

# touchpoints

Connecting you to the Heritage Provider Network

Issue 18 | Summer 2014



## Rite Aid and Heritage Provider Network

Forming an Alliance  
for a Healthy Community



### »» LATEST NEWS

The initial Covered California enrollment period is closed and it's time to tally the results. Who are the winners? Who are the losers? How did HPN fare? The answers may surprise you. Get updated Covered California news on Page 7.

### »» WHAT'S INSIDE

#### FEATURED STORY:

Rite Aid and Heritage Provider Network – Forming an Alliance for a Healthy Community ....P2

**CLINICAL FOCUS:** Pharmacy Services Brings Added Care Dimension to Medical Groups...P4

**GROUP SPOTLIGHT:** Hospital Outreach Case Management Program .....P5



In order to manage the increasingly complicated medical issues facing our patients, healthcare organizations must look outside the box – and the doctor’s office – for

fresh solutions. From developing multi-disciplinary care programs, to forming strategic collaborations with like-minded healthcare-related organizations, Heritage Provider Network (HPN) is committed to finding ways to reduce the cost of care and improve the health and quality of life of our members.

In this issue of TouchPoints, we introduce our partnership with Rite Aid, through the Rite Aid Health Alliance. As two complimentary healthcare companies with a shared commitment for innovative, high-quality care, we are working together to open new avenues of care coordination that benefit both patients and physicians.

This issue also profiles HPN’s internal pharmacy services. Wide-reaching programs combining the expertise of the physician and the pharmacist to improve outcomes related to chronic conditions. Our medical groups are integrating medication management services into their continuum of care with great success.

HPN is creating a multidimensional care model, drawing on many different facets of healthcare to create a seamless and comprehensive program for our patients. Ultimately, this approach provides physicians with the resources necessary to successfully meet the diverse and complex needs of a growing patient population.



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# Rite Aid and Heritage Provider Network

## Forming an Alliance for a Healthy Community

**“Providing quality, accessible, cost-effective care to our members has long been the hallmark of Heritage Provider Network,”** said HPN’s president and CEO **Richard Merkin, MD**. By partnering with Rite Aid Corporation, Heritage Provider Network (HPN) is bringing another innovative care management tool to our members and providers through the Rite Aid Health Alliance program. Working with Rite Aid pharmacists and specially trained care coaches, this program offers physicians a means to provide comprehensive care and support to their patients with chronic and poly-chronic health conditions, without placing an additional burden on the physicians’ resources.

Targeting conditions, such as congestive heart failure, COPD, diabetes, hypertension, and hyperlipidemia, any physician, as well as case managers and other members of the care team, can refer patients into the program. Rite Aid pharmacists and specially trained care coaches provide one-on-one coaching sessions with patients, in select Rite Aid pharmacies or by phone, to help them achieve physician-identified wellness goals.

**“The program functions as a seamless extension of the physician’s office,”** explains **Brian Bobby, Pharm.D.,** director of Rite Aid Health Alliance. **“Our role is to engage the patient and empower them to make the changes necessary to improve their health and well being.”**

During the 30 to 60 minute sessions, care coaches, who are specially trained in behavior modification related to lifestyle, work directly with the patient to create a personalized care plan, tailored to reinforce the physician’s specific goals and patient’s health status. Topics such as disease education, nutrition and exercise, and smoking cessation can be addressed.

In addition, pharmacists conduct comprehensive medication reviews to improve compliance and adherence, and to screen for dangerous drug interactions. Ultimately, the goal is to get the patient to the point of disease self-management, reducing emergency room visits and hospital admissions and improving health and quality of life.

There is no set timeline for the pharmacists and care coaches to get the patient to the point of self-management. These interactions are as frequent and ongoing as necessary. Only when the patient successfully reaches their goals, are they released from the program. If at any time they feel they need additional help, the patient can self-refer back into the program. Currently, Rite Aid Health Alliance services are available for patients meeting the program inclusion criteria and the patients are not required to be an existing Rite Aid customer and/or patient to participate.

A centralized electronic record of patient interactions occurring at the Rite Aid pharmacy, physician updates, lab results, medications and patient history can be readily accessed by both the physician and the Rite Aid care team to ensure all parties are kept in the patient care loop and continuity of care is maintained.

Rite Aid developed this new integrated care-model in response to the evolving nature of the healthcare delivery system. “Rite Aid sees the shift in healthcare to a value-based model and we would like to leverage our expert pharmacists and our select retail locations to partner in improving the patient’s health and wellness,” said Dr. Bobby, “as well as working with the physicians to help lower the healthcare costs/spend of these patients.”

The Rite Aid Health Alliance pilot program began in 2012 and is available today in five markets. The results among enrolled patients, so far, have been quite encouraging. For example, patients enrolled with the health focus of weight loss have lost as much as 20 pounds, with an average weight loss of 4.5 pounds. Data shows reductions in blood pressure have occurred among enrolled patients through monitoring and coaching. In addition, the program has demonstrated a high level of patient and physician satisfaction.

The HPN family of medical groups joined the Rite Aid Health Alliance on June 2 of this year. There are 30 Rite Aid stores selected to participate in the program. An additional 11 stores are slated to come online in mid-July. Initially, several hundred HPN patients were identified to take part in the program.

According to Adam Goldston, HPN vice president of business development, Dr. Merkin’s vision for more accessible, convenient healthcare was the driving force between HPN’s partnership with Rite Aid. “Dr. Merkin wanted to ensure our members had the best access to care,” Adam said.

“Rite Aid is a great company, their stores are conveniently located and their program is an extension of our care model,” said Dr. Merkin. “It was the perfect partnership.”

The Rite Aid Health Alliance is an innovative program that reaps big benefits. Our partnership with Rite Aid makes it possible to offer a higher level of care and help drive positive health outcomes to our patients with chronic conditions.

**If you would like more information on this program, or want to participate, please call Sarah Blain, Rite Aid Clinical operations manager, at 619.517.0930.**



#### Anticipated Patient Benefits include, but are not limited to:

- ✓ Fewer ED / hospital utilizations
- ✓ Improved health status
- ✓ Better health literacy
- ✓ Greater medication adherence
- ✓ Out-of-pocket cost savings
- ✓ Personalized advice and support
- ✓ Higher quality of life



#### Anticipated Practice Benefits include, but are not limited to:

- ✓ Improved outcomes and reduced total cost of care for patients with chronic and poly-chronic conditions
- ✓ No cost versus creating and expanding your own population health management programs
- ✓ Opportunity increase membership through a unique, value-added offering
- ✓ Better member retention through high patient satisfaction

# Pharmacy Services Brings Added Care Dimension to Medical Groups

As a managed care organization, Heritage Provider Network (HPN) relies on a host of clinical services to ensure our members receive the most efficacious, comprehensive healthcare. Our Pharmacy Services departments play a critical role in our members' continuum of care, delivering effective pharmaceutical care to improve patient outcomes and overall quality of life. The overarching goal is to provide our patients with appropriate and accessible medications and medication therapies in a cost-effective manner.

## Medication Reconciliation

Our pharmacy teams perform medication reconciliation on all our post-discharge HMO, MA and ACO patients, creating a concise list of all medications the patient is taking to identify potential drug interactions, duplication of drugs, known allergies, incorrect dosing or inappropriate therapy. Pharmacists review patients' charts, make outreach phone calls to recently discharged patients and visit patients in SNFs to ensure they receive optimal medication therapy and health outcomes.

## Patient Assistance

In addition to providing medication reconciliation outreach, Pharmacy Services provides follow-up for medication-related issues, such as dosage and drug interaction, patient education regarding medication changes and answers medication related questions.

The team also works to ensure patients are compliant with their medications and to remove barriers that could hinder the patients' access to medications. This is achieved by assisting with the prior authorization process, coordinating medications and delivery with pharmacies, checking insurance benefits and helping reduce the cost of medications by identifying rebates and co-pay assistance for patients who cannot otherwise afford their prescriptions.

## Disease Management/Quality Measures

Pharmacy Services works in collaboration with the STAR/HEDIS Quality teams, case managers, social workers and medical directors to ensure we meet our quality measures and help our patients effectively manage their chronic diseases—particularly diabetes, congestive heart failure (CHF), coronary artery disease (CAD), and chronic obstructive pulmonary disease (COPD).

Our high-risk patients, ACO beneficiaries and MA patients receive proactive care through medication reconciliation, disease education, and review of lab results to monitor for

dosage adjustments. In addition, the Pharmacy Services teams work with patients on medication adherence and compliance, making sure patients not only fill or refill their prescriptions, but are compliant in taking their medications as prescribed.

## Outreach and Education

The Pharmacy Services team works closely with our physicians, conducting one-on-one meetings to address patient issues, providing education for quality measures and helping physicians address complex drug therapy questions. They also help physicians and other prescribers choose insurance-eligible drugs that will meet patients' needs. As part of their educational initiative, they work with pharmaceutical companies to sponsor larger-scale physician education programs addressing chronic disease management and medication therapies.

In an effort to promote health and wellness to the communities we serve, our pharmacists perform community outreach, speaking at educational events on important issues such as medication safety, medication reviews and other medication and disease management topics.

Pharmacy Services is involved in every step of the patient care process and the team is committed to ensuring medications are used in an appropriate manner for positive patient outcomes throughout each and every step. While their duties may seem complex and diverse, the end results are worth it.

**“This process aids in keeping healthcare costs under control by preventing hospital admissions or readmissions due to medication errors or non-adherence,” says Bahar Davidoff, Pharm.D., director of Pharmacy Service for Regal Medical Group, Lakeside Community Healthcare and ADOC Medical Group.**

**“Ultimately, providing this comprehensive management to our patients' care allows them to receive the medications necessary to improve their health and quality of life.”**

# Hospital Outreach Case Management Program



## Bakersfield Family Medical Center

Bakersfield Family Medical Center (BFMC)/Heritage Physician Network takes pride in our distinctive case management program designed to monitor and offer support to patients who are recently discharged from the hospital. There are two main aspects of the Hospital Outreach Case Management Program: patient outreach after a hospital stay or 23-hour observation and following up with patients who were recently placed on hospice care.

After a BFMC member undergoes a hospital stay or observation, a case manager from this outreach team—comprised of RNs and LVNs—places a call to the member within 48 hours of discharge to ensure the patient receives all services necessary to prevent re-hospitalization to the extent possible. These services may include, but are not limited to, placement (either at home or in another facility), assistance with referrals or authorizations for specialty care, social services, assistance for possible Medi-Cal eligibility, and transportation benefits. Case managers also act as liaisons between patients, provider offices, and BFMC/HPN to ensure that all referrals and authorizations are facilitated efficiently.

When a patient returns home after their hospital visit, RNs and LVNs on the outreach team work with the patient and patient's family members to ensure the patient feels comfortable in their own home and continues to receive all necessary medical services. This team also assists with deciding if the member is eligible for BFMC's Priority Care program, which provides intense case management for patients with certain medical conditions.

Additionally, the outreach team reviews emergency room (ER) utilization information to determine why a patient might be over-utilizing the ER instead of seeking medical care from their assigned primary care physician or specialty network. The case managers will reach out to these members to provide patient education, assist them in receiving expedited service at our Urgent Care Center, or help them make any necessary appointments.

The second aspect of the Hospital Outreach Case Management Program is focused on patients who have recently been placed on hospice care. The RN or LVN will contact the patient or family members within 48 hours to determine what medical services are necessary and what services they are receiving. The RN or LVN works with the contracted hospice care provider to ensure that all the patient's needs are being met and that the patient is comfortable at home. There are two categories of hospice care patients: low risk and high risk. Low-risk patients are typically only contacted once within the first 48 hours. High-risk patients are monitored more closely, as they are identified as patients who are more likely to call 911 for medical assistance. Case managers provide patient education on medical diagnoses and services available through the hospice provider to ensure the patient is taking advantage of all services available to him or her.

**Patient education combined with personal contact with these patients contributes to the success of the Hospital Outreach Case Management program.**

## Desert Oasis Healthcare

**The landscape of the US healthcare system is changing and Heritage Provider Network (HPN) continues to embrace the evolution of patient care.**

Beginning in 2005, Desert Oasis Healthcare (DOHC), an HPN affiliate, began the task of design and implementation of an anticoagulation service whose goal was to encompass 100% of patients taking Warfarin.

At that time, one pharmacist was handling 300 enrolled patients. Fast forward nine years, and the program now encompasses 11 pharmacists, seven pharmacy technicians, and 32 staff members managing 3,400 anticoagulation patients, representing most of the HPN affiliates throughout Southern California. Throughout those nine years, the process was optimized for pharmacist management of those chronic diseases that are treated primarily by medications.

Chronic disease management was phased in over multiple years and includes: medication review and reconciliation (2006), hepatitis C (2007), poorly controlled diabetes (2010), newly re-vascularized coronary artery disease (2013), as well as antibiotic stewardship. In addition, two postgraduate year-one resident pharmacists and up to 30 third and fourth-year pharmacy students each year are trained through this program.

These efforts have assisted DOHC in achieving 5-STAR status for our diabetes measures, as well as those relating to medication reviews for Special Needs Plans (SNP) members. The program has shown consistent and considerable reductions in A1c and lipids that are sustainable and contribute to an overall reduction in all cause utilization for those patients in the Diabetes Management program. The Coronary Artery Disease program has seen a 1.5% reduction in 30 day readmissions post CABG/stent in less than one year.

DOHC continues to invest in those pharmacists that demonstrate the ability to connect with our patient population through their passion and knowledge. These pharmacists are predominantly residency trained and in 2013, five of our pharmacists achieved board certification status with an additional three scheduled to sit for the exam in 2014.

Pharmacists have recently been recognized in California as “providers” and a House of Representatives Bill (HR 4190) is pending to grant pharmacists provider status under CMS Medicare Part B, in underserved areas.

It is clear the future of population-based health management will require a team of professionals working in a patient-centered community model, each contributing their unique skills. HPN’s evolution and investment in innovative models place it at the forefront of the wave of transformational change. The use of pharmacists is a critical piece of that evolution.

The programs and clinical expertise in medication use strategies have been well described by DOHC as well as our affiliated sister groups. The best stories are told by our clinicians, though, and they describe how they have positively changed patient’s lives. A few of these examples follow.

“Here is a patient care experience that will stick with me. I have a patient who is a type 1 diabetic who had a hemoglobin A1C above 9% at time of his referral. Complicating his care was the fact that he was a recovering heroin addict with just 3 months of sobriety. While going through withdrawal in those first weeks, I saw him weekly as he was having frequent lows. In just two months, his A1C dropped to 7.3%. The patient is now active in his care, wants to keep his diabetes under control, and wants to remain sober. He is being discharged from rehab next week and plans to get a stable job and has a spot at a sober living house. He frequently says thank you during our calls and feels that MMDMs caring for him helped him get better and that he would never have made it this far without that help. – Jennifer Pharm.D.

Last December, a case manager asked one of the pharmacists to accompany her to see a patient who very recently suffered a heart attack and was taken off Warfarin to undergo catheterization and revascularization. The patient’s INR was down to 1.4 and had developed a clot in his arm where they had placed the IV line. We got him restarted on Lovenox and Warfarin. At first he was upset when I spoke with him, but I reassured him and told him not to worry. I told him that I would personally take care of his case and that he could always ask for me when he calls in. He was pleased that I was listening to him and cared about keeping him safe. We quickly got him therapeutic and he always calls me when he has any concerns because I helped him right away. He has had several procedures since and I always make sure he is bridged with Lovenox and keep in touch with him every step of the way. He is very grateful to our department for taking good care of him. – Jan Pharm.D.

# Covered California Open Enrollment Finishes Strong; Exceeds Expectations

The closing days of the Covered California’s open enrollment period saw a last minute surge of sign-ups, pushing final enrollment numbers to just shy of 1.4 million. The final tally for the historic first open enrollment period was far above the initial projections of 580,000. In addition, nearly 1.9 million individuals across the state have been enrolled in Medicare during the 6-month period, which ended March 31.

Los Angeles County enrollees totaled 400,889 consumers, representing roughly 29 percent of the total enrollment in California. The county makes up 31 percent of those eligible statewide to enroll in the Covered California health insurance marketplace.

The coveted 18-to-34-year-old “young invincibles” demographic—who make up about a quarter of the state’s population—represented about 36 percent of new enrollees. This is seen as good news for the health law, which needs this often-healthier age group to help balance the risk pool and keep costs down.

Latino enrollment, which was 28 percent of the total, fell short of expectations. Latinos make up more than half of the state’s uninsured population.

Nationwide, more than 8 million enrollees signed up. This exceeded the initial expectation of 7 million. Of these other 8 million, 28 percent were in the 18-43-year-old age bracket.


The figures on enrollment do not reflect whether individuals have paid their premiums or started coverage. This information will be available in future reporting.

Heritage Provider Network was very pleased with its Covered California enrollment, surpassing its expectations for exchange membership.

### Covered California Highlights:

- **88%** were eligible for financial subsidies.
- **90%** chose one of the four health insurance carriers that have traditionally been the largest in the individual market: Blue Shield of California, Anthem Blue Cross of California, L.A. Care Health Plan and Health Net.
- **70%** of individuals who were eligible for subsidies, selected the Silver level of benefits, which is the level at which the federal premium assistance is targeted. Those who were not eligible for subsidies were more likely to buy across the spectrum of levels of coverage
- **41%** self-enrolled, while 39 percent enrolled through agents



 CALIFORNIA EXCHANGE	Base Projection** for 3/31/2014	Total Enrolled (with plan selection) by 3/31/2014*	Difference from base projection for 3/31/14	Performance as of 3/31/2014* (% of 3/31/14 base projection)
<b>Geographic Regions</b>				
Greater Bay Area	89,599	289,021	199,422	323%
Sacramento	28,726	69,540	40,814	242%
Central Coast	32,602	95,499	62,897	293%
Los Angeles	177,602	400,889	223,287	226%
<b>Statewide</b>				
<b>Total</b>	<b>580,000</b>	<b>1,395,929</b>	<b>815,929</b>	<b>241%</b>

\* Data include individuals who finished their applications and selected plans through April 15, 2014.

\*\* Covered California projections based on available information, including CalSIM 1.8 data.