

EXECUTIVE SUMMARY

RESEARCH SYMPOSIUM AT AMCP NEXUS 2015



According to the Centers for Disease Control and Prevention, chronic disease treatment accounts for more than 1/5 of total health care costs. About 50% of American adults have at least one chronic illness. About ½ of the medications for chronic conditions are not taken as prescribed, so nonadherence accounts for \$300 billion in avoidable expenses.

In 2015, the Academy of Managed Care Pharmacy (AMCP) Foundation held its 5th annual symposium on challenges and innovations in **adherence** and **prevention**, obesity as a **chronic disease**, the revolution in **data collection and analysis**, **patient-centered care** in cardiovascular disease and prevention, and rapid changes in **patient monitoring**.

Fauzea Hussain, MPH, Senior Vice President, Avalere Health, led the attendees through a highly interactive symposium of learning and discussion, and facilitated conversation about health outcomes, health in general, and how to increase collaboration in efforts to improve prevention, treatment, and adherence in chronic disease. The AMCP Foundation expresses thanks to the generous funding partners: Amgen Inc., Eisai, Merck & Co, Inc., and Novo Nordisk, Inc. Following are brief summaries of the various presentations. A full report is available at www.amcpfoundation.org.

Keynote: A Prescription for Health Care in America. “Eighty-six percent of health care spending is associated with chronic disease,” said G. William Hoagland, MS, Senior Vice President, Bipartisan Policy Center, Washington, DC. Fifty percent of the U.S. adult population has at least one chronic disease. “Yet, it is surprisingly difficult to find support (bipartisan or partisan) for emphasizing prevention,” he commented.

There is a recognition throughout the country that prevention, he believes, when delivered correctly, holds vast potential to improve health at the individual and population levels, while also reducing avoidable health care expenditures. Just as not all prevention strategies will be effective in improving health outcomes, not all improvements in health will result in immediate or scalable cost savings. “Yet, we’ve come to the conclusion that a better integrated, more prevention-focused approach has a role to play in advancing the goal of better health and lower health care spending,” he stated.

Of the task force’s recommended tactics, several focused on investigating the “accountable health care community model,” which focuses on the health care outcomes of a population in a defined geographic area. “This offers the opportunity to create linkages between providers and communities,” Mr. Hoagland stated, including the evolution to accountable health care communities. The greater part of any successful prevention program, according to the task force, happens outside the walls of the clinic. Therefore, “an integrated approach is necessary,” said Mr. Hoagland, “including evidence-based policy, which aligns financial incentives with objectives, and can be self-sustaining.”

Medication Management & Patient Medication Adherence. Multiple researchers have published studies that demonstrate medical cost offsets from prescription drug utilization, according to Tom Hubbard, MPP, Vice President of Policy Research, The Network for Excellence in Health Innovation, and the amount of savings is directly related to patients’ degree of adherence with drug therapy.

The continuum of medication care, starting from the initial doctor’s visit, through dispensing at the pharmacy and subsequent refills, offers several opportunities for improving adherence and better use of medications. For example, Mr. Hubbard pointed out that “E-prescribing is actually an adherence intervention.” He explained that when an E-prescription is received by the dispensing pharmacy, it may trigger a call to the patient to fill that medication.

The Center for Medicare & Medicaid Innovation is gambling that medication therapy management (MTM) is the best way to reach, on a patient-by-patient level, a better continuity of medication care and enhanced adherence in those

with chronic disease. In 2017, CMS will roll out its “next-generation MTM” pilot. In addition, the U.S. House Committee on Energy and Commerce has developed its own proposal on MTM. It seems that policy makers are relying more than ever on pharmacy-led MTM efforts. Yet, Mr. Hubbard pointed to the issues of reimbursement and scarce time as the limiting factors in introducing MTM widely.

Obesity as a Chronic Disease: Panel Discussion. Perhaps more than any other chronic disease, obesity affects society, health care delivery, and individuals. Its prevalence has risen over the last three decades, said Scott Kahan, MD, MPH, Medical Director, Strategies to Overcome and Prevent (STOP) Obesity Alliance, to about 35% of all U.S. adults, and the prevalence of extreme obesity has rocketed 10-fold since 1985. Obesity costs close to \$300 billion annually (\$65 billion in indirect expenditures), and its comorbidities cover nearly the entire spectrum of chronic disease in addition to several acute disorders (e.g., acute pancreatitis and gall bladder disease). “Yet we still do not treat obesity like we would any other chronic disease,” he stated. The U.S. Office of Personnel Management claimed that some plans in the Federal Employee Health Benefits Program were failing in their responsibility to treat obesity by refusing to cover obesity medications because of its perception as a result of lifestyle.

The benefits of treating obesity may be seen in reducing patients’ body weight by 10% or even only 5%, including on comorbidities such as diabetes (e.g., lowering blood glucose levels and reducing the need for antiglycemic medications), diabetes, heart disease, and musculoskeletal disorders like arthritis. Even though effective obesity therapies are available, patients often have difficulty accessing them. Routine policy exclusions, lifetime procedure caps, and high out-of-pocket costs are all barriers to receiving treatment; additionally, health plans’ low reimbursement rates for medical and surgical treatment of obesity discourage providers from more aggressively treating their patients’ disease, commented Theodore Kyle, RPh, MBA, Principal and Founder, ConscienHealth, and Chairman of the Board, the Obesity Action Coalition. He added that “good obesity care will often result in substantial improvements in quality of life, better physical function, and even improved productivity.”

The bias against obesity as a disease also translates into bias against individuals themselves. “People with weight problems are often subjected to prejudice, discrimination, rejection, and abuse,” stated Joseph Nadglowski, President/CEO, Obesity Action Coalition. The stigma of obesity is reinforced every day in the media, in the workplace, and in social situations. “Unless you live in the state of Michigan, you can be fired because of your weight,” according to Mr. Nadglowski. He emphasized that weight bias is no different than other forms of bigotry; “It dehumanizes people, it’s a violation of their dignity. It’s like any other disease, except for bias.” Even health care providers demonstrate a bias against people with obesity; they fail to delivering empathetic care to these patients, he said, even though obesity is driven more by biology than by behavior.

Translating Big Data into Big Insights. One of the premier challenges in medical practice is the existence of a tremendous amount of information, and the continual input of new evidence on best practices. No one physician can stay absolutely current; no one physician can assimilate the latest medical information into daily decision-making at the point of patient care. Kyu Rhee, MD, MPP, Chief Health Officer and Vice President, IBM Corporation, described the IBM Watson approach to collecting, collating, and analyzing health data to improve patient care.

Considering that only 10% of health outcomes are related to health delivery, “it’s really important that we consider health care and all other influences and opportunities for positively affecting the right health and health care choices,” he emphasized. If a physician only sees a patient for a matter of minutes throughout the year, and behavioral, environmental, and genetic factors influence the 90% of health outcomes, the need for other sources of health information becomes clear. Dr. Rhee said, “This is helping to drive the evolution of an instrumented, connected, and more intelligent health care system (e.g., through medical wearables). There can be so many more access points and information sources.”

The foundational question that IBM Watson tries to address is whether the population is getting the right care at the right value at the right time. IBM Watson tries to answer this question by analyzing the numerous health care decisions people make daily. It uses real-world evidence to create data-driven insights. The first Watson health and wellness

application using “cognitive computing” will be available next year for use on the Apple Watch. Cognitive computing systems are in development as well to predict risk, prevent disease, and personalize health care.

Promoting Patient-Centered Heart Health. About 80 million people have hypertension but only 54% have their blood pressure under control, and 17% remain undiagnosed (and therefore are completely untreated). The American Heart Association (AHA) decided to consider programs in which it can be an “integrator,” addressing this widespread problem by moving forward with a multimodal approach involving systems of care, providers, patient engagement, and the communities, explained Kathleen Shoemaker, PharmD, MBA, Director, Quality Integration Project/HIT, AHA.

She and Kirstin Siemering, DrPH, RD, Health Initiatives Manager, AHA, described community-based pilots taking place in Atlanta and San Diego, which may be scalable and extended to other communities in the future. These efforts have evolved over 6 years, headed by Kaiser Permanente pharmacists. “Across this time span, we have seen that self-monitoring in the communities, linked to support, leads to improved blood pressure control,” according to Siemering.

Lisa C. Clough, MEd, CHES, Vice President, Public & Patient Programs, WomenHeart: The National Coalition for Women With Heart Disease, described a series of national public health educational campaigns that her organization provides for women with this complex disease. These start with a literature review, followed by a survey of women living with heart disease. These data are collated and evaluated by a group of key opinion leaders, Ms. Clough explained, and issued recommendations for improving the lives of women living with that condition. Campaigns underway or completed include: patient empowerment, adherence improvement, heart failure, and hypercholesterolemia.

The Patient Perspective. To date, the health care community has not done a good job of including “the patient’s voice” in both policy and individual clinical decision-making, according to Eleanor M. Perfetto, PhD, MS, Senior Vice President, Strategic Initiatives, National Health Council. The concept of patient centeredness includes the involvement of patients in all aspects of care and care delivery: (1) active involvement of patients and families in the design of new care models and in decision making; (2) providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions; and (3) ensuring active patient engagement at every level of care design and implementation.

Dr. Perfetto said the goal is to move toward greater direct patient involvement in the entire health system, but there seems to be a long way to go in achieving this aim. In terms of clinical trials, patient-centeredness would be characterized by a system in which patients are not just asked questions, rather “the patients help develop the questions to be asked.” She urged consideration of patient centeredness in the overall health care system’s quality measures, financing, and care delivery components.

Key Takeaways. The symposium resulted in valuable conversation and specific messages for the health care community.

- Compelling clinical and individual patient information supports the need for prevention and the need to expand efforts to spreading the message of prevention, especially as it pertains to chronic disease.
- The magnitude of the implications, both in financial and human terms, of chronic diseases like obesity and cardiovascular disease cannot be overemphasized to stakeholder groups.
- Broader systemic changes are needed to support care integration and coordination to drive prevention.
- Some innovative activity in accountable care community models is occurring at the state level, particularly in Colorado and Minnesota. Scaling these programs to larger populations and geographic areas represents a challenge and an opportunity for progress.
- Effective and meaningful engagement is needed at all levels, with payers (to determine the value of services and interventions), with the community (to identify the intrinsic and extrinsic value factors), as well as the patient (to support that engagement, motivating them to make the appropriate choices).
- In efforts to engage the patient specifically, the patient’s point of view must be incorporated much earlier in the process for developing chronic disease prevention, treatment, and adherence programs. Quite often, the metrics for improving outcomes are not patient-centered, and therefore fail in a basic way to incentivize or motivate the patient.