

Michigan Summary of Care Report

Michigan Pharmacists Transforming Care and Quality

5th Edition



Presented by



2016

Welcome

The health care delivery model in the United States is evolving rapidly and with continued pressure to address all aspects of value: reducing health care expenditures, improving quality of care, and enhancing the patient experience. Last year's *Sanofi Michigan Summary of Care Report* focused on specialists and their significant role in the continuum of care for shared patients with their primary care physician (PCP) partners as Patient-Centered Medical Home Neighbors. This year's focus is on the growing role of the pharmacist in population health management.

to ensure efficacy, safety, and cost-effective therapy as the standard of care, patients needing better disease control, ongoing medication management, and adherence counseling can be identified more efficiently and are triaged to the appropriate member of the care team.

Additionally, optimal medication use is a critical factor in producing positive outcomes in chronic conditions, and yet only about 50% of patients take their medications as prescribed. Clinical pharmacists have extensive knowledge and experience in identifying medication adherence barriers and providing customized solutions. Clinical pharmacists' involvement in primary care teams has shown to significantly improve medication adherence.

Clinical pharmacists performing comprehensive medication and disease management services in the team-based PCMH model can provide an array of patient care support to address medication- and disease-related topics, including treatment goals, adherence, medication costs, education, and gaps in care.

BCBSM was excited to launch the Michigan Pharmacists Transforming Care and Quality (MPTCQ) initiative in the fourth quarter of 2015. This statewide consortium is led by the University of Michigan Health System (UMHS). MPTCQ is modeled after UMHS's long-standing integrated program of incorporating the pharmacist into their primary care practices. Ten physician organizations (POs) from across Michigan are actively engaged in MPTCQ. The short-term goal of the program is to adopt UMHS's integrated pharmacist practice model within participating POs, with the long-term goal of working to improve patient care and outcomes.

This is a great opportunity to better serve people with chronic illnesses. POs can support physicians and pharmacists in delivering optimal patient care by supporting the integration of clinical pharmacists into primary care practice units.

Together we can continue to make a difference in the life of Michiganians.

Sincerely,

Thomas Leyden, MBA
Director II, Value Partnerships
Blue Cross Blue Shield of Michigan

Laurie Wesolowicz, PharmD
Director II, Pharmacy Services
Blue Cross Blue Shield of Michigan

Over the past decade, Blue Cross Blue Shield of Michigan (BCBSM), in partnership with the primary care community, has addressed quality and cost of care via the multidisciplinary, team-based care model called the Patient-Centered Medical Home (PCMH). This model engages all clinical care players—PCPs, specialists, nurses, care managers, behavioral health providers, nutritionists, and other health care providers—to come together as teams collaborating in the care and support of the health care goals of their patients.

In a 2013 American College of Physicians position paper, *Principles Supporting Dynamic Clinical Care Teams*, clinical pharmacists were specifically noted as integral members of “well-functioning teams.” In addition, a Program Guide for Public Health by the Centers for Disease Control and Prevention states, “the role of the pharmacist has expanded beyond just dispensing medications and is evolving into active participation in chronic disease management as a part of team-based care.”

Given the complexity of medication regimens and the potential adverse events associated with polypharmacy, having health professionals, including clinical pharmacists with expertise in medication management, as part of the integrated care team is critical. With clinical pharmacists reviewing all medications (prescription, over the counter, vitamins, and supplements)

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Introduction

The *Michigan Summary of Care Report*, now in its fifth edition, highlights the care management strategies implemented by leading physician groups across the state of Michigan. This year's report profiles the embedded pharmacist model at physician organizations participating in the Michigan Pharmacists Transforming Care and Quality (MPTCQ) Collaborative Process Initiative (CPI).

MPTCQ Overview

Clinical pharmacists serve as an integral member of the care management team within Blue Cross Blue Shield of Michigan's (BCBSM) Patient-Centered Medical Home and are further involved in direct patient care. Integrating pharmacists into this clinical role is part of the goal of the MPTCQ Collaborative. Under the leadership of the MPTCQ Coordinating Center, care teams learn to address safe and effective use of medications for patients by training and embedding pharmacists into the PCMH model within their practices. BCBSM provides financial support to the MPTCQ Coordinating Center, as well as to physician practices actively participating in this initiative. BCBSM, in concert with the MPTCQ Coordinating Center, provides program oversight, sharing of best practices, and continuous evaluation of the initiative.

Prescription drugs account for 9.3% of all health care spending nationwide.¹ The complexity of medication regimens and potential adverse events make the emerging role of the clinical pharmacist on an integrated care team more important than ever. The specialized knowledge and experience of clinical pharmacists allow them to identify barriers to medication adherence and provide customized solutions. Their involvement in primary care teams significantly improves medication adherence² and chronic illness care, which may lead to HEDIS and Star Rating improvement.

By joining the MPTCQ Collaborative, physician organizations (POs) receive access to a range of specialized resources, including boot camps for Pharmacist Transformation Champions; access to the MPTCQ Data Registry and Web site; clinical forums and practice development mentoring; and other tools in development, such as monthly Webinars and practice implementation tool kits.

Pharmacist Transformation Champions

In collaboration with the MPTCQ Coordinating Center, each of the selected POs hired or appointed a Pharmacist Transformation Champion. This pharmacist implemented an integrated pharmacist model at two to three practice sites, providing services such as medication review (prescription, over the counter, vitamins, and supplements) for appropriate patients to ensure efficacy, safety, and cost-effective therapy; ongoing medication management; and adherence counseling. These pharmacists proactively target patients with diabetes, hypertension, or hyperlipidemia through use of the POs' patient registries.

After the successful integration of clinical pharmacy services at the POs' larger physician practices, the Pharmacist Transformation Champion can collaborate with PO leadership to devise a plan (e.g., central/regional model) to meet the unique needs of smaller, dispersed PO primary care practices and apply the program more broadly.

¹ Centers for Disease Control and Prevention. (2013). National Center for Health Statistics. Retrieved from <http://www.cdc.gov/nchs/fastats/health-expenditures.htm>

² Sokol, M. C., et al. (2005). Impact of Medication Adherence on Hospitalization Risk and Healthcare Cost. *Medical Care* 43:521-30.

Program Leadership— University of Michigan Health System



The **University of Michigan Health System** (UMHS) is the Coordinating Center for the MPTCQ Collaborative and a premier academic medical center with three hospitals and 40 outpatient locations with more than 150 clinics. In 2009, UMHS created and launched an integrated pharmacy program in primary care.

The clinical pharmacists in this program provided proactive outreach to target diabetes, hypertension, and polypharmacy patients, and built on close patient-provider relationships. The Michigan Primary Care Transformation Project (MiPCT)—a five-year, multipayer project aimed at improving health in the state, making care more affordable, and strengthening the patient-care team relationship—opened new, multipayer reimbursement streams, allowing pharmacists to bill for the patient care they performed.

This innovative pharmacy program now includes 5.2 full-time equivalent pharmacists (11 clinical pharmacists) embedded in 14 primary care sites, and has expanded to specialty areas, including chronic kidney disease, psychiatry, palliative care, and anticoagulation/cardiology. This program extends care to homebound patients using telehealth solutions. New, emerging services include Central Transitions of Care, to address medication discrepancies and help identify and resolve medication problems post-hospital discharge, and Community BP Centers, to improve blood pressure checking and management by engaging community pharmacists.



*Hae Mi Choe,
Program Director,
MPTCQ Coordinating
Center*

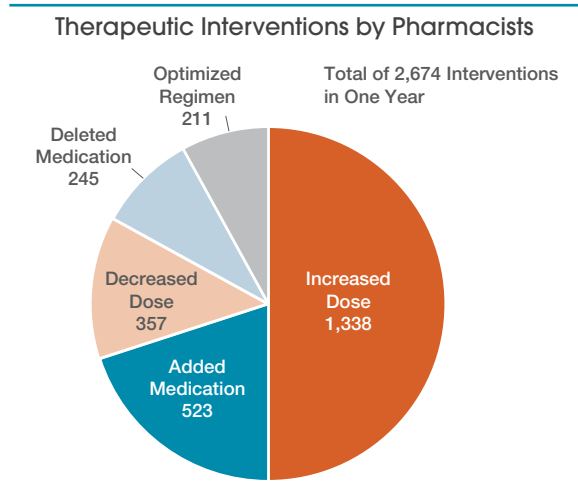
MPTCQ Coordinating Center

The nationally recognized University of Michigan Health System serves as the Coordinating Center for the MPTCQ. UMHS's ambulatory clinical pharmacists have been successfully integrated into patient care for more than seven years, and their team-based care model was selected for the Innovative Pharmacy Practice Award from the Michigan Pharmacists Association and the Best Practice Award from the American Society of Health System Pharmacists. In October 2014, UMHS was highlighted and profiled as one of the five best integrated pharmacy practice models in the nation by The Advisory Board Company. The UMHS pharmacist practice model was created, developed, and implemented by Hae Mi Choe, PharmD, program director for the MPTCQ Coordinating Center. She has received numerous awards for developing innovative care delivery models, including the American Pharmacists Association's Pinnacle Award for Individual Career Achievement.

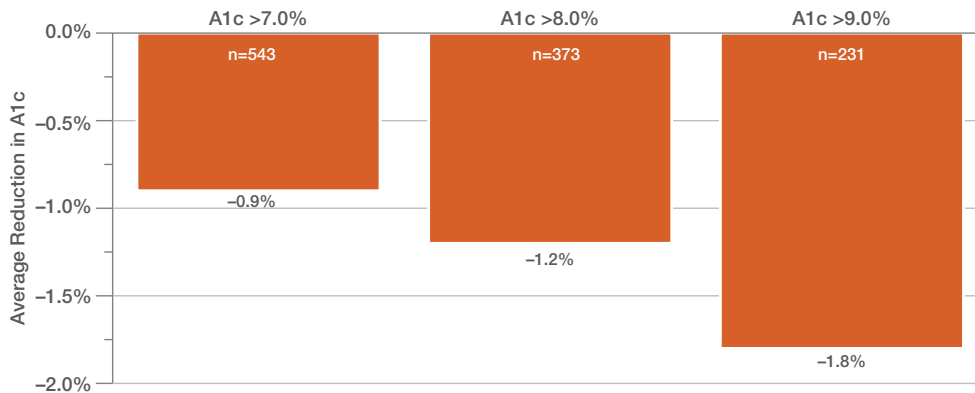


UMHS Clinical Pharmacy Program Results

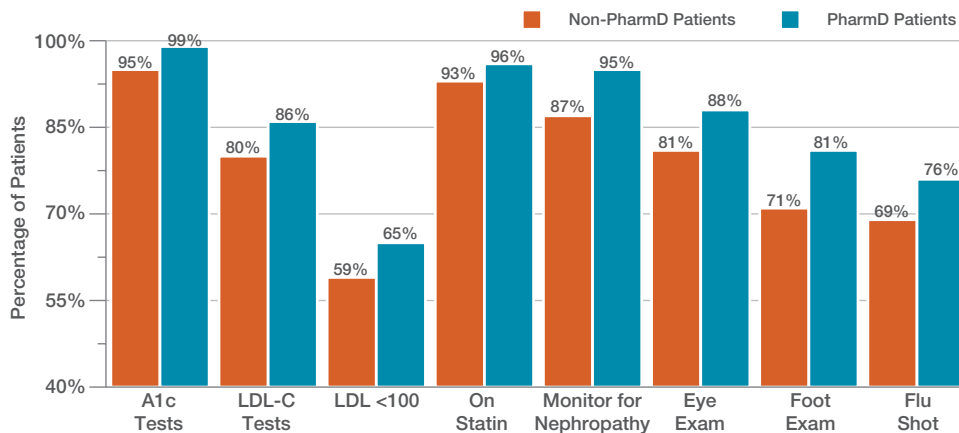
In a single year of the UMHS program, clinical pharmacists provided more than 2,600 therapeutic interventions—in 50% of these interventions, pharmacists increased a patient’s medication dose; in nearly 20%, they added a medication to the patient’s regimen; and, in the remaining 30%, pharmacists either decreased a medication dose, deleted a medication, or optimized a patient’s regimen. The clinical outcomes were positive, too. Over the course of the program, the clinical pharmacists’ diabetes patients showed a 0.9% decrease in A1c for those with baseline A1c greater than 7.0%, and a 1.8% decrease for those with baseline A1c greater than 9.0%.



Average Decrease in A1c Level in Patients With Diabetes and Co-Managed by Clinical Pharmacist



Diabetes Registry Quality Report, 2013–2014



Data Source: UMHS self-reported

MPTCQ Physician Organizations



Accountable Healthcare Alliance (AHA) is an independent, physician-led organization in southeast Michigan with 248 total physicians. Thirty-nine of these physicians are in 17 practices that are designated PCMHs. AHA contracts with **Medical Advantage Group** for full infrastructure support, offering health care providers expertise and advanced industry knowledge to enable the successful deployment of value-driven health care initiatives.



Affinia Health Network is a physician-led clinically integrated network that is a wholly owned subsidiary of Mercy Health. It includes west Michigan physicians at Mercy Health and Mercy Health Physician Partners. Affinia Health Network has more than 520 physicians and advance practice providers in 100 primary and specialty care practices, and includes three hospitals, as well as ancillary providers.

Jackson Health Network

Jackson Health Network (JHN) is a clinically integrated network of physicians, health care community leaders, and Henry Ford Allegiance Health collaborating to improve patient outcomes and safety, enhance patient experience, and reduce overall cost through an integrated system of care. JHN comprises 75 primary care and 276 specialty care physicians. Approximately two-thirds of the physicians are employed, and the balance remain independent.



Medical Network One (MNO) is a health care management organization that offers a broad array of infrastructure, technology, and clinical services to independent physician practices, mid-level professionals, and specialists who are focused on successfully transitioning to fully integrated, population-based, patient-centric practices that meet health reform mandates. In addition, MNO is actively engaged in developing and implementing care management strategies and multidisciplinary team care, with a special focus on providing whole-person care to individuals with chronic conditions.



Mercy Health Physician Partners serves patients across west Michigan and has more than 500 providers in its extensive primary care and specialty network, including family medicine, pediatrics, obstetrics and gynecology, and internal medicine, as well as a variety of specialty types. It includes two networks based in Grand Rapids and Muskegon.



MidMichigan Collaborative Care Organization (MCCO) is a platform through which people, processes, and technology are developed to improve the health and quality of life of its population. The organization collaborates with providers and facilities across the health care continuum to care for the community. MidMichigan Health includes five medical centers; multiple health parks; 32 primary care practice units, plus 24 advanced practice providers and 16 family practice residents; and 44 specialty practice units.

Northern Physicians Organization (NPO) is made up of over 520 physician members serving northern Michigan. The NPO mission is: Healthcare leadership through an independent physician organization. NPO physicians have invested in a technology interface to improve patient care composed of a community registry for analytics and a longitudinal patient record that can be viewed across providers. NPO is a state-approved Qualified Data Sharing Organization (QO) with its own health information exchange for admission, discharge, and transfer—and soon, medication reconciliation.



Oakland Southfield Physicians (OSP) is a physician-led Independent Practice Association, with sizes from sole practitioners to large groups with a dozen or more physicians. OSP represents more than 430 physicians, mostly in primary care, across seven counties in southeastern Michigan. Created in 1986 with a focus on supporting primary care in Michigan, OSP seeks to free physicians from the administrative burdens of health care, thereby allowing physicians to spend more time caring for patients.



Spectrum Health is a not-for-profit health system based in west Michigan comprising 12 hospitals and a total of 178 ambulatory offices and service sites. There are more than 3,400 physicians employed by Spectrum Health, with around 1,400 practicing at ambulatory sites in Spectrum Health Medical Group. All of the ambulatory offices are on the same electronic health record (EHR) system, with the hospitals scheduled to convert to the system in November 2017.



United Physicians contracts with more than 2,300 physicians across southeast Michigan, in both independent- and employed-model practices. Approximately 25% of the network is primary care focused, and approximately 80% of the providers practice in BCBS-designated PCMHs. United Physicians' mission is to deliver a health care system of excellence to its community through a coordinated, efficient, and integrated network of physicians.



Pharmacist Transformation Champions (Year 1 Cohort)



Setting the Stage

The POs participating in the MPTCQ Collaborative were methodical in their approaches to launching this new care paradigm. Their process included carefully selecting the right pharmacist to succeed in a clinical setting and ensuring he or she had proper training; ensuring providers were supportive of the program; putting provider agreements in place; tackling logistical considerations and making sure the embedded pharmacists had access to patient registries, health records, and other platforms; and setting goals for the program.

Getting the right pharmacist is really important! The initial foray into putting a new licensure into the team has to be done with somebody who is competent clinically, flexible enough to adapt to other people's work habits, a sufficient "people person" to understand how to talk to people and gain support, and enough of a professional to be able to both achieve and communicate successes.

—Medical Advantage Group

The Right Stuff

Embedded pharmacists play a unique and important role in patient care, so it was critical for the organizations to hire pharmacists with the appropriate background.

- **Ambulatory care specialty**—Some of the embedded pharmacists in the MPTCQ program had completed post-graduate training to specialize in ambulatory care. Indeed, for many, their goal was to be embedded and act as a physician extender. Others had been in a similar role for many years and were expert in the nuances of meeting the needs of patients.
- **Empathy and skillful communication**—An effective patient care pharmacist must be comfortable with talking to patients in plain language, yet he or she also must be able to speak clinically with providers.
- **Patient care techniques**—Most pharmacists underwent (or had previously completed) some combination of training in self-management support, complex care management, motivational interviewing, or commercial pharmacy medication therapy management (MTM). In some practices, current guidelines for treating chronic illnesses were included in collaborative practice agreements, and the pharmacists were expected to know them before seeing patients.
- **Shadowing and mentoring**—New pharmacists “shadow” established embedded pharmacists and other providers. Spectrum set up a structured shadowing program for its pharmacists, where each of the shadowing experiences built on the previous one and increased the new pharmacist’s responsibility level until he or she was providing patient care under the supervision of an established pharmacist.
- **Ongoing support**—In some locations, the organization’s pharmacists meet regularly as a group for education and information sharing.

Logistical Considerations

Many of the MPTCQ physician organizations put agreements in place to define formally the provider-pharmacist relationship. All of them had to be oriented to their practices, and tackle the details of gaining IT access, setting up a workspace, and scheduling patients.

- **Agreements**—Organizations formalized the provider-pharmacist relationship through HIPAA business associate agreements (BAAs), collaborative drug therapy management (CDTM) documents, or collaborative practice agreements (CPAs). Such agreements are critical for pharmacists to realize their full potential in supporting the patient, and to ensure that their engagement with the providers is at the highest level of licensure.
- **Access**—Pharmacists had to be granted access to various technologies used by the POs, including EHR systems, patient registries, and scheduling software. They also had to be trained in the specifics of each system and had to know how to run patient-level reports with initial parameters of interest.

Top Tips

From the POs

- Attend provider meetings to introduce yourself.
- Provide a menu card with the services you can offer patients.
- Make sure your IT system permissions give you access to the full chart and are set up in a way that you can order labs, medications, etc.
- **Consider timing**—I'd recommend being in offices frequently. Perhaps start with half days every week rather than trying full days every other week. A consistent presence is better for developing relationships and being viewed as a member of the team. Relationships are key. I encourage sitting in the break room at lunch to engage with the physicians and office team. Attending provider meetings and clinical/ clerical meetings are important as well. If you have openings in your schedule, talk to the physicians and their MAs in the morning to see if they have any patients coming in who may benefit from meeting with the pharmacist before or after their appointment that day.

—Affinia Health Network

- **Framing the patient visit and building relationships**—For patient engagement, I always start with the question, “What would you like to get out of this visit?” so I can make sure I am meeting their needs. For provider engagement, it’s important to remember that provider relationships take time to develop, and provider referrals are often slow at first. To ensure the pharmacist has productivity from the start, it is important to proactively reach out to patients and engage them in pharmacy services.

—Spectrum Health

- **Champion provider success**—One of our three-month action plans was to review the physicians’ STARS/HEDIS reports provided by BCBSM to each PO. These reports, in addition to the pharmacy data, would be reviewed with the physicians and the care teams. The HEDIS and STARS metrics would be reinforced, and the pharmacist would assist the primary care practices in achieving those goals.

—Medical Network One



Engagement

Key to the success of this initiative in all the participating POs is the engagement of the entire practice—leadership, providers, nurses, care managers, and office team. Having a pharmacist in the primary care setting is new to most of the people involved, so effectively educating and engaging all participants is critical.

Physician Participation

Even with enthusiastic support, changing the patient care patterns and workflow can prove challenging. Clinical pharmacists were eagerly welcomed, but they still had to navigate inserting themselves into, in many cases, strong and long-standing patient-provider relationships.

- **Role of pharmacist**—In each PO, the pharmacist’s role had to be defined and expectations set. Pharmacists sat down with primary care physicians before the program began to discuss any potential concerns. Once physicians knew that they would receive updates about patients on an ongoing basis, they felt more confident in supporting collaborative care. Communicating success stories, process points, and other aspects of the program to the providers was critical.
- **Recruiting appropriate patients**—Face-to-face or EHR task communication with physicians helps to recruit patients for chronic illness management with the clinical pharmacist. Indeed, once the role of the pharmacist is well defined, everyone in the office is encouraged to identify patients for referral.

- **Leadership support**—When clinical pharmacists hit barriers or encounter challenges, strong leadership support is vital and helps all care providers drive toward sustainability and success with patients.
- **Jumping in**—Most of the physicians and members of the care team are excited to have support and help. They see the clinical pharmacist as a valued peer, but it is important that the pharmacist adjust his or her approach based on the individual physician’s comfort levels.

Physicians view the pharmacist as a highly educated clinician who complements the activities in the patient-centered medical home. She reinforces the concept of whole patient care.

—CEO, Medical Network One

Full-Practice Focus

Many of the embedded pharmacists and practice leaders emphasized how important it is to have the PO’s full team involved in the program. PO team members were made aware of the program and the pharmacist’s new role. Practices need strong internal processes, but also the ability to remain flexible so that adaptations could be made as needed.

- **Engaging office team**—Having providers who can “tell the story” to other providers helps create demand. An engaged office manager helps the team develop workflows and relationships with the clinical pharmacist. Devote time to the entire team. Although physician engagement is critical, knowing the team from check-in to check-out ensures that patients can be confident in the coordination of their care.
- **Generating buy-in**—One clinical pharmacist noted that she shared anecdotes and data about how pharmacist services could enhance patient care in the practice to make sure everyone knew the importance of what she was doing. The Oakland Southfield Physicians’ pharmacist makes sure to refresh and re-share documentation quarterly to maintain awareness even through team changes.
- **Physical presence**—Dedicated pharmacist time in clinics each week was seen by many as important to the success of the program. Clinical pharmacists also found it helpful to attend provider and team meetings to foster the strength of the care team.
- **Working with other care managers**—Several of the POs participating in the MPTCQ already had robust care management programs in place, including nurse and social work care managers. Embedded pharmacists worked to coordinate care with the other care managers for shared patients by clearly delineating roles, mutually referring patients, and creating decision trees to determine the appropriate care manager for a given patient.

Patient Communication

Patients are often not familiar with pharmacists beyond their role in filling prescriptions in a retail setting. The holistic care management provided by an embedded pharmacist is new to patients, so education proves to be indispensable in making patients comfortable with this type of care management.

- **Initial patient appointments**—Many of the POs noted that the main hurdle is getting patients to a first appointment with a clinical pharmacist. Once they have a medication review or other face-to-face encounter with a pharmacist, they see the value and are appreciative of the service and personal attention.
- **Warm hand-offs**—The most effective way of engaging patients in this unfamiliar care paradigm is for the physician to introduce the clinical pharmacist and his or her role during a patient's appointment. Often the physician will emphasize the importance of the services the pharmacist provides, which increases a patient's acceptance of the services.
- **Follow-up**—In addition to the face-to-face time during appointments, clinical pharmacists call or see patients for follow-up on medication-related issues discovered at appointments, as well as to share lab results. Patients contact the pharmacists with any medication-related questions they have, including side effects they may be experiencing.

My vision of success is that every office in our area will have some dedicated pharmacist time to benefit patients with our unique area of expertise.

—Pharmacist, Affinia Health Network

Top Tips

From the POs

- We have experimented with a few approaches for patient engagement, but one of the most consistently impactful is having the primary care physician tell patients that they want the patient to see the PharmD as part of the important care that they need. That type of “personal referral” has been demonstrated to increase patient engagement during PharmD visits and to decrease no-show rates when compared with “cold-calling” patients to set up appointments.
—Mercy Health Physician Partners
- NPO is providing lists of polypharmacy patients and patients who don't meet guidelines for diabetes, hypertension, or dyslipidemia, to help physicians refer patients. We follow up routinely with the practices to ensure that the processes are working and to identify and remove any barriers. Patients are engaged when the physician refers them and the patient meets a friendly, welcoming, knowledgeable pharmacist who can help them in practical ways.
—Northern Physicians Organization
- Some effective patient-engagement tactics we've used are: flyers in exam rooms and periodic mailings promoting pharmacist services, and pharmacists participating in chronic disease group classes with other care management disciplines.
—United Physicians
- The patient response has been excellent so far. Patients are engaged and feel that this additional support is giving them the opportunity to review medications one by one, express concerns, and really understand all their medications and how they relate to their overall health and well-being. Patients and providers who have had the opportunity to work and collaborate with the pharmacist in this team-based approach have shown a positive response and feel the pharmacist has been a valuable asset to the team.
—Jackson Health Network

Sustainability

Pharmacists are a highly educated, expensive resource. The MPTCQ practices are using a variety of tactics to make the embedded pharmacist model sustainable for the long term.

Reimbursement Considerations

Key to maintaining the role of embedded pharmacist for the long-term is ensuring that funding is in place. POs are testing various methods to receive reimbursement for these important services.

- **Reimbursement structure**—I find our biggest obstacles are the expense of a pharmacist and inadequate/complicated billing structures for our services. To overcome these, it will become critically important to make data collection a priority in order to show the impact on quality. We also have to work with the billing structures available and try to maximize the reimbursement for our services. Another way to increase the impact and revenue is to do shorter visits, more frequent patient touches. This has the additional benefit of keeping patients on track with their goals and preventing information overload with too much at one time.

—Affinia Health Network

- **Increase provider access**—The reimbursement model is still based on fee-for-service, but our organization (like the nation) is moving toward a value-based model. To overcome this challenge, we are partnering with payers on unique reimbursement strategies (which cover approximately 50% of the pharmacists' salary/benefits) and also measuring the pharmacists' ability to increase provider access and decrease provider time on non-revenue items.

—Spectrum Health

- **Payer negotiations**—We already have two payers on board and are working with two more for future contracts. Definitive cost analyses are difficult at this point, because payers have different fee schedules. Negotiating with payers takes time, but they believe the program is good and the right thing to do.

—Jackson Health Network

- **Achieving financial sustainability**—The key to financial sustainability is including the pharmacist as a member of the care team. Payers are willing to pay for care management, so we've trained all our embedded pharmacists as care managers, and they use specific codes to bill for the services provided to chronically ill patients.

—Medical Network One

The truly excellent primary care offices are those that embody a team-based approach to care. When physicians, advanced practice providers, social workers, care managers, nurses, clinical pharmacists, and other key members all work collectively toward outstanding care for patients, we achieve our greatest success. Our clinical pharmacist brings a number of unique tools to help that team. Having detailed pharmaceutical knowledge is certainly helpful. Beyond this, it is the careful attention to detail and close follow-up with patients that I find most impressive. I have had a number of diabetic patients, for instance, achieve greater success with their glycemic control after working with our pharmacist. The same is true for a number of our hypertensive patients. I am now a believer.

—Physician, MidMichigan Health

Scaling the Program

POs participating in the Collaborative have locations beyond those piloting the embedded pharmacist model. They all are looking to increase the reach of the clinical pharmacists to serve larger portions of the patient populations they serve.

- **Value-based collaboration**—Medical Advantage Group’s participation in MPTCQ is not a short-lived opportunity. The organization is using MPTCQ to kick off our long-term pharmacist program. Pharmacists are an integral part of the multidisciplinary team, and true, value-based collaboration between payers and physician organizations requires their participation for success.

—Medical Advantage Group

- **Travel team**—Our future plans include adding ambulatory pharmacists to our multidisciplinary community care travel team. MNO currently deploys multispecialty teams to primary care physician offices on a regular basis. We are hopeful that pharmacists will attain provider status so that pharmacists will be compensated for providing comprehensive, patient-centered care.

—Medical Network One

- **Group visits**—We plan to continue expansion of pharmacists in primary care and eventually some specialty practices, partially through providing more centralized services—including exploring the potential of group visits—for some of the smaller, geographically dispersed practices. We also may consider ambulatory pharmacists providing medication reconciliation at post-hospitalization visits or in conjunction with insurers, for example, to meet Medicare STAR measures while improving care.

—MidMichigan Health

- **Additional chronic illnesses**—We plan to expand the work done under collaborative practice agreements to other chronic and/or acute conditions.

—Mercy Health Physician Partners

Harnessing Technology for Expansion

One method to increase clinical pharmacists’ reach is the innovative use of technology to host virtually the one-on-one interactions between pharmacists and patients.

- **Telephone follow-up**—We want to continue the on-site presence of a pharmacist and also to grow pharmacist-provided services to include telephonic transitions of care support and consultations with the broader care management team.

—Oakland Southfield Physicians

- **Video visits**—Currently, the program is based on in-person office visits and telephone follow-up. The future is a group of pharmacists available on demand to provide video visits. This will allow us to reach offices with a small number of providers and/or those in rural areas. It will also allow us to take care of patients when and where they want care.

—Spectrum Health, United Physicians



Case Studies

The MPTCQ physician organizations had insightful case studies to share that highlight successful interactions between embedded pharmacists and patients. Below are four that showcase a few key themes in the central role these pharmacists are playing in enhanced patient care.

Overcoming Cost Barriers

At United Physicians, a middle-aged diabetes patient was in and out of provider offices over a number of years and eventually stopped returning for follow-up. After being off her medication for two years, the patient came back complaining of extreme lethargy. The provider found that the patient's A1c level was near 12%. The doctor wanted to start the patient on insulin right away, but was concerned about cost (the patient had no prescription coverage, only Medicare Parts A and B). The Pharmacist Transformation Champion at United Physicians met with the patient and enrolled her in a patient assistance program. They kept in close contact, titrating her insulin every one to two weeks. The pharmacist was able to provide the extra support and reassurance this patient needed to gain greater control.

Tailoring Treatment to Patients' Comfort Level

At MidMichigan Health, a patient had very poor blood sugar readings, and his primary care provider kept increasing his insulin dosage to no avail. The patient was referred to the Pharmacist Transformation Champion to investigate further. During his appointment with the pharmacist, the patient admitted that he was not using even half the amount of insulin that was prescribed, but did not want to admit this to his doctor. The pharmacist made adjustments to the patient's therapy based on what he felt comfortable doing, and worked closely with him to get his A1c level down to a more acceptable range.

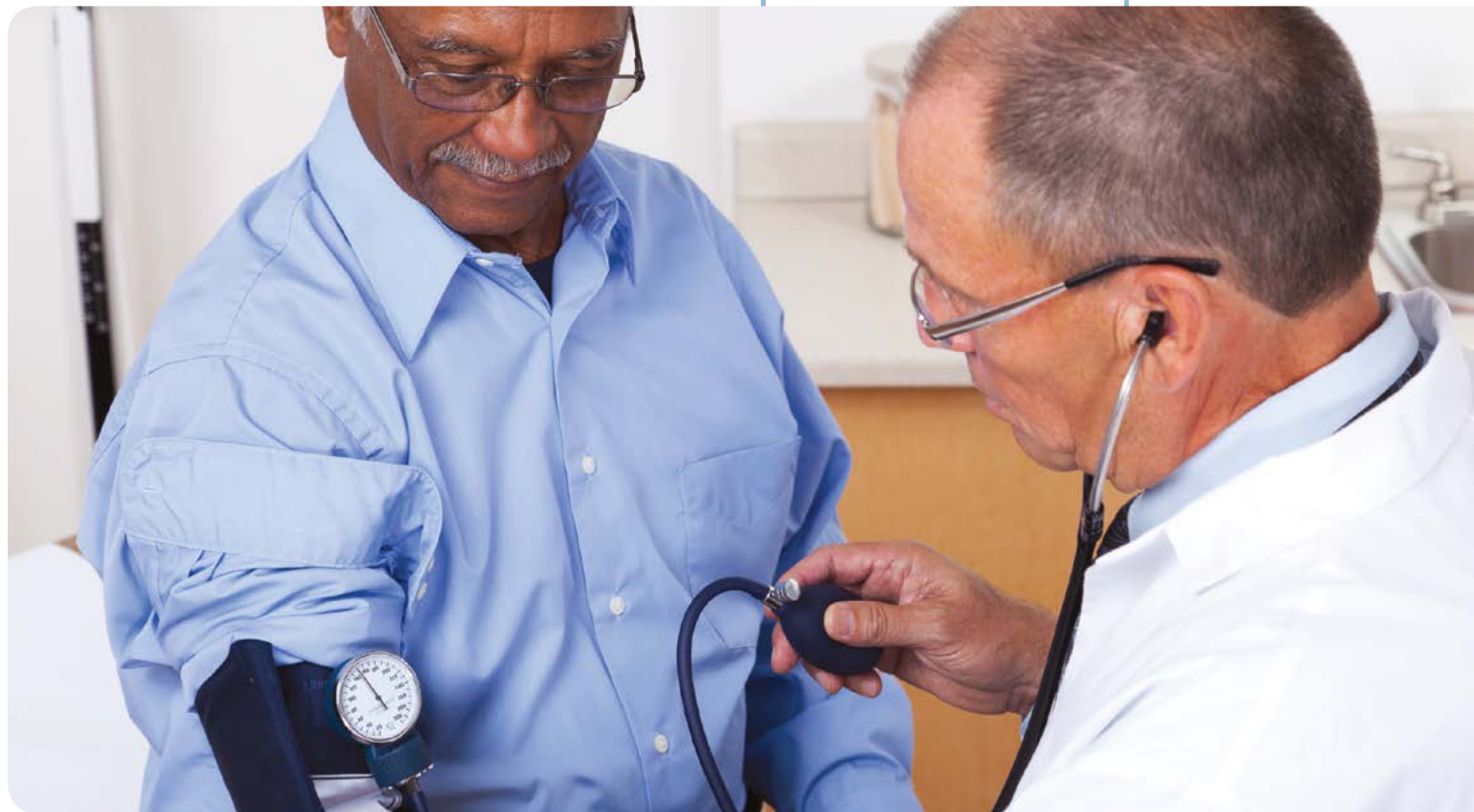


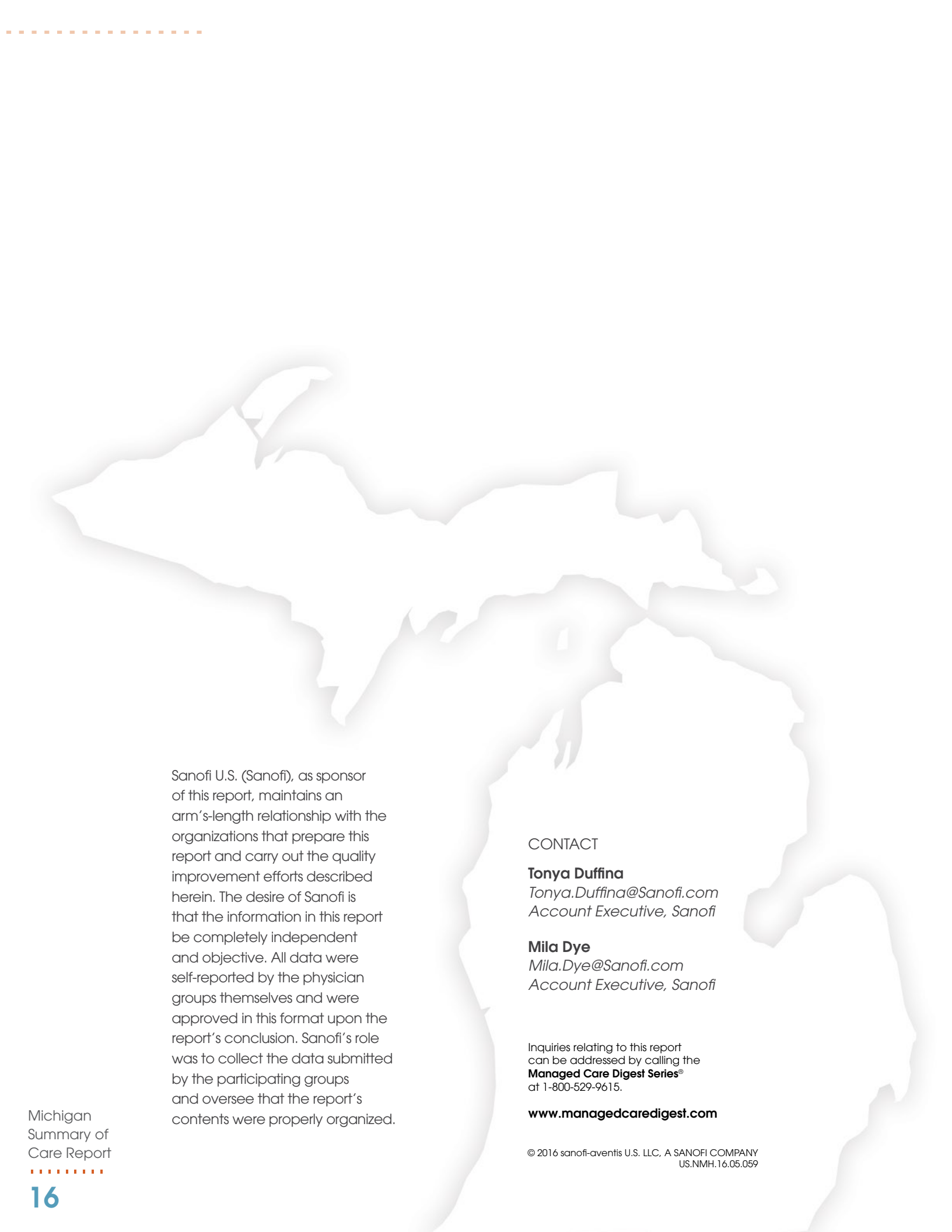
Patients Tell Different Things to Different People

During an appointment with the NPO Pharmacist Transformation Champion, one diabetes patient mentioned that every time he exercised, he would have a hypoglycemic episode—something he had never mentioned to his primary care provider. The pharmacist made adjustments to the patient’s medications and reviewed how to reduce the risk of hypoglycemic episodes. Through these adjustments in treatment, the patient was able to stabilize his blood sugar and reduce the risk of these persistent hypoglycemic episodes.

Testing Various Tactics

Medical Advantage Group treated a 68-year-old female for hypertension. Her blood pressure consistently fluctuated from 190–200/90–100 mmHg despite a three-drug regimen. The Pharmacist Transformation Champion assessed the patient’s compliance, and had her start using a medication box and a calendar checklist. After one month, the pharmacist recommended discontinuing one drug and starting a new one. One month later, the pharmacist adjusted the dosage of the new medication, and her most recent blood pressure was significantly reduced. The next step is to optimize her diet (reducing sodium intake and eating a more balanced diet) and exercise to get her blood pressure under optimal control.





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CONTACT

Tonya Duffina

Tonya.Duffina@Sanofi.com
Account Executive, Sanofi

Mila Dye

Mila.Dye@Sanofi.com
Account Executive, Sanofi

Inquiries relating to this report can be addressed by calling the **Managed Care Digest Series®** at 1-800-529-9615.

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