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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.

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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

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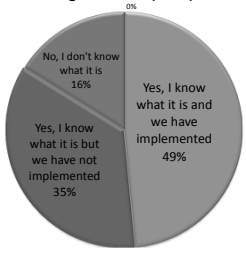
Pre-workshop Survey

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



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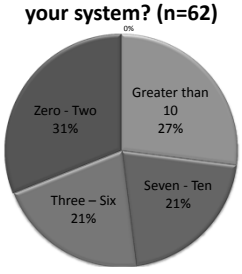
Pre-workshop Survey

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



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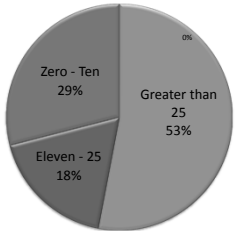
Pre-workshop Survey

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



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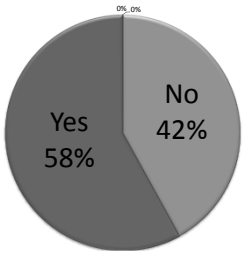
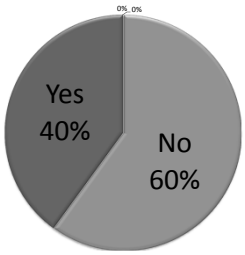
Pre-workshop Survey

Do you have pharmacists in the Primary Care Clinic/PCMH model? (n=62)



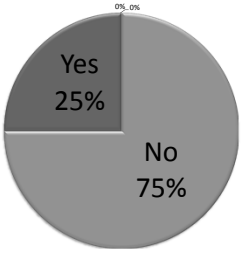
Pre-workshop Survey

Do you bill for pharmacy services in the ambulatory setting? (n=55)



Pre-workshop Survey

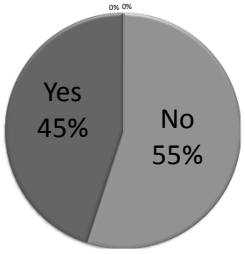
Do pharmacists have provider status in your state? (n=55)



Yes = NC, OR, VA, MN, CA, WA

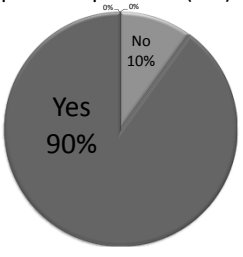
Pre-workshop Survey

Are you tracking outcome data? (n=49)



Pre-workshop Survey

Does your state allow collaborative prescribing agreements or other prescriptive authority protocols for pharmacists? (n=48)



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

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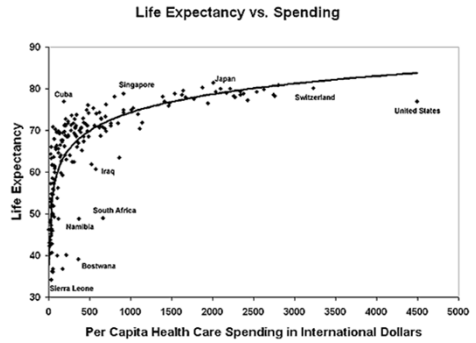
Evolution of Health Care Funding

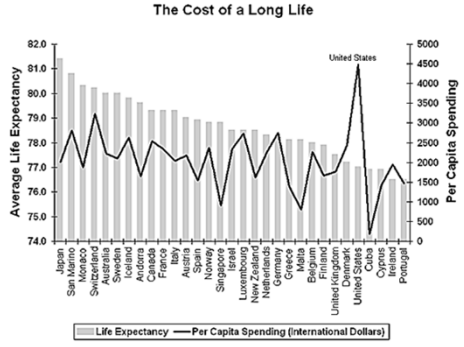
- 1900s average American spent $5/year
  - Health insurance did not exist
- 1920 Baylor University Hospital Dallas
  - Idea of paying a little per month (50 cents) to cover hospital expenses if needed
  - Blue Cross plans formed 1929 based upon Baylor model
- WWII rationing/wage/price controls
  - Fringe 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%)

Evolution of Health Care Funding

- 70% of US population covered by private health plans by 1960s
- Prior to 1965 only half of seniors had health care coverage
- 1960 Kerr-Mills Act matching funds for states
  - Precursor to Medicare
- 1965 Medicare and Medicaid act
- Fee for service (FFS), percent of charges
- Medicare Prospective Payment System
  - 1983 DRGs nationwide (beginning of the end of FFS)
  - Shifted power from providers to Federal Government
  - Other insurance providers followed



Health Care Spending, UC. At http://ucatlas.ucsc.edu/spend.php



Health Care Spending, UC At http://ucatlas.ucsc.edu/spend.php las

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)

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

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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 (RHQDAPU/Hospital Compare)
  - Patients' perspectives of care (HCAHPS)
  - Outcomes (Mortality)

Shifting Risk from Purchasers to Providers

Performance Risk		Utilization Risk
Cost of Care	Quality of Care	Volume of Care
Bundled Pricing	**Pay for Performance**	**Shared Savings**
Episodic Efficiency	Process Reliability	Chronic Care Management
Readmission Reduction	Clinical Quality	Care Substitution
Care Standardization	Patient Experience	Disease Prevention

The Advisory Board Company

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

❖ 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]

[1]David Kindig – *American Journal of Public Health*, 2003
[2]Stiefel M, Nolan, K. A Guide to Measuring the Triple Aim: Population Health, Experience of Care, and Per Capita Cost. IHI Innovation Series White Paper. Institute for Healthcare Improvement; 2012.

Current State of Healthcare

❖ Population Health 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

❖ 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?

www.cms.gov. Accountable Care Organizations

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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)

www.cms.gov. Shared Savings Program Fact Sheets

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

Current State of Healthcare

- Transitions in care
  - Managing the movement of patients
    - Hand-offs between each setting key to ensure patient outcomes
- Patient Centered Medical Home (PCMH)
  - Bringing care to the patient
  - Team based approach to care
    - Each team member fills a unique and vital role
    - Each team member working at the top of their license
    - Utilizing the unique talents to ensure quality of outcomes

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?

Break – 10 minutes

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)

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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

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Initial Work

❖ Pharmacist placement
- Selected 3 clinics based upon criteria identified
- Developed collaborative drug therapy agreements (CDTA)

HTN	Hyperlipidemia	Asthma	COPD	GERD
CHF	Diabetes	Thyroid	Seasonal Allergies	Vaccinations

- Used CDTAs to lead providers to use pharmacist to manage chronic diseases
- Created education modules to support staff education

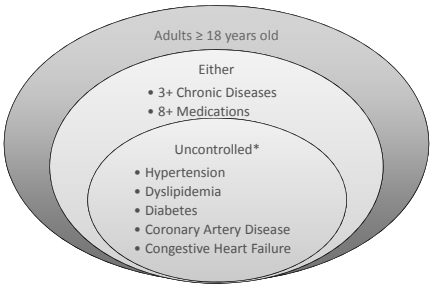
❖ Clinic introduction
- Took an "all comers" approach
  - Say **YES** to everything and anything

Target Patients

High risk patients need pharmacists the most

Multiple chronic diseases	Multiple medications needed	Validated, measurable markers for disease control	Diseases managed with medications

Target Patients

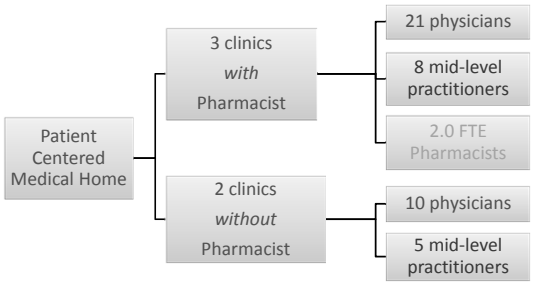


Targeting Patients

❖ Developed indicators to help trigger pharmacist review

New anticoag patients	A1C > 9	> 8 – 10 medications and/or needs education	Patients discharged from hospital with > / = 2 medication changes
COPD / Asthma exacerbation	HF decompensation	Smoking cessation	DM complications
Post MI	Post CVA	Uncontrolled HTN	Uncontrolled hyperlipidemia

Measuring Impact



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

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Initial Quarter's Results

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

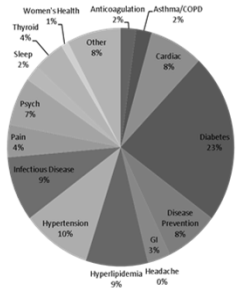
- Trends
  - Heavy refill request help
  - Familiar with using pharmacists for anticoagulation / warfarin management
  - Helping out with phone outreach when requested
  - Fishing provider schedules for potential patients

Latest Quarter Results

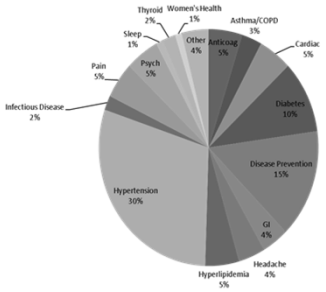
St. Joseph Medical Center Clinic	Gig Harbor Clinic (s)
#1 Patient phone calls	#1 Patient phone calls
#2 Anticoagulation visits	#2 Diabetes services consult
#3 Diabetes services consult	#3 Anticoagulation visits
#4 Refill of scripts under RPh care	#4 Outreach overdue labs/visits
#5 Med rec patient visits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

- 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

	PCMH **without** Pharmacist	PCMH **with** Pharmacist
Blood Pressure	+7.7%	+11.8%
Appropriate Statin Potency	+2.7%	+8.9%
A1c	+12.5%	+30.4%
# ED visits ACS	+12.5%	-6.7%
# ED visits ADHF	+20%	-20%

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

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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

Break – 15 minutes

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)

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

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

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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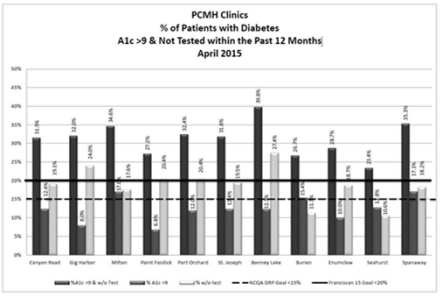
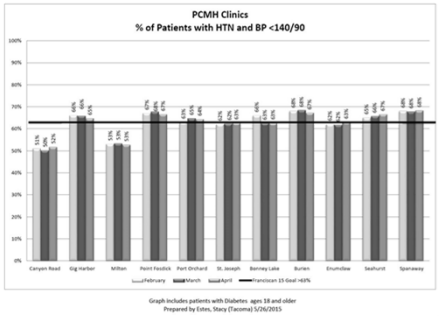
❖ Refocus on organizational priorities

Key Process Measure
Access - Time to third next available appt
Annual Wellness Visit for Medicare
Breast Cancer Screening
Colon Cancer Screening
Depression Screening
DM - eye exam
DM - HbA1c >9
DM Nephropathy Screening
Fall Risk screening
Flu Vaccine
Hypertension BP control
Patient Experience - Recommend
Pneumonia Vaccine
Childhood immunization - Combo 10
Well child visits/childhood access >=6 visits in 0-15mo

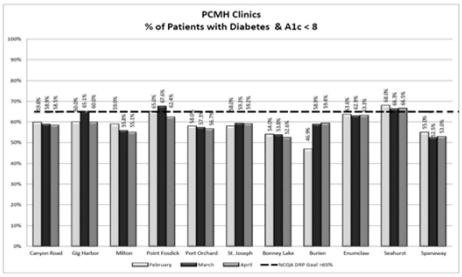
CHI Franciscan Health - Data



CHI Franciscan Health - Data



CHI Franciscan Health - Data



CHI Franciscan 15 Focus

			System Goal			Benchmark		
Key Process Measure	Baseline (FY15, Q3 YTD)	Source	Threshold	Target	Max	2	3	4
DM – HbA1C > 9	17.71%	2014 ACO	< 30%	<20%	<15%	30.5%	18.7%	
Hypertension BP control	66%	Epic	63%	68%	70%	64.4%	68.7%	63%

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

Internal goals only

CHI Franciscan Health

❖ 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

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- 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

CHI Franciscan Health

FMG PRIMARY CARE CLINIC STAFFING

A	C	D	E	F	G	H	I	J	K	L
						Clinical support staff				
Clinic Name	# of MA FTEs	# of LPN FTEs	# of RN FTEs	# of Care Mgr / Care Coord FTEs	# of Pharmacist FTEs	Certified Diabetes Educator (CDE) FTEs	Total Clinical FTEs (C+D+E+F+G+H)	# of provider FTEs	Clinical Staff to Provider Ratio (I/J)	Additional Clinical FTEs needed to reach 2.0 ratio (J/2=A-I)
FMC - Bonney Lake	0.0	4.0	0.0	0.50	0.40	0.40	4.40	4.0	1.10	3.60
FMC on 11th Place	2.0	2.0	0.0	0.50	0.00	0.00	4.50	3.0	1.50	3.90
FMC- Auburn	1.0	2.0	0.0	0.50	0.20	0.20	3.70	2.0	1.85	1.90
FMC- Burien	3.0	1.0	0.0	0.00	0.20	0.20	4.20	4.0	1.05	7.60
FMC - Canyon Road	1.3	4.7	1.0	0.35	0.40	0.60	9.80	5.25	1.86	4.90
FMC- Des Moines	7.0	0.00	0.00	0.00	0.00	0.00	7.00	5.00	1.40	7.00
FMC - Enumclaw	12.0	4.0	0.0	0.00	1.00	0.40	17.40	11.0	1.49	14.40
FMC- Federal Way	7.0	2.0	0.0	0.50	0.20	0.20	9.70	9.0	1.08	13.50
FMC - Gig Harbor	3.0	3.0	1.0	0.33	0.50	0.80	8.63	5.0	1.71	5.47
FMC- Lakewood	5.0	2.0	0.0	0.25	0.00	0.40	7.65	5.0	1.51	6.35
FMC- Milton	3.0	1.5	0.0	1.00	0.00	0.20	5.70	4.0	1.43	5.50
FMC - Pt. Fosdick	4.0	3.0	1.0	0.34	0.50	0.20	9.04	5.0	1.81	4.96
FMC - Port Orchard	5.0	2.0	0.0	0.33	0.00	0.20	5.53	4.6	1.20	7.35
FMC- Riverton	5.0	1.0	0.0	0.00	0.00	0.00	6.00	2.0	3.00	2.00
FMC- Seahurst	0.0	6.0	0.0	0.00	0.00	0.00	6.00	6.0	0.00	11.00
FMC at St. Francis	4.0	1.0	0.0	0.50	0.00	0.00	6.50	6.0	1.08	10.70
FMC - St. Joe's	8.0	10.0	1.0	1.00	1.00	0.20	29.20	24.0	1.22	57.80
FMC South Seattle	5.0	0.0	0.0	0.00	0.00	0.00	5.00	3.0	1.67	5.00
FMC - Spanaway	1.0	2.0	0.0	0.25	0.00	0.00	3.25	2.0	1.63	2.50
FMC- University Place	8.0	6.0	1.0	0.35	0.50	0.20	15.65	11.0	1.42	15.35
FMC- Vashon Island	4.0	0.0	1.0	0.00	0.00	0.00	5.00	6.0	0.83	13.00
FMC- West Seattle	5.0	1.0	0.0	0.00	0.00	0.00	6.00	6.0	1.00	12.00
FMC- Westwood	5.0	0.0	0.0	0.00	0.00	0.00	5.00	4.0	1.25	4.00
FMC- Yakima Ave	0.0	1.0	0.0	0.00	0.00	0.00	1.00	0.5	2.00	0.00
	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL	AVERAGE	TOTAL
Total Clinics: 24	97.25	82.20	8.00	8.30	5.80	4.80	179.35	137.35	1.31	285.35

Patel, M et al. *American Journal of Managed Care*. 2013; 19(6):513.
Berra, Amanda. The Advisory Board Company, March 2011.

CHI Franciscan Health

FMG PRIMARY CARE CLINIC STAFFING

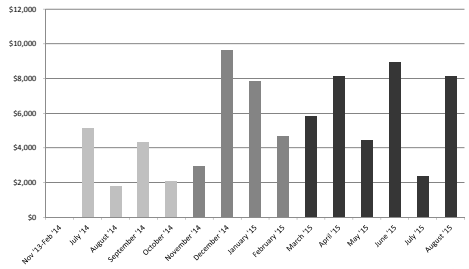
A	E	F	G	H	J
	Clinical support staff				
Clinic Name	# of RN FTEs	# of Care Mgr / Care Coord FTEs	# of Pharmacist FTEs	Certified Diabetes Educator (CDE) FTEs	# of provider FTEs
FMC - Bonney Lake	0.0	0.50	0.40	0.40	4.0
FMC on 11th Place	0.0	0.50	0.00	0.00	3.0
FMC- Auburn	0.0	0.50	0.20	0.20	2.0
FMC- Burien	0.0	0.00	0.20	0.20	4.0
FMC - Canyon Road	1.0	0.35	0.40	0.60	5.25
FMC- Des Moines	0.00	0.00	0.00	0.00	5.00
FMC - Enumclaw	0.0	0.00	1.00	0.40	11.0
FMC- Federal Way	0.0	0.50	0.20	0.20	9.0
FMC - Gig Harbor	1.0	0.33	0.50	0.80	5.0
FMC- Lakewood	0.0	0.25	0.00	0.40	5.0
FMC- Milton	0.0	1.00	0.00	0.20	4.0
FMC - Pt. Fosdick	1.0	0.34	0.50	0.20	5.0
FMC - Port Orchard	0.0	0.33	0.00	0.20	4.6
FMC- Riverton	5.0	0.00	0.00	0.00	2.0
FMC- Seahurst	0.0	0.00	0.00	0.00	6.0
FMC at St. Francis	0.0	0.50	0.00	0.00	6.0
FMC - St. Joe's	1.0	1.00	1.00	0.20	24.0
FMC South Seattle	0.00	0.00	0.00	0.00	3.0
FMC - Spanaway	0.0	0.25	0.00	0.00	2.0
FMC- University Place	1.0	0.25	0.50	0.20	11.0
FMC- Vashon Island	1.0	0.00	0.00	0.00	6.0
FMC- West Seattle	0.0	0.00	0.00	0.00	6.0
FMC- Westwood	0.00	0.00	0.00	0.00	4.0
FMC- Yakima Ave	0.0	0.00	0.00	0.00	0.5
	TOTAL	TOTAL	TOTAL	TOTAL	TOTAL
Total Clinics: 24	6.00	6.00	3.00	4.80	137.35

Patel, M et al., *American Journal of Managed Care. 2013; 19(6):513.*
Berra, Amanda; *The Advisory Board Company*, March 2011.

CHI Franciscan Health

- 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

Results: Potential Revenue TCM Billing Codes



Wenke, B, St. Joseph Medical Center Resident Project – Internal Data

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- 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

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