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URAC & AMCP

QUALITY MANAGEMENT NEWS AND INFORMATION FOR PHARMACY

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Focusing on Medication Adherence

In the words of former U.S. Surgeon General, C. Everett Koop, MD, "Drugs don't work in patients that don't take them." Simple, yet complex. That is the reality of medication adherence. And although the

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Quality Corner: AMCP Releases New Guide for Implementing Quality Measures

The Academy of Managed Care Pharmacy's (AMCP's) Quality Task Force has developed a guide for managed care organizations to use when implementing quality measures. The "how to" guide provides

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National Priorities Partnership: Improving Care through Consensus

The National Priorities Partnership, convened by the National Quality Forum (NQF) in 2007, is a diverse partnership of more than 40 stakeholders including private and public sector representatives at the

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Excellence and Quality are Common Attributes of AMCP Award Winners

A dedication to excellence and adherence to the highest professional standards are just two of the common attributes that distinguish winners of the Academy of Managed Care Pharmacy's annual awards. AMCP takes great pride each year in being able to recognize a group of outstand-

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LOOKING AHEAD...

Pharmacy Excellence and Quality will be the focus of the next issue as we highlight recent examples of best practices in pharmacy, and the individuals and organizations having a positive effect on the lives of the consumers they serve.

Focusing on Medication Adherence

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terms medication adherence, compliance or persistence can be used interchangeably, the ultimate desirable outcome is the patient "taking the medication like the prescriber has ordered."

Medication adherence is a major challenge to the effectiveness of health care services. An estimated 15 to 20 percent of Americans don't fill their prescriptions at all. Of those who fill their prescriptions, 15 percent do not take their medication. In addition, an average of 25 percent of Americans stop taking their medication before the supply dispensed runs out, or they take less of the medication than prescribed. Non-adherence results in additional healthcare costs and lost productivity.

How do we measure adherence?

To directly measure adherence, one would have to directly observe the administration or consumption of the medication, which is very time-consuming and logistically difficult. Medication dosage counts, either manual or automatic, are relatively accurate but not practical. Indirect measures, from databases and medical records, are more common. Clinical data (lab tests results and other clinical markers) can indicate some of the physiologic changes resulting from taking medications. However, administrative data from medical and pharmacy claims as well as other billing records are used to calculate the Medication Possession Ratio (MPR) or the Proportion of Days Covered (PDC), the most common proxy measures for adherence.

Medication possession ratio is calculated as the number of doses supplied divided by the dosing intervals in study (MPR = # days supply/#days). This represents the percentage of days for which a patient has medication on-hand to treat as prescribed. Although this calculation is relatively straightforward, it does not account for the various possible gaps in refills when applied to the same measurement period. An MPR threshold of 80% is the most commonly targeted value. Another proxy measure for adherence is the proportion of days covered, calculated as PDC = time with drug available/time of observation. Both the medication possession ratio and the proportion of days covered measure prescription fill data. These calculations tell you how much medication the patient receives and not if the patient actually consumed or used the medication as prescribed.

With any calculation of adherence measures, it is important to understand what factors can affect the data used, which in turn, can affect any conclusions made from the calculations. Administrative data can be affected by the completeness of the data, data entry errors, the ability to link records across databases, the available data elements, and the many assumptions that are made. Doing "drill downs" deeper into the data using stratifications by the specific lines of business (e.g., commercial, Medicaid, Medicare), by age groups, by specific disease/conditions or by medication classes helps to gain more insight on what factors are behind the calculated numbers.

The abundance of medications currently available and widely prescribed makes it difficult to understand how medication non-adherence is such a widespread problem. Some of the main reasons why adults age 50 and older are not getting prescriptions filled include the following: cost of the medication; side effects of the medication; belief that the medication would not help much or that it is not needed; dislike for taking prescription medications, or already taking several medications; or the condition improved on its own or with the use of an over-the-counter, non-prescription medication. Adherence is a multidimensional phenomenon that is determined by the interplay of the following sets of factors, several listed above: patient-related factors; therapy-related factors; condition-related factors; provider/patient/health care system factors; and social/economic factors. It is along these dimensions that with the proper motivation, education and support the barriers to medication adherence can be overcome.

Finding a Solution

There are several solutions that have been used to try to improve adherence. Some of the tools currently available include: medication reminder devices; refill reminder programs; auto-refill programs; reduction in patient's share of the cost of the medication; incentives tied to participation in medication or disease management programs; various education

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Focusing on Medication Adherence

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and communication materials for patients or their caregivers; and e-prescribing. Each of these solutions addresses a different aspect of medication use/ behavior continuum, and none are a "one-stop solution."

The problem of medication adherence and the potential solutions are of great interest to employers, who are mostly concerned about increased health-related costs, decreased productivity and an unhealthy workforce. Nearly nine in ten employers rate medication adherence as an important objective in managing employee health. The "drill-down" analyses described above can provide some direction for the actions that can be taken to address non-adherence. Identifying which age-bands or conditions of the employee population or which therapeutic classes of medications tend to have the higher rates of non-adherence can help employers and others better plan which programs and tools to implement. These initiatives may be perceived as effective; however, the initiatives that employers are most confident about in terms of effectiveness are those that are most measurable.

In the most recent version of URAC standards for Pharmacy Benefit Management accreditation (PBM version 2.0), Performance Measures and Reporting Standards have been added. One of the performance measures is Medication Possession Ratios, as a retrospective proxy for medication adherence, and is required to be reported for specific medication classes. Detailed specifications for these measures are provided to organizations applying for accreditation.

The issue of medication adherence today is growing in importance and concern. Understanding the problem, how it is measured and potential solutions are all essential to ensuring that people achieve the desired therapeutic outcomes of medication therapy. There are more discussions and more activities that need to happen. Consider the following readily available tools and resources:

- www.takingmeds.com
- www.mymedschedule.com
- www.adultmeducation.com
- The World Health Organization (WHO)
- International Society for Pharmacoeconomics and Outcomes Research (ISPOR) ●

ABOUT URAC

URAC is an independent, non-profit organization whose mission is to promote continuous improvement in the quality and efficiency of health care management through the processes of accreditation and education. To support this goal, our Board of Directors represents the full spectrum of stakeholders interested in our health care system, including consumers, employers, health care providers, health insurers, purchasers, workers' compensation carriers and regulators.

Incorporated in 1990, URAC pioneered utilization management accreditation by creating a nationally recognized set of standards to ensure accountability in managed care determinations of medical necessity. As the health care industry evolves, URAC continues to address emerging issues: we now offer 27 accreditation and certification programs across the health care spectrum.

Many states have found URAC accreditation standards helpful in ensuring that managed care plans and other health care organizations are meeting quality benchmarks. Forty-six states and the District of Columbia currently reference one or more URAC accreditation programs in their statutes, regulations, agency publications or contracts, making URAC the most recognized national managed care accreditation body at the state level.

At the federal level, four federal agencies recognize URAC accreditation. The Centers for Medicare and Medicaid Services recognize URAC Medicare Advantage Health Plan Accreditation for the Medicare Advantage (formerly Medicare+Choice) Program; the Office of Personnel Management recognizes all URAC accreditation programs under the Federal Employee Health Benefits Program; TRICARE/Military Health System recognizes URAC's Health Network Accreditation; and the Department of Veterans' Affairs recognizes URAC's Health Call Center Accreditation. ●

Quality Corner: AMCP Releases New Guide for Implementing Quality Measures

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high-level information and links to resources that can help AMCP members initiate quality measurement programs within their organizations.

The guide is intended for those members not already familiar with implementing quality measures. Topics covered include:

- What is a measure?
- How do you measure?
- Pitfalls to avoid when developing measures
- Selecting the right set of measures for your organization
- Developing a detailed task plan and identifying hurdles and challenges
- Gaining administrative support by building a business case for quality improvement
- Goal setting

The guide also provides a glossary of terms as well as web links and publication references for readers to drill down to multiple layers of authoritative detail.

The guide comes amid growing expectations around quality improvement. Increasingly, managed care organizations must implement and report results of quality initiatives not only to third-party payers, government agencies, and organizations that are studying quality, but also directly to the public.

In addition, health care organizations are under pressure to lower costs. Improving quality and lowering costs and are frequently linked, both positively and negatively. "Throwing money at the problem" as a solution to a quality issue should not be the knee-jerk response. But lasting change often requires an initial investment of time, money or both. The ultimate goal of quality improvement is to provide better structures and processes of care, which may ultimately result in improved health care outcomes and lowering the cost of care (e.g. improving operational efficiency, avoiding error, reducing rework, educating for appropriate medications, and improving outcomes by enhancing compliance and safety).

An understanding of quality improvement techniques can help improve the chances that the desired outcome(s) are achieved. It was with this in mind that AMCP's Quality Task Force, in place from 2007-April 2010, developed this guide. The following are some of the concepts explored in the document.

What is a "Measure"?

It is important to understand the difference between "indicators" and "measures," and their relationship to "goals."

- A "goal" is a broad, overarching, general intention—i.e., "Improve the accuracy of our outpatient prescription dispensing."
- A quality "indicator" refers to an attribute of care or service that is conceptual in nature—i.e., an indicator of the accuracy of outpatient prescription dispensing could be, "Directions for use on the Rx label are accurate."
- A "measure" is used to quantify the performance relevant to an individual indicator. A measure for accurate directions for use on the Rx label would be—"The percent of Rx labels dispensed that contain the correct directions for use," or "The number of incorrect directions for use on a sample of 10,000 Rx container labels."

How do you Measure?

Once the technical specifications for the finalized quality measure have been detailed and tested, pertinent data can then be collected, analyzed and reported in a consistent, reliable and effective manner. Most quality measures are expressed as a rate. The basic construct

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of a measure usually begins with the numerator, denominator, exclusions and measure logic. In general, electronic claims data are the least resource-intensive method available to collect targeted quality measure components.

Pitfalls to Avoid When Developing Measures

The process for developing quality measures can be time consuming and resource-intensive. To maximize the likelihood that any given measure will be predictive of quality and universally accepted, certain practices should be avoided. These include avoiding the use of medications as a marker for diagnosis and measures that require multiple steps for analysis or incorporate complex algorithms.

Selecting the right set of measures for your organization

The standards or measures used by an organization will be determined by the specific quality goals of the organization. Managed care organizations can select from existing measures and standards, including those required for voluntary, third-party accreditation from URAC, NCQA and others. URAC accreditation, for example, requires compliance with a comprehensive set of standards addressing core organizational quality, program-specific services and operations. NCQA accreditation requires performance data on a variety of clinical and other quality measures. Organizations also may select from existing measures developed and required by government agencies, prospective clients and within the organization itself.

Developing a Detailed Task Plan and Identifying Hurdles and Challenges

Implementing quality measures requires an organizational-wide commitment. Consider the proposed task list to identify key hurdles/challenges:

Task 1:	Kick off meeting with assigned facilitator and staff.
Task 2:	Identify goals and objectives.
Task 3:	Measurement strategy design.
Task 4:	Review quality and usefulness of individual measures.
Task 5:	Validate final list of measures and the availability of supporting data.
Task 6:	Build measures and test against sample test data to ensure accuracy and appropriateness.
Task 7:	Stress test measurement performance execution time to maximize performance and ensure measurement completion is obtainable in large data scenario.

Gaining Administrative Support/ Building a Business Case for Quality Improvement

For a quality improvement approach to be most effective, it's important that it be a recognized and prioritized initiative within the organization. Therefore it is important to seek out and gain administrative support for proposed quality improvement initiatives before they begin.

Goal Setting

Goals and objectives need to be identified and clearly stated when implementing a program that measures quality. Goals need to state objectives; what needs to be done, why these goals are important, who is involved, what needs to be ultimately accomplished and how it will be accomplished. A step by step plan to reach these goals must have specific time frames with deadlines and must be realistic. There should be ongoing evaluation of the goals and the process. Endpoints must be concise and there needs to have an established criteria on how to measure the progress of achieving these goals so that change can be seen. Program interventions should measure the program's success, areas for improvement and measure what else needs to be completed in order to achieve the goal.

Members of AMCP's Quality Task Force through April 2010: Michael Tocco (chair), Janice Anderson, Carey Cotterell, Sue Cooper, Nancy England, Ed Lennard, Kim McDonough and Terri Moore

To access "A Guide Toward Quality," visit *www.amcp.org* and click on the Professional Practice tab followed by AMCP Publications. ●

National Priorities Partnership: Improving Care through Consensus

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national, state, and community level that is leveraging its collective influence to align public and private sector activities with the National Priorities, and support their implementation. The Partners believe that reaching consensus around high-leverage issue areas can drive transformational change in the nation's healthcare delivery system, dramatically improving the quality of care patients receive while simultaneously making better use of resources.

Recently, the Department of Health and Human Services (HHS) requested NQF to convene the National Priorities Partnership (NPP) to provide input on the National Quality Strategy and offer recommendations for a set of national priorities and goals. NPP is recommending the original six priorities:

- Patient and Family Engagement
- Safety
- Care Coordination
- Palliative and End-of-Life Care
- Elimination of Medical Care Overuse
- Population Health

In addition there are two additional areas of focus. Equitable Access will ensure all patients receive affordable, timely, and high-quality care; while Infrastructure Supports (like HIT) will address underlying system changes critical to achieving the national priorities and goals.

The Partners—each representing a distinct voice in healthcare—are uniquely positioned to help achieve these National Priorities and Goals, and fundamentally transform the nation's healthcare system. To make NPP as effective a body as possible, 16 new organizations were recently added, bolstering the Partnership's already deep bench of expertise that can drive towards better care, affordable care, and healthy people/healthy communities. Margaret E. O'Kane, president of the National Committee for Quality Assurance, and Bernard Rosof, chair of the American Medical Association-convened Physician Consortium for Performance Improvement, serve as NPP co-chairs.

"The addition of new Partners positions us well to make informed, actionable recommendations to the Secretary for how care in this country can be dramatically improved," said O'Kane. "After the long debate around reform, Americans deserve a healthcare system that achieves better outcomes for them and their loved ones. We believe our work can make that delivery system more of a reality."

HHS's National Quality Strategy is intended to include priorities and goals that address:

- Person-centeredness and family engagement
- Care for patients of all ages, populations, service locations, and sources of coverage
- Elimination of disparities in care
- Opportunities for the alignment of public and private sectors

The recommendations put forward by NPP address all of these key principles. Furthermore, the Partners have several years' worth of action and cooperation to demonstrate the broad support for NPP's national priorities and goals.

"NPP's initial framework was the result of a multi-stakeholder effort, and its results—both visionary and implementable—align with many aspects of health reform legislation," said Rosof. "We believe NPP's collective efforts will provide an important starting point for the development of the Secretary's National Strategy. The National Priorities Partnership encompasses the diversity of representation needed to support real implementation and the diversity of knowledge needed to effectively improve the delivery system."

Implementing a higher-quality health system is a challenging task, but NPP is building on an impressive foundation of accomplishments. In 2009, the definition of meaningful use for electronic health records was tied to a framework structured around the National Priorities and Goals. In 2010, the Institute of Medicine (IOM) recommended that future versions of the Agency for Health Research and Quality's (AHRQ's) National Healthcare Quality and Disparities Reports (NHQ/DR) should align with nationally recognized priority areas, including NPP's original priorities and expanding to emphasize access and infrastructure supports. In a sign of the broader acceptance of NPP, the nursing and child health communities both embraced NPP's framework and have begun work to align efforts around the priority areas.

Momentum is growing around NPP's work, but the support and alignment of stakeholders at every level is critical. To learn how you can make a difference, visit *www.nationalprioritiespartnership.org.* ●

Excellence and Quality are Common Attributes of AMCP Award Winners

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ing managed care pharmacy professionals; individuals who exemplify the best of our profession.

Below are descriptions of each award, which we hope will start you thinking about nominations for 2011. Please check the AMCP website for more details and application deadlines.

The AMCP Distinguished Service Award recognizes an AMCP member for exceptional and sustained volunteer service and commitment to the Academy.

The AMCP Fellow Program is intended to recognize sustained excellence in the pharmacy profession and grant recognition for exceptional contributions, long-term commitment and active participation in the Academy.

The Grassroots Advocacy Award is given to an individual or group responsible for significant activity around a grassroots cause.

The Individual Contribution Award is given to an individual making a significant contribution to the Academy by any means other than service as an AMCP Committee Member.

The AMCP Spirit of Volunteerism Award recognizes a current AMCP Committee Member who has demonstrated exemplary and outstanding service to AMCP over the past year, as well as provided volunteer activities that resulted in successful and/or high quality AMCP programs, projects or services for its members.

The Steven G. Avey Award, presented by AMCP's Foundation for Managed Care Pharmacy (FMCP), recognizes an individual for sustained, exemplary and distinguished service to the practice of managed care pharmacy.

For more information on these awards, please visit *www.amcp.org*. ●

ABOUT AMCP

Academy of Managed Care Pharmacy®

The Academy of Managed Care Pharmacy is a professional association of individual pharmacists who use the tools and techniques of managed care in the practice of pharmacy. At the heart of every member is commitment to a simple goal: Provision of the best available pharmaceutical care for patients.

As an organization, the Academy strives to achieve its mission of empowering its members to serve society by providing opportunities for continued professional growth, by advancing individual and collective knowledge. Throughout the year, AMCP provides conferences, online learning access, peer-reviewed literature through its *Journal of Managed Care Pharmacy,* and leadership development seminars.

The focus of the Academy has been to create scientifically designed methodologies for making medical choices as intelligently as current knowledge will allow, supported by evidence-based clinical studies. Some of the Academy's most successful products to date are AMCP's *Format for Formulary Submissions* and the AMCP *Framework for Quality Drug Therapy.* The *Format* is a standardized methodology for assessing drugs scientifically, based on the value they provide. Widely adopted by numerous health plans, governmental agencies such as the Department of Defense and leading pharmacy benefit management companies, the *Format* has become a de facto industry standard. Managed care organizations employing the *Format* cover approximately half of all pharmacy care beneficiaries.

Two other significant contributions to managed care practice include AMCP's *Guide to Pharmaceutical Payment Methods* and *Sound Medication Therapy Management Programs, V2.0.* The *Guide* is a comprehensive, factual description and analysis of alternative drug payment methods and payment systems, including a review of the history, current application, potential future utility, impact on managed care pharmacy, other stakeholders in the pharmaceutical marketplace and the overall health care delivery system. It includes a glossary of payment terms, tables showing which payers and settings utilize which methods, payment flowcharts to illustrate how the money flows with each of the payment systems and examples of payment calculations. Downloadable in a summary and a comprehensive format from the AMCP website, it is accompanied by a web-based interactive resource library.

These and all other AMCP publications, including the *Journal*, can be found on the AMCP website, **www.amcp.org.** ●

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