Integrating Primary and Pharmacy Care: What Works for Patients?

Tuesday, December 17, 2019 12:30-1:30 ET
Welcome & Updates

PCPCC is now PCC!
Become a member
Upcoming webinars
Speaker introductions
Today’s Speakers

Maria Kobylinski
Geisinger Health

Heather Schultz
IngenioRx

Shannon Brownlee
Lown Institute

Moderator:

Julie Schilz
Mathematica
Geisinger’s Ambulatory Pharmacy Program (MTDM)
Ambulatory Pharmacy Programs

MTDM Family Practice

**Model:** Comprehensive, high-value, high-touch, longitudinal disease management

**Key components:**
- Embedded in Family Practice and Internal Medicine sites
- Relatively standardized role across sites
- Collaborative Practice Agreement and referral process (proactive and reactive sources)
- Coordination/Transitions of Care
  - Clinicians, Care Team Partners, Pharmacy Platforms, etc
- Provider/Patient education source (proactive and reactive)
- Preventative health focus
- Patient care ‘ownership’ or ‘high value touchpoints’

**Current Targeted Populations:**
- Anticoagulation
- Diabetes
- Hypertension
- Hyperlipidemia
- Hi-risk Osteoporosis
- Chronic Pain (specialized clinics)
- Asthma
- COPD
- Tobacco Cessation
- Heart Failure

**Practice Model*:**
- Pharmacy Tele-management 40%
- Office Visit Based 60%

*Goal to get to 20% / 80% by FY21
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By the numbers…….

Operational Statistics:
• Patient encounters per month 24,000
• New Referrals per month 1,550

Staffing:
• Pharmacists 54
• Sites 43

Clinic/Staff Expectations
• Patient panel size 500-750 / 1.0 FTE (condition-based)
  4000-6000 /1.0 FTE (risk score based)

Financial Model:
• Billable Visit Revenue (E/M codes, insulin pump billing, AWVs, etc)
• Return on Investment (E.g. physician access improvement, clinical outcomes, quality metrics, total cost of care reduction, etc)
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Example of Regional Structure*

West Region
5 Assets to support clinics

- A/M
- Pain
- A/M
- Hub Clinic #1
  - 3 RPhs A/M
  - 1 RPh Pain
- Hub Clinic #2
  - 2 RPhs A/M

Central Region
4 Assets to support clinics

- A/M
- A/M
- A/M
- A/M
- Pain
- Hub Clinic
  - 3 RPhs A/M
  - 1 RPh MCC
  - 1 RPh H/O
  - 2 RPhs A/M
  - 1 RPh Neuro
  - 1 RPh GI
  - 1 RPh Anemia

East Region
4 Assets to support clinics

- A/M
- A/M
- A/M
- A/M
- Pain
- Hub Clinic #1
  - 2 RPhs A/M
  - 1 RPh Pain
  - 1 RPh H/O
  - 1 RPh Neuro

- Hub Clinic #2
  - 1 RPh GI

Key:
- A/M: Anticoag/Metabolic Dx
- H/O: Hematology/Oncology
- Neuro: Neurology
- GI: Gastroenterology
- HF: Heart Failure
- Ger: Geriatrics
- MCC: Medically Complex Kids
  - Coming this year

*Note: Visual from 2017
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Referral Workflow

Flow 1

- Referral Placed in EPIC
- Auto-route MTDM EPIC Pool
- Referral Reviewed
- Patient Added to Roster
- Patient Placed on Appropriate MTDM Clinic Schedule (w/in 24 hrs)
- MTDM Clinic Pharmacist Calls Patient to Schedule Initial Appl
- Anticoagulation w/in 24 hrs
- MTDM based on need (Max of 7 days)

Flow 2

- Referral Placed Via Warm Hand-Off (P)
- Patient Seen in Clinic Real-Time For Introduction
- Added to Patient Roster
- Initial Appl Scheduled

Lost Referral Report Auto-Generated and Reviewed Every Mon and Thur; Lost-to-Follow-Up Report Reviewed Weekly; Clinical/Productivity Outcome Metrics Presented to Team Monthly (and Avail On Demand)
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MTDM Clinic Scheduling Template

10/30/40 Model
- 10 min POC INR
- 30 min Chronic Disease F/U
- 40 min Chronic Disease New
- 40 min AWV (+ address care gaps)

- No POC INR ‘double books’
- 90 minutes per day of schedule blocks
- Option available for 20 min POC INR if New or Peri-op visit
- Option available for 40 min Chronic Disease F/U x 1 if complicated

90 minute schedule block options
- Decision point A (choose one option from below)
  - 60 min: 1200pm-100pm (lunch)
  - 60 min split: 930am-10am (AM)
    and 12pm-1230pm (lunch)
- Decision point B (Acute Slot*)
  (choose one option from below)
  - 30 min: 200pm-230pm (mid afternoon)
  - 30 min: 4pm-430pm (end of day)

FY21 Tentative

10/30/45 Model
- 15 min POC INR
- 30 min Chronic Disease F/U
- 45 min Chronic Disease New
- 45 min AWV (+ address care gaps)

- POC INR ‘double books’ if needed
- 60 minutes per day of schedule blocks
  (rest of cushion built into longer appt slots)
- Option available for 45 min Chronic Disease F/U x 1 if complicated

60 minute schedule block options
- Lunch Break
  - 30 min: 12pm-1230pm
- Decision point A (ACUTE Slot*)
  (choose one option from below)
  - 30 min: 200pm-230pm (mid afternoon)
  - 30 min: 4pm-430pm (end of day)

- No POC INR ‘double books’
- 60 minutes per day of schedule blocks
- Option available for 20 min POC INR if New or Peri-op visit

60 minute schedule block options
- Lunch Break
  - 30 min: 12pm-1230pm
- Decision point A (Acute Slot*)
  (choose one option from below)
  - 30 min: 200pm-230pm (mid afternoon)
  - 30 min: 4pm-430pm (end of day)

Model depends on patient mix (% anticoag to % chronic dx)
Schedule blocks for meetings and to make telephone calls
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MTDM Family Practice

MTDM Clinic Panel Size and Template Utilization Goals

Patient Panel Size Per FTE

<table>
<thead>
<tr>
<th>Family Practice</th>
<th>Pre - 2019</th>
<th>2019 - on</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>450 – 600 Active Patients (Based on high trend conditions: specialty populations)</td>
<td>6000:1 New Clinics 4000:1 Existing Clinics (Not adopted pharmacy-based panel. Based on 5G degree patient exam)</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Care</th>
<th>Pre - 2019</th>
<th>2019 - on</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>750 – 1200 Active Patients (Based on high trend conditions: specialty populations)</td>
<td>Under Development (Not adopted pharmacy-based panel. Based on 5G degree patient exam)</td>
</tr>
</tbody>
</table>

Template Utilization

<table>
<thead>
<tr>
<th>Family Practice</th>
<th>Pre - 2019</th>
<th>2019 - on</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>80 – 87% (Pharmacy Telemanagement: Clinical AID)</td>
<td>&gt; 90% (Pharmacy Telemanagement: Clinical AID)</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Specialty Care</th>
<th>2019 - on</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Under Development</td>
</tr>
</tbody>
</table>

Pending call volume reduction from pharmacy telemangement
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MTDM Financial Model: Mixed Revenue + ROI/Cost Savings

Revenue Opportunities

- Revenue generation
  - Fee For Service
    - Anticoagulation mgmt. code (93793)
    - E/M or ‘Incident to’ (99211)
    - Facility Fee (HOP sites)
    - Nursing Home Contracts (negotiated)
    - Insulin Pump Contracts (negotiated)
  - AWV (G0438/0439)
  - CGM placement (95249)
  - Smoking Cessation (99406/99407)

Return on Investment/Cost Savings Opportunities

- Examples: ED utilization, Hospital admissions/readmissions, quality metrics, reduction in medication errors, physician access, physician satisfaction and reduction in turnover, patient satisfaction, condition/medication specific savings, Caresite retail/mail order capture, Specialty capture, 340B opportunities
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MTDM Initial Competency

- Comprehensive training process
  - High priority placed on hands-on patient care experience
  - Supplement with didactics, assigned readings, reference materials, and CE offerings
  - Training checklist
  - Assigned mentor
  - Lean on clinical partners to help develop

- Have a reliable credentialing process in place
  - Competency and/or certification exam(s)
  - Proof of licensure; CE requirements

Example of Training Manual / Checklist
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MTDM Maintenance of Clinical Competency

- Annual competency assessments
  - Updated annually and as treatment guidelines change
- QA/QI process
  - Peer reviews
  - Outcome assessments
- Real-time clinical outcome data available to staff
  - Reviewed at monthly staff mtgs
  - Available on demand for staff
- Provide staff with tools they need to succeed
  - Pharmacy CE days and retreats
  - Funding for external CE conferences/courses
  - Readily available clinical resources and treatment protocols (based on ‘best practice’)
  - Collaborative Practice Agreement
- Promote / support Board Certification, pursuit of advanced degree, and/or career advancement
- Set expectations high
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Resource Optimization Efforts: Telepharmacy Support

Anticoagulation Telemanagement:
- Decant 3500-5000 anticoagulation mgmt. calls from MTDM Family Practice Sites
- Goal: Growth in office visit volume at MTDM clinic sites due to improved access

Example from 1st Phase of Project (East Region):

As Anticoag calls were onboarded for East Region, significant office visit growth occurred. Data collection for Central/West Region underway.
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Outcome Tracking: Data/Metric Evolution

Evolution of Data Needs / Capabilities in Parallel with Practice Model Maturation
(Level of Complexity Rises at Each Step)

- Initial Assessment for Areas of Opportunity
- Track Outcomes and Provide for Ability to Report-out (Point in Time)
- Gain Interactive Functionality (E.g. Filters)
- Re-Assess for Additional Areas of Opportunity
- Utilize Data for Predictive Analytics / Machine Learning
- Track and Have Available Data in Real Time

Evolution of Outcome Metrics Needed as Practice Model Matures
(Level of Complexity Rises at Each Step BUT NEED to make the progression)

- Productivity Metrics (E.g. patient encounters, office visits)
- Intervention Metrics (E.g. pt. education performed, ADR, duplicate med)
- Clinical Outcomes (E.g. A1C improvement)
- High Value Metrics (E.g. total cost of care utilization reduction)
<table>
<thead>
<tr>
<th>Month</th>
<th>Total in person visits</th>
<th>Change from 2018-19</th>
<th>Referral trends</th>
<th>Month</th>
<th>MTDM</th>
<th>Coag</th>
<th>Total</th>
<th>Refill Call Center</th>
<th>Month</th>
<th>Anticoag encounters</th>
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<td>Jul-19</td>
<td>10,228</td>
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<td>1,528</td>
<td>496</td>
<td>2,024</td>
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<td></td>
<td>1,611</td>
<td>646</td>
<td>2,257</td>
<td>29%</td>
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<td>↑</td>
<td>Sep-19</td>
<td></td>
<td>1,477</td>
<td>996</td>
<td>2,473</td>
<td>40%</td>
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<td>Nov-19</td>
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<td>Nov-19</td>
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<td>Jun-20</td>
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</table>
# Ambulatory Pharmacy Programs
## MTDM Family Practice

### Outcome Tracking: Clinic/Staff Productivity Monthly

<table>
<thead>
<tr>
<th>Clinic location</th>
<th>In person completed visits</th>
<th>Phone completed visits</th>
<th>Total completed appts</th>
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<tbody>
<tr>
<td>Bellefonte</td>
<td>235</td>
<td>248</td>
<td>483</td>
</tr>
<tr>
<td>Berwick</td>
<td>456</td>
<td>256</td>
<td>712</td>
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<tr>
<td>Bloomsburg RR</td>
<td>355</td>
<td>307</td>
<td>662</td>
</tr>
<tr>
<td>Dallas</td>
<td>298</td>
<td>270</td>
<td>568</td>
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<tr>
<td>Frackville</td>
<td>300</td>
<td>231</td>
<td>531</td>
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<tr>
<td>Grays Woods</td>
<td>105</td>
<td>227</td>
<td>332</td>
</tr>
<tr>
<td>Hazleton</td>
<td>181</td>
<td>151</td>
<td>332</td>
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<tr>
<td>Holy Spirit Camp Hill</td>
<td>118</td>
<td>528</td>
<td>646</td>
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<tr>
<td>Holy Spirit Dillsburg</td>
<td>66</td>
<td>271</td>
<td>337</td>
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<tr>
<td>Holy Spirit Mech</td>
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<td>255</td>
<td>351</td>
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<tr>
<td>Holy Spirit Prog Ave</td>
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<td>189</td>
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<td>Juniata</td>
<td>110</td>
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<td>Kingston</td>
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<td>Kulpmont</td>
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<td>495</td>
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<td>239</td>
<td>507</td>
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<td>285</td>
<td>418</td>
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<td>Lewistown</td>
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<td>1,087</td>
<td>1,875</td>
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<td>300</td>
<td>373</td>
<td>673</td>
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<td>Milton</td>
<td>256</td>
<td>360</td>
<td>616</td>
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<td>Mo. Valley</td>
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<td>432</td>
<td>666</td>
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<td>Mt. Pleasant</td>
<td>691</td>
<td>468</td>
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<td>Mt. Pocono</td>
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<td>185</td>
<td>468</td>
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<td>Mtn Top</td>
<td>241</td>
<td>109</td>
<td>350</td>
</tr>
<tr>
<td>Nicholson</td>
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<td>-</td>
<td>38</td>
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<tr>
<td>Orwigsburg</td>
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<td>340</td>
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<td>Pittston</td>
<td>314</td>
<td>175</td>
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<td>Pottsville</td>
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<td>176</td>
<td>406</td>
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<td>Scen Park</td>
<td>379</td>
<td>670</td>
<td>1,049</td>
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<td>Selingsgrove/CPSL</td>
<td>217</td>
<td>410</td>
<td>627</td>
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<td>SBW</td>
<td>160</td>
<td>130</td>
<td>290</td>
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<td>Tunkhannock</td>
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<td>539</td>
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<td>Refill Call Center</td>
<td>-</td>
<td>3,698</td>
<td>3,698</td>
</tr>
</tbody>
</table>
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MTDM Family Practice

Outcome Tracking: Patient Satisfaction (Press Gainey)

<table>
<thead>
<tr>
<th>Quarterly Mean Trend Analysis</th>
<th>Quarterly Percentile Rank Trend Analysis</th>
<th>Quarterly Overall Mean/Rank by Section</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Section</th>
<th>Trend Mean Score</th>
<th>Current Percentile Rank</th>
</tr>
</thead>
<tbody>
<tr>
<td>Informed Facility Rating</td>
<td>94.2</td>
<td>100</td>
</tr>
<tr>
<td>Access</td>
<td>92.5</td>
<td>100</td>
</tr>
<tr>
<td>Access</td>
<td>92.5</td>
<td>100</td>
</tr>
<tr>
<td>Moving Through Your Visit</td>
<td>91.8</td>
<td>100</td>
</tr>
<tr>
<td>Nurse/Assistant</td>
<td>90.9</td>
<td>100</td>
</tr>
<tr>
<td>Care Provider</td>
<td>88.1</td>
<td>100</td>
</tr>
<tr>
<td>Personal Issues</td>
<td>84.0</td>
<td>100</td>
</tr>
<tr>
<td>Overall Assessment</td>
<td>74.4</td>
<td>95</td>
</tr>
</tbody>
</table>

**PHARMACIST**

1. **Explanations the pharmacist gave you about your problem or condition**
2. **Concern the pharmacist showed for your questions or worries**
3. **Pharmacist’s efforts to include you in decisions about your care**
4. **Information the pharmacist gave you about medications (if any)**
5. **Pharmacist’s discussion of any proposed treatment (options, risks, benefits, etc.)**
6. **Your confidence in this pharmacist**
7. **Likelihood of your recommending this pharmacist to others**

Comments (describe good or bad experience):
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Outcome Tracking: Clinical and Operational Metrics (Example: BH)

Operational

Clinical

- After Medication Initiation,
  - Seen for follow-up within 2 weeks: 50%
  - Seen for follow-up within 4 weeks: 64%

- Average starting PHQ: 13 → Average PHQ at 6 weeks: 7

- Patients now in remission (PHQ/GAD<4): 14 (22%)
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Outcome Tracking: Clinical Metrics (Example: DM)

<table>
<thead>
<tr>
<th>Bundle Name</th>
<th>measure_description_short</th>
<th>Overall Rate</th>
<th>Followed.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Eye Exam in last year</td>
<td></td>
<td>67.0%</td>
<td>67.0%</td>
</tr>
<tr>
<td>Foot exam in last year</td>
<td></td>
<td>75.9%</td>
<td>75.9%</td>
</tr>
<tr>
<td>HbA1c in Goal</td>
<td></td>
<td>30.3%</td>
<td>30.3%</td>
</tr>
<tr>
<td>Influenza Vaccine</td>
<td></td>
<td>65.1%</td>
<td>65.1%</td>
</tr>
<tr>
<td>Nephropathy monitoring completed in last year</td>
<td></td>
<td>85.1%</td>
<td>85.1%</td>
</tr>
<tr>
<td>Patient on Moderate/High Intensity Statin</td>
<td></td>
<td>81.7%</td>
<td>81.7%</td>
</tr>
<tr>
<td>Pneumococcal Vaccine</td>
<td></td>
<td>82.9%</td>
<td>82.9%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Bundle Name</th>
<th>measure_description_short</th>
<th>Total Patients</th>
<th>Patients w/ A1c Data</th>
<th>% insulin Pump</th>
<th>% IP w/ MTM</th>
<th>% IP Followed</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diabetes</td>
<td></td>
<td>1,544</td>
<td>1,544</td>
<td>100.0%</td>
<td>100.0%</td>
<td>100.0%</td>
</tr>
</tbody>
</table>

A1c Impact

Quality Metrics and A1C Improvement for Baseline A1C>9

Grand Total 1,544
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MTDM Family Practice

Outcome Tracking: Clinical Metrics (Example: DM)

Example of Data on Impact on 2nd Line Diabetes Prescribing

All Patients: 54% GLP1 / SGLT2

MTDM Managed: 90% GLP1 / SGLT2
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Outcome Tracking: Clinical Metrics (Example: Pain Mgmt)
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MTDM Family Practice

Outcome Tracking: Clinical Metrics (Example: Pain Mgmt)

- Average 29% reduction in patients on opioids at 12 months
- Average 21% reduction in morphine MEQs at 12 months
- Average 54% reduction in patients on opioid/benzo combination at 12 months
- Average 35% reduction inpatients on opioid/gaba combination at 12 months
Promoting Pharmacy Collaboration: Discovery to Action

Heather Schultz, PharmD.
Director, Clinical & Specialty Pharmacy
Role of the pharmacist in reducing healthcare costs: Current insights

“The role of the pharmacist has evolved substantially in recent decades. The traditional activities of the profession primarily focused on the dispensing and supply of medications...Nowadays, pharmacists also ensure the rational and cost-effective use of medicines, promote healthy living, and improve clinical outcomes by actively engaging in direct patient care and collaborating with many healthcare disciplines.”

https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5774321/
Promoting pharmacy engagement

- Evaluate Government & Alignment
- Clinicallly Integrated Pharmacist Support
- Align Strategies with Standards of Care
- Information Sharing & Process Improvement
Moving from discovery to action
Evaluate government and alignment

Establish the role of pharmacist and pharmacy strategy in defining, operationalizing and evaluating best practices
Moving from discovery to action
Clinically integrated pharmacist support

Align pharmacist support with team-based care
Moving from discovery to action

Information sharing and process improvement

Review clinical workflows and processes that impact patient and provider experience
Moving from discovery to action

Align strategies with standards of care

Evaluate for best practices and outcomes
Pharmacy engagement

Direct collaboration cost savings example

- Medical Director, Pharmacist and Health Plan Pharmacist

- Education Campaign for Prescribers
- Use of EMR technology

Engage Clinical Team

Discover Opportunities

- Pharmacist created EMR workflow messaging
- Pharmacist and Prescriber discussion

Take Action
The Epidemic of Medication Overload

Shannon Brownlee
Senior Vice President, Lown Institute
Lecturer, Department of Health Policy
George Washington School of Public Health

Bold ideas for a just and caring system for health
# Medication Overload: the use of multiple medications that pose a greater risk of harm than benefit

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td>1. <strong>Healthcare</strong></td>
<td>5 million older adults sought medical attention for ADEs in 2018</td>
</tr>
<tr>
<td>2. <strong>Medication Usage</strong></td>
<td>42% of older adults take 5 or more prescription medications</td>
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<td>3. <strong>Healthcare Data</strong></td>
<td>There was a 200% increase in polypharmacy over 20 years</td>
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<tr>
<td>4. <strong>Hospitalization</strong></td>
<td>750 hospitalizations every day due to ADEs in older adults</td>
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<tr>
<td>5. <strong>Unnecessary Spending</strong></td>
<td>$62 billion in unnecessary hospitalizations over 10 years</td>
</tr>
<tr>
<td>6. <strong>Deaths</strong></td>
<td>150,000 premature deaths in next 10 years due to ADEs</td>
</tr>
</tbody>
</table>
Lown released “Medication Overload: How the drive to prescribe is harming older Americans” report in April 2019

Working group of 22 experts in medication use and polypharmacy

“Eliminating Medication Overload: A national action plan”
Drivers of Medication Overload

1. Culture of Prescribing
2. Information & Knowledge Gaps
3. Fragmentation of Care

Source: www.goneintorapture.com
5 Categories of Recommendations for Stopping Medication Overload

1. Implement Prescription Checkups
2. Raise awareness about medication overload
3. Improve information at the point of care
4. Educate and train health professionals
5. Reduce industry influence
Prescription Checkup: a medication review that makes relieving medication overload its primary focus and uses a shared decision making process

4 Steps:
1. Inventory
2. Inquiry
3. Intervention
4. Follow-Up

A week of medications, before and after deprescribing.
What can you do to take action now?

For Clinicians:

- **Learn about the risks** of medication overload
- **Participate in continuing education** programs about careful prescribing and deprescribing
- **Make deprescribing guidelines available** at the point of care
- **Lobby your clinical membership organizations** or specialty societies to update clinical practice guidelines with appropriate targets for older patients
- **Become a “pharma free” clinician**
What can you do to take action now?

For Policymakers:

- Support a public awareness campaign about medication overload
- Support patient-directed awareness plans for specific medications
- Create a Medicare reimbursement code for prescription checkups
- Fund convenings of clinician specialty groups to identify changes needed to clinical practice guidelines.
- Address key issues with adverse drug event reporting
- Restrict/regulate direct-to-consumer drug advertising
- Close the Physician Sunshine Act loophole for drug samples
What can you do to take action now?

For Health Facilities:

- Implement prescription checkups for patients taking multiple medications
- Launch an educational campaign for clinicians to raise awareness of medication overload
- Make deprescribing guidelines available to clinicians
- Become a “pharma free” institution
What can you do to take action now?

**For Health Care Organizations:**

- Launch related continuing education programs
- Implement a “Deprescribing Champions” program
- Launch an educational campaign for clinicians to raise awareness
- Make deprescribing guidelines available to clinicians
- Incorporate training on careful prescribing and deprescribing into school curricula
- Pilot a polypharmacy/deprescribing concentration for clinicians specializing in geriatric care
For more information about the Lown Institute’s medication overload work and to download our current report and future action plan (to be released Jan 2020) go to: www.lowninstitute.org/pills
Questions?
Questions for the panel

Maria Kobylinski
Geisinger Health

Heather Schultz
IngenioRx

Shannon Brownlee
Lown Institute

Moderator:

Julie Schilz
Mathematica
Thank you!