ASHP Value-Based Care Implementation Resource Guide

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Introduction:

This guidance document is a supplement to the ASHP FAQ: Value-Based Payment Models document

Value-based care (VBC) is a healthcare model that focuses on improving the quality of care, patient experience, and provider performance. The goals of value-based care include providing the best patient care experience, advancing health equity, improving the patient's health outcomes, delivering healthcare services at a reasonable cost and supporting the well-being of the healthcare workforce.(1 AMA What is value-based medical care | American Medical Association).

Population-based care, which may be considered a subset of value-based care, refers to the management of patients based on specific segments of the population using data and informed analysis, thereby identifying patterns to address care at the population level as opposed to a general approach in value-based care. Both models are focused on patient outcomes, preventive care, care coordination, incentivizing quality over quantity, and rely on data to identify trends and assess risk factors.

Value-based care models typically tie payment amounts for patient care services to results such as quality, customer service, equity, and cost of care. As opposed to a fee-for-service model, or quantity-based care, incentivizing the alignment of care with quality could result in more evidenced-based care and augment preventative care, thereby enhancing the patient experience, decreasing morbidity and mortality, and realizing an increased cost savings or avoidance. In fact, the Centers for Medicare & Medicaid Services announced in 10/2024 that the Medicare Shared Savings Program yielded more than 2.1 billion in net savings in 2023. (2, Medicare Shared Savings Program Continues to Deliver Meaningful Savings and High-Quality healthcare | CMS)

Value-based care is oftentimes accomplished through accountable care organizations (ACO). An ACO encompasses a group of physicians, hospitals and healthcare professionals that work together to provide coordinated care to improve health outcomes, share the responsibility for overall quality and share the cost of care. ACOs may be in a specific geographical area or focused on patients with specific conditions. ACOs may be able to share savings with their constituents but may also share in losses if there is increased spending. Patients receiving care through an ACO may circumvent repeated medical tests or services avoiding unnecessary healthcare utilization and benefit from integrated systems. This will streamline services, decrease healthcare spending, and can help prevent serious health issues.

Benefits of value-based care for providers:

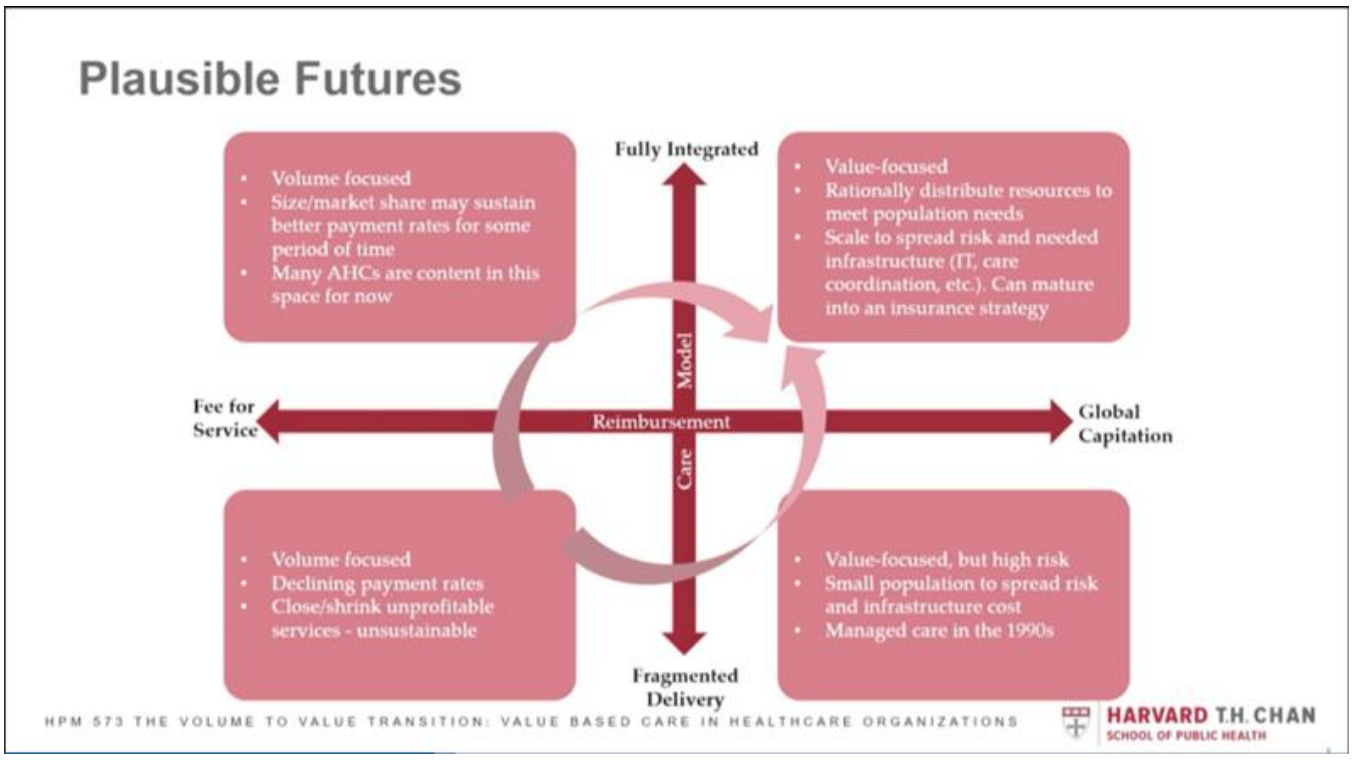
- Financial incentives: opportunity to share savings.
- Getting paid for what matters: providers focusing on work that is meaningful vs. number of patients/procedures.
- Control: empowers providers to administer care they think a patient needs, rather than what is covered by insurance
- Better partnerships: promotes coordinated and team-based care. ACOs make investments in technology to improve communication across sites.
- Less administrative burden: ACOs provide administration functions for providers, such as hiring care managers, improving office flow, and collecting/submitting quality data.

Benefits of value-based care for the patients:

- ACOs have incentives to better meet patient needs
- Reduces unnecessary services and saves patient time
- Coordinated care because team members have access to patient records, medications and test results
- ACOs have better quality results on quality measures compared to similar physician groups (CMS 2023 performance year, comparing top 10 quality measures in ACOs compared to other physician practices)
- Full access to all providers without restriction in choice
- Research demonstrates that patient experience improves in ACOs
- ACOs help patients manage social needs in addition to clinical needs

Healthcare organizations may be at different places in their journey to becoming a value-based care organization. Figure 1 lists plausible current and future states. The goal is to shift towards a value-based model where one can distribute resources and utilize a mature infrastructure to meet the patient's needs while being fiscally responsible. It will take some time and effort to shift from a volume focused to a more value-based organization.

Figure 1: Plausible futures for value-based care



The pharmacist is in a unique position to contribute to value-based care that will positively impact their organization. As part of an integrated healthcare organization, a pharmacist would have access to a patient's health information across the continuum of care and can focus on comprehensive medication management to achieve optimal outcomes. Furthermore, a pharmacist can affect multiple facets of the patient's healthcare journey. This includes comprehensive medication management and monitoring across all care settings, as well as being a main driver of the transitions of care process.

How does an organization or pharmacist start if they have not worked in a VBC environment? -

- Assess current state of VBC within the organization
    - What is the structure of any contracts in which the organization already participates?
    - What are the organizational priorities that can be influenced by pharmacist intervention?
    - Are there other departments or associates doing this work within the organization currently?

- Determine contacts which may include:
    - Payor partners - payors often employ pharmacists who can meet with the pharmacy team and share effective practices from other organizations. They can also provide care gap data and updates on performance throughout the year.
    - Internal partners (e.g., payor/contracting relations, ambulatory care quality team, finance, population health director)
    - External partners - other pharmacists in similar organizations that are doing similar work

How do health systems leverage data to identify VBC opportunities?

- IT/Technology support (e.g. reports)
- Payor reports
- Data analytics (e.g., population health dashboards, internal registries, EHR tools)

How do health systems identify patients not meeting VBC goals?

- Step 1: It is essential to work closely with payors to obtain the most up to date data. This can be achieved initially through understanding payor platforms and reports.
- Step 2: Once the team understands the payor resources and data they can then focus on getting this information in the most actionable manner. Pharmacists are uniquely positioned to filter payor lists by actionability because they take into consideration the potential interventions.

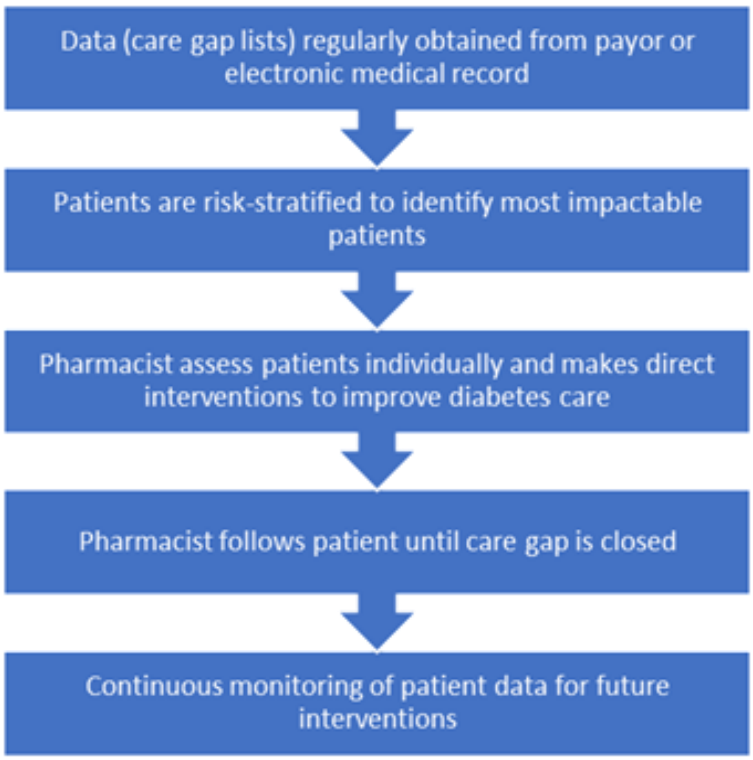


Figure 1. Example Population Health Pharmacist Workflow

What are communication strategies with patients and providers?

- Communication strategies to address value-based care measures should be considered with both patients and providers and tailored to the organizational structure and goals in order to be successful with patient outreach and closing care gaps.

- Communication strategies to consider with providers:
    - Include pharmacy-related metrics on VBC quality reports
    - Provide continual education with providers and organizational leaders to identify areas of opportunities for pharmacy involvement in VBC initiatives
    - Apply consistent documentation techniques and note templates to improve communication with providers and other members of the patient care team
    - Utilize automated reports or clinical decision support tools within the EMR to identify patients with open care gaps

  Communication strategies to consider with patients:
    - Outreach to patients may be considered via telephone and/or electronic messaging
    - Electronic surveys, questionnaires, or text messaging via the EMR may be a convenient tool for the patient to communicate with the pharmacy team regarding care gap closure and any potential barriers
    - If applicable, patient communication may also occur face-to-face during scheduled pharmacist appointments or as collaborative visits with providers in addition to telephone or video opportunities
    - Consider assigning VBC pharmacy team member to a consistent group of patients based on factors such as attributed provider or VBC contract

What are measures of success to support growth of pharmacist participation in value-based care models and contracts?

Success in value-based care models depends on pharmacist-driven interventions improving patient outcomes and reducing costs. Measures of success can include clinical, financial, and humanistic outcomes. You will want to make sure at least some of these outcomes align with organizational goals to further demonstrate success.

- *Examples of Clinical Outcomes*
    - Medication Therapy Management (MTM) Completion Rates - Percentage of eligible patients receiving comprehensive medication reviews
    - Chronic disease management - Improvements in A1c, blood pressure, LDL
    - Adherence measures (PDC $\geq$ 80%) - Proportion of days covered for key medications (e.g., statins, diabetes)
    - Transitions of Care Interventions - Medication Reconciliation Post-discharge (MRP) Number of pharmacist-led medication reconciliations reducing discrepancies post-discharge
    - HEDIS and CMS quality measures (e.g., blood pressure control for patients with diabetes, statin therapy for patient with diabetes)
- *Cost Savings and Utilization*
    - Reduced ED Visits and Hospitalizations - Quantify pharmacist-led interventions that prevent high-cost encounters
    - Medication Cost Avoidance - Savings through formulary adherence, biosimilar use, and deprescribing efforts
    - Impact on Bundled Payment Programs - Demonstrating pharmacist involvement in reducing total cost per patient episode
    - Shared Savings Participation - Contribution to organizational shared savings through improved quality metrics
- *Patient and Provider Satisfaction*
    - Patient Experience Scores - Survey data showing improved medication understanding and adherence
    - Provider Satisfaction - Qualitative and quantitative feedback on pharmacist impact in reducing provider workload
- Merit-Based Incentive Program System (MIPS)
    - Please see ASHP FAQ: value-based Payment Models document updated 2025

How do you quantify pharmacy work vs. others?

- Pharmacist care vs other healthcare team members
    - Pharmacists can track the type and frequency of interventions they are making specific to the pharmacist's role
    - Dedicated pharmacists for medication adherence measures (hypertension (HTN), diabetes (DM), statins)
    - Leverage resident projects to quantify this work (e.g., transitional care management, , readmission rates)
    - Align similar organization quality measures to demonstrate pharmacist value
    - Number of visits (e.g., pharmacist versus nurse)
    - Care gap closures and financial incentives

What are resources to justify expanding the pharmacist team?

- Cost savings from pharmacist-led interventions
- Revenue generation from billable clinic visits and prescription capture
- Improved Medicare Star ratings for Medicare Advantage and Part D Plans
    - These ratings directly influence reimbursement from CMS
    - Financial impact on healthcare providers
        - Higher star ratings lead to financial incentives
        - CMS offers bonus payments to organizations based on the star rating
        - Direct financial reward for delivering high-quality care
        - Pharmacy related Star measures and ratings

How are health systems using pharmacy technicians to support VBC?

Pharmacy technicians are valuable members of value-based care teams in many settings. Technicians can support pharmacist staff and make interventions with patients as part of the VBC team. Those with community pharmacy experience may be particularly suited to outreaching directly to patients, though with proper training programs, technicians with all forms of experience can take on these roles.

- Technician roles can include, but not limited to:
    - Patient identification utilizing EHR reports and payor lists for measures such as
        - Statins use in persons with diabetes
        - A1c > 8 %
        - BP > 140/90 last pharmacist visit
        - Medication adherence- med fill due before critical date, PDC< 80%
    - Complete chart review and triage to pharmacist
    - Adherence outreach directly to patients
    - Schedule patients referred to pharmacists for management
    - Assist patients with cost saving interventions and patient assistance programs
    - Communicate with pharmacies and payors regarding medication fills

What are barriers to implementation?

- Lack of data integration between healthcare providers
- Fragmented healthcare systems that hinder collaboration
- Limited workforce capacity in terms of time and resources
- Regulatory and legal constraints on the roles of providers, including pharmacists
- Insufficient training and education on value-based care principles
- Poor patient engagement and adherence to treatment plans
- Lack of infrastructure for data analytics and reporting
- Delays and inaccuracies in data reporting from payors
- Financial barriers to adopting new technologies and models

- Financial rewards are delayed

What are some organization examples?

- Community Health Network
    - Geographic location - central Indiana
    - Pharmacy team FTEs/make up
        - Pharmacists: Pharmacy team consists of embedded clinic pharmacists within primary care and specialty care sites. Pharmacists are involved with VBC work through direct patient care in clinics but do not have dedicated pharmacist resources for population health.
            - 35 FTE for pharmacists in primary care clinics
            - 15 FTE for pharmacists in specialty care clinics (cardiology, women's health, infectious diseases, behavioral health, COPD, rheumatology)
            - 3 PGY2 ambulatory care pharmacy residents
        - Pharmacy technicians: 2.6 FTE dedicated for VBC work.
    - Embedded vs centralized
        - Pharmacists: Primary role of embedded clinic pharmacists is for chronic disease state management for all patients (VBC and nonVBC) utilizing CDTM. Embedded clinic pharmacists will receive communication from pharmacy technicians for specific medication adherence barriers. As workload allows, embedded clinic pharmacists may also be involved with statin measure reviews and CMRs
        - Technicians: primary responsibility for medication adherence outreach and assessments
    - Number/type of value-based contracts
        - ACO, MA, Commercial, MSSP, IFP
    - Total patient population and covered lives
        - 250K covered lives
    - Process on how the organization started the concept of value-based care
        - Started as a student run service for medication adherence assessments and outreach. Based on improvement shown with student run service in quality ratings for medication adherence measures, received justification to hire pharmacy technician FTEs solely dedicated to work
        - Prioritize other VBC measures based on contracts and workload of embedded clinic pharmacists
    - Current direction
        - Utilize pharmacy technicians for medication adherence assessment, outreach, and identification of potential medication adherence barriers. Prioritize other pharmacy-related VBC measures based on contracts and workload of embedded clinic pharmacists
    - Future goals
        - Integration of payor lists into EMR for improved outcomes tracking and prioritization
        - Dedicated pharmacist for population health work

- Avera Health
    - Geographic location: South Dakota, southwest Minnesota, northwest Iowa, and northeast Nebraska
    - Pharmacy team FTEs/make up: 11 Pharmacist FTE embedded in primary and specialty clinics; 1 centralized population health pharmacist
    - Embedded vs centralized
        - Embedded pharmacists: Work primarily from provider referrals for chronic disease state management and anticoagulation management.
        - Centralized population health pharmacist: Focus on largest VBA addressing quality gaps and medication adherence. Provides pharmacy services for these VBA patients within clinics that do not have an embedded clinic pharmacist.

- Number/type of value-based contracts: 12 contracts including Medicare Shared Savings Program, Medicaid, Medicare Advantage, and commercial contracts. Mix of shared savings and shared risk.
- Total patient population and covered lives: Covered lives 155,000
- Process on how the organization started the concept of value-based care
    - 2019: Approximately 5 pharmacist FTE embedded in clinics focused on diabetes and anticoagulation management. A new position was created in 2019 for a centralized pharmacist to provide pharmacy services to sites that did not have an embedded pharmacist in addition to administrative roles in ambulatory care.
    - 2020 - 2023: Pharmacists demonstrated outcomes in diabetes care with average A1c reduction of 2.5% and two-thirds of patients meeting A1c goal of less than 8% in under 6 months. A focus on the organization's own health plan showed an average A1c reduction of 2.8%.
    - 2023: By demonstrating significant outcomes in diabetes management, pharmacy was included in initial discussions when a new VBA contract was signed. Multiple high-dollar pharmacy metrics were tied to this contract allowing for a new population health pharmacist position.
- Current direction
    - Integration of VBC activities into embedded pharmacists workload.
    - Developing systems, tools, and workflows to target and improve specific quality measure performance
    - Pharmacist collaboration with remote patient monitoring nurse teams for blood pressure management
- Future goals
    - Population Health Technician position
    - Utilize tools within the EMR to identify and prioritize patients with pharmacy related care gaps or who are high/rising risk patients

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