Population Health and Patient Centered Medical Homes: New Opportunities for Pharmacists

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Objectives

- Apply available data sets to discover, design, and implement pharmacists within the Patient-Centered Medical Home (PCMH).
- Apply early lessons learned on practical applications such as prioritization, key indicators, and overall population health initiatives.
- Evaluate use of technology to use data to support and develop workflows for transitions of care and population health management.
- Design a plan to track data to build pharmacy programs and monitor for improved outcomes.

Workshop Outline

- Pre-workshop survey review
- Highly interactive session and less lecturing
- Present key concepts for each objective
  - Topic discussion
  - One roundtable discussion for background
  - Three interactive case scenarios
  - Case study report out
- Key takeaways and next steps

Pre-workshop Survey

Do you know what a Patient Centered Medical Home is and do you have it implemented in your organization? (n=62)

- Yes, I know what it is and we have not implemented 33%
- Yes, I know what it is and we have implemented 49%
- Yes, I don’t know what it is 18%

How many hospitals are within your system? (n=62)

- Greater than 25 53%
- Eleven or 25 18%
- Seven – Ten 21%
- Three – Six 21%
- Zero - Two 31%

How many clinics are within your system? (n=62)

- Greater than 25 53%
- Eleven or 25 18%
- Seven – Ten 21%
- Three – Six 21%
- Zero - Two 31%
Pre-workshop Survey
Do you have pharmacists in the Primary Care Clinic/PCMH model? (n=62)
Yes 58%
No 42%

Pre-workshop Survey
Do you bill for pharmacy services in the ambulatory setting? (n=55)
Yes 40%
No 60%

Pre-workshop Survey
Do pharmacists have provider status in your state? (n=55)
Yes 25%
No 75%

Pre-workshop Survey
Are you tracking outcome data? (n=49)
Yes 45%
No 55%

Pre-workshop Survey
Does your state allow collaborative prescribing agreements or other prescriptive authority protocols for pharmacists? (n=48)
Yes 90%
No 10%

Pre-workshop Survey
What kind of services/activities are pharmacists providing in your clinic?
- Anticoag / Warfarin
- CMS wellness visits
- Consult service
- Population health
- Comprehensive Medication Reviews / Med Recon
- DM, HTN, Lipids
- Hep C
- MTM
- Transition of care services
**Evolution of Health Care Funding**

- **1900s average American spent $5/year**
  - Health insurance did not exist
- **1920 Baylor University Hospital Dallas**
  - Idea of paying a little per month (50 cents) to cover hospital expenses if needed
  - Blue Cross plans formed 1929 based upon Baylor model
- **WWII rationing/wage/price controls**
  - Fringe benefits to attract employees
  - 1943 IRS rules employer based health care is tax free
  - 1954 tax advantages increase for employer based plans
- **Exponential growth in lives covered:** 1940 (9%) to 1963 (63%)

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**Current State of Healthcare**

- **Moving from volume to value**
  - **Past (Pay for Reporting)**
    - Structured to pay for services rendered
    - Including correcting the results of poor quality or unsafe care
    - No incentive for quality the first time
  - **Present/Future (Pay for Performance)**
    - CMS moving to reimbursement based on quality of care
    - No reimbursement for poor quality or injuries due to error
      - Present on Admission Indicators
    - True Pay for Performance based on quality
  - **Value Based Purchasing (Patient Protection and Affordable Care Act – H.R. 3590)**

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**Drivers of Change**

- Healthcare system incurred $177 billion annually
  - In part due to avoidable costs due to Adverse Drug Events (ADE) from inappropriate medication use.
  - Medication treatment of chronic diseases ($1.3 trillion annually) consumes 75 cents of every healthcare dollar.
- 32% of medication ADE lead to hospitalization
- Affordable Care Act
- Value-based Purchasing
Value-Based Purchasing

- Medicare Hospital Quality Improvement Act of 2008
  - Proposed to start in 2012
  - Funded by a carve out from Medicare inpatient payment (1 to 5%)
  - Increases/decreases in Medicare reimbursement tied to hospital performance quality indicators (three domains)
    - Clinical process of care indicators (RHQAPU/Hospital Compare)
    - Patients’ perspectives of care (HCAHPS)
    - Outcomes (Mortality)

Current State of Healthcare

- New models of care
  - ACO’s, medical homes, care coordination
  - Managing populations and total cost of care key to success as payment shifts from encounter to quality or outcomes
  - Integration and consolidation
    - Formation of IDNs (integrated delivery networks)
      - Primary/specialty care, acute care, post-acute care
    - Partnerships between acute care and providers with shared incentives

Current State of Healthcare cont.

- “Owning patients” and their success in healthy care/behaviors
- Problem: How do we take care of whole populations in a community hospital/health-system setting
- Answer:
  - Align with organizational goals/metrics
  - Everyone is working to figure it out for themselves
  - Sharing of practices to stimulate new models of pharmacy services

Current State of Healthcare

- Population Health – What is it?
  - “The health outcomes of a group of individuals, including the distribution of such outcomes within the group”\(^1\)
  - IHI – Triple Aim White Paper
    - Population Health, Experience of Care, and per Capita Cost
    - Measure: life expectancy, mortality rates, health and functional status, disease burden (incidence and/or prevalence of chronic disease), and behavioral and psychological factors\(^2\)

Current State of Healthcare

- Accountable Care Organizations (ACO’s)
  - “Groups of doctors, hospitals, and other health care providers, who come together voluntarily to give coordinated high quality care to their Medicare patients”
  - Goal is to ensure patients, especially chronically ill, get the right care at the right time, while avoiding unnecessary duplication of services and preventing medical errors
  - How many participants in the room have ACO’s?

Shifting Risk from Purchasers to Providers

<table>
<thead>
<tr>
<th>Performance Risk</th>
<th>Utilization Risk</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cost of Care</td>
<td>Quality of Care</td>
</tr>
<tr>
<td>Bundled Pricing</td>
<td>Pay for Performance</td>
</tr>
<tr>
<td>Episode Efficiency</td>
<td>Process Reliability</td>
</tr>
<tr>
<td>Readmission Reduction</td>
<td>Clinical Quality</td>
</tr>
<tr>
<td>Care Standardization</td>
<td>Patient Experience</td>
</tr>
</tbody>
</table>

The Advisory Board Company

\(^1\)David Elinzg – American Journal of Public Health, 2003
Current State of Healthcare

- ACO Programs
  - Medicare Shared Savings Program
    - Established by section 3022 of ACA
    - Reward ACO's that lower their growth in health care costs while meeting performance standards on quality of care and putting patients first
  - Two tracks offered
    - 1-sided model – sharing of savings only for the term of the first agreement (good introductory model)
    - 2-sided model – sharing of both savings and losses for all years (potential for greater share of savings)


Current State of Healthcare

- Accountable Care Organizations (ACO’s)
  - Allow additional data to be collected and ability to focus on patient populations
  - Strategically very important for organizations
  - Large opportunity for pharmacists to participate and drive how the organization cares for these patients

Roundtable Discussion (15 min)

- What is the current status of your market with regards to pharmacists roles in PCMH/primary care clinic?
  - Assign facilitator
  - Assign recorder / report-out person

- Report Out (10 min)
  - What information from your discussion is new to the group?
  - Did you learn anything interesting to share with the larger group?

Interactive Scenario # 1 (15 min)

- C-suite proposal
  - We have 50 primary care/specialty clinics for which I am willing to give you two pharmacists FTE's
  - List the data you would use or need to complete this analysis
  - Please present a plan on how you will implement pharmacists into this setting

- Report Out (10 min)
**CHI Franciscan Health Story**

- FY 2013 system strategic priority
  - Poly-pharmacy project
    - Problem/Opportunity
      - Poly-pharmacy can lead to negative health outcomes
        - Adherence related to complexity
        - Poor optimization of drug therapy
        - Increased risk of falls
        - Increased ADRs
        - Increased readmissions

**Poly-pharmacy Project**

- Creation of a comprehensive process to optimize drug therapy
  - Will produce:
    - Improved clinical outcomes
    - Reduced readmissions
    - Avoidance of ED visits or increased utilization
      - Due to improved adherence
      - Decreased ADRs
    - Positive financial outcomes for CHI Franciscan Health
      - Reduction in 30 day readmission
      - Improved clinical outcomes for patients enrolled in risk sharing programs
  - Move into a clinically integrated network

**Poly-pharmacy Project**

- Project Charter
  - Evaluate cost/benefit associated with creation of an outpatient poly-pharmacy program
    - Identifying and intervening on highest risk patients
    - Calculate an ROI resulting from program implementation
  - Design and implement program based in ambulatory setting (Franciscan Medical Group primary care practice)
  - Focus on high risk patients
    - Over 65 Years of age
    - 8 or more chronic medications
  - Assumptions
    - Pharmacist FTE, sponsoring provider

**Medical Home**

- Franciscan Medical Group (FMG) Medical Home project
  - Creation of a patient centered medical home
    - Focused on
      - Chronic disease management
      - Care coordination
    - Poly-pharmacy program fell under both chronic disease management and care coordination
  - 715 patients identified as eligible for program from FMG provider panels
    - Spread among multiple clinics
    - 1 pharmacist FTE proposed initially

**Provider Considerations**

- FMG provider analysis
  - Shortage of primary care providers
    - Both APC and physicians insufficient to meet demands of patients identified
    - Target clinics with a shortage of providers
  - Provider acceptance
    - Identify clinic providers familiar with clinical pharmacist
      - Understand the scope of practice of pharmacists
    - Identify providers supportive of pharmacist in clinic
  - Quick wins
    - Providers with large panel size
      - Pharmacist help improve efficiency

**Leveraging Resources**

- Over 130 FMG clinics over 3 counties
  - Large geographic area to cover with over 500 providers
  - 2 FTE pharmacists approved to support PCMH
  - How to cover multiple clinics with limited pharmacist resources
    - Identified key clinics
      - High patient volume
      - Provider support/acceptance
      - Close to tertiary care facility to impact transitions in care (original project charter)
    - Clinics with high percentage of “high-risk” patients
**Initial Work**

- Pharmacist placement
  - Selected 3 clinics based upon criteria identified
  - Developed collaborative drug therapy agreements (CDTA)
- Used CDTAs to lead providers to use pharmacist to manage chronic diseases
- Created education modules to support staff education

**Clinic introduction**

- Took an “all comers” approach
  - Say YES to everything and anything

### Target Patients

<table>
<thead>
<tr>
<th>High risk patients need pharmacists the most</th>
</tr>
</thead>
<tbody>
<tr>
<td>Multiple chronic diseases</td>
</tr>
</tbody>
</table>

### Targeting Patients

- Developed indicators to help trigger pharmacist review

### Measuring Impact

- 3 clinics with Pharmacist
  - 21 physicians
  - 8 mid-level practitioners
  - 2.0 FTE Pharmacists
- 2 clinics without Pharmacist
  - 10 physicians
  - 5 mid-level practitioners

### Initial Results

- Aligned metrics with standardized reporting for medication related problems
  - Most frequent pharmacist interventions
    - Appropriateness and Effectiveness
    - Untreated medical problems
    - Monitoring standard not being followed
  - Safety
    - ADR
    - Dose discrepancy between patient and prescriber
  - Non-adherence and patient variables
  - Patient refuses treatment or poor adherence
  - No follow-up appointment with PCP
Initial Quarter’s Results

<table>
<thead>
<tr>
<th>St. Joseph Medical Center Clinic</th>
<th>Gig Harbor Clinic (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 Processing refill authorizations</td>
<td>#1 Processing refill authorizations</td>
</tr>
<tr>
<td>#2 Resolving refill issues</td>
<td>#2 Resolving refill issues</td>
</tr>
<tr>
<td>#3 Anticoagulation visits</td>
<td>#3 Anticoagulation visits</td>
</tr>
<tr>
<td>#4 Patient phone calls</td>
<td>#4 Patient phone calls</td>
</tr>
<tr>
<td>#5 Provider drug consult / questions</td>
<td>#5 Provider drug consult / questions</td>
</tr>
</tbody>
</table>

- **Trends**
  - Heavy refill request help
  - Familiar with using pharmacists for anticoagulation / warfarin management
  - Helping out with phone outreach when requested
  - Fishing provider schedules for potential patients

Latest Quarter Results

<table>
<thead>
<tr>
<th>St. Joseph Medical Center Clinic</th>
<th>Gig Harbor Clinic (s)</th>
</tr>
</thead>
<tbody>
<tr>
<td>#1 Patient phone calls</td>
<td>#1 Patient phone calls</td>
</tr>
<tr>
<td>#2 Diabetes services consult</td>
<td>#2 Diabetes services consult</td>
</tr>
<tr>
<td>#3 Anticoagulation visits</td>
<td>#3 Anticoagulation visits</td>
</tr>
<tr>
<td>#4 Refill of scripts under RPh care</td>
<td>#4 Outreach overdue labs/visits</td>
</tr>
<tr>
<td>#5 Med rec patient visits</td>
<td>#5 Patient education</td>
</tr>
</tbody>
</table>

- **Trends**
  - Decreased focus on refill request
  - Patient phone calls are top request for pharmacist involvement
  - Anticoagulation remains a top need in the clinics
  - Diabetes management is in top 5 requests

St. Joseph Medical Center Clinic Interventions

Gig Harbor Clinic Interventions

PCMH Pharmacist Impact Change in Goal Attainment from Baseline

<table>
<thead>
<tr>
<th></th>
<th>PCMH without Pharmacist</th>
<th>PCMH with Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood Pressure</td>
<td>+7.7%</td>
<td>+11.8%</td>
</tr>
<tr>
<td>Appropriate Statin Potency</td>
<td>+2.7%</td>
<td>+8.9%</td>
</tr>
<tr>
<td>A1c</td>
<td>+12.5%</td>
<td>+30.4%</td>
</tr>
<tr>
<td># ED visits ACS</td>
<td>-12.5%</td>
<td>-6.7%</td>
</tr>
<tr>
<td># ED visits ADHF</td>
<td>+20%</td>
<td>-20%</td>
</tr>
</tbody>
</table>

Kellison, E; St. Joseph Medical Center Resident Project – Internal Data

Clinic Culture

- Provider acceptance is vital
  - Providers often do not understand the scope of practice for pharmacists
  - Need to educate providers on what pharmacists can do
  - Need to educate office staff on the role of a pharmacist
  - Perception often reflective of traditional retail pharmacist roles
- Target clinics with providers that are supportive of pharmacy
  - More inclined to engage pharmacist in patient care
  - Easier to demonstrate value and impact
  - Providers talk to providers
  - They are your best or worst advocates
**Approach is Key**
- Say yes to everything
  - No request is too small or too unimportant
- Started with refill authorizations
  - Quick win, helps with clinic efficiency
  - Helps support not just provider but clinic staff
- Complexity of request will change overtime
  - More request for disease state management
- After acceptance and value recognized can focus efforts
  - Migrate from an "all-comer" approach to targeted disease states
    - High-risk patients where value can be demonstrated

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**Interactive Scenario # 2 (15 min)**
- Had two pharmacists FTEs for one year
  - Data states you have made no impact
  - What changes will you propose to the workflow or practice model?
  - What data and outcomes will you need to support your recommendation?
  - Report Out (10 min)

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**Pre-workshop Survey**
What data are you tracking for outcomes?
- Readmission data
- HbA1C
- Hyperlipidemia
- Hypertension
- INR in range
- Anticoag side effects
- Premature death rates MED’s

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**Pre-workshop Survey**
What data did you use to justify pharmacist positions?
- HEDIS measures
- Resident projects
- Innovation Grant from CMS
- Improved controlled substance prescribing and lower death
- Improved measures, HbA1C’s, Lipids
- Clinic/medical practice request
- Reduced readmissions
- Improve quality measures of ACO and PCMH

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**CHI Franciscan Health cont**
- How to handle growth and requests?
  - Phone calls from multiple clinics – “We want a pharmacist”
  - Lots of providers need help with routine tasks
- What data was used from an evaluation standpoint?
  - We had good patient data for our targeted patients / study patients
  - However, did not reflect at the higher level / population level
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- Refocus on organizational priorities

<table>
<thead>
<tr>
<th>Key Process Measure</th>
<th>Access - Time to third next available apppt</th>
<th>Annual Wellness Visit for Medicare</th>
<th>Breast Cancer Screening</th>
<th>Colon Cancer Screening</th>
<th>Depression Screening</th>
<th>DM - eye exam</th>
<th>DM - HbA1c &gt; 10</th>
<th>DM Nephropathy Screening</th>
<th>Fall Risk screening</th>
<th>Flu Vaccine</th>
<th>Hyperension BP control</th>
<th>Patient Experience - Recommended</th>
<th>Pneumonia Vaccine</th>
<th>Childhood immunization - combo 10</th>
<th>Well child visits/childhood access &gt;= 6 visits in 0-15mo</th>
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CHI Franciscan Health - Data

CHI Franciscan Health - Data

CHI Franciscan Health - Data

CHI Franciscan 15 Focus

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- Implementation of Pharmacist Practice Model – "40/30/30"
  - Targeted focus
  - 40% - Scheduled face-to-face visits – DM, HTN, COPD, Psych, Anticoag, Transition of Care Visits (co-visits), CCM
  - 30% - Population health review – clinic lists priorities
  - 30% - On the fly visits, requests from provider, nursing staff

How do you focus on population measures when you are in the storm?

Internal goals only

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**CHI Franciscan Health**

- How do we spread limited FTE’s across multiple sites?
  - Staffing model of the clinic
  - Clinics with strong clinic management support and strong provider / medical director
  - Access issues, how far out 3rd next available etc.
  - Clinics have a large number of providers
  - Staffing ratio pharmacist : provider

**Results: Potential Revenue TCM Billing Codes**

![Graph showing potential revenue from TCM billing codes]

![Table showing staffing issues across CHI Franciscan Health clinics]

**Revenue generation**

- Visits – straight billing
  - Currently billing as incident-to (Level 1 visit only)
  - January 1, 2016 – WA state SB5557
  - Pharmacists recognized as credentialed providers
  - Insurance companies not allowed to exclude class

- Medicare Shared Savings Plans
- Third party payers
- Increase TCM and/or CCM
- Medicare codes – can participate in process-have provider drop charges

**Provider education**

- “40/30/30 Model”
- Educate providers on re-focus
- Target “their patients” and improve “their measures/metrics”
- Not just here to do refills and help with prior authorizations

**Prioritizing patient contact**

- Still a priority
- Educate patient that you are “their doctors” pharmacist
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- Virtual models of care
  - Phone contact / Outreach / Email
  - Lots of interventions available via outreach process
  - Collaborated effort with rest of clinic staff
    - Avoid the silos
  - Face time / Skype
    - Some patients adopt and prefer
    - Social barriers to acceptance
  - Experience in a virtual diabetes project – demonstrated an absolute 2.2% improvement in Hb-A1C

Interactive scenario # 3 (15 min)

- Another year has passed and your organization has formed an ACO
  - CEO wants to give you an additional four more FTEs to cover 100 primary / specialty clinics
    - Six total FTEs to cover 100 clinics
  - What will you do?
- Report Out (10 min)

Key Takeaways & Next Steps

- Take back your learning’s and discuss with Primary Care Leadership / CEO
  - What is your location / market plan?
- How can you implement or expand pharmacists into your primary care setting
  - Focus on population health management
  - Focus on ACO work
- Build your network of resources from this meeting to support and share learning’s across sites
  - We are all trying to adapt to new models of care and support the profession