Monthly Campaign Webinar
August 15, 2019
Today’s Webinar

• Together 2 Goal® Updates
  – Webinar Reminders
  – 2019 AMGA IQL
  – AMGA Acclaim Award
  – T2G Plank Mentors

• Embedded Pharmacists in Primary Care
  – James Kalus, Pharm.D. of Henry Ford Medical Group

• Q&A
  – Use Q&A or chat feature
Webinar Reminders

• Webinar will be recorded today and available the week of August 19th
  – www.Together2Goal.org

• Participants are encouraged to ask questions using the “Chat” and “Q&A” functions on the right side of your screen
2019 AMGA Institute for Quality Leadership

Embracing Disruption
Delano Las Vegas
Las Vegas, NV

September 25 – 28th
AMGA Acclaim Award

• Applications due: Friday, October 18th
• Webinar on Wed., August 7th at 3:00 P.M. (ET) for more information
T2G Plank Mentors

 Ree Ann Williams, M.D., FACP
 HealthPartners Care Group
 Regional Medical Director, Primary Care
 Contact

 Mark R. Greenwood, M.D.
 Intermountain Medical Group
 Family Medicine Medical Director
 Contact

 Valdrin Spajer, M.P.H., RD, CDE
 Sutter Health
 Clinical Performance Improvement Consultant
 Contact

 Frank Colangelo, M.D., M.S. HGSS, FACCP
 Premier Medical Associates, P.C.
 Chief Quality Officer
 Contact

 Carrie Kneising, M.D.
 Mercy
 Medical Chair of the Quality Department, Medical Director of Care Management
 Contact

 Jaret Appel, R.N., M.S.N.
 Sharp Rees-Stealy Medical Group
 Director of Population Health and Informatics
 Contact

 Brian Stobie, M.D., M.S.
 Lehigh Valley Physician Group
 Quality Liaison, Internal Medicine, Prevention Lead WPNG W. Berks
 Contact

 Scott Hines, M.D.
 Crystal Run Healthcare
 Chief Quality Officer and Medical Director
 Contact

 Stephen Cente, M.D., CPE, FACP, FIAAP
 Bailed Health
 Vice President and Chief Medical Officer, Bailed Medical Services
 Contact

 Liana Sporzo-Berrymen, D.O., FACC
 Summit Medical Group, P.A.
 Cardiologist
 Contact

 Brian Jensen, D.O.
 Gehring
 Chair, Endocrinology
 Contact

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Today’s Featured Presenter

James Kalus, Pharm.D.
Henry Ford Medical Group
Embedded Pharmacists in Primary Care

James Kalus, PharmD
Director of Pharmacy, Henry Ford Health System
jkalus1@hfhs.org
Objectives

1. Compare and contrast the skills and knowledge of the pharmacist, relative to other traditional members of the primary care team
2. Describe the role of the pharmacist embedded in a primary care clinic
3. List the patient care benefits of deploying embedded clinical pharmacists in primary care clinics
4. Develop a plan for efficient and cost effective deployment of pharmacist within an organization
Significantly improved medication adherence

Why Pharmacists in Primary Care?

Success in specialty areas: Oncology

Implementation of oral chemotherapy management program in a large integrated health care system and its impact on patient safety

Jessica J. Yoo, PharmD; Salim Nheen, PharmD; Prabha Dhanaphal Vogel, PharmD; Igor I. Rybkin, MD, PhD; Diana Kostoff, PharmD
Henry Ford Cancer Institute, Henry Ford Health System, Detroit, MI

Abstract # 279

BACKGROUND

(FP) was not to provide care to all patients

characteristics

Survival of Oral
Pharmacy Regimens

responsibility

to complex dosing of oral therapy

Dosage

supervision and other treatment

outcomes

Programs have been implemented across the nation, but there is limited evidence on the impact of these programs on the reduction of chemotherapy-induced toxicities and prevention of emergency department (ED) visits and hospitalizations.

METHODS

Study objectives:

Primary: To compare the incidence of all-grade and grade 3/4 toxicities that are commonly associated with capcitabine before and after OCMCP initiation.

Secondary: To compare the incidence of ED visits and/or hospitalizations due to toxicities, treatment outcome and adherence rates

Eligibility:

Inclusion criteria: ≥ 18 years old, ≥ 1 dose of capcitabine between January 2012 – September 2016

Exclusion criteria: Enrolled in clinical trial or pregnant

Retrospective chart review

RESULTS

OCMCP improved clinical outcomes by reducing ED visits and hospitalizations due to chemotherapy-induced toxicities.

OCMCP decreased the frequency and severity of chemotherapy-induced toxicities.

RESULTS (cont.)

OCMCP improved clinical outcomes by reducing ED visits and hospitalizations due to chemotherapy-induced toxicities.

Total number of ED visits

Total number of hospitalizations

All-Grade Toxicity

Significantly improved medication adherence

15% reduction in ANY oral chemo adverse effects and 70 – 85% reduction in severe oral chemo adverse events

Journal of Clinical Oncology 36, no. 30_suppl (October 2018) 279-279.

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Why Pharmacists in Primary Care?

**Success in specialty areas: Pulmonary**

Improved outcomes in COPD

- 61% of patient inhaler devices switched based on pharmacist objective assessment
- Rescue inhaler use decreased from 22 times per week to 10 times per week (p < 0.01)
- Patient assessment scores significantly improved in 4 weeks
- Statistically significant improvements in medication adherence
- Decrease in ED visits/hospitalizations over 12 weeks

Pilot study of 44 patients with COPD who had clinic visits with a pharmacist

Reduced out-of-pocket costs for patients

<table>
<thead>
<tr>
<th>TOTAL POPULATION ANNUAL OUT-OF-POCKET COSTS FOR COPD MEDICATIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Costs Prior to Intervention</td>
</tr>
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<td>Cost After Intervention</td>
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<tr>
<td>Cost Savings</td>
</tr>
</tbody>
</table>
Why Pharmacists in Primary Care?

• Proven success in specialty clinics within HFHS
• Growing chronic disease burden in primary care
• Medication-sensitive metrics important in primary care
  – HgbA1c control, Blood pressure control, statin use
• Emergency department utilization and hospitalization due to sub-optimal chronic disease control
• Advanced data analytic capabilities
  – Proactive instead of reactive
Why Pharmacists in Primary Care?

The pharmacists’ skillset is complementary to the clinic team:

- Identify medication non-adherence
- Resolve barriers to medication adherence
- Design and redesign medication regimens customized to patient characteristics and needs
- Medication focused patient education
- Assist with the resolution of medication access issues
DATA TO DEFINE THE PROBLEM
Background

• Multiple interventions have been put in place to impact A1c control over many years.
• Henry Ford Medical Group overall improved.
• Interventions were very impactful at some sites.
• Several sites did not improve significantly
  – Control rates stayed low and flat.
• Needed to find a more targeted approach for these sites.
Interventions in Place

• Robust Diabetes Care Center Services
• Diabetes in Active Control with automatic referral for patients with A1c>9
• Standing orders for “no missed opportunities”
• Standard Diabetes Treatment Algorithm
• POC testing in some clinics (targeted)
• Dashboard with un-blinded results
• Quality incentive
Diabetes Control Improvement: Not Good Enough!

All HFMG Primary Care Clinics
Data Analytics: Medication Opportunities

- On 2 gm/day Metformin
- On LA Insulin greater than 15u/day
- On LA Insulin: Less than 15u/day
- On Metformin: Less than 2 gm/day
- Not on Metformin
- Not on Long-Acting Insulin

HgbA1C > 9

- 6081
- 3008
- 1153
- 790
- 2590
- 1920
- 2701
Primary Care – Pharmacy Collaboration Pilot

November 2016 – August 2017

• Pharmacist embedded in two primary care clinics
• Clinic selection based on:
  – 2016 improvement data (flat and low performance)
  – Medication optimization opportunity data
  – Clinic leadership
• Pharmacist-patient encounters were tracked
• Overall clinic diabetes control was used to assess impact
Initial Pilot Data:
Patients “Touched” by the Pharmacist

10.2 ± 2.0 mg/dL → 8.4± 1.7 mg/dL
Average A1C pre/post pharmacist involvement

1.25 ± 1.99 mg/dL
Average A1C reduction 3 mos post pharmacist involvement

39.11%
Patients w/ A1C <8.0 mg/dL at 3 mos post pharmacist involvement

Patient-level A1C Improvement Analysis (n = 320 patients evaluated, 307 patients with A1C > 8.0 mg/dL)

November 2016 – August 2017
OUTCOMES OF INITIATIVE

Clinic-level Data

HARBORTOWN

EAST JEFFERSON

A1c <8 rate over the 12 months

Pharmacist Started Here

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# OUTCOMES OF INITIATIVE

## December 2015 DM/HTN Metrics Rankings & August 2017 DM/HTN Metrics Rankings By Site

<table>
<thead>
<tr>
<th>DM A1c &lt; 8 Ranking</th>
<th>DM A1c &lt; 8 Ranking</th>
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<tbody>
<tr>
<td>Novi 76</td>
<td>Novi 80↑</td>
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<tr>
<td>Farm 71</td>
<td>Hamtramck 77↑</td>
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<tr>
<td>LKS 71 ↓</td>
<td>Farmington 74↓</td>
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<td>Colum. C 69</td>
<td>Lakesides 76↑</td>
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<td>SH 69 ↓</td>
<td>Harbertown 74↑</td>
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<td>K-15 63↑</td>
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<td>FRL 64</td>
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<td>Harbert 59 ↓</td>
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<td>DNW 59 ↓</td>
<td>Milford 50↑</td>
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Primary Care – Pharmacy Collaboration Pilot

November 2016 – August 2017

• Success of pilot → expansion
  – 2 additional pharmacists deployed
  – Clinics with a pharmacist increased from 2 – 6
    • 1 pharmacist ~ 400 uncontrolled patients with diabetes
      ▪ Usually 2 clinics per pharmacist unless clinic is large
Additional Clinics Added

<table>
<thead>
<tr>
<th>December 2015 DM A1c &lt; 8</th>
<th>August 2017 DM A1c &lt; 8</th>
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<td><strong>Ranking</strong></td>
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<tr>
<th>90th percentile HEDIS</th>
<th>75th percentile HEDIS</th>
<th>50th percentile HEDIS</th>
<th>25th percentile HEDIS</th>
<th>&lt;25th percentile HEDIS</th>
</tr>
</thead>
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EMBEDDED PHARMACISTS
What is an Embedded Pharmacist?

• Pharmacist physically located in clinic 2 – 5 days per week
  – Pharmacist develops a relationship with providers in clinic
  – Pharmacist collaborates with providers and other health care professionals frequently

• Pharmacist conducts face-to-face, virtual and telephone encounters
  – Pharmacist develops a relationship with patients
Greater Efficiency Through Analytics

Traditional Approach

• Wait for referrals from provider
  – **Challenge**: Slow to start

• Review all/many patients coming into clinic
  – **Challenge**: Many patient charts must be reviewed to find the patient that needs the pharmacist
  – **Challenge**: Difficult to establish relationship with the patient. Try to catch patient before or after provider or see patient with provider.
Greater Efficiency Through Analytics

Our Approach

• Analytics tool
  – Patients with uncontrolled chronic disease identified

• Pharmacist fills schedule with appointments by engaging patients identified in tool

• Advantages:
  – Fill pharmacist schedule more quickly
  – More patient encounters = improved quality metrics
How Does the Pharmacist Establish a Relationship with Patients?

Analytic Tool

- Identification of patients with HgbA1C >8 mg/dL
  - Sort by: Clinic, Provider, A1C level
- Real time linkage with scheduled appointments

Goal: > 10 patient encounters per day

**Pulls the patient in**
Pharmacist works through the list of patients with HgbA1C > 8 mg/dL.

Engages the patient and schedules appointments with patients

~80%

Pharmacist reviews “real time” appointment list to identify patients coming in to see provider

Providers refer patients to pharmacist

~20%
Pharmacist Workflow

1. Appointment made
   - Patient identified through data analytics tool
   - OR
   - Referral by PCP
   - Same day or future appointment

2. Face to face visit
   - A1c done or reviewed
   - BP measured
   - Medications reviewed
   - Set goals with patient
   - Medication changes implemented to achieve goals

3. Follow up set up
   - Combination of face-to-face and telephone visits
   - Continue to follow until clinical goals accomplished
   - Medication changes and updates communicated with PCP
How Does the Pharmacist Maintain a Relationship with Providers and Patients?

Pharmacist develops a plan for an identified patient.

Pharmacist discusses plan with provider and modifies as needed.

Pharmacist implements the plan with the patient and establishes a follow-up plan.

Pharmacist maintains relationship with the patient until DM goals achieved.

Note: Once involved for DM, pharmacist plan also addresses other medication gaps

A1C < 8 mg/dL
Funding a pharmacist

Billing Opportunities

Quality Payments

Prescription Insourcing

Value-Based Contract Performance

Improved Medication Adherence

Reduced ED/Hospital Visits

Leverage Pharmacy Students and Residents

Improved Quality Metrics

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IMPACT OF EXPANSION
Clinical Improvements

Aug 2017-Feb 2018

238 patients evaluated

<table>
<thead>
<tr>
<th></th>
<th>Average A1c reduction 4 months post pharmacist involvement:</th>
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</thead>
<tbody>
<tr>
<td>pre/post pharmacist involvement:</td>
<td>10.3% → 8.4%</td>
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<tr>
<td></td>
<td>↓ 1.96 +/- 0.17%</td>
</tr>
<tr>
<td>Patients with A1c &lt;8.0% at 4 months post pharmacist involvement:</td>
<td>52.1%</td>
</tr>
</tbody>
</table>

CONFIRMS PILOT DATA!
# Clinic – Level Data

## August 2017 HFMG DM Metrics Rankings By Site

<table>
<thead>
<tr>
<th>DM A1c &lt; 8</th>
<th>Ranking</th>
<th>Novi</th>
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## April 2019 HFMG DM Metrics Rankings By Site

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<td>DNW</td>
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<td>AIM (K15)</td>
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<td>Waterford</td>
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</tbody>
</table>
OUTCOMES OF INITIATIVE

Clinic-level Data

DETROIT NORTHWEST

A1c < 8 Rate over the last 12 months

Diabetes control maintained or continues to improve in these clinics!
## Therapy Changes

<table>
<thead>
<tr>
<th>Therapy</th>
<th>New</th>
<th>Modified</th>
<th>Discontinued</th>
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<tbody>
<tr>
<td>Aspirin</td>
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<tr>
<td>Statin</td>
<td>29</td>
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<td>ACEI/ARB</td>
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<tr>
<td>Insulin</td>
<td>81</td>
<td>442</td>
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<tr>
<td>Non-insulin injectable</td>
<td>42</td>
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<tr>
<td>Oral anti-diabetic</td>
<td>80</td>
<td>92</td>
<td>60</td>
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<tr>
<td><strong>Total</strong></td>
<td>256</td>
<td>564</td>
<td>95</td>
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August 2017 – February 2018; n = 238 patients
Increased DM Related Referrals

August 2017 – February 2018; n = 238 patients

- Diabetes Education (n=34)
- Ophthalmology (n=21)
- Endocrinology (n=1)
- Podiatry (n=5)
- Physical Therapy (n=1)
Increased Patient Encounters

- Reviewed patient office visits 6 months prior to pharmacist visit vs 90 days after
- Before Pharmacist: 1.9 encounters per patient (all physician)
- After Pharmacist: 6.2 encounters per patient
  - 0.7 encounters per patient (physician)
  - 5.5 encounters per patient (pharmacist)
- Overall, physician productivity did not decline during this time
Increased Patient Encounters

August 2017 – February 2018; n = 238 patients

NOTE: Physician productivity did not decline over this time period

<table>
<thead>
<tr>
<th></th>
<th>Pre Pharmacist</th>
<th>Post Pharmacist</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician</td>
<td>441</td>
<td>171</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>0</td>
<td>1303</td>
</tr>
</tbody>
</table>
Diabetes-related Hospital/ED Visits

Compared 90 days pre vs 90 days post first encounter with pharmacist

<table>
<thead>
<tr>
<th></th>
<th>Pre-Pharmacist</th>
<th>Post-Pharmacist</th>
<th>P-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>ED Visits</td>
<td>14</td>
<td>3</td>
<td>0.016</td>
</tr>
<tr>
<td>Hospitalizations</td>
<td>16</td>
<td>0</td>
<td>0.001</td>
</tr>
<tr>
<td>Total Days of Hospitalization</td>
<td>39</td>
<td>0</td>
<td>0.0001</td>
</tr>
</tbody>
</table>

August 2017 – February 2018; n = 238 patients
Next Steps for HFMG

• Expand to 4 target chronic disease states
  – Diabetes (HgbA1C > 8)
  – Hypertension (BP > 140/90)
  – COPD (any)
  – Heart failure (any)

• Use analytic tool to increase complexity of patients
  – More than 1 chronic disease in the same patient
Chronic Disease States

17,540 patients with at least 1 target chronic disease in clinics with a pharmacist

HTN in 76%

HTN in 85%

Target 600 – 800 uncontrolled patients/pharmacist
Conclusion

• Embedded pharmacists equipped with analytic tools utilizing a proactive approach
  – Improve chronic disease surrogate measures and outcomes
  – Provide physicians with a highly skilled partner in care
  – Lead to better results with lower physician work burden
Questions
September Webinar

• **Date/Time:** September 19, 2019 from 2-3pm Eastern

• **Topic:** Innovator Track Eye Care Cohort Results

• **Presenters:** AMGA