Maximizing Patient Centered Care: Clinical Pharmacy Management of the High Risk Patient

presented by
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• Qualis Health is one of the nation’s leading healthcare consulting organizations, partnering with our clients across the country to improve care for millions of Americans every day
• Serving as the Medicare Quality Improvement Organization (QIO) for Idaho and Washington
• QIOs: the largest federal network dedicated to improving health quality at the community level
The Three Part Aim

• **Better care:** for individuals - safety, effectiveness, patient-centeredness, timeliness, efficiency and equity

• **Better health:** for populations through attacking the upstream causes

• **Lower cost:** reducing per-capita costs through improvements
Objectives

• Describe the Patient Safety and Clinical Pharmacy Services Collaborative and consider how your organization can get involved.

• Understand how to access national, evidence based resources for improving medication safety and overall management of high risk patients.

• Apply the experiences of a local team to quality improvement activities at your organization.
What’s the Issue?

- Medication related problems are common, costly and preventable and lead to poor patient outcomes.
- 15% of the nation’s population (46 million people) are at high medication risk and are in need of coordinated care.
- Uncoordinated medication management accounts for >1/3 of total health care costs, an estimated $240 billion/year.
The Collaborative
Patient Safety and Clinical Pharmacy Services

• Led by the Health Resources and Services Administration (HRSA)
• PSPC 1.0 began in August 2008
• In PSPC 4.0 (Fall 2011) HRSA partnered w/ the Centers for Medicare/Medicaid (CMS) and the Quality Improvement Organizations (QIOs)
• QIOs actively work with partnered teams and recruit for new teams
PSPC Approach

• Patient centered, coordinated outpatient primary care armed with CPS for high risk patients
• Integrated medication management and other services to minimize harm related to ADEs
• Application of best, evidence based practices – The Change Package.
• Use of rapid performance improvement cycles to achieve results quickly (PDSA)
• Registries to manage these high risk patients and track their care and health outcomes
PSPC 4.0 Measures

QIO Partnered Teams

Anticoagulation
Diabetes
Antipsychotics
High Risk Patients

- One or more chronic conditions
- Multiple providers
- Use of high risk medications
- Use of multiple medications
- Pt medication control and self management or low health literacy
Who is participating?

• Community based teams across the country
  • 195 Teams from 48 states + DC, Puerto Rico and Virgin Islands
  • 124 Teams are partnered w/ QIOs
  • 42 QIOs participating

• Organizations include safety net providers and hospitals, rural health clinics, senior care centers

• 520 Partnering Organizations: Schools of Pharmacy, colleges and universities, pharmacies, clinics
Results

• Fewer gaps in the healthcare system
• Reduction in ED visits and hospitalizations/IP days
• Cost savings
• Reduction of pADEs and ADEs
• Improved patient safety and better health outcomes
• Increased provider and patient satisfaction
Highlights of the National Story
(from PSPC 3.0)

• Can bend spending down 10-15%
• 2/3 of teams are operational in 6-12 months
• Patient health can go from “out of control” to under control in < 9 mo.
• When error screening added
  • pADEs reduced from 1.5 to .8 per encounter
  • ADEs decreased from .7 to .5 per patient
Team Commitment

• Leadership commitment, support
• Identify your team leader & form multi-disciplinary team
• Identify a Population of Focus with minimum of 50 Medicare beneficiaries
• Commitment to improving care, tracking pADEs/ADEs
• Participation in education sessions & PSPC resource calls
Data Requirements

- EMR system to support monthly data extraction for required metrics
- Data submission and Change Package Log due by the 10\textsuperscript{th} of each month
- Use of data to develop action plans to foster changes in areas for improvement
Benefits of Participation

• Sharing of best practices, resources, tools
  • The Change Package – best practices
  • Healthcare Communities Website, ListServ
  • Outcomes Sharing Site
• QIO support of monthly data reporting
• QIO staff provides onsite support to enhance participation
Questions?

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Maximizing Patient Centered Care:

Clinical Pharmacy Management of the High Risk Patient

Melissa Hull, PharmD, CACP, CLS
The Polyclinic ACC and Lipid Clinic
The Polyclinic

- Serving patients in Seattle, WA since 1917
- Multi-specialty clinic: more than 180 primary care and specialty physicians in most areas of medicine
- Motto: “Where YOU come first.”
Anticoagulation Clinic

• 2 pharmacists & 2 nurse practitioners
• 2 clinic locations
• About 900 patients currently enrolled
• Services and benefits:
  – Immediate test results
  – Ongoing patient education
  – Communication with providers
  – Management around surgeries and/or procedures
Our PSPC 4.0 Team

• Administration:
  – Michael Tronolone, MD CMO
  – Anita Geving, RN COO
  – Michael Davis, VP Practice Management

• Clinical Team:
  – John Doces, MD
  – Melissa Hull, PharmD
  – Ming-Ming Tung-Edelman, PharmD
  – Patricia Giurgevich, ARNP
  – Katherine Negron, ARNP

• Jennifer Villanueva, Quality Coordinator
• Dan Capshaw (IT)
• QIO Partner: Qualis Health
  – Kristen Dittmaier, RN,QIC
  – Diane Schultz, RPh, Pharmacist Consultant
Population of Focus

• Total population of care: ~160,000

• High risk population for CPS services (patients taking warfarin): ~1600

• Population of focus: patients enrolled in the Anticoagulation Clinic: ~900
Published reports estimate annual savings of event avoidance by anticoagulation management services at $1000 per patient year of therapy

Cost savings for **CPS-Anticoagulation Services**

- More recent study of pharmacist-managed ACC
- Decreased anticoagulation-related ER visits and Hospitalizations
- Saving $10,182.76 and $141,277.34 respectively in one year

Rudd, KM. Pharmacotherapy 2010;30(4):330-338
Team’s Aim Statement

• Over the 12-month life of the Collaborative, we aim to improve the health outcomes and safety for our patients in the ACC

• By the end of the program period, we will realize improvements in the measured outcomes listed:
  – % of visits with INR in range
  – % of patients with monthly INR visits
Being “Green”

- New to PSPC
- QIO Connection
- PSPC 3.0 Summary and Change Package tools as roadmap
- Learning Session in Virginia
# PSPC Team Progress Scale

## Green Team
- **Setting Up**
- Team Formed/ Patient Services arranged
- Population and Baseline data established

## Orange Team
- **Change Package Action**
- Action on improvement strategies

## Blue Team
- **Patient Population Improvement**
- First signs to value proposition

## Gold to Gold Star
- **Scale Up and Spread**
- Systematic roll out
- Financing plan for spread
- Health plan payment reform
Rapid Improvement Cycles

PDSA examples:

• Trial of paper tool for tracking pADE
• MA assistance with documentation
• Expanding spreadsheet to capture all Medication Related Problems, Classifications, and Severities
• Highlighting HTN related MRPs separately
Challenges

- Understanding reporting responsibilities
- Back to paper - tracking pADEs outside of EHR
- Incorporating pADE reporting into EHR
- Reporting pADE/ADEs consistently for ACC POF
- Continued leadership engagement
Successes

• Easily identifiable POF and narrow focus
• Polyclinic Quality Department staff
  – Time to collect and report data
  – Experience with prior collaboratives/ skilled in tracking progress and PDSAs
• IT staff to aid in data reporting
• Patient involvement adding to perspective and keeping patient-centered
Successes

- QIO Partnership
  - Support
  - Ideas/ Troubleshooting
  - Communication
  - Connection to collaborative
Benefits to The Polyclinic

- Participating in nationwide effort to improve care of high risk patients
- Benchmarking/ Shared learning
- Advanced our quality data for our service- resuming TTR and adding pADE
- Provider job satisfaction
Clinical Pharmacy Services

- Medication Therapy Management (MTM)
- Patient Counseling
- Medication Reconciliation
- Medication Access Services
- Preventive Care Programs
- **Disease State Management**
- Prospective Chart Review Consult
- Provider Education
- Drug Information
- Retrospective Drug Utilization Review
Questions

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