

Building Partnerships Between a College of Pharmacy and ACOs: Development of the ACORN SEED

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ABSTRACT

In an effort to promote partnerships among value-based health systems and institutions of higher education, the steps undertaken and initial challenges faced during partnership development between a college of pharmacy and accountable care organizations (ACOs) are discussed. The Affordable Care Act created value-based payment models, such as ACOs, that provided pharmacists with opportunities for employment and service growth. However, training for pharmacy students in these emerging value-based models is lacking. In 2014, Nova Southeastern University College of Pharmacy launched the Accountable Care Organization Research Network, Services and Education (ACORN SEED) initiative with the purpose of uniting health-care practitioners, academics, and ACOs for mutual fiscal, scholarly, and patient care benefits. The network represents over 240 southern Floridian primary care practices that host pharmacy faculty's clinical practice and research, and will provide Advanced Pharmacy Practice Experiences for pharmacy students. During the development of ACORN SEED, the College overcame several challenges related to trust, assuring mutual benefits, and allocating resources. Such tactics as Ambassador Group development, strategic hiring, and communicating via provider meetings were utilized to overcome these challenges. Despite pharmacists' ability to positively affect patient care, little has been done to integrate pharmacists in ACOs. Tactics such as gaining ACO executives' trust, integrating into clinics, and properly allocating resources can improve pharmacist utilization.

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In 2010, the Affordable Care Act (ACA) reformed healthcare reimbursement and incentivized health systems to aggregate into value-based payment models, such as the accountable care organization (ACO).¹ ACOs are groups of providers that voluntarily unite to coordinate care and are characterized by their compulsion to report quality measures to CMS for reimbursement purposes. As of 2015, Medicare Shared Savings Program ACOs must report on 33 quality measures spanning 4 domains related to patients' experiences, safety, preventative health, and managing high-risk populations.² A common trait among domains is their heavy dependence on the medication use process. As such, ACOs' reimbursement is not only determined by optimized prescribing habits, but also by patients' medication adherence; therefore, ACOs require medication use experts as leaders and pharmacists (because they have extensive training in the safe and effective use of medications) as part of the healthcare team. However, although pharmacists in care teams have assisted ACOs in obtaining positive results,³⁻⁵ their services have been historically underutilized, as only 22% of ACOs use clinical pharmacists' services.⁶ Furthermore, this underutilization is expected to increase, as the US Office of the National Coordinator (ONC) asserts that ACOs will experience a missed opportunity by not engaging pharmacists in care teams.⁷ Therefore, to foster the

utilization of pharmacists in ACOs, Nova Southeastern University (NSU) College of Pharmacy established the Accountable Care Organization Research Network, Services and Education (ACORN SEED) initiative in 2014.

In an effort to promote future partnerships among colleges of pharmacy and ACOs, this article describes several initial challenges to partnership formation, including those related to agenda setting and resource utilization.

Reasons for Relationship Development

NSU College of Pharmacy's impetus for developing partnerships with ACOs emerged from the need to be proactive to changes brought on by the ACA. The ACA created value-based payment models, such as the newly formed ACOs, that provided pharmacists with opportunities for employment and service growth; however, training for pharmacy students in these emerging models was lacking. As the pharmacy profession began to grow in primary care and wellness services, shifting the focus toward accountable care would unquestionably better serve the profession as drug-related services could readily affect reimbursement and optimize patient care. Thus, in order to provide students a premiere educational experience and create pharmacists who are prepared for accountable care employment, the faculty sought to revamp the curriculum by expanding experiential education to ACOs.

South Floridian ACO executive leadership, including chief executive officers (CEOs), finance directors, quality directors, and chief medical/nursing officers, felt pressure from similar learning curves, as competition among organizations mounted to remain up-to-date with periodically changing quality measures. Despite various levels of success among the south Florida ACOs, leadership was unclear on the best approach to remain successful. Aiming to be the premiere national example and achieve the best results and savings possible, each ACO realized that refinements in medication utilization could provide even greater patient outcomes and, hence, provide financial reward to relevant stakeholders. However, despite recognizing medication utilization challenges, difficulties in obtaining consistent, positive drug-related outcomes remained.

Predevelopment Communication

To forge relationships with ACO leadership and providers, the College faculty identified ACOs in south Florida through CMS's online directory.⁸ Local ACO organizations were then contacted via the directory's e-mail address by the chair of the Department of Pharmacy Practice to assess initial interest in receiving pharmacist services from faculty. The chair described the range of services pharmacists provide, the College's research capabilities, and how faculty could provide ancillary support in the form of precepting pharmacy students within their clinical sites. Similarly, the College initiated an "Ambassador Team"; this diverse group of faculty was assembled for

college representation and included assistant professors, experiential directors, the chair of the Pharmacy Practice Department, and the assistant dean of Pharmacy Services. The College Ambassador group traveled to each interested ACO office for initial introductions. During each initial meeting between ACOs' executives and the College Ambassador group, ACORN SEED's purpose, goals, and expectations were established, and opportunities where pharmacists could have the greatest impact within each ACO were identified.

Agenda Transparency

ACO leaders were initially concerned with the College's agenda and apprehensive that faculty could be intrusive and/or expensive. The ACOs' leadership had never worked with clinical pharmacists and worried that by introducing them to physician offices, the pharmacists could potentially hurt ACO-physician relationships. Similarly, ACO leadership questioned a clinical pharmacist's cost, not only in salary expenses, but also in overhead, such as space and training. Furthermore, ACOs had been approached by other entities, such as nonprofits and technology companies, for potential collaboration; each new partnership undertaken came at an opportunity cost for another partnership and, therefore, ACO leadership had to prioritize projects and partnerships simply based on time.

To establish a College-ACO relationship and create trust and understanding, meetings between only the College's dean, department chair, and ACO executives took place. These series of small meetings consisting of only senior officials were imperative for transparent conversation and explanation of the College's agenda. Specifically, the dean and chair explained what benefits the College expected, including practice site formation and potential grant funding. Additionally, College leaders described the potential benefits to ACOs, as many quality measures could be impacted by pharmacists' traditional scope of practice, without regard to any advanced state laws or collaborative practice agreements. Please refer to the [Table](#) for a list of the ACO Medicare Shared Savings Program quality benchmark measures.² After assessing their own quality measures, ACO leadership agreed that improvements could be gained by pharmacists' clinical skills and educational support. Thus, trust was established between both organizations by bringing together senior officials for transparent conversation and assuring all goals were mutually beneficial.

Defining Roles and Allocating Resources

ACORN SEED's potential projects were limitless. ACO and College leadership faced an intricate challenge in deciding which projects to pursue and which to forego. Therefore, in order to optimize utilization of each pharmacist's skills while achieving their mutual goals, the partnerships needed to define roles and ensure all stakeholders complemented each other's skills in working toward a single shared vision. Defining roles required several discussions between the ACO and College over the course of 3 months, as once they

learned pharmacists' capabilities, ACO leaders' expectations gradually modified over time. This shift in expectation came as many of CMS' ACO quality measures and performance standards could be impacted by the pharmacists' scope of practice and, therefore, adaptability and flexibility among College faculty was of utmost importance. To ensure chosen projects matched the most suitable

faculty's skillset, the faculty needed a driver to organize and delegate tasks; hence, the chair of the Department of Pharmacy Practice was named the director of ACORN SEED and 2 coordinator positions, a coordinator of Clinical Services and Education and a coordinator of Research and Grants, were created. A decision to expand faculty positions was requested by ACO leaders and approved by

Table. Benchmark Measures Likely to Be Impacted by Pharmacist Interventions

DOMAIN	MEASURE	PHARMACIST INTERVENTION*
PATIENT SAFETY	ACO #8: Risk standardized, all condition readmissions	Patient education, medication management
	ACO #35: Skilled nursing facility 30-day all-cause readmission measure	Patient education, medication management
	ACO #36: All-cause unplanned admissions for patients with diabetes	Patient education, medication management
	ACO #37: All-cause unplanned admissions for patients with heart failure	Patient education, medication management
	ACO #38: All-cause unplanned admissions for patients with multiple chronic conditions	Patient education, medication management
	ACO #9: Ambulatory sensitive conditions admissions for COPD or asthma in older adults	Patient education, medication management
	ACO #10: Ambulatory sensitive conditions admissions for heart failure	Patient education, medication management
	ACO #39: Documentation of current medications in the medical record	Documentation, medication reconciliation
	ACO #13: Screening for fall risk	Screening
PREVENTIVE HEALTH	ACO #14: Influenza immunization	Screening, immunizations
	ACO #15: Pneumococcal vaccination	Screening, immunizations
	ACO #16: Adult weight screening and follow-up	Screening, patient education
	ACO #17: Tobacco use assessment and cessation intervention	Screening, patient education, medication management
	ACO #18: Depression screening	Screening
	ACO #19: Colorectal cancer screening	Screening
	ACO #20: Mammography screening	Screening
	ACO #21: Proportion of adults who had blood pressure screened in the past 2 years	Screening, vitals
AT-RISK POPULATION	ACO #40: Depression remission at 12 months	Patient education, medication management
	ACO #27 and #41 (composite): Percent of diabetic beneficiaries with A1C in poor control; percent of diabetic beneficiaries with eye exam	Patient education, medication management, screening
	ACO #28: Percent of beneficiaries with hypertension whose blood pressure is <140/90 mm Hg	Patient education, medication management, screening, vitals
	ACO #30: Percent of beneficiaries with ischemic vascular disease who use aspirin or other antithrombotic	Patient education, medication management, screening
	ACO #31: Beta-blocker therapy for left ventricular systolic dysfunction	Patient education, medication management, screening
	ACO #33: ACE inhibitor or ARB therapy for patients with CAD and diabetes and/or left ventricular systolic dysfunction	Patient education, medication management, screening

A1C indicates glycated hemoglobin; ACE, angiotensin-converting enzyme; ACO, accountable care organization; ARB, angiotensin II receptor blocker; CAD, coronary artery disease; COPD, chronic obstructive pulmonary disease.

*Considers only pharmacists' traditional scope in the United States without regard to advances of Collaborate Practice Agreements. Certain states allow pharmacists to provide advanced services and increase interventions to include both ordering labs and prescribing medications.

College administrators. Thus, 3 ambulatory care faculty positions, 1 medication therapy management clinical pharmacist position, 2 postgraduate year (PGY) ambulatory care residents, 1 fellowship, and 4 PharmD work-study positions were created and allocated to ACORN SEED.

Clinic Integration

Once goals and roles had been solidified between College and ACO leadership, the newly formed ACORN SEED pharmacist team needed integration into the ACOs' primary care sites. Primary care physicians within the ACOs had limited, if any, experience working with clinical pharmacists; providers hitherto were virtually unaware of pharmacist competency and skills. Therefore, to reach the largest amount of primary care physicians possible and create a forum for questions, it was decided the vision of integrating pharmacists would be introduced via formal presentations at the ACO quarterly meetings and/or physician meetings, respectively. At each successive meeting, presentations outlined opportunities for improvement specific to each ACO and the potential for pharmacists to positively impact those opportunities. Providers were also educated on which benchmark measures could be undertaken in phases, the steps needed to reach these benchmarks, and expected outcomes. Hence, 2 physicians' offices—1 championed by an ACO CEO and another by a physician member of the ACO's executive board—were the first adopters.

At these 2 pilot sites, office managers played a key role in pharmacist integration by aiding in logistics, such as gaining electronic health record (EHR) access and introducing pharmacists to the staff. The pharmacists then saw patients with their physician champion at each office and worked with each member of the staff to understand their role. This "outpatient rounding" was similar to inpatient rounding in that it included discussion via the Socratic method to synchronize the care team and allowed for greater communication between the pharmacist and physician. Similarly, to develop trust and show reliability during this introductory period, it was crucial that pharmacists were present within the clinics as much as possible, and they therefore received protected time from their department to spend half the work week within the offices.

Likewise, the faculty pharmacists felt it necessary to show their value quickly. Therefore, on the first days of providing services, pharmacists targeted small and quickly achievable goals by delivering immunization counseling to patients who had previously refused vaccination due to fear of needles. Pharmacists called each patient, used motivational interviewing to convey the importance of needed vaccination, and ensured patients maintained upcoming vaccination appointments. Due to these brief interventions, over 95% of patients contacted received the recommended vaccination. This quick success was imperative, as the relationship between pharmacists and providers required initiation on a positive note. Once physicians observed

improved outcomes in select patients and heard patients' positive feedback of their interactions with the pharmacists, eventually pharmacists gained the providers' trust to the point where they were perceived as an integral part of the multidisciplinary team.

Discussion

At the time of this article, NSU College of Pharmacy has partnered with 3 ACOs representing thousands of covered lives in over 240 primary care practices in south Florida. By embracing a disruptive and innovative approach, this academic institution was able to create partnerships with newly formed ACOs for mutual benefit. ACO-pharmacist partnerships are expected to substantively increase, even among community pharmacies, as the ONC will require EHR vendors to enable features that facilitate communication with pharmacies, such as prescription change requests, fill status notifications, and medication history transactions.⁹

Value-based models are a newly emerging phenomenon in the wake of the ACA, and little evidence exists to declare what is a best practice. Because value-based institutions, such as the ACO, have the great potential to innovate such practices, they are also poised for a great risk of failure if direction is not considered carefully. It was therefore rational that most challenges to the relationships building between the College of Pharmacy and its ACO partners are related to trust.

Conclusions

Despite the vast opportunity for pharmacists' services in ACOs, future challenges persist and provide opportunities for innovation. For example, the College will be challenged to develop curriculum and educational approaches to produce pharmacists who are adept in value-based reimbursement models. This challenge of aligning curriculum with policy is not unique to the College of Pharmacy, as all centers of higher healthcare education will be obliged to create graduates with bravura in such skills. Also, maintaining future collaborations that lead to mutual benefit may be challenging, as no history of interdependency on pharmacists exists within ACOs. The College and ACOs have just begun learning each other's industry, hence evaluation of common needs and goals must be completed before branching into new areas. Consequently, partnering organizations must weigh the potential benefit when evaluating expanded programs in the future.

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