Finding a Room for the Pharmacists in the Medical Home

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The speaker has no conflict of interest to disclose.

Learning Objectives

- Describe the potential role and value of the pharmacist in a medical home model.
- Outline strategies for funding pharmacists' time within a medical home program structure.
- List potential process or outcomes measures that could be proposed as measures of effectiveness of pharmacist involvement in a medical home model project.

Our Medical Home

Before the Medical Home Days…

- Various pharmacy practice models
  - direct patient care services vs. consultative services
  - clinical pharmacy services dependent on clerkship teaching
  - collaborative practice agreement only at some of the practice sites

Preparation for Medical Home

- Develop systematic and comprehensive approach to patient care
- Develop innovative clinical pharmacy services to improve and impact patient care outcomes
- Promote clinical pharmacy services to the health centers

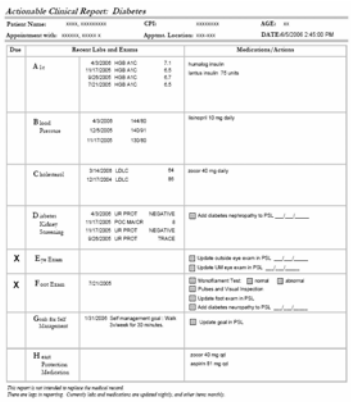
What is the Role of a Pharmacist?

- Evaluate and optimize therapeutic regimen
  - Poly-pharmacy consults
- Provide medication management to achieve treatment goals
- Provide education on chronic medical conditions and medications
  - Asthma, Diabetes, Hyperlipidemia, Hypertension
- Assist in limited physical assessment
- Order diagnostic tests/medical equipments
- Initiate and facilitate referrals to other health care providers (i.e. nutritionist, podiatry, ophthalmologist)

How is the Service Provided?

- Proactive patient recruitment
- Scheduled patient visits/consults
  - new patients (30 – 60 minutes)
  - return visits (30 minutes)
  - phone consults (15 minutes)

Daily Actionable Clinical Report



Actionable Clinical Report: Diabetes

Patient Name: xxxx, xxxxxxxxx CPI: xxxxxxxx AGE: xx

Appointment with: xxxxxx, xxxxx x Approx. Location: xxx-xxx DATE:4/5/2006 2:45:00 PM

Due	Recent Labs and Exams	Medications/Actions
	A1c 4/3/2006 HGB A1C 7.1; 11/17/2005 HGB A1C 6.5; 8/26/2005 HGB A1C 6.7; 7/21/2005 HGB A1C 6.5	humalog insulin lantus insulin 75 units
	Blood Pressure 4/3/2006 144/80; 12/5/2005 140/91; 11/17/2005 130/80	lisinopril 10 mg daily
	Cholesterol 3/14/2006 LDLC 84; 12/17/2004 LDLC 90	zocor 40 mg daily
	Diabetes Kidney Screening 4/3/2006 UR PROT NEGATIVE; 11/17/2005 POC MA/CR 0; 11/17/2005 UR PROT NEGATIVE; 8/26/2005 UR PROT TRACE	Add diabetes nephropathy to PSL __/__/____
X	Eye Exam	Update outside eye exam in PSL __/__/____ Update UM eye exam in PSL __/__/____
X	Foot Exam 7/21/2005	Monofilament Test normal abnormal Pulses and Visual Inspection Update foot exam in PSL Add diabetes neuropathy to PSL __/__/____
	Goals for Self Management 1/31/2006 Self-management goal : Walk 3x/week for 30 minutes	Update goal in PSL
	Heart Protective Medications	zocor 40 mg qd aspirin 81 mg qd

This report is not intended to replace the medical record.
There are lags in reporting. Currently labs and medications are updated nightly, and other items monthly.

Who Pays the Rent for the Room?

- College of Pharmacy/Department of Pharmacy
- Faculty Group Practice
- Payor's pay for performance or other initiatives (i.e. medical home funding)
- Payors who provide reimbursement for MTMS
- Health Centers

Challenges in Obtaining the Rent

- Competition for funding/roles with other providers
- Offer competitive cost for services
- Identifying and engaging the stakeholders

Strategies in Obtaining Funding from the Health Centers

- Effective/efficient communication
- Persistent
- Persuasive
- Provide data and clear outcomes

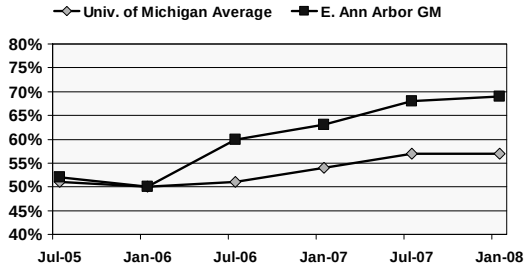
Diabetes Registry Feedback

Site Name	N	A1c Test	A1c ≤ 9%	A1c ≤7%	LDLC Test	LDLC < 130 mg/dL	LDLC <100 mg/dL	On Statin	Monitor for Nephrop-athy	Urine Protein & on an ACE/ARB	Foot Exam	Eye Exam	B.P. < 135/80	Self Mgmt Goal
General Medicine Group A														
Briarwood GM	860	97	88	53	88	80	63	83	89	87	69	79	55	26
Canton GM	883	95	85	50	85	75	55	80	89	81	74	80	62	33
Canton Med/Peds	263	94	82	55	85	68	49	84	92	88	76	75	55	36
Chelsea GM	273	90	81	48	87	78	55	75	90	82	72	69	62	12
E. Ann Arbor Geriatric	237	94	92	55	86	78	62	84	92	77	78	78	62	43
Livonia GM	271	96	83	51	90	80	57	80	94	75	78	76	57	37
Saline GM	260	95	85	49	92	79	55	83	91	88	80	83	52	43
W. Ann Arbor GM	258	94	87	54	84	77	63	86	86	80	77	79	66	21
General Medicine Group B														
Brighton GM	862	93	85	55	88	79	62	83	91	85	78	80	68	40
E. Ann Arbor GM	527	95	85	50	88	80	61	83	90	85	80	82	67	73
E. Ann Arbor Med/Peds	137	97	80	52	91	80	49	79	95	88	85	80	65	68
Taubman GMF	342	95	86	50	87	78	55	86	88	77	73	76	60	30
Taubman GMO	366	91	73	40	76	66	49	81	91	78	76	72	57	48

Improving Blood Pressure Control in Patients with Diabetes

- Trained medical assistants to place a bright green sticker on billing form if BP greater than target goal
- Scheduled follow up appointments within 2 weeks with a pharmacist
- Pharmacist intensify treatment per protocol
- Developed home BP monitor loaning program

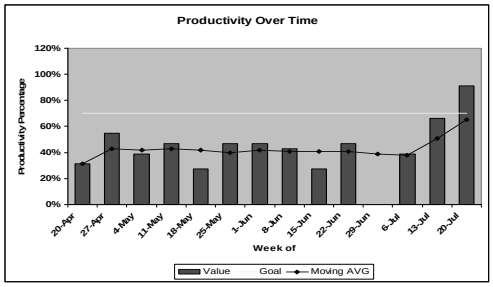
PDSA Redesign Cycles: *(Blood pressure < 135/80)*



Patient Outcome Measures

- Improvement in clinical indicators
- Provider/patient satisfaction
- Number of therapeutic interventions
- Number of non-therapeutic interventions
  - lifestyle reinforcement
  - patient education on chronic medical conditions/medications
  - medication non-adherence/cost issues

Clinic Productivity

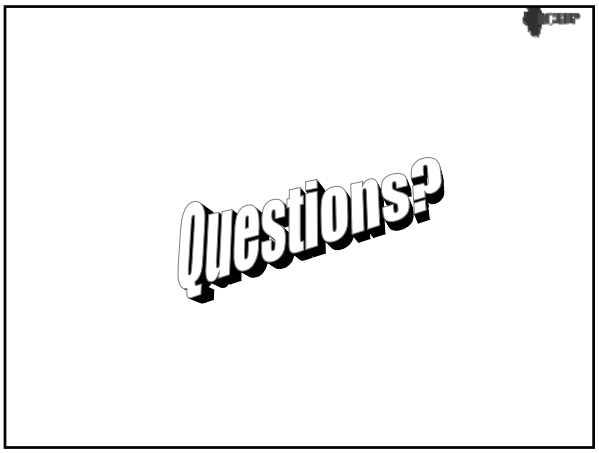


Billing for Pharmacy Services

- Developed new billing structure and process for service reimbursement
- BCBS and BCN
  - *T1015:* Clinic visit (face to face). $60 per 15 minutes with a maximum of 3 units per day, per patient.
  - *T1019*: Telephone consults. $30 per 15 minutes with a maximum of 2 units per day, per patient.

How to Find Your Room?

- Start from where you are today
- Find good roommates
- Partner with key stakeholders
- Inform and engage all team members
- Collect and evaluate outcomes
- Look for a bigger room!


Questions?

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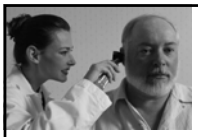
Post-test questions:

1. Finding a room for the pharmacists in the Medical Home is feasible as long as you have the support from the most influential stakeholder. True or False

2. Which of the following are the major roles of a pharmacist in the Medical Home?
    a. Provide chronic care management and medication management services
    b. Provide medication management services and drug information services
    c. Provide pharmacokinetic dosing services and chronic care management services
    d. Provide pharmacokinetic dosing services and drug information services



History and Status of the Patient Centered Medical Home

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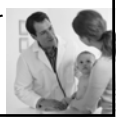
Rush University Medical Center



The speaker has no conflict to disclose.

Objectives

1. State the history of the medical home
2. Compare & contrast the current primary care model to the medical home redesigned health delivery system
3. Review the principles of the patient-centered medical home
4. Describe the Medicare Medical Home Demonstration Project
5. Describe the NCQA assessment program for the medical home

How many have heard the term “Medical Home”?

Is the Medical Home?

A. Special private residence where you can go to be treated for a chronic illness – long weekend stays are offered
B. Coordinated model of medical care
C. Place where physicians, pharmacists and nurses retire
D. Evaluation program for patient care delivery models

Definition

"Medical home models provide
- *accessible,*
- *continuous,*
- *coordinated, and*
- *comprehensive*

patient-centered medical care, and are managed by a ***primary care physician***

with the active involvement of non-physician practice staff"

What is it?

- Single point of coordination for all health care
  - Specialists
  - Hospital
  - Post-acute care
- Primary care provider acts as the facilitator or manager
- Serves as the patient's advocate
- Rationale is to decrease fragmentation of care

History of the Medical Home

- 1967 - Term first appeared in the Standards of Child Health Care
  - Intended to serve as a central source of medical records for children with chronic diseases or disabling conditions
- 1992 - the American Academy of Pediatrics (AAP) published a policy statement on the term

History of the Medical Home

- 2004 – American Academy of Family Physicians (AAFP) recognized a personal medical home as a characteristic of a new model of family medicine
- 2007 – AAFP, AAP, the American College of Physicians (ACP), and the American Osteopathic Association (AOA) endorsed *Joint Principles of the Patient-Centered Medical Home*

History of the Medical Home

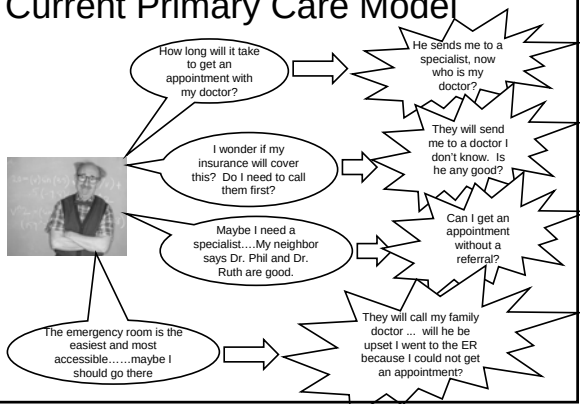
- 2006 – Section 204 of the Tax Relief Act

Required the Secretary of HHS to establish a demonstration to redesign the healthcare delivery system to provide targeted, accessible, continuous, coordinated, family-centered care to high need populations.

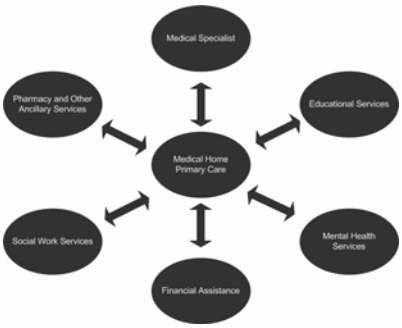
History of the Medical Home

- 2007 – United Health Group, AAFP, AAP, ACP, AOA announced a private health insurance medical home project in Florida
- Several state Medicaid programs also have demonstration projects.

Current Primary Care Model



The Medical Home Concept



Which professionals could coordinate a Medical Home?

A. Primary care physician
B. Sub-specialty physician
C. Surgeon
D. Nurse practitioner
E. Pharmacist

Principles of the Patient-Centered Medical Home

- Personal physician
  - Point of first contact
  - Continuous, comprehensive care
- Physician directed medical practice
  - Physician leads team
- Whole person orientation
  - Personal MD takes responsibility for patient including arranging for care by other professionals

2007 AAFP, AAP, ACP, AOA Joint Statement

Principles of the Patient-Centered Medical Home

- Care is coordinated and/or integrated
  - Subspecialty care
  - Hospitals
  - Home care agencies
  - Nursing homes
  - Patient's community (family, community-based services)

2007 AAFP, AAP, ACP, AOA Joint Statement

Principles of the Patient-Centered Medical Home

- Quality and safety are hallmarks
  - Advocate for patient, robust partnership
  - Evidence-based medicine
  - CQI – engaged in performance measurement
  - Patients participate in decision making
  - HIT to support patient care
  - Voluntary recognition by non-government entity (NCQA)
  - Patients & families participate in quality activities

2007 AAFP, AAP, ACP, AOA Joint

Practical Issues

Practical Issues

- *60% of primary care physician practices are only 1 or 2 physician practices* – don't have infrastructure for Medical Home
- Alternate model - community health team coordinated through the hospital & meeting the definition of a medical home
- Pharmacists and nurse practitioners will provide the care coordination for 10 – 12 physicians

Medicare Medical Home Demonstration Project

- Motivation:
  - Unsustainable Medicare cost inflation
  - Quality of care suboptimal
  - Care is fragmented and inefficient
- Goals:
  - Improve care management
  - Improve quality
  - Improve patient and provider satisfaction'
  - Reduce costs

Medicare Medical Home Demonstration Project

- 3-year demonstration project
- Qualified practices to begin January, 2010 – December 2012
- 8 states – will include rural, urban and medically underserved sites
- 50 practices per state – 400 total
  - 2,000 physicians (family practice, IM, geriatrics, general practice, & some sub-specialty practices)
  - 400,000 Medicare beneficiaries with 1 eligible chronic condition (86% of beneficiaries)

Medicare Medical Home Demonstration Project

- Two tier medical home model
  - Tier 1: Basic medical home services, basic care management fee

    $40.40 PMPM → HCC <1.6 = $27.12 PMPM

    → HCC ≥1.6 = $80.25 PMPM
  - Tier 2: Advanced medical home services, full care management fee

    $51.70 PMPM → HCC <1.6 = $35.48 PMPM

    → HCC ≥1.6 = $100.35 PMPM

Medicare Medical Home Demonstration Project

- Utilizes NCQA's Physician Practice Connections program to evaluate practices
- 28 core capabilities/six general domains
  1. Access and communication
  2. Patient tracking and registry functions
  3. Care management
  4. Patient self-management support
  5. Electronic prescribing
  6. Test tracking

Medicare Medical Home Demonstration Project

- 17 capabilities required for Tier 1
  - Establish written standards for patient access
  - Use data to identify/track patients
  - Use integrated care plan
  - Provide patient education/support
  - Track tests/referrals

http://www.cms.hhs.gov/DemoProjectsEvalRpts/downloads/MedHome_PPC.pdf

Element A: Access and Communication Processes	Tier I (required)		
The practice establishes in writing standards for the following processes to support patient access:	Yes	No	NA
1. Scheduling each patient with a personal clinician for continuity of care	☐	☐	
2. Coordinating visits with multiple clinicians and/or diagnostic tests during one trip	☐	☐	
3. Determining through triage how soon a patient needs to be seen	☐	☐	
4. Maintaining the capacity to schedule patients the same day they call	☐	☐	
5. Scheduling same day appointments based on practice's triage of patients' conditions	☐	☐	
6. Scheduling same day appointments based on patient's/family's requests	☐	☐	
7. Providing telephone advice on clinical issues during office hours by physician, nurse or other clinician within a specified time	☐	☐	
8. Providing urgent phone response within a specific time, with clinician support available 24 hours a day, 7 days a week	☐	☐	

Scoring	100%	75%	50%	25%	0%
	Practice has written process for 9-12 items(must include Factors 1,3,4,5,6, & 8)	Practice has written process for 7-8 items(must include Factors 1,3,4,5,6, & 8)	No scoring option	Practice has written process for 2-6 items	Practice has written process for 0-1 items

Medicare Medical Home Demonstration Project

- Tier 2 requirements include:
  - Tier 1 requirements
  - Electronic health record to capture clinical information
  - Systematic approach to coordinate facility based and outpatient care
  - Review post-hospitalization medication lists
  - 3 of 9 additional capabilities (for example, use of e-prescribing, collecting performance measures)

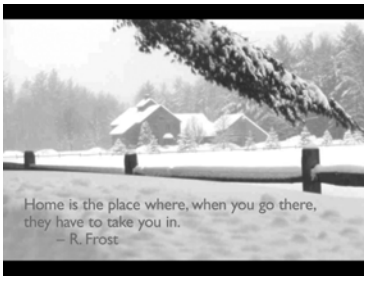
Medicare Medical Home Demonstration Project

Project Evaluation

- How practices provide medical home services
- Impacts of medical home services on:
  - Medicare cost and utilization
  - Quality of care and health outcomes
  - Physician and practices – work flow, costs, satisfaction
  - Patients and their families – experience of care

Which apply to the Medical Home?

A. The program is only for Medicare patients.
B. NCQA has an instrument to evaluate practices that qualify for a medical home.
C. Medicare Advantage patients may participate in the CMS demonstration project.
D. Pharmacists can play an important role in the medical home.


Home is the place where, when you go there,
they have to take you in.
– R. Frost