hour set aside allows me to sit down, focus and ask questions without feeling rushed. I take three different medications, and

the pharmacist explained what each one does in my body. I also learned that my medications might not have been working right because of how I was taking them. I probably wouldn't have asked my doctor about that.

My morning readings were very high, Working with (my pharmacist), my doctors increased the dosage of medicine I take at night, had me take it with my meals and have a snack before I go to bed. I've been able to bring down my numbers and work on losing some weight, which has been a major factor. I feel much better.

When I found out I had diabetes, I was devastated. Since enrolling in this program, I've made major changes in my life, including losing weight and exercising every day. My pharmacist coach has become one of my closest friends and she continues to inspire me at every visit. This program has taken away so much of my fear and truly saved my life.

Physician Testimonial:

The key to success of the program is to make sure that additional burden isn't placed on the physician for managing these patients. Physician engagement is driven by the patients, and they will respond best when they hear from their patients why this is a huge benefit.

How the Program Works

APhA Foundation contracts with employers to implement its HealthMapRx program which include program guidelines, templates and software for documentation. The Foundation also provides staff support and assists with identifying a local network of pharmacist providers to establish the program in the selected community.

Employers offer a voluntary employee benefit with incentives to encourage success (typically waiving participants' co-payments for diabetes medications and supplies) and compensate pharmacists for the care provided.

Participants meet regularly with a specially trained pharmacist "coach," learn how to self-manage their diabetes and track key indicators with medical tests, foot exams and eye exams.

Pharmacists are specially trained and use the Patient Self-Management Program to educate patients and record their clinical progress on key diabetes quality-of care indicators.

Collaborative care teams including pharmacists, diabetes educators and physicians communicate regularly to optimize care.

Success is measured by evaluating:

- improvement in clinical outcome indicators, such as A1C concentrations (blood sugar control)
- increased patient satisfaction with pharmacy and diabetes care services
- decreased costs of medical care.

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