Milestone 2 Action Group: Medication Management: Measurement and Data Recording

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June 16, 2015

Hello, everyone. This is Rose Langdon from TMF Health Quality Institute. Welcome to our Milestone 2 Medication Management Action Group entitled, Measurement and Data Recording. I would like to start off today with a few announcements. A new post-event survey has been developed with the aim of capturing information that will help us understand our audience as we plan for future events. We are requesting that all attendees, practices, panelists, faculty and other guests complete the attendance and organization demographics portion of the survey as well as provide us feedback on today's discussion. Up to 10 attendees participating in the same room may be listed on one survey. We appreciate the presenters' time and effort in preparing for and sharing their valuable knowledge. Any statements about the quality or utility of any product or vendor made in this presentation is an expression of the opinion of the person making the statement only and is not an opinion nor endorsement of the Center for Medicare and Medicaid Innovation, TMF Health Quality Institute or the host of the presentation. And now I would like to introduce you to the speakers for today's session. Leading our discussion will be presenters from Providence Medical Group in Oregon and Primary Care Partners in Colorado. The facilitators for today's session are the Arkansas Regional Learning Faculty and Marie Smith is our subject matter expert. I would like to now turn the microphone over to Rachel Wallis, who is going to take us through the rest of the session. Welcome, Rachel.

Thanks so much, Rose, and thank you all today for attending. We really appreciate your time. We know it's an investment to take time out of your day to participate in these learning events so thank you all. Very quickly I see a lot of you are already complying. If you could click on your arrow and you can find that under the blue marker if you hover over it on the left hand side, and tell us where you are located today. All right. A lot of people. Thanks so much. Pretty much spread out across all of the markets. So that's good to know. It should be a rich discussion and with that I encourage you all to participate in the discussion. We know that measuring medication management is somewhat of a new task to new practices and so we really hope to get into the conversation of how to do this best practices and identifying barriers of how to overcome them today. All right thanks so much for indulging me there and letting me know where you all are. It looks like we have a pretty good dispersion. All right. So, those of you who have participated in a lot of these action groups the next few slides are slides that we go through every time and it's just really to encourage you that this is your session though we come with presentations and we come with agenda items, these calls are really about you all and your needs and what you would like to learn about and chat about with each other. And so what I would like to do is ask

right now if you would just open up your Chat function and you can do that by clicking on the bubble that says Chat on the upper right-hand side if it's not already open and let us know what questions or what comments or what would you like to learn today about measuring the impact of medication management and your efforts there in your practice. So is there some specific things that you hope to get out of the day today please don't hesitate to let us know that using the Chat function. All right, and I see we've got a lot of annotation going on there. Let me see if I can clear some of that off the screen. Jeff, let's see I'm going to clear and I can't seem to get the lines off but that's okay. We're going to go to the next slide anyway. All right. So as a reminder here, we always want to continue the learning outside of these calls and our forum for that is on the Collaboration website and we recognize that there are some bugs associated with the website right now and some of you may be having issues with getting access and retaining access, but those of you that are able to go on and access the forum for medication management please go out and post your questions following today's sessions or your learnings or any tools and resources that you might have that you think others would benefit from. That is the forum for you all to distribute those and you can also tell us some other topics that you might like to hear about in upcoming action group calls. All right. So as always, again, very similar slides that you've seen in the past. There's three ways that you can experience the collective knowledge of today's presentation. That's use your telephone. If you are muted, there should be a right, on the right-hand side a little red microphone. Be sure you unclick that. If you would like to speak and if you want to raise your hand, we can have Jeff unmute you and you can speak as well. Throughout the conversation today please don't hesitate to interrupt us. It's not interrupting it's just joining in the discussion. In our prep earlier, Rose Langdon mentioned that this is really like sitting around the table having coffee discussion measurement and we really want it to feel that way for you all this is just a discussion that you're a part of. You can use your telephone, you can use the Chat function that we described earlier or if you still feel like you're in the stage of where you don't really know enough yet to ask questions or even know what you need to know, that's okay. You can just sit in and listen and learn from others and begin to formulate your ideas and then those questions will start flooding in. All right. Move on to the next slide here. So, there again I'm going to ask you to get your arrows back out and tell me what your role is in the practice. Perfect. All right. Lots of pharmacists, lots of care managers, practice managers. Dr. Lawrence, thanks, we see Dr. Boyan [phonetic]. Got a couple of physicians there. Thank you guys for attending today. All right a good mix. So I expect there to be a lot of perspectives in this conversation from each of you with different disciplines which always adds and makes for good conversation. All right thank you so much for indulging me there. I see a lot of you are still clicking. I don't want to cut you off. I want to give you the opportunity to tell us who you are. Perfect. Perfect, all right. Quality Specialists, thank you guys. You all should be able to help us identify some good process measures all of you quality experts out there. So thanks for joining us today as well. All right with that I'm going to move on and just a brief overview of last session. So many of you are familiar names at least. I don't get to see your faces or I would say similar faces but familiar names so I know a lot of you have participated previously and on our last session we really talked about integrating pharmacists into the transition of care workflow, and if you haven't gone out to the Collaboration website, Kristy shared a wonderful resource from APHA on measuring medication management in the transition of care workflow and that is out on the Collaboration website on the Med Management Forum. If you haven't taken a look at it, please go and do so. That was in follow-up to our transitions of care session. We also talked about pharmacists

supporting transition of care in the inpatient side and the outpatient side and what that transition looks like. Then we talk about other team member roles in transitions of care as well. A little bit more about what's going on in the forum. So in addition to that APHA article, we asked some questions around triggers, what triggers the pharmacist's role in transitions of care. We also posted a resource from the Multi-Center Medication Reconciliation Quality Improvement. The MARQIS I think is the short acronym for that. So if you haven't checked that out, go out and take a look at that and be sure and let us know if there's specific things you would like to hear about or have access to. We'll do our best to get those out on the forum for you. Okay, so let's get started with today's topic. The proposed agenda item today is measuring the impact of pharmacist integration and the impact that your medication management program or processes are having on your practice. They may be outcome measures that you're looking at or just the outcomes of your process measures that you have in place. So we're going to get into some details today in talking about that. So that's our proposed topic, but if there's something else you may have a question about or something else you may want to hear about, we want to be able to answer that for you as well. So just use your Chat function there and share that with us and if you will just click send to all panelists, that'll go to all of us panelists and we can make sure that we get your feedback. All right. So I'm going to ask you to use your arrows one last time for today and that is to respond to this brief survey. Have you identified a method for measuring the impact of a pharmacist's role in your practice? Yes or no? All right. Lots of no's. Good, I'm glad you guys are here today. Hopefully you will leave some actionable items from all of these individuals over here on the left that answered yes. That's perfect. All right. Good to know there's a lot of people on here that are hoping to learn today. Great, great.

10:09

So now at this time if you'll indulge me, I'm going to call on a couple of you all that answered yes and see if you might be willing just to briefly share a couple of the measures that you are using to identify the effectiveness of your medium management program. So, Amy Stump, I see you are the first one at the top. Lucky you, Amy. Would you mind if we unmuted you and you shared with us a couple of the ways you are measuring med management in your practice? And, Jeff, I don't know if we need to unmute Amy?

The best way to do that is for her to raise her hand like she is doing.

Perfect. Hello, Amy.

Hello, how are you?

I'm doing well.

Good. Well, some of the measures that we're using to I guess show the impact of me having been in our practice. I've been in our practice for about 2 years now. One is our high-risk medication HEDIS measure. We have a bunch of shared risk contracts with payers and so that is a very easy way to look at a very, I guess a very objective piece of information that we get quarterly from all of those payers. So that's one thing that we're using. I've been doing targeted chart reviews in working with patients with Poly Pharmacy to reduce the amount of high-risk medications that are prescribed in our practice. Our

measure when we started was at about 8.2 and now we're at about 3.4 percent. So it's been impacted quite heavily so it's pretty awesome. And then the other things that we're looking at are actually the same things that we're using for our navigators and our care team, our care managers and our care coordinators. We're looking at, you know, A1Cs, you know, improving care for diabetes and all types of measures. Mostly the A1C greater than 9 group. We're also looking at our cumatin clinic that I started, our anti-coagulation clinic, and with that we're looking at our time in therapeutic range. So for a lot of what I'm doing it's very specific high-risk medication measures for disease states And, finally I would say for our practice, our physician and provider satisfaction is pretty key and that is something that we haven't formally polled, but it's quite evident that our physicians are very satisfied with having a clinical pharmacist onboard versus not having one. [Laughter]

Wonderful, Amy, thank you so much. Those are all great, great indicators there of the effectiveness of your program. Let me ask is there anyone else that would like to share? If so, raise your hand. We'd love to hear from you. Anyone? I'll give you guys just a second and if you can't find your hand icon, it's right under the list of panelists there. Okay, well thanks, Amy. Thank you for indulging me and letting me call on you and you did a beautiful job describing that you guys are measuring, and I hope that we get into that conversation a little more as we move forward. Okay, well, let's get on into the conversation with our panelists here, and we're going to start out with Primary Care Partners in Grand Junction, and I'm going to turn it over to Tom McCloskey and Misti Scott. So, Tom, I'm going to turn it over to you and if you'll just unmute yourself by clicking on that red microphone. There you go.

Thank you and welcome everybody. I appreciate the invitation to participate. As well as Misti Scott, I'm joined by Jeannie Lewis, another care coordinator involved in kind of a dual site that we practice in with regards to our primary care initiative here. As you can see by the data that's presented on this slide, we're a fairly large practice serviced by one pharmacist. We have 22 physicians, 8 mid-levels, 33,000 plus patient empanelment and so I know that a lot of you are jealous of my role here as a clinical pharmacist looking at chart reviews, et cetera, and fielding drug questions. [Laughter] With that said it's been a challenging but also a rewarding opportunity to get involved in ambulatory care in this setting and we have 6 total care coordinators, care managers kind of funneling information and tasks to me as well and it's been an exciting opportunity to get that done. I don't think I'm able to get to everything but as well as I can, I do. We use Allscripts Touchworks, which is our EHR. We also intake patients coming in and out of the hospital from two site specifically although we also serve as a BA occasionally, but our majority are two community hospitals. One a regional medical center, St. Mary's, and the community hospital both of those generate plenty of transition of care opportunities for us and so we focus on a lot of that is transition of care and our care coordinators and the nurses and MAs that receive the patients on follow-up visits are heavily involved in doing transition of care med reconciliation, et cetera. And I try to watch from afar for the patients a couple of the sites when transitions of care are anticipated and try to alert physicians or clinicians as to issues that may arise when they do make that transition, but it's quite different than being onsite and watching the patient ambulate out of the hospital door into the clinic so, but fortunately we have lots of electronics that help us with this. With regards to processes these were kind of devised before I even got involved in it. We have a spreadsheet and Abby and Kristy can smile about that, that we use to stratify our patients into high risk, moderate risk and low risk and virtually no

risk, although everybody would realize that even the no-risk patient has the opportunity I should say for a drug misadventure and so unfortunately of those 33,000 we probably only follow closely, you know, a very, very minor percentage, but that said we do have some tools in place that allow us to identify patients either on the fly, of priority or as they developed with regards to that care, and I'll speak a little bit more about how we kind of keep up to date on that going forward. So the high-risk patients identified those are patients that have high utilization, lots of office visits, phone calls, multiple medications, those at risk for polypharmacy, those that have non-compliance or barriers to successful treatment. As you probably are aware, there's a lot of psychosocial comorbidity in the patients in these groups. And so we have to work closely with our psychiatric assistance, ATT is an abbreviation for a care team that we work with collaboratively with the county health department. Our care coordinators also do a lot with regards to assisting patients and making sure they get into behavioral health specialists appropriately and to visit et cetera. High-risk medications, of course, we've identified those but not so much in our spreadsheet. Those are generally picked up on during chart review. Those include, you know, the obvious anticoagulants, the polysubstance narcotics and sedation so sedative medications. Seizure meds, you know, the list goes on and on. I think you all can access information with regards to that, but to be keyed in on those, that is typically [inaudible] reveal patients that have either not been closely monitored or need increased awareness of the clinician because sometimes things happen outside of the realm of the primary care physician, by the specialist and consultants that see our patients, and they may go undetected unless somebody actually delves into the chart and sees the consultant note that was faxed until two weeks prior to the office visit. So those are things that we find are helpful. So, as far as measuring, we don't have anything formal measured other than some of the standard things that both our insurers look at, hemoglobin A1Cs, management of COPD, readmissions, et cetera. So we have some kind of more gross measures of it. I've been during my work at [inaudible] looking at the number of medication profile reviews. I send myself messages using our electronic health records and then I do follow-up and I'm gathering information, I haven't compiled it yet, with regards to recommendations accepted. These include things from just routine laboratory monitoring and vaccinations that aren't up to date to really kind of elaborate recommendations that require a consultant or consultants to be in conversation with the primary care physician. I recall one that just went off the other day to one of our psychiatrists and a patient had 3 or 4 medications that were I guess it's difficult to actually put an evaluation on this, but it seemed like there needed to be a little bit more attention paid to the way the patients antipsychotics were being followed as well as other therapy into the realm of neurology and cardiology. So with that said that's what we're doing.

20:26

It seems like drug information requests on the fly through an EHR task have been increasing. I get curb sides on a more increased basis and I float from site to site in different offices. And so I'm available on a varied basis that everybody knows at any one time according to my schedule where I can be found and we use our electronic health records for tasking as well. Cost and coverage data we're gathering that information ongoing and, again, this is something that probably the next speakers can probably talk to you about I guess the benefit and the drawbacks of that and the utility of that when monitoring what it is that your pharmacy reviews are doing and what kind of impact the pharmacist has. I've also increased my face-to-face patient contact as clinicians have become more aware of my ability to convey and assist

in drug therapy. We have initiated a collaborative drug therapy management agreement where I'm assisting patients with smoking cessation and I've reached out to patients both in the office and telephonically on a regular basis. There's talk about escalating that or increasing the role into things such as chronic pain, polypharmacy. There's talk now of hypertension and lipid management as well. And so although those are informal metrics as far as the impact goes, I think it does speak to how we can make a change with regards to ambulatory care pharmacy when we're embedded with the clinic. Next slide, please.

Hey, Tom, real quick before we move on. This is Rachel. I had a couple of questions for you. So in the trends observed down here portion you talk about things that you're collecting. So drug information and cost and coverage data, how are you collecting that? What's the mechanism?

Well, so a lot of this is pretty, like I said it's on a gross level. So we're looking at pharmacy utilization and I've been in conversation, I serve on the P&T Committee for one of our largest local insurers as well, and they have looked at, you know, compliance issues, health, you know, hospital readmission issues related to non-compliance and possibly maybe substandard or not quite up to the clinical guidelines with regards to drug therapy. And so those are, you know, those are some of the metrics. They're kind of out of my hands and so when we look for a report we have to seek out IT help from other providers. We do look at things like polypharmacy and we have not been tracking that but I will let you know that in an EHR world where not everybody does the same documentation, i.e., you can have 30 meds on a patient but half of them can be lancets and syringes. So until we actually get all of this dialed in as far as being consistent with what's a medication, what's not a medication, some of these things are really hard to actually identify and track.

Okay. All right. Thanks, Tom, for that. I just wasn't real clear about what you were collecting like cost and coverage data on individual patients and logging that somewhere or anything like that, but it sounds like you may be getting to that point but you're still trying to figure out the mechanism. Is that correct assumption?

Well, yeah. If you would hearken back to the first slide where we have 33,000 patients and I'm one pharmacist. [Laughter] So, just to let you know and, again, I'll let Kristy and Abby talk about their successes in monitoring these kind of things.

Okay.

And I definitely, it's on my list of things to do, but as everybody probably realizes that, you know, you have a patient that needs a consult or a chart review that's priority one at least as far as what I've been tasked to do and so that's what I try to go for. And so, you know, I'm not saying that it's not worthwhile and that we don't want to do it, but right now we haven't moved that far.

Perfect. Thanks, Tom.

You're welcome. So, additional medication management activity in collaborative drug therapy I've spoken about that. We have initiated a chronic pain task force. This was, this kind of comes from really a

nationwide and probably in a lot of countries a global need for change in the way that we're using chronic narcotics and sedative hypnotics and so we have instituted a new pain contract across the practice. We've basically done a practice transformation with regards to how narcotic substances and high-risk medications are being utilized. I will say that, you know, this is a work in process and you're never going to completely change it until I guess practitioners that decide to come to the table and fully embrace it. But I will say that the majority of our providers are fully invested in this and they realize the pain contract or controlled substance agreement is a very, very useful tool when we're trying to inform our patients as to how we're going to manage their chronic pain condition. And I know that a lot of you also struggle with this and I would just say that fight the good fight that continuing a patient on chronic opioids is not necessarily the treatment of choice and, you know, that's been substantiated by lots of studies and lots of expert opinions. We participated in it's called Project Echo, which is a multi-site organization which we attend bi-weekly webinars and we present cases and listen to case presentations and didactics related to pain management and so that's been a very useful tool in getting physician and provider awareness and buy in into this process. We do controlled substance patient lists. We're identifying in our IT department patients that are high risk. That is on two or more sedating or high-dose narcotic agents chronically and we're using that to stratify patients within our risk tool and try and improve both physician/patient interaction with regards to pain management as well as ancillary services that may benefit the patient including behavioral and occupational therapy. INR protocol development. One of the things that we struggled with was when on-call physicians or PAs and mid-levels were tasked to take care of an INR result, it seemed like there was quite a bit of variability with regards to how the clinician would respond to that. And we have implemented a review and a tool that the clinicians can refer to that standardizes what the action that's taken as well as improves our data gathering so that clinicians feel like they're a lot more in tune with what's going on with the patient and not just listening to a number confirming that the patient is able to take a tablet and then making a dose adjustment. So, it's not really a pharmacist-driven protocol but it is pharmacist enhanced and we do get inquiries with regards to questions with regards to bridging therapy, et cetera.

Hey, Tom?

Yes?

We've got a couple of questions here. So, the first one is do you have any contact information for Project Echo?

Yeah. I can post that after the, but if you just, I would imagine that if you do a Google search for Project Echo, it is very widely discussed and knowledgeable. Right now they're in the middle of the current calendar and I think it will go for another 6 months. So they try to roll people in on an annual basis, but you certainly can access a lot of the tools on the Project Echo website and these include things like recommendations with regards to managing specific types of pain. There's lots of didactic slide sets that are very, very educational and informational, and I would encourage people to seek those out because they're not proprietary or trademarked. Project Echo team members are very open and sharing with regards to the things they are bringing to the table. This group is out of Arizona in Tucson and they have

a number of pain specialists including anesthesiologists, behavioral health specialists, psychologists, pharmacists, OT, et cetera.

Okay. Perfect. Thanks, Tom. And one more question before you continue is someone is wondering if you could share your risk tool? If you could share that on the Collaboration website if you are able to, but there's some interest in seeing that from participants.

30:17

I will do that. I'll have to redact all of our patient information. I'll see if I can get a generic empty one and just send that on and that'll go through you if that's okay and I'll let you post them.

That's fine. Absolutely, Tom.

But just to speak about that it really does other people outside of our circle have discussed this and they're very, you know, these are people that are high level with regards to stratifying and risking patients and they felt like it was a very, very useful tool and had a lot of, you know, good evidence behind it. So, I certainly will share it and go for it.

Thank you.

You're welcome. So lastly on this about medication management activity I was involved in a request by one of our, they're a small employer but they have a very, very high level of service for their patients or for their clients. The insurer wants to improve and expand patient compliance and ease of getting some of their medications particularly when they're short, you know, acute care issues or things that can be easily, the patient can easily be sent home on after their clinic visit. So we have established a generic drug program where we have a number of maybe 20 or 25 medications for adults and 10 to 15 medications for our pediatric patients where the patient walks out of the clinic visit and the physician has started them on a small sample, you know, a month's worth of a medication and a follow-up prescription results in their pharmacy. So, they can go home possibly on, you know, an antibiotic or a non-steroidal for short term knowing that there's a follow-up prescription for them but they can start feeling better already and these are even simple things like a nasal steroid for seasonal rhinitis and, you know, this generates a physician visit and then the patient has to go get the prescription. But often it's easier for us to just say here's your, you know, you cost us $10 for a generic Flonase and the patient goes home satisfied as well as receives counseling with regards to how to use the medication, et cetera. So that's been perceived as a very good benefit by the patients within that insurer.

Right, hey, Tom, quick question for you. So this sounds like a really great program and I know as you guys were adopting it and developing it there's probably a lot put into that, but was there anything discussed about a way to measure whether it's making an impact or what that impact might look like?

Well, you know, I think we're going to leave it up to the insurers with regards to a satisfaction survey, but I would think that that's in the works. Right now it's been underutilized. We're reaching out to the insured population at a couple of meetings and kind of highlighting this because there seems to be an awareness lag with regards to it. The other thing is just the number that get dispensed would be a

simple metric on how many patients presumably started therapy immediately versus as you all know in the pharmacy realm, you know, the 50 or 60 percent of prescriptions that actually just get bagged up and sat on the shelf and never get picked up. So at least we know these are going home to the medicine cabinet and presumably are being started not necessarily continued but I think there's some assumptions that you can make that at least the patient might have tried, you know, the Naprosyn for their muscular skeletal complaints or were successfully treated with nasal steroids for their rhinitis as opposed to having to go through the expense, et cetera, of all of the processing that's involved with each prescription.

Okay, all right. Thanks, Tom. Yeah, my mind was just spinning a little bit about potential ways. It seems like there might be a lot of ways to measure that program of a brand versus generic or how many are actually started on generic off the bat by a provider and things of that nature. So it sounds like a lot of potential there for being able to measure the impact.

Send on your thoughts.

[Laughter] Okay, I'll do that.

Okay. Thank you. So we can go to the next slide.

Okay.

Am I doing okay on time?

Yep, you're doing okay. You've got let's see these last few charts here and then we'll pause for some questions.

Sounds good. Very good. So, this is a chart that was generated by our IT department at the behest of Carol [inaudible], and I have to give her credit for a lot of this information that's been garnered as well as some of the bullet points that she's added to my slide. She's been instrumental in providing guidance and counseling with regards to my role here. So I would definitely make certain that people that are involved in these processes. I know that pharmacists have a good sense of what direction is but on the other hand it's nice to have that 30,000 foot view and so I would say definitely make sure that you stay in touch with the people that are coordinating the process. So these are just, and I don't understand why there was a dip here other than possibly I've been tasked in the first quarter of 2015 to do some of these other things that have taken me away from looking at patient charts. So these are touches basically as well as they're listed as chart reviews and I would say that the majority probably 75 percent of them are actual either formal medication chart reviews or quick transition of care confirmation that patients are on appropriate therapy. Oftentimes just a brief drug question. We also have patients on our CPCi risk stratification list that they come into office visits. I'll do a brief medication review and review of the chart for consultant notes to see that the medication list is reasonably up to date and if there's any concerns that I can identify, I've tasked the physician prior to the office visit so that they have actionable data before the patient comes into the room. So, you know, 25,000 or 2,500 chart reviews in a quarter is

incredible. So I'm telling you that's not fully what it seems to be so, but it does represent what it is that I'm doing and how I'm increasing my utilization.

Yeah, it's impressive, Tom. So this is more really not necessarily comprehensive chart reviews looking back for adverse drug events or anything like that. It's more you could be doing that but you also could just be interacting with the patient. Is that correct description?

That's correct. And just to reiterate I am just one man. I'm not a woman, okay? [Inaudible] to be 4,000. [Laughter]

[Laughter]

All right. Next slide, please. Okay, so here's the list of formal pharmacy reviews and this is a more accurate assessment of, you know, of fairly detailed review and note with regards to our high-risk patients. So, remember that, yeah, we have thousands of patients that could benefit from formal reviews and oftentimes, you know, in this world these kind of things are, they are certainly beneficial for patients and I will tell you that there are oftentimes things that are identified that I think go under, they fall below the scrutiny and awareness of a lot of the clinicians and they're appreciative of those notes. On the other hand, there are some things that the clinicians know that I am not privy to and no amount of electronic medical records details will provide you with that information. I can give you lots of anecdotes with regards to I could do, you know, 3 or 4 recommendations and the clinician will appreciate my input but they'll say she will never change her drug therapy, she's been on that drug therapy for 30 years and there's no guideline that will ever convince her that she needs to be off it and onto something different. So, can I get an Amen from the group out there? [Laughter]

They're all on mute, but I envision them amening.

Okay. Thank you. So that's pretty much my last -- thank you, thank you, Angela. So that's pretty much my presentation. And, again, I can field some questions. Thank you.

Okay, Tom. We'll pause and see if there are any questions specifically for Tom and his group, we'll take a moment and you can raise your hand and ask those or chat those in as you think of them and thank you, Tom, that was a great presentation. Listening to all of the work you do you are one man but you have covered a lot of work and you guys got a lot of good stuff going on. It looks like we have a hand raised here from Angela. Angela, you are unmuted.

Thank you. Can you hear me?

Yes.

Hi, Angela.

Hi, Tom. I'm wondering if you have a dedicated IT analyst that you work with? And if so, how much time do you spend with that person during the week?

No, I don't, Angela, and you know what you bring up a very, very good point in that there was no IT attendance in this webinar, and I would definitely encourage Rachel and the other powers that be in following up that maybe we need to have a little bit more direct input with regards to that. Long story short and you're supposed to say too late. We do have limited access to our IT people. When Carol, my director, has access to them and views something as a very critical event to track, she will, she pretty much prioritizes and has the ears of our IT department. But I do not have, you know, a dedicated IT person. Certainly there's lots of things that we could be doing, you know, monitoring for a specific drug interactions, checking for, you know, on the grossest level, you know, the polypharmacy issue that's one thing, but I think our IT department really helps but if you were ever faced with a new FDA issue with regards to a drug interaction or, you know, a patient that's on a medication that probably shouldn't be because of a diagnoses, I can't just get on the phone and say, hey, can you run me a report and I'm going to start calling people and alerting triage.

Okay. Thanks, Tom, and that was a great point, Angela. Great question, great point, Tom. I think that we are missing a piece here and we will definitely take that back and try to brainstorm on how we can incorporate some IT perspective into this because I think it's huge, but thanks both of you.

41:48

All right, okay. Well, next up we have Providence Medical Group and I'm going to ask Kristy Butler and Abby Frye to take it over and just let me know when you would like for me to change your slides.

Great. Thank you very much. Hi everybody, my name is Kristy Butler. I'm the Manager of the Clinical Pharmacy Specialist Team with the Pharmacy Department with Providence Medical Group in the Oregon Region of Providence Health and Services. In our region, we have 46 primary care clinics actually soon to be 47 and that also includes three pediatric clinics, but so the majority are family medicine and internal medicine. Of those 13 are CPCi participants. We have over 300,000 patients in our primary care environment and you can see on the slide our physician FTE and how it breaks down between the total Oregon region and the CPCi clinics. For our clinical pharmacists we are blessed to have 16 amazingly talented clinical pharmacy specialists. Six and a half of those FTEs are dedicated to the CPCi clinics and in Thomas's numbers we can somewhat feel your pain. Our in our CPCi clinics our range of patient ratios is actually better than in the general population. In our CPCi clinics, we range from one pharmacist per about 8,000 patients kind of luxury staffing ratio to about 35,000 at the lower end and then our non-CPCi clinics we're at 25,000 at our best and 50,000 at our worst as far as ratios go. So we understand still how difficult it can be to do everything you want to do even though we have a lot more pharmacists at our disposal. Our EHR is EPIC and if you'll go to the next slide we have had our comprehensive medication management program with clinical pharmacy specialists for almost 18 years now and we are like I said we have an amazing team of generally PGY 2 trained more experienced clinical pharmacist specialists and we use about a dozen collaborative drug therapy management agreements and use our comprehensive medication management programs as well as addressing consults and drug information and a lot of other services. Next slide. So I wanted to talk a little bit about some of our process measures and you can read all the things that we have on our slide. How we break these down we have some productivity measures and I want to I guess encourage everyone out there or reassure them that they're not alone in their struggles with tracking. We've only recently gotten some better reporting out of EPIC

to look at our visits. We still don't have a great way in EPIC to track our consults and so we're working on that. Historically we've used spreadsheets, which when 16 people are working simultaneously on a massive spreadsheet it crashes often. So we've had technological problems and tried to also work with more robust databases but like Angela mentioned, IT support is sometimes our rate limiting [inaudible]. We do, we have historically tracked other process measures. When we were very first getting started, we kind of tracked what I think a lot of pharmacists are familiar with is looking at pharmacy interventions. How many times did we start a med or stop a med or make changes around safety. And we had that data kind of early in our history. Now our medical leadership doesn't want to see that kind of information. They're more interested in what are we doing as far as our buckets of interventions related to initiatives. So, and more so on the actual outcome. So, a lot of our work is related to HEDIS or CMS 5 star quality metrics like Amy had mentioned looking at kind of those end results. We also work with about 50 percent of our patients now are some sort of shared risk whether that's an ACO or other shared cost risk. So we are responsible for their clinical outcomes as well as their utilization. So we're looking kind of broadly and then some of the specific metrics that we've used as far as process measures or I guess they're the end points of how often are we adding the appropriate therapy like bisphosphonates or statins. Obviously we need to talk about that more, how often are we getting LDL or AICs or blood pressures, things like that. Also to follow up on Thomas's comment about pain we also have put a significant amount of work into it because you're right it's a systemic issue and so we are looking at patients who are on greater than 120 morphine equivalents a day and evaluating those patients, providing that information to the providers providing consults and papers on how to help manage this patient, participating in complex case management or case reviews for this patient. And ultimately we've been very successful in about a year of doing this we've reduced the number of patients on greater than 120 morphine equivalent to it was .43 of our total population to now it's .25. So not quite half but we are making significant progress in that regard. I will put before I pass it on to Abby I'm going to put one plug in. We are hopeful that we are moving forward on a way to track things better within EPIC. So those other EPIC users I know, I actually know a couple of you who have access to I-vent [phonetic] and we are hopefully getting that turned on for the ambulatory care. It's been historically more inpatient focused, but we are hoping that will be a way for us to be able to track our interventions based on which initiative they're related to. I'm going to pass it to Abby.

Okay, we can go to the next slide. So I'm Abby Frye, and I'm a Clinical Pharmacy Specialist at the Providence Medical Group at Saint Vincent in Portland, and it's an internal medicine residency teaching program. And I just am going to give a couple of examples of ways that we have measured both within our group as a large group and in my clinic measured medication management. So the first one is we looked at a couple of different interventions to improve appropriate statin use and I think a key in figuring out what you should measure or how you should measure medication management is thinking about what's important to providers, what's important clinically to patients to improving their health, what's going to be meaningful and also identifying gaps for your specific population. So at least here in our clinic and in our Providence Medical Group as a whole our statin numbers are pretty poor and so we wanted to target that and so the first thing we tried was, you know, looking at our patients with a history of ASCVD, who are not on a statin, we had a database that could provide that information, doing some chart reviews, reaching out to the PCP to receive kind of the okay to contact the patient and have

the conversation and hopefully initiate a statin. And in doing so as you can see 100 percent fail rate as far as initiating statins. Had a lot of nice conversations with patients. Some were, you know, appreciative of the information but wanted to talk to their provider or didn't want to start it for various reasons like we've all ran into. So this is kind of an opportunity to say, okay, that's not working but we still need to target this so what is another way we can target that? So we can look at the next slide. So kind of this part is part of the Plan Do Study Act cycle. We saw that lack of success with the first process and tried the second process again using a database to look for patients with an opportunity or indication for statin who were not on it. But in this iteration looking for patients who had an upcoming appointment with their provider, PCP or another physician in the practice. Since it's a residency clinic they often see other providers, but with the provider. Reviewing the charts, reaching out to the provider, again, kind of giving them the background on this is why they have an indication for a statin, this is the intensity of statin we'd recommend but then kind of putting it in the provider's hands to have that conversation. As you can see since there's more colors on this pie chart, it was more successful. So, in the darkest blue 28 percent of interventions actually had statin initiated. In 20 percent of cases, the provider had the conversation documented it but chose a different route for whatever reason, lifestyle, checking the bids, various things. And then still in about half it was not addressed, but as far as statin interventions go, we thought it was much more successful and it was meaningful to our providers to say, hey, this is working.

52:05

So that's one example and then if we go to the next slide, I want to provide another example of how our group has measured. Oh, sorry?

I want to ask a quick question. So, this is great. This depiction is fantastic. How did you capture this? Was this captured in EPIC to be able to report out on?

So, one of those spreadsheets that we've all talked about.

Okay.

Kind of a low-level way of just keeping track of the patients we made an intervention on because we did a lot of that through staff messages in EPIC, which are little harder to track. So, just kind of kept in a spreadsheet saying like message sent to provider and then looked back and I mean so it was through chart review but it's pretty quick chart review. It's not very intensive.

Okay.

Yeah.

Perfect. All right moving on.

So this is another example of how our group as a whole has measured our impact in terms of medication management, and I will say this probably looks a little daunting to smaller clinics. It definitely is made possible by having pharmacy residents. Most of this work was completed in terms of the actual study was completed by my co-resident a few years ago and also having a data analyst. So that is really key to some of this kind of bigger types or kind of more systematic ways of measuring medication

management, but wanted to share it nonetheless. So this was a retrospective matched case cohort study. We looked at patients who were referred to our pharmacy group for collaborative drug therapy management specifically related to diabetes and then matched them to the kind of usual provider care. So matched them to patients that had similar A1Cs but were in similar characteristics but were not referred to the pharmacist for CDTM. Go to the next slide. So we were able to identify a 170 matched pairs. We included their baseline characteristics there so approximately 6 years of age on average. As far as the CDTM with the pharmacist, it's a pretty limited intervention. So 140 days versus obviously if they're an unusual provider care they had no intervention with the pharmacist. Go to the next slide. And then I think as we kind of all know intuitively when we work with patients and do intensive medication management, we have really good success and that's been shown in other publications but we wanted to show it within our group. So we were able to show that similar baseline or kind of beginning A1C at 8 we were able to show a significant both statistically and clinically meaningful reduction in A1C in the pharmacist management group there in kind of teal bar versus the orange bar, which is the usual care group.

That's great.

On the next slide for completeness, we looked at some other clinical outcomes like blood pressure and LBL and while the blood pressure was statistically significant improvements in the clinical pharmacist group I think probably the clinical significance could be argued but we wanted to kind of look at the total picture in terms of providing this information to our providers, our administration and kind of showing pretty objectively our impact when we manage patients for diabetes. I think that's the end of our slides, but happy to entertain any questions or discussion.

Yeah, Abby, this is Rachel. Thank you. That was a great presentation and my wheels are spinning and this is all good stuff. I just have a couple of questions and I encourage participants to think of some questions for Abby and Kristy as well. But you guys have all of this data and I hear that you just had to accumulate it via Excel spreadsheet is that right?

As far as the last study?

Uh-huh.

So, like I was saying that last study was definitely made possible by the fact that we have access to a data analyst who can pull a lot of the data and then use kind of a database or a, instead of just an Excel spreadsheet it's a little bit more high functioning and then she knows how to use that. It's over my head admittedly but then the time consuming part is the chart review for sure and kind of the tracking of that and we're lucky enough to have our missing residents and second year pharmacy residents in ambulatory care and that's where that data came from. It was a major project for our pharmacy residents and we kind of take advantage of that.

Oh, okay. [Inaudible] like that. We've got about 3 minutes left and there are whole lot of practices on the line today that are not measuring the impact of their med management program. And so I want to ask Tom, Kristy, Abby, Misti, those of you that are on the phone and any others, Amy, Dara, I noticed

you guys answered that you were tracking. Where should they start? So what is a process that they could begin with in measuring the impact of their program? What would you guys suggest? And what we'll do is take note of this on the white board and then send it all over to the Collaboration website.

I would echo what Abby said is to ask your key stakeholders that they need to see to show that it's effective. So often we get a little pharmacy centric I think and try to start showing data that may not be as impactful for various reasons. And so depending on how experienced they are with pharmacy they may want to see those early what are you doing as a pharmacist, how many times are you recommending or starting a med or stopping a med or doing those kind of intervention oriented process measures versus do they only care about the end result or, you know, or is it productivity? So I think the biggest variable is what do they need to see? If they don't know, then you should have the dialogue about here are our options but starting with things that are more feasible and trying to get kind of that low hanging fruit if you can out of your EMR.

My big thing is thinking about what you're already doing because even if you're not measuring it we all know that we're doing great work. So thinking about what you're already doing and then just finding some way to keep track of that whether it's something as basic as an Excel spreadsheet or something more sophisticated but just figuring out how to make it relatively easy to at least provide some numbers to what you're doing.

59:30

Can I comment?

Yes, absolutely.

I think the stakeholders where certainly agree that the targeted chart reviews would be a crucial part of that. And so as people have difficulty with buy in I think at least providing them with the information that you can find in a decent chart review with a focus on poly pharmacy I think that also brings the stakeholders to the point where they say, wow, I've got an office visit of five patients this week that have confounded me with regards to drug therapy and that's where the expertise of a pharmacist input. I also would definitely incorporate the care coordinators in this process because if they're keyed in on specific medications, i.e., the high-risk, high-alert meds, the patients that are continually losing their prescriptions or non-complying. ER trips those are also kind of, I think those are good, they're informal metrics but they are nonetheless useful and you're trying to measure what it is you're doing and document whether you're using EPIC, the I-vents and let's face it an I-vent that happens if you're not familiar with an I-vent it's highly variable, and I'm sure Abby and Kristy can confirm that. It's like one review is totally different from pharmacist to pharmacist and they can be really in depth or they can just be and that's even within pharmacists. So, I think you should probably stratify your interventions when you're measuring that, when you're marking down an I-vent or whatever it is that you're using. I wish I could do that more intensively in my EHR system, but I think retrospectively we could go back fairly easily and look at what it was that I documented. I think the other metrics, and I really have to give kudos to the people of Providence and their ability to wrangle in IT involvement to do some of these monitoring and it's nice to have a resident, a pharmacy resident at the, you know, helping you do that

because their input is also very beneficial. We're going to try to work on that. I think just for the second time being reminded by your group about how involved and how helpful they are. I recall that they typically want to do a poster session at mid-year and some of these research projects that are involved are highly beneficial and, you know, underscore how pharmacists impact ambulatory care clinics.

All right. Well, thank you, Tom, so much for that input. That was very important, guys, and I know we have Q and A questions still in the queue and I apologize we are over time, but we will take the answers to those questions out to the Collaboration website and try to get those from the presenters and post those up for you all. Very quickly it seems like that even some of these practices like Providence have been doing this for 18 years, guys. Measurement is still something that we're working on and it sounds like to me it's process of elimination. Try something if it works, great, look for a way to improve it. If it doesn't work, you know, it's just like a PDSA cycle try something new. So it's good to hear that people are still, well not good to hear people are still using spreadsheets. So if you're using a spreadsheet, don't feel like you're in ancient time because it sounds like that's still the thing that's going on. So, again, I apologize that we're over time. Great information. We're going to take all of this and put it on the forum and if you have any other questions about how to get started or potential ways to track, please post those up there and with that, Rose, I'm going to turn it back over to you.

Thank you so much, and we're not going to be able to do the audience response. We want to move right to getting you back to what you love to do most, but I want to thank you for attending. As WebEx closes, you'll be automatically directed to a survey. Your feedback on this survey is used to continually improve our learning opportunities. In addition, please remember that it is important to accurately collect information on each individual and each organization in attendance. If you're not from a region or a practice, please select not applicable in both the region and practice ID drop downs and then select your organization. Keep in mind that if you're in a practice and multiple people are viewing the session together, up to 10 people may be added to the same form. Thank you again for joining our discussion and we look forward to seeing you next time. Have a great day.