The Role of the Pharmacist in Value Based Health Care Systems

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“It is not the strongest of the species that survives, nor the most intelligent, but the one most responsive to change.”

Charles Darwin
The “Medical Village”

- Collaborative Care
- Coordinated Care
- Shared Responsibilities
- Community Resources
- Team Care in and outside the practice
- Interoperable Technology
- Shared vision/alignment
- Education
Chronic Care Model (CCM)

Health System
- Health Care Organization
  - Clinical Information Systems
  - Decision Support
  - Delivery System Design
  - Self-Management Support

Community
- Resources & Policies
  - Informed, Activated Patient
  - Prepared, Proactive Practice Team

Informed, Activated Patient

Prepared, Proactive Practice Team

Productive Interactions

Improved Outcomes

Slide from E. Wagner
Value = Quality / Cost

Managed Care versus Accountable Care
Medication Therapy Management

**Medication Therapy Review**
- Interview patient and create a database with patient information
- Review medications for indication, safety, effectiveness, and adherence
- List medication-related problem(s) and prioritize
- Create a plan

**Intervention and/or Referral**
- Possible referral of patient to physician, another pharmacist, or other healthcare provider
- Interventions directly with patients
- Intervention via collaboration with physician and other healthcare providers

**Implement Plan**
- Create/Communicate

**Personal Medication Record**
- Create/Communicate

**Medication-Related Action Plan**
- Complete/Communicate and Conduct

**Documentation and Follow Up**

**MTM is an example of coordinated collaboration between pharmacists and other healthcare providers**
# Roles & Responsibilities Task Grid: COPD

<table>
<thead>
<tr>
<th>Sample Tasks*</th>
<th>Provider (MD/NP/PA) [Date/Time]</th>
<th>Nurse (RN/LVN) [Date/Time]</th>
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<td>&quot;Treat Forward&quot;—set goals and identify means to achieve them</td>
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<td>Create/update care plan (pharmacotherapy, nonpharmacotherapy/lifestyle) according to COPD severity and risk factors (eg, smoking)</td>
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<td>Regularly assess adherence to comprehensive patient care plan</td>
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<td>Review treatment plan regularly and revise as appropriate</td>
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<td>Schedule referrals when appropriate (eg, pulmonary rehab, pulmonologist, other)</td>
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<td>Include family, friends, and/or others in care plan and implementation</td>
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<td>Educate patient on COPD and how to help manage his/her COPD</td>
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<td>Teach patients how to identify risk factors and reduce exposure</td>
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<td>Show patient how to use or take his/her medication</td>
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<td>Educate patient on the importance of following his/her treatment, including nonpharmacologic interventions and lifestyle changes, as prescribed, such as smoking cessation, physical activity, etc.</td>
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**Sample Tasks**

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<td>Assess/evaluate health literacy</td>
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<td>Educate patient on how to access Patient Portal</td>
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<td>At Patient Portal, provide links to other sites, as appropriate</td>
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<td>Refer patient to group visit</td>
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<td>Schedule next follow-up appointment(s) before patient leaves office</td>
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<td>Make all referral appointments (e.g., pulmonary rehab, influenza and pneumococcal vaccinations, etc) before patient leaves office</td>
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**POST-OFFICE VISIT**

| Input information and therapeutic regimen in EHRs and Patient Portal                        |                     |                |                                     |            |                        |         |              |       |
| Regularly update information in EHRs and Patient Portal, add tips/tools                    |                     |                |                                     |            |                        |         |              |       |
| After each appointment, call patient to evaluate for barriers/problems, etc                 |                     |                |                                     |            |                        |         |              |       |
| Office calls/emails with reminders for appointments, refills, etc                          |                     |                |                                     |            |                        |         |              |       |
| Review your practice’s registry to track patient population progress, best practices, etc   |                     |                |                                     |            |                        |         |              |       |
| Other:                                                                                      |                     |                |                                     |            |                        |         |              |       |
| OTHER                                                                                        |                     |                |                                     |            |                        |         |              |       |

Below are two ways you may use this task grid:

1. **As an overview of team member responsibilities for COPD patients**: To ensure that someone is responsible for each required task for COPD patients, go through the tasks line by line and assign a responsible team member for each task by placing a check in the corresponding box (i.e., Provider, Nurse, etc) and writing in the initials of the responsible team member.

2. **To record when each task has been completed for an individual COPD patient**: When using the task grid for an individual COPD patient, in addition to checking off a responsible team member for each task, you can also write in the date, time, and initials of the responsible team member when the task was completed for that patient.

*This task grid is by no means comprehensive and is meant to serve as a sample task grid for your practice to consider when implementing a team-based approach to managing your COPD patients.*
Population Health and Disease Management

• Risk Stratification

• Patient Segmentation

• Medication Adherence Monitoring

• Complex and Multichronic Condition Patients
The Illness Burden Pyramid

<table>
<thead>
<tr>
<th>Illness Burden (5.00 and Above)</th>
<th>Percent of Population</th>
<th>Percent of Cost</th>
<th>Cost PMPM</th>
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</thead>
<tbody>
<tr>
<td>Extremely heavy health care users with significant advanced/critical illness.</td>
<td>3.0%</td>
<td>32.7%</td>
<td>$3,940</td>
</tr>
<tr>
<td>Illness Burden (2.00-4.99)</td>
<td>8.4%</td>
<td>26.9%</td>
<td>$1,084</td>
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<tr>
<td>Heavy users of health care system, mostly for more than one chronic disease.</td>
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<tr>
<td>Illness Burden (1.00-1.99)</td>
<td>12.7%</td>
<td>18.7%</td>
<td>$504</td>
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<tr>
<td>Fairly heavy users of health care system who are at risk of becoming more ill.</td>
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<tr>
<td>Illness Burden (0.25-0.99)</td>
<td>27.3%</td>
<td>15.8%</td>
<td>$204</td>
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<tr>
<td>Generally healthy, with light use of health care services.</td>
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<tr>
<td>Illness Burden (0-0.24)</td>
<td>48.6%</td>
<td>5.9%</td>
<td>$50</td>
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<tr>
<td>Generally healthy, often not using health system.</td>
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</table>
Patient Care Pathway Creates a Map of the Patient Experience through the Healthcare System
Principles of The Patient Centered Medical Home/Accountable Care/Clinical Integration

- Personal Physician trained to provide continuous, comprehensive care
- Physician-Directed Medical Practice
- Whole Person Orientation
- Coordinated Care
- Quality and Safety
- Enhanced Access to Care
- Payment appropriately recognizes added value provided to the overall system
- “Better patient care for the best price”
Transition Connector

• Collaborative Team
  • Patient
  • Physician
  • Pharmacist
  • Nurse
  • Social Worker
  • Case Manager
  • Allied Health
    • Respiratory Therapist
    • Dietitian
    • Physical Therapist
    • Educator

• Community Team
  • PCP
  • Specialist
  • Skilled Nursing Facility
  • LTC Services
  • Pharmacy
  • Community Clinic
  • Home Care
  • GCM/CM
  • Rehabilitation
  • Hospice
  • Community Resources
  • Health Plan
  • Medical Home

WHO IS THE CONNECTOR?
The Integrated Team

- Patient
- Physicians
- Wellness or Health Coaches
- Lab and Radiology Professionals
- Rehab
- Skilled Case Managers

- Caregivers
- Pharmacists
- Specialists
- Hospitalists
- Nurses
- Therapists
- Behavioral Health
Transitioning The Continuum of Care with Bi-Directional Communication

- Home Care
- Community Health Center
- Health Plan
- Pharmacy
- Hospice
- PCP/Medical Home
- Hospital
- Specialist
- TOC CM

Adherence
Assessment & Support Coordination & Care Plan
Facilitation
Motivational Advocacy
Prescription
Assessment & Care Plan
Increase Productivity
Health Promotion
Non-Adherence
Behavior Health Change
Medication Reconciliation
Assessment Care Plan
Adherence
Assessment & Support
Care Coordination

**Definition:**

Care coordination is a function that helps ensure that the patient’s needs and preferences for health services and information sharing across people, functions, and sites are met over time.

Coordination maximizes the value of services delivered to patients by facilitating beneficial, efficient, safe, and high-quality patient experiences and improved healthcare outcomes.
Team Responsibilities in Ensuring a Safe and Successful Care Coordination

- Educate the patient and ensure patient & caregiver understanding on their disease process and factors that can influence their condition
- Ensure the patient has the resources to manage their disease after transition
- Make certain that the transition will be for the individual patient and they feel confident they can manage
- Ensure that the patient understands the plan for transition of care and their medication plan to the next transition setting
- Make certain that the patient has access to the follow up care and therapy
Active Patient & Family Engagement

• Patient’s and family caregivers need resources they can use and understand

• Health coaching supports patients and their family caregivers in addressing interaction with the providers and team collaboration

• Written directions without any support or coaching are often lost, forgot or not understood

• The patient is the expert in his or her own life

• Understanding the patient’s perspective and motivation is key to bi-directional communication
Patient Empowerment

• Health care needs to be more inclusive, integrated and collaborative.
  • Specialists working together with primary care physicians to prescribe the best medical treatment for patients
  • Physicians teaching their patients about new medical procedures and techniques relevant to their disease state
  • Diabetic patients networking over Facebook to learn how they can better manage their current condition and overall health and wellness.
• Collaboration or “team care,” appears to be the direction the medical profession will need to head to address some of the growing complexities of today’s health care system.
• Health care knowledge is global but health care delivery is local.
Patient Education

- Does the patient know:
  - What’s wrong?
  - What they need to do?
  - Why is it important?

- IF not,
  - What’s your plan for:
    - Patient/caregiver education
    - Identifying and removing barriers to adherence
  - Who implements the plan?
  - Who gathers information and outcome information?
Engagement & Motivational Interviewing: R-U-L-E

- **R** – Resist the temptation to “fix” the patient problem
- **U** – Uncover and understand the patient’s motivation for engaging, working and changing behavior
- **L** – Listen carefully to the patient and try to understand their perspective that may be different than yours
- **E** – Encourage the patient in their ability to self manage adherence to the care plan and change
A 22-month study at a single academic center in Boston showed that compared with usual care, intervention in a Re-Engineered Discharge (RED) program reduced hospital utilization in a general medical population within 30 days of discharge.

Project RED Overview

- **In-hospital component (discharge advocate)**
  1. **Educate patient** about relevant diagnoses throughout hospital stay
  2. **Make appointments** for clinical follow up and postdischarge testing
  3. **Confirm medication plan** and compare it with national guidelines and critical pathways
  4. **Transmit discharge summary** to physicians and services accepting responsibility for the patient’s care
  5. **Assess the degree of understanding** by asking the patient to explain, in his or her own words, the details of the plan (this may require contacting family members who will share in the caregiving responsibilities)

- **After-hospital care plan**
  6. **Give the patient a written discharge plan** at the time of discharge

- **Pharmacist postdischarge telephone component**
  7. **Call the patient to reinforce discharge plan**, review medications, and solve problems

Adherence is Not Solely a Patient Problem

- WHO definition: “the extent to which a person’s behavior including taking medication, following diet plans, and executing lifestyle modifications, correspond with the agreed recommendations from a health care provider”
- Requires mutual consent to the recommendations by the 2 involved parties, patient and physician
- Reasons for non-adherence:
  - Social and cultural barriers
  - Attitude
  - Physician attitude and behavior
  - Patient perception
  - Economics
  - Poor health literacy

The Population Health Model

Everyone Knows What You Should Do But How Do You Do It?

1. **Before the Visit**
   - **Gather Clinical Data**
     - labs
     - screenings
     - specialist reports
   - **Gather Patient Experiences**
     - symptom monitoring
     - medication taking
     - stressors

2. **During the Visit**
   - **Front Office**
     - build relationships
     - explore needs and preferences
   - **Provider Exam**
     - set agenda
     - review clinical and patient experience information
     - collaborate to set goals in care plan

3. **After the Visit**
   - **Follow Up**
     - revise action plan
     - problem solve
   - **Specialist Referrals**
     - coordinate care referrals
   - **Community Linkages**
     - patient education programs
     - fitness and nutrition
     - faith-based health promotion programs
   - **Peer Programs**
     - voluntary health organizations
     - web-based chat rooms
     - lay-led groups
   - **Improved Outcomes**
     - increased healthy behaviors
     - improved clinical outcomes
     - increased collaboration between patient and provider
     - improved physician satisfaction and retention

**CARE PLAN**
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<td><em>Treat forward</em>—set goals and identify means to achieve them</td>
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<td>Create/update care plan (pharmacotherapy, nonpharmacotherapy/lifestyle) according to COPD severity and risk factors (e.g., smoking)</td>
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<td>Regularly assess adherence to comprehensive patient care plan</td>
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<td>Review treatment plan regularly and revise as appropriate</td>
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<td>Schedule referrals when appropriate (e.g., pulmonary rehab, pulmonologist, other)</td>
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<td>Include family, friends, and/or others in care plan and implementation</td>
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<td>Other:</td>
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<td><strong>Patient Education</strong></td>
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<td>Educate patient on COPD and how to help manage his/her COPD</td>
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<td>Teach patients how to identify risk factors and reduce exposure</td>
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<td>Show patients how to use or take his/her medication</td>
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<td>Educate patient on the importance of following his/her treatment, including nonpharmacologic interventions and lifestyle changes, as prescribed, such as smoking cessation, physical activity, etc.</td>
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### Sample Tasks*

**Patient Education (continued)**

- Assess/evaluate health literacy
- Educate patient on how to access Patient Portal
- At Patient Portal, provide links to other sites, as appropriate
- Refer patient to group visit
- Schedule next follow-up appointment(s) before patient leaves office
- Make all referral appointments (e.g., pulmonary rehab, influenza and pneumococcal vaccinations, etc.) before patient leaves office
- Other:

**POST-OFFICE VISIT**

- Input information and therapeutic regimen in EHRs and Patient Portal
- Regularly update information in EHRs and Patient Portal, add tips/tools
- After each appointment, call patient to evaluate for barriers/problems, etc.
- Office calls/e-mails with reminders for appointments, refills, etc.
- Review your practice’s registry to track patient population progress, best practices, etc.
- Other:

**OTHER**

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Below are two ways you may use this task grid:

1. **As an overview of team member responsibilities for COPD patients:** To ensure that someone is responsible for each required task for COPD patients, go through the tasks line by line and assign a responsible team member for each task by placing a check in the corresponding box (i.e., Provider, Nurse, etc.) and writing in the initials of the responsible team member.

2. **To record when each task has been completed for an individual COPD patient:** When using the task grid for an individual COPD patient, in addition to checking off a responsible team member for each task, you can also write in the date, time, and initials of the responsible team member when the task was completed for that patient.

*This task grid is by no means comprehensive and is meant to serve as a sample task grid for your practice to consider when implementing a team-based approach to managing your COPD patients.*

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*Shared Responsibilities to Reach a Common Goal*
LEADERSHIP

The leader always sets the trail for others to follow.