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How CVS is taking on more acute and chronic care

By Jessica Sweeney-Platt | March 9, 2017

In 2014, CVS Pharmacies stopped selling tobacco products in any of its locations — foregoing $1.8 billion in sales to make a statement about its evolving role in healthcare.

"We were never going to be acceptable as a real member of the healthcare system if we continued to provide tobacco products," says Troyen Brennan, M.D., executive vice president and chief medical officer of CVS Health.

Since then, Brennan says, the company has continued to capitalize on its retail convenience and face-to-face contact with patients — with a strategic focus on partnering with heath systems to offload acute and chronic care. Much of that care, he argues, can be provided most efficiently by pharmacists and nurse practitioners, working at the top of their licenses, supported by artificial intelligence-based algorithms.

Brennan recently sat down with Jessica Sweeney-Platt, Executive Director of Physician Performance at athenahealth, to discuss CVS's strategy and its potential to reshape population health.

Q I'd love to hear about the vision CVS has for care delivery.

A For most people, the most prevalent — often the first — place they use their medical benefit is in the drugstore. So, before they have any interaction with the rest of the healthcare system, they're interacting with us. Our data on individual patients is very deep and available very quickly, which gives us a real advantage in terms of thinking about interventions.

Q We keep talking healthcare's shift from volume-based, episode-focused care to value-based population health. How do you see CVS playing a role in that transition?

A With our ability to extract data from health plans or electronic medical records, and analyze that data relatively quickly using artificial intelligence-based algorithms, we're able to move our practitioners much higher up in terms of what their license allows. And that creates efficiency.

So, for instance, MinuteClinics have been taking care of acute ailments. But we can get into taking care of common chronic diseases, and perhaps

even do a better job than the traditional system has done with diabetes and hypertension and hyperlipidemia and the like. We're never going to replace the primary care doctor and we certainly don't want to. But we do think there's a lot more care that can be rendered by nurse practitioners and pharmacists than has ever been the case in the past.

Q What sort of insights are you learning about chronic care management? It's a skill set that most providers would agree is critical for population health.

A One of things we've done is integrate our rare disease management — such as MS and scleroderma — with our specialty pharmacy. We've now got nurses who are acting as care managers, working very closely with our pharmacists. And we're finding that bringing those two together is providing real synergy in terms of making sure people are taking their medications and lowering overall costs.

It's a good example of the power of specialized knowledge and integration. If you know how to counsel a woman who's got multiple sclerosis and get her to adopt behaviors that reduce her chances of urosepsis, you end up saving a good deal of money on the medical side. We're always trying to use pharmacy to reduce medical costs. We think that's our big role in population management.

Q Have you met any resistance to CVS coming in and playing a role in chronic care management? How have you worked with the provider community to partner with them as opposed to be seen as a threat?

A We've been very careful about that. All our providers are trained to stay on algorithm. We set up the EHR to control what they can and can't treat. As people turn to population management, you want your busy primary care doctor taking care of the 10 percent of patients who are 80 percent of your costs, the sickest patients. So, they're perfectly happy to have us do a number of things that we can do less expensively. A doctor might complain that you leave all the tough cases for them. But that's what you're supposed to be doing as a doctor.

Q You have a number of strategic alliances with health systems. What does the ideal partnership look like?

A In the ideal ones, both sides benefit. For instance, if we have a pharmacist counsel a patient when they leave the hospital, we can reduce the readmission rate by about 50 percent. Or we can work on care pathways where a patient sees us for certain elements of care, and then sees their primary care doctor or their specialist. Or we can work with telemedicine so we can do simple things — informed by specialists — in the retail clinic, but also refer the patient appropriately for care on the specialist side.

Q Are there levers that you have to influence patient behaviors? Or is it really about being in the right place at the right time?

A A lot of it is about adherence. We know coming out of the hospital after a heart attack, only about 50 percent of [patients are taking their] medications at the end of six months. In terms of population management, if we can get them to take that prescription, we lower their overall costs and prevent morbidity and mortality.

Q So what insights are you bringing to the idea of patient adherence?

A A lot of our work is around predictive analytics. Because we can manipulate pharmacy data very quickly, we can predict which patients are most likely to do poorly over the next 2 to 3 months. We need to gear up what we're doing for them, increase outreach, offer them different programs.

In April, we will be offering a glucometer whose data will go to the cloud. We'll analyze that information and they'll fall into one of 20 or 30 different archetypes. So, if I see a person with this pattern of blood glucose readings,

I'll be able say, "This is the dose you need to change," or "This is when you need to think about taking your insulin," or "This is when you should be exercising." Through better use of data, a nurse practitioner can counsel a patient and provide information that even a very, very good internist or endocrinologist couldn't have provided five years ago. When you see that, you start to think: Well, this is a healthcare system that could actually change.

Q **Healthcare has been hospital-centric for the better part of two centuries. Now, it's diffuse and incorporates retail clinics and telemedicine and other non-hospital provider organizations. It's interesting to see how quickly that change has taken shape.**

A It's a less expensive and broader-spaced system. So, people's expectations will need to change about personalization and the way services are delivered. They're always going to need that excellent physician in the background, but I see more and more of this algorithmic work being taken off the primary care doctor's plate so that [doctors] can be working with the patients who need them most.

Diabetes, hypertension, hyperlipidemia, depression, asthma — all lend themselves to an algorithmic approach that is more efficient and less expensive. Which is important because, going forward, individual consumers are going be making more choices about what they can afford. It's going to be an excitingly different healthcare system in 15 years. It's up to us to try to make sure that it goes in the right direction and gets there quickly enough.

Jessica Sweeney-Platt is executive director of research at athenahealth. Lia Novotny contributed to this article.

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