Accountable care organizations (ACOs) are groups of health care providers (e.g., physicians, hospitals, health systems) that are jointly held responsible for improving the quality of care and reducing costs (or the rate of growth in costs) across the health care continuum, including the ambulatory care, inpatient, and long-term-care settings. The Patient Protection and Affordable Care Act (generally known as the Affordable Care Act) enacted in March 2010 authorized the Centers for Medicare and Medicaid Services (CMS) to contract with ACOs to provide health care to Medicare beneficiaries under the Shared Savings Program beginning in January 2012. The goals of the Shared Savings Program are threefold: improve care for individuals, improve the health of the population, and reduce the rate of growth in health care expenditures. Several models for reimbursement have been explored involving the payment of bonuses to such health care groups as incentives for achieving CMS goals for performance and cost savings. Shared risk is part of some models. Assessment of quality outcomes ensures that cost savings are not realized at the expense of the quality of care provided. Pioneer ACO programs, which are demonstration projects established by the Center for Medicare and Medicaid Innovation, have been established at selected health care facilities. Starting in October 2012, CMS began to reward hospitals that provide high-quality care for their inpatients through the new Hospital Value-Based Purchasing (VBP) Program. CMS will reduce diagnosis-related group payments for excess readmissions for certain conditions (pneumonia, acute myocardial infarction, and heart failure in fiscal year 2013, which began October 1, 2012, and chronic obstructive pulmonary disease, coronary artery bypass graft surgery, percutaneous transluminal coronary angioplasty, and other vascular conditions in fiscal year 2015, which begins October 1, 2014). ACOs may be administered through private health insurance plans or state Medicaid agencies instead of CMS. The goals of these ACOs are the same as those of ACOs administered by CMS (i.e., improved health outcomes and reduced health expenditures). The extent to which ACOs have been established by CMS, Medicaid, and private insurers varies widely, with some ACOs in the early stages of planning and others further along in the implementation process. Most Medicaid ACOs are in an early stage of development, partly because of the challenges associated with meeting state and federal legislative and regulatory requirements and the needs of low-income and chronically ill patients. An initiative is underway by the Center for Health Care Strategies, a nonprofit health policy resource center whose mission is to improve the health of these patient populations, to help state Medicaid agencies design and implement ACOs. As states devise strategies to implement the Affordable Care Act, state health officials are likely to collaborate with federal health officials to facilitate Medicaid ACO implementation. The ACO model of health care delivery promotes continuity of care, which requires communication among health care professionals. The implementation of ACOs contributes to health reform by ensuring that patients are treated in the most convenient and cost-effective location, avoiding unnecessary hospital admissions and readmissions, requiring collaboration among physician groups and hospitals, focusing on chronic and preventive care, referring patients internally (i.e., within the ACO where services are most accessible).
cost-effective), providing for smooth transitions in care, minimizing costs, and providing value. Considerable cost savings are often realized by avoiding referrals to health care providers outside a health system.

In 2010, U.S. health expenditures reached nearly $2.6 trillion, representing a more than 10-fold increase since 1980. In 2008, one in eight hospitalized surgical patients and one in five nonsurgical hospital patients were readmitted to the hospital within 30 days. Chronic diseases (e.g., hypertension, heart disease, stroke, cancer, diabetes mellitus, pulmonary disease) account for roughly 75% of health care expenditures in the United States, and medications play an important role in the management of chronic diseases. Inappropriate medication use is a major factor contributing to U.S. health care costs. In the late 1990s, approximately $2 billion in hospital costs alone were attributed to preventable adverse drug events affecting inpatients each year in the United States. Recent data suggest that the rate of adverse drug events in hospitals may be 10-fold higher than was previously thought, affecting one in three hospitalized patients. In the ambulatory care setting in the United States, the estimated cost of drug-related morbidity and mortality was $76.6 billion in 1995; by 2000, this cost exceeded $177 billion. The pharmacist’s role in improving health outcomes, reducing the need for hospitalization or rehospitalization, and reducing health care costs through medication therapy management (MTM), discharge planning, and other direct patient care services has been well documented. Pharmacist involvement in ACOs is less well established.

On June 29, 2012, ASHP convened the ASHP Task Force on ACOs in Bethesda, Maryland, to make recommendations on how best to help its members integrate pharmacy services into the ACO model. The Task Force provided insight into the medication-use process in ACOs, made recommendations for implementing ACO models, identified opportunities for and barriers to pharmacy involvement in ACOs, anticipated future evolutionary changes to ACO models and the impact on health care reform, and made suggestions for possible ASHP actions to assist members with ACO-related issues.

The ASHP Task Force on ACOs comprised individuals with administrative and clinical experience with ACOs in various academic and nonacademic settings, including several individuals involved with pioneer ACOs. A complete roster of Task Force members is provided in Appendix A.

This report summarizes the discussions of the Task Force and will be used as part of ASHP’s strategic planning process by the ASHP Board of Directors and ASHP staff.

**New paradigm**

The ACO is an integrated patient care model that emphasizes payment for quality of care instead of quantity of care (i.e., pay for performance instead of a fee-for-service model). Implementation of the ACO model of health care delivery requires a change in mindset among health care providers and patients. In the past, the health care provider was the focus of the health care delivery model, with competition among members of various health professions for roles and responsibilities in the health care delivery process. Compensation was provided for specific services. The ACO model involves a new patient-centric approach in which pharmacists and other health care professionals focus on how they can best use their expertise to meet patient needs. To allay concerns about the potential adverse impact of ACO implementation on scope of practice and livelihood, health care professionals should seek to assume roles and obtain compensation as valued members of a team that provides patient care instead of securing payment for specific services.

The new paradigm associated with ACOs requires a change in the health-system leadership culture from one in which personnel have narrowly defined responsibilities, often based on departments (i.e., silos), to one in which the health care team has shared responsibility for patient outcomes. Specific tasks should be delegated to team members who are best equipped to assume the responsibility based on their education, training, and experience, regardless of departmental affiliation.

It is in pharmacists’ best interest to collaborate with other health care professionals and build effective working relationships. Developing these relationships early in the process of establishing an ACO can help avoid contentious debate and conflict about scope of practice as ACO planning proceeds. Pharmacists should focus on assuming roles and responsibilities with the greatest impact on patient safety and outcomes and be willing to relinquish their involvement in other roles and functions with comparatively less impact.

Health-system administrators need to recognize pharmacy services as core patient care services instead of ancillary services, as has often been the case in the past. Health-system administrators should be encouraged to help pharmacy administrators redesign pharmacy services as part of a “system of care” model in which budgets are allocated based on the disease, condition, treatment, or other intervention so that appropriate pharmacy resources can be deployed across multiple settings within the system of care.

Automation and technology (e.g., electronic communication among pharmacists, other health care professionals, and patients; robotics for dispensing; cloud computing for data sharing) should be used to
improve the efficiency, accuracy, and convenience of patient care services in ACOs. These technologies are particularly helpful in rural areas where geographic distances between patients and health care professionals are large. Pharmacy technicians contribute to efficiency in providing pharmacy services, so pharmacists should seek to optimize the use of trained pharmacy technicians, allowing pharmacists to spend more time providing direct patient care services.

Patients in ACOs need to assume greater responsibility for their own health care. Providing incentives for patients to adhere to their drug therapy plan or removing barriers to adherence (e.g., eliminating copayments and other value-based insurance design strategies to promote the use of cost-effective services) can facilitate this process. The ambulatory care patient population should be targeted in strategies to motivate and empower patients to assume greater self-care responsibilities because of the large size of this patient population and the high costs associated with institutionalization for avoidable health problems.

Pharmacists are recognized as medication-use experts and should provide leadership in ensuring that medication-related ACO quality-performance standards are met. Pharmacists also should take a leadership role in addressing medication-related performance measures used in CMS’s Hospital VBP Program. ACO performance ties in with VBP performance, though the latter relates more narrowly to the acute care hospital setting than the former. The ACO and VBP performance standards and measures represent opportunities for pharmacists to demonstrate their impact on patient outcomes. The impact of the pharmacist could extend to performance standards beyond those that are medication related (e.g., patient satisfaction), especially as pharmacists advance their role as members of the health care team.

A goal of implementing ACOs is to provide high-quality population-based care, and the transition from a fee-for-service model to population-based care has led to a change in incentives focused on providing quality patient care instead of a high volume (i.e., quantity) of services. This shift in incentives has already begun to break down barriers between health care professions (i.e., eliminate silos) because of alignment of incentives among members of these professions. Shared accountability (i.e., shared risk) for patient outcomes and health care costs is needed to provide quality care and reduce waste.

Integrating the pharmacy profession

Many health-system pharmacists practice in acute care settings. The Pharmacy Practice Model Initiative put forth by ASHP is focused primarily on the inpatient setting, as well as ambulatory care and clinic settings in health systems. As health-system pharmacists become involved in ACOs, they need to think beyond the walls of their institutions and in broader terms about health systems as part of the health care continuum. This continuum includes the ambulatory care or home setting, acute care hospitals, clinics, physicians’ offices, and long-term-care facilities, such as rehabilitation facilities, skilled-nursing facilities, and nursing homes. Nonacute conditions need to be considered along with acute conditions when developing strategies to provide pharmacy services in ACOs.

Most health care consumers obtain care in the ambulatory care setting, where the continuity of care is often interrupted because of a lack of infrastructure and mechanisms for health care professionals to follow patients after they leave health care institutions (e.g., hospitals, rehabilitation and long-term-care facilities). Although many community pharmacists are active in disease screening and monitoring programs, immunization programs, MTM services, and other advanced patient care activities, community pharmacist participation in patient counseling and other patient care activities often is hindered by a large workload (i.e., high volume of prescriptions). A lack of access to complete patient data and compensation for patient-oriented services beyond the most basic functions involved in filling prescriptions also may limit the extent to which patient care can be provided in this setting. Community pharmacists need to become engaged in the patient care process to a greater extent and network with pharmacists across the care continuum to meet the goals of ACOs. Strategic partnerships and alliances between health-system pharmacists and community pharmacists are needed.

Various pharmacy associations were originally established to meet the unique needs of pharmacists practicing in specific settings, such as hospitals, community pharmacies, long-term-care facilities, and managed care organizations. These pharmacy associations will need to collaborate in helping members become involved in ACOs due to the need for communication during care transitions (i.e., medication reconciliation) and other pharmacist interventions across the care continuum.

Pharmacy education and training

The curricula at pharmacy schools and colleges need to be evaluated and reworked to prepare students to practice effectively as members of the health care team in ACOs. Health-system pharmacists should collaborate with the academic thought leaders who are responsible for professional training to ensure that students are equipped for the new practice roles required in ACOs. Additional training of students is needed in physical assessment, medication reconciliation, and com-
munication skills. The creation of a business case to obtain funding for pharmacy services as part of an ACO could also be part of the pharmacy curriculum. Experiential programs should place students in a variety of practice settings across the health care continuum to provide students with a broad view of the patient care services needed in ACOs. Pharmacy faculty who coordinate experiential programs for pharmacy students should establish partnerships with health care professionals at diverse practice sites to ensure that students are exposed to an integrated health care model and develop the skills needed to function effectively in these settings. Interprofessional collaboration among the faculty at pharmacy, medical, nursing, and other health care professional schools is needed to prepare students to assume effective roles on health care teams in ACOs.

The use of informatics (e.g., clinical decision-support programs with alerts, follow-up medical appointment and medication administration scheduling programs) is a vital component of education. Pharmacy schools and colleges should consider working with information system vendors to train students in the use of these systems.

Simulation centers with computer-based programs have been established for training students and staff in medicine, pharmacy, nursing, and other health professions in clinical decision making. These programs illustrate a team-based approach to addressing patient cases. Many of these cases (e.g., emergency scenarios) cannot be taught in a real-world setting because of the need for prompt decision-making and the serious consequences of mistakes. Good patient cases that illustrate common scenarios encountered in pharmacy practice within ACOs need to be developed for use in these simulation centers. The technologies used for pharmacy student education and training also may be useful for pharmacy staff development programs in health systems.

Challenges and opportunities

Integrating pharmacy programs into the ACO model of care presents many challenges, including difficulty with (1) identifying high-risk patients who stand to benefit most from pharmacy services designed to improve outcomes and reduce costs, (2) planning, coordinating, and communicating among hospitals, clinics, physicians’ offices, and community pharmacies (i.e., across the health care continuum), (3) measuring the quality (i.e., clinical) and financial impact of the pharmacist, and (4) communicating effectively with patients and influencing their medication- and health-related behavior. Many of these challenges represent opportunities for pharmacists to devise innovative solutions to meet ACO goals.

Prioritizing patients for pharmacy services. To obtain the greatest return on investment in pharmacists as members of the health care team in ACOs, it is important to allocate pharmacist time and efforts wisely. Although a minimum standard of care should be provided to all patients, pharmacist interventions should target high-risk patients who are likely to experience poor health outcomes or use costly health resources. For example, high-risk patients could receive face-to-face discharge medication counseling from a pharmacist and follow-up contact by a pharmacist after discharge instead of written information from a nurse with no follow-up. Risk stratification is needed to identify high-risk groups of patients, but risk analysis is a complex process. The criteria to use in risk stratification are not entirely clear because of a lack of scientific data. Patients with certain complex chronic diseases or conditions commonly associated with poor outcomes (e.g., diabetes mellitus) are one group that should be prioritized for pharmacy interventions because these patients are responsible for a disproportionately large investment of health care resources and costs. Other groups to target for pharmacist intervention are less well-defined but could include patients receiving certain high-risk drugs with a low therapeutic index and patients receiving a large number of medications. Point-based risk-scoring systems have been developed for use in the inpatient setting, but their applicability in other settings is limited. Some risk-stratification systems are homegrown, and others are commercially available. Lack of an evidence base, reliance on empirical data, and lack of validation for criteria used to identify high-risk patients are problems associated with some of these systems. A relevant set of criteria for risk stratification (e.g., certain conditions known to be associated with a high rate of hospital readmission at a particular facility) and workable methods for applying the criteria are needed. For example, several days before hospital discharge, a trained pharmacy technician could screen for patients meeting the criteria for a high risk for readmission and schedule patient discharge medication counseling with a pharmacist, follow-up telephone calls with the pharmacist, and a follow-up patient visit with the primary care provider. Mechanisms for communicating with patients after they make the transition to another care setting are needed for such follow-up. Automation of risk-stratification systems across the health care continuum would improve efficiency, but automating systems is a challenge.

Coordinating and communicating across the health care continuum. Avoiding fragmentation of care is vital for optimizing patient outcomes and preventing avoidable problems that result in the use of costly health resources (e.g., hospital readmission). Discharge plan-
ning, medication reconciliation, and communication among health care professionals about other aspects of patient care at the time of transition between care settings contribute to the continuity of care. These processes are particularly important for patients who are at a high risk for poor outcomes because of chronic diseases, use of large numbers of medications, or lack of a support network at home. Pharmacists should collaborate with care coordinators to avoid fragmentation of care.

Difficulty sharing patient information across the health care continuum is a major barrier to the successful incorporation of pharmacy programs into ACOs. Pharmacists in some settings (especially small community and rural health care facilities) often have limited access to patient information beyond what is provided in the prescription. Information about the diagnosis, comorbid conditions, immunization history, laboratory data, vital signs, and other physical examination results is often not available in these settings. Communication between health-system pharmacists and physicians in the community about the health status of patients discharged from the hospital often is difficult. Connectivity among central and remote patient care locations to facilitate communication among health care providers is often lacking, especially when patients seek health care from providers outside health systems. Patient privacy and confidentiality, system security, and identity theft also are concerns. An integrated patient care system requires support from an integrated information system.

Health information technology is available, and the Pharmacy e-Health Information Technology Collaborative (a group of pharmacy organizations, including ASHP) has defined a minimum data set and functional pharmacy practitioner electronic health record (PP-EHR) capabilities. However, the limited extent to which health information system vendors have accommodated pharmacy needs and a lack of standardization of pharmacy software applications are problems.

Establishing collaborative drug therapy management agreements between pharmacists and physicians is vital to optimizing the use of pharmacists to meet ACO goals. The lack of quality-improvement tools to monitor and evaluate the effect of pharmacist interventions on patient care as part of these agreements is a potential barrier to the successful incorporation of pharmacy services into ACOs. A quality-improvement tool that is part of an integrated system is needed. Such systems can facilitate scheduling of patient care visits with multiple health care providers in different settings (e.g., a pharmacist and dietitian) to optimize convenience for and satisfaction of the patient.

Physician acceptance of pharmacists in collaborative drug therapy management agreements may vary, depending on physicians’ perceptions of and confidence in the training, experience, skills, and abilities of the pharmacist. Marketing of the scope, depth, and value of pharmacy training (especially residency training) may improve physician acceptance of pharmacists in collaborative drug therapy management agreements. Nevertheless, assurance of pharmacist competence through certification or other credentialing beyond licensure may be needed to gain physician and payer acceptance of pharmacists in collaborative drug therapy management agreements. Some health systems have developed formal annual staff-credentialing programs, with peer evaluation of performance. This credentialing process leads to designation as an advanced-practice pharmacist, analogous to advanced-practice nurses with specialized education, knowledge, skills, and clinical roles. In 2011, the Council on Credentialing in Pharmacy (a group of 13 organizations, including ASHP) published guiding principles for postlicensure credentialing of pharmacists. This document encourages the implementation of credentialing and privileging processes in all pharmacy practice settings based on the patient care responsibilities of the pharmacist. The complexity of care provided by pharmacists practicing in ACOs may vary, and new models for credentialing and privileging of pharmacists in ACO models are needed. The Council currently is working on a follow-up report with model credentialing programs that might be helpful.

Liability may be a concern for pharmacists entering into collaborative drug therapy management agreements. Pharmacists should consult with institutional legal advisors and risk-management personnel about these concerns.

Measuring pharmacists’ quality and financial impact. Pharmacists often are able to convince physicians and nurses of the value of pharmacist input into patient care but find it more difficult to demonstrate their value to health-system administrators, payers, and other decision-makers. A business case needs to be made to convince health-system administrators and payers of the wisdom of investing resources in the use of pharmacists in ACOs to meet the goals of improving patient outcomes and population health and containing costs. This business case should be built on documented evidence of the impact of the pharmacist on patient adherence to drug therapy plans; prevention of adverse drug events, medication errors, and hospital admissions and readmissions; and related reductions in costs. The large potential return on investment should be emphasized in the business case.

Pharmacy staff members need to examine what the health-system leadership uses as performance metrics. In addition to financial metrics (e.g., the number and cost per day of
readmissions, cost of drugs), process metrics (e.g., the tasks involved in and amount of time required for patient care), clinical or quality outcome metrics (e.g., culture and susceptibility test results), and satisfaction metrics (e.g., patient surveys, physician consultations) are often used. Understanding which metrics are used in the institution can help pharmacists prioritize their efforts to demonstrate a favorable effect on ACO performance.

An integrated care map or flow chart should be developed illustrating core service lines (i.e., which health care professional performs which functions) and identifying high-risk diseases and conditions that represent opportunities for intervention to improve outcomes. The role of the pharmacy service (i.e., who, what, how, when, and how often) in providing care for patients with these diseases and conditions should be defined. This approach has been followed in the inpatient setting for traditional services (e.g., pharmacokinetic consultations, with dosage adjustments made for patients with renal impairment). Pharmacy services that are new as a result of the VBP Program and the ACO model in the inpatient setting include readmission medication histories and reconciliation, provision of early inpatient education, medication reconciliation at the time of discharge focusing on factors that promote medication adherence in a real-world setting, and postdischarge patient follow-up.

Templates or other tools are needed that yield qualitative and quantitative clinical and financial data based on valid metrics. Metrics are needed to capture the impact of pharmacist interventions on hospital readmission rates. Cost data are particularly valuable for ensuring that pharmacists are not omitted from ACO plans for providing patient care services. The net cost of treatment after taking into consideration resource consumption should be ascertained. Standalone tools are available but are inadequate.

The health-system and pharmacy leadership may have limited familiarity with the performance metrics required by ACOs and CMS’s VBP Program, including the weighting of the VBP Clinical Process of Care Measures (e.g., acute myocardial infarction, heart failure, pneumonia, Surgical Care Improvement Project) and Patient Experience of Care Measures (i.e., Hospital Consumer Assessment of Health Care Providers and Systems). An understanding of pay-for-reporting and pay-for-performance requirements and the four domains of quality measures for pioneer ACOs (patient/caregiver experience, care coordination/patient safety, preventive health, and at-risk populations) is needed. Health-system pharmacists should partner with hospital-based regulatory or quality-reporting-department personnel to stay abreast of federal, state, and other (e.g., Joint Commission) performance measurement requirements.

Large volumes of data are generated in large health systems, and quality-improvement personnel may require pharmacist input to identify which data are most useful. Pharmacists should collaborate with quality-improvement personnel to ensure that data selected for analysis yield information that is relevant and useful.

Predictive models are needed to identify gaps in care where pharmacist interventions could yield substantial benefits in improving patient care. Identifying such gaps would allow pharmacists to prioritize their efforts and optimize results from limited resources. Software programs are needed to facilitate the identification of patient care issues and streamline the pharmacy workload.

The pharmacy services provided to selected high-risk patients in an ACO often exceed what are provided for low-risk or non-ACO patients, because focusing limited resources on the subset of patients most likely to experience poor outcomes that are costly is efficient and wise. In many health systems, care is provided to some patients in an ACO model and to other patients using a fee-for-service model. The approach to demonstrating the financial impact of pharmacists when integrating pharmacy services to support the VBP Program and reduce hospital readmissions is similar to that used when justifying pharmacy services for an ACO.

Communicating with patients and influencing patient behavior. Inabilities to communicate effectively with patients and influence their medication- and health-related behavior can present a barrier to achieving ACO goals. These goals require that patients gain an understanding of their disease or condition and its management and adhere to the treatment plan. Standardized terminology and content are needed in patient education to provide this understanding and prevent the confusion that can arise when different (sometimes conflicting) messages are received from more than one health care professional. Collaboration among practitioners in hospitals, physician offices, managed care organizations, and community, mail-order, and home infusion pharmacies is needed to provide a consistent message to patients and avoid the confusion and nonadherence that can result from mixed or conflicting messages.

Face-to-face counseling may be helpful for patients with complex needs (e.g., a new diagnosis of diabetes or another complex disease, a need to learn how to use inhalers or other complex devices for treatment or monitoring of chronic diseases). Face-to-face counseling sometimes can be provided effectively for patients at remote locations using modern technology (e.g., Internet-based audio and video communication). However, face-to-face counseling is
not essential for all patients. Patients should be stratified based on their educational needs to prioritize the use of counseling resources for patients with the greatest need.

Providing patient education promotes adherence, which may be measurable in an integrated system by using prescription-refill data and calculating the medication possession ratio (percentage of time a patient has access to prescribed medication) or proportion of days covered (number of days all prescribed drugs are available out of the number of days of follow-up). However, it can be difficult to assess adherence across the care continuum. Programs to promote adherence are needed, but developing such programs is time-consuming.

Providing patient education does not always translate into behavioral change that promotes health goals because of a lack of motivation or other barriers to change. Some patients need to be provided with incentives to overcome these barriers and make necessary changes. Incentives should be framed in the context of a patient’s personal values, needs, and goals (e.g., a wish to avoid ill health, disability, hospitalization, and premature death for the sake of loved ones). Because human behavior is complex, multiple strategies involving more than one member of the health care team may be needed to overcome barriers to change. Interprofessional collaboration may be needed.

Motivational interviewing—a collaborative, patient-centered form of guidance used to elicit and strengthen motivation for and commitment to change in the patient—is an important technique and skill that pharmacists need to develop and use to help patients achieve health goals. Pharmacists need to avoid what patients may perceive as lectures about medication use. Patients need to be empowered and positioned to succeed as they prepare for and make changes. Education alone is often insufficient to achieve behavioral change. Nevertheless, education is an important component of motivational interviewing to elicit the desired behaviors. The timing of this education can be critical. Education and follow-up reinforcement should be provided at a time when the patient is most receptive and likely to retain the information presented, not at a time when he or she is distracted by pain, other discomfort, or concerns about imminent discharge from a hospital or another care transition. Ideally, patient education is provided in the ambulatory care setting to preempt the need for hospitalization. In the acute care hospital setting, education might be provided early in the course of the hospital stay as well as near the time of discharge and after the transition to another care setting (i.e., in the home or a rehabilitation or long-term-care facility).

Most pharmacists are experienced in establishing a rapport with patients and educating them about drug therapy, but training in motivational interviewing skills is needed for many pharmacists. Motivational interviewing has been incorporated into the curriculum at some pharmacy schools and colleges, but opportunities are needed for practitioners who graduated years or decades ago to obtain practical experience and develop skills and confidence in motivational interviewing.

Patients should be encouraged to set therapeutic goals. The involvement of family members and caregivers should be encouraged. Various patient-led support groups (e.g., Mended Hearts for patients with heart disease and their families and caregivers) have been created and can serve as models for successful approaches to increasing patient, family, and caregiver involvement in the health care process and commitment to achieving health outcomes. Pharmacists and other members of the health care team should work with patients, family members, and caregivers to establish therapeutic goals, perhaps by developing a contract outlining the goals and responsibilities of the patient. The success of such efforts usually hinges on establishing an effective personal relationship between the pharmacist and the patient and building patient trust in the pharmacist.

Technology may be used to facilitate the setting and achievement of health goals. For example, devices are available that allow the patient to monitor and share with his or her health care provider information about diet, exercise, body weight, sleep patterns, and other variables associated with favorable health outcomes.

Other challenges. Access to medications can be an issue because of formulary restrictions and prior-authorization requirements (among other factors). Sorting through the complex formulary restrictions and prior-authorization requirements of a large number of health plans is time-consuming and costly for health care providers. Pilot projects have been established in health systems using specially trained pharmacy technicians to anticipate and resolve problems with prior-authorization requirements before a patient is discharged from the hospital so that access to medications is not a problem in the ambulatory care setting.

Creating a standardized prescription drug benefit and formulary for ACOs would address the medication-access problem, but a standard benefit cannot be required for Medicare and Medicaid beneficiaries who by law must be given a choice of plans and benefits. Modifying prescribing is another potential solution. Increasing the use of evidence-based prescribing would reduce the need for prior authorization.

Pharmacists in health systems are sometimes asked to participate in the
preparation and administration of costly, large-molecule, biotechnology-derived, injectable drug products obtained from specialty pharmacies (i.e., through restricted drug distribution systems), a practice known as “white bagging.” The health-system pharmacist cannot be certain about the integrity of products obtained from sources other than manufacturers and wholesalers. Storage conditions may have been compromised, and there are no mechanisms to establish and track the product’s pedigree (i.e., origin and subsequent sales transactions) and accommodate product recalls.28 Personal and institutional liabilities are associated with the use of these products, and the institution may bear the cost of administering the drug. White bagging is not consistent with the integrated health care model in ACOs because of the resulting fragmentation in the patient care process; the relationship between the patient, physician, and pharmacist; and the drug supply, preparation, and administration processes.

Opportunities for collaboration

The need to provide integrated care across the health care continuum in the ACO model creates a need and opportunities for health-system pharmacists to collaborate with pharmacists and other health care professionals outside health systems. The potential for improved health outcomes and reduced costs may justify placement of pharmacists in practice settings outside the health system. These pharmacists can be placed in clinics and other settings to provide MTM services, resulting in increased quality of care and reduced costs.

Patient education is often omitted for hospitalized patients discharged to a skilled-nursing facility or other long-term-care facility because the patient is under medical supervision in these settings. However, in recent years, the acuity of care in these settings has increased, and some patients are poorly managed, resulting in readmission to the hospital. Some health systems have placed staff in long-term-care facilities to address this problem by working with personnel in these settings. The health care team should develop care plans and provide discharge education for patients leaving the hospital for skilled-nursing facilities and other long-term-care facilities because many of these patients eventually return home, where medication use and other aspects of patient care are not under medical supervision.

The ACO model provides opportunities for collaboration with payers. Health systems have established collaborative risk-sharing agreements with payers for the provision of MTM services. The most costly medications could be the focus of MTM services initially. Cost-savings data generated by such agreements can be used in a business case to justify incorporating or expanding pharmacy services within the ACO.

Collaborative agreements between health systems and private physician practices outside the health system could be established as part of an ACO. Such agreements have been explored for the provision of care management services in rural areas with sparse population densities.

Private payers have considerable flexibility and often are amenable to establishing contracts with health systems to provide health services for managed care beneficiaries or employee groups. Innovative approaches have been used by private commercial health plans to provide services to large employers. In some cases, health clinics with pharmacies have been established in the workplace to improve the health and productivity of employees, reducing the cost per member per month for the plan and the employer. Pharmacists need to become involved early in the process of contracting for services.

Role of ASHP

ASHP has sought input about the role of pharmacists in ACOs from thought leaders in institutions across the country with experience in or knowledge of these roles. In June 2012, the Society approved a policy on the pharmacist’s role in ACOs (Appendix B).29 ASHP has provided members with ACO-related information and products in a variety of formats, including publications (e.g., articles in the American Journal of Health-System Pharmacy, a January 2011 ASHP policy analysis on the pharmacist’s role in ACOs29), continuing-education and networking sessions at meetings, and a one-hour archived webinar on the Affordable Care Act and ACOs.31 Nevertheless, many pharmacists are unaware of the need or how to become involved in ACOs. Assistance is needed with basic patient care skills (e.g., physical assessment), identifying care bundles (i.e., groups of evidence-based best practices that improve care to a greater extent than when each practice is used alone), innovative technology, and pharmacy practices at transitions of care for patients with specific diseases (e.g., pneumonia) or in certain care settings (e.g., skilled-nursing facilities). ASHP should continue to educate its membership about ACOs and how to incorporate pharmacy programs into the integrated care model.

Descriptive reports of successful strategies for the incorporation of pharmacy services into ACOs and related performance metrics would be useful. As part of its Medication Management in Care Transitions project, ASHP has partnered with the American Pharmacists Association to identify models of successful collaborations between inpatient and outpatient pharmacists that could serve as helpful examples for members seeking to improve the medication reconciliation and care transition processes and reduce hospital readmissions. A report describ-
ing these models was released in late fall 2012.

ASHP could serve as a clearinghouse for information (e.g., how to negotiate collaborative drug therapy management agreements), best practices, and tools for decision-making in ACOs. Assistance in the development of a business case to obtain financing for pharmacy services as part of an ACO would be helpful. Pharmacy managers need to understand how best to demonstrate the impact of pharmacist involvement in the patient care process. ASHP also might develop a white paper about issues related to ACOs.

ASHP might develop patient cases that illustrate the role of the pharmacist in improving patient health in ACOs for use at simulation centers in training pharmacy students and staff. Medication reconciliation could be the focus of some of these patient cases, but training should extend beyond medication reconciliation to other aspects of patient care (e.g., MTM services) in an integrated model.

ASHP could identify and share with its members effective programs to promote patient adherence across the health care continuum, especially outside the hospital setting. Readmission of patients with pneumonia is a current concern for many health-system pharmacists.

ASHP might assist members who need training in motivational interviewing skills by providing education about the approaches used and skills needed to motivate patients to make medication- and health-related behavioral changes. Referring members to resources for developing such skills would be a valuable service.

ASHP might convene an advisory group of pharmacy leaders and care managers to develop strategies for effective collaborative working relationships within ACOs. Participants in such an advisory group could have a more powerful voice as members of a group than when working alone.

ASHP should continue to work with the Pharmacy e-Health Information Technology Collaborative to promote use of the PP-EHR as a model in national health information technology initiatives. ASHP also should work with this and other groups to address the concerns related to the lack of connectivity and inability to share patient information among practitioners in various settings across the care continuum. ASHP should establish a dialogue with health information technology companies about pharmacy issues and needs, including the standardization of pharmacy software applications.

ASHP can play an important role in addressing concerns raised about the need for credentialing to ensure the competence of pharmacists who enter into collaborative drug therapy management agreements in ACOs. As a member organization of the Council on Credentialing in Pharmacy, ASHP should work to resolve these concerns.

ASHP might work with the Accreditation Council for Pharmacy Education to suggest changes to pharmacy school and college accreditation standards related to the curriculum. These changes should reflect the role of pharmacists practicing as team members in ACOs and offering primary and preventive pharmacy services to patients.

ASHP should advocate for the role of the pharmacist in ACOs through the residency accreditation process. Senior administrators in health systems typically meet with ASHP accreditation services staff during accreditation visits, and these meetings provide an opportunity for ASHP staff to leverage their considerable influence to encourage involvement of pharmacists in ACOs. ASHP should reevaluate and modify residency accreditation standards to reflect pharmacist roles in ACOs.

ASHP should work with other professional pharmacy organizations; professional organizations representing physicians, nurses, and members of other health professions; governmental leaders; and health-system administrators to address ACO-related issues, minimize interprofessional conflict, and improve collaboration among health care professionals in ACOs. Issues related to the scope of pharmacy practice and use of pharmacy technicians to free up pharmacist time for patient care services might be addressed by working with the National Association of Boards of Pharmacy.

ASHP should establish a dialogue among and create a sense of urgency in pharmacy educators involved in schools and colleges of pharmacy and residency training programs to prepare the next generation of pharmacy leaders for their future role in ACOs. Incorporating pharmacy services into ACOs requires transformation and innovation (e.g., new practice and payment models, incentives) that are disruptive. A strategic plan needs to be developed to manage disruptions associated with innovation. The ASHP Research and Education Foundation might consider funding research (e.g., demonstration projects) to evaluate innovative practice and payment models.

ASHP might provide members with guidance about the marketing of pharmacy services in an integrated patient care model to the public. Requests for pharmacy services from patients in ACOs are envisaged.

Next steps
The pace of change in health care delivery and financing that influences approaches used by pharmacists involved in ACOs is rapid. The ASHP Board of Directors and staff will monitor these changes and develop strategies to help members position themselves within the ACO structure and incorporate pharmacy services to meet ACO goals.

Conclusion
The ACO model of health care de-
Accountable Care Organizations


Appendix A—Members of the ASHP Task Force on Accountable Care Organizations

Ernie Anderson Jr., M.S.
System Vice President of Pharmacy
Steward Health Care
Brighton, MA
Joseph T. Botticelli, M.S.
System Director of Pharmacy
Bellin Health
Green Bay, WI
Appendix B—ASHP Policy on the Pharmacist’s Role in Accountable Care Organizations

To recognize that pharmacist participation in collaborative health care teams improves outcomes from medication use and lowers costs; further,

To advocate to health policymakers, payers, and other stakeholders for the inclusion of pharmacists as health care providers within accountable care organizations (ACOs) and other models of integrated health care delivery; further,

To advocate that pharmacist-provided care (including care coordination services) be appropriately recognized in reimbursement models for ACOs; further,

To encourage comparative effectiveness research and measurement of key outcomes (e.g., clinical, economic, quality, access) for pharmacist services in ACOs; further,

To encourage pharmacy leaders to develop strategic plans for positioning pharmacists in key roles within ACOs.