Medication Optimization Use Case

FEDERALLY QUALIFIED URBAN HEALTH NETWORK (FUHN)—Minneapolis, Minnesota	
Focus Area	Comprehensive medication management (CMM) contributes to improved quality metrics and shared savings for participation in an Integrated Health Partnership Accountable Care Organization (ACO) demonstration project with the State of Minnesota. Patients are referred to a clinical pharmacist for CMM using a population health approach.
At-a-Glance	■ **Organization Type:** Coalition of eight Federally Qualified Health Centers (FQHCs) ■ **Launched:** 2013 ■ **Payment and Funding Sources:** FUHN receives shared savings through an ACO contract with the state of Minnesota. The clinical pharmacist position is funded by FUHN and FUHN-secured independent grants. The organization has committed to supporting the clinical pharmacist position regardless of grant support at this time. The clinical pharmacist does not bill for CMM as they are not recognized as providers at the federal level. However, the prospective payment system (PPS) rate for each FQHC may include pharmacy services as part of their overall reimbursement rate.
Organization Details	FUHN (Federally Qualified Health Center Urban Health Network) is a collaborative partnership of eight FQHCs in Minneapolis and St. Paul, Minnesota, working as a Healthcare Controlled Network (HCCN) in partnership with Minnesota's Department of Human Services on Medicaid. These efforts include FUHN's participation in an Integrated Health Partnership Accountable Care Organization demonstration project. The goals of FUHN are to reduce total cost of care for all medical services and improve clinical quality, patient experience and primary care access for vulnerable populations. The FUHN pharmacist provides CMM as a shared service across member clinics, improves clinical quality metrics and enhances the patient-centered comprehensive care provided across member clinics. FUHN has achieved a cost savings of over $26 million from 2012 to 2018 through its ACO contract with the Minnesota Department of Human Services.[1,2]
Brief History of CMM Program	The CMM program started in 2018 in partnership with the University of Minnesota Pharmaceutical Care Leadership Residency program. The practice recruits patients for CMM who are not meeting clinical quality goals. In addition, patients are also referred by providers or other staff. A second-year pharmacy resident started this practice in one FQHC, then it expanded to two FQHCs. In 2019, the position transitioned to a contracted FUHN clinical pharmacist, and the practice expanded to three total FQHCs in 2020. The program expansion is directly related to consistent improvement seen in associated quality metrics and positive feedback from providers and patients. The practice reviewed here exists in three distinct FUHN clinics. Additional clinical pharmacists are employed by other FUHN clinics; however, the practice model of these other sites may differ from what is reviewed here.

PRODUCED BY HEALTH2 RESOURCES GTMRX INSTITUTE 2022© | 03.2022

Results & Achievements

Focus on the Quadruple Aim:

- *Better Outcomes*
- *Cost Savings*
- *Patient Satisfaction & Engagement*
- *Clinician Satisfaction*

Better Outcomes:

- CMM provides whole person care.
  - The top 10 conditions for which the FUHN pharmacist resolved medication therapy problems through CMM in 2020: diabetes, hypertension, dyslipidemia, pain, asthma, coronary artery disease, heartburn, smoking cessation, insomnia and COPD.
  - The top 5 medication therapy problems resolved through CMM: dose too low, synergistic therapy needed, undesirable effect, does not understand directions and medication requires monitoring.
- There was an average A1c reduction of 2.4% across 3 FUHN clinics for 291 patients over 24 months.

Cost Savings:

- Estimated cost savings were $158,000 to $195,000 for 167 patients over 24 months (extrapolated from literature showing cost savings of $950 to $1,169 per patient per year for those experiencing a decrease of ≥1% in A1c.)[3,4]

Patient Satisfaction & Engagement:

- In 2020:
  - Average of three encounters per patient (median of two encounters per patient).
  - 55% of patients had a second visit with the clinical pharmacist, and 66% of those patients had a third visit with the clinical pharmacist.
  - The number of visits with the clinical pharmacist ranged from 1 to 16 depending on need.
- Patients lost to follow up were re-engaged by clinic staff using their population health practices.
- A plan for capturing patient experience data is underway; however, in a small sample (n=9):
  - 8 of 9 patients surveyed strongly agree that their clinical pharmacist helped them to understand why they are taking each of their medications.
  - 7 of 9 patients surveyed strongly agree that they feel more confident in managing their medications after meeting with the clinical pharmacist.

Clinician Satisfaction:

- Clinician satisfaction has not yet been formally evaluated, but the team frequently acknowledges the value of the clinical pharmacist.

Patient Success Story

A patient was identified as a candidate for the CMM program in mid-2020 with an A1c of 11.4%. When the clinical pharmacist contacted the patient for CMM, they had not seen their provider or had updated labs for four months—due to barriers to care such as cost and schedule conflicts with their job.

The clinical pharmacist met with the patient for a CMM telehealth appointment during the pandemic using the network-wide follow up parameters and reconnected with their primary care provider and diabetes educator. At the appointment, the clinical pharmacist identified and resolved a medication causing an adverse effect. At this time, the patient also lost their job and insurance during the pandemic. The clinical pharmacist was able to help them access affordable medications and connect them to an insurance navigator.

continued

continued **Patient Success Story**	After 12 visits over seven months, the patient's A1c improved to 6.6%, their blood pressure remained at goal on fewer medications and they were prescribed an appropriate statin. Unnecessary medications were eliminated and evidence-based medications were added when indicated. In addition, when the patient became eligible for the COVID-19 vaccine, they contacted the clinical pharmacist to discuss their vaccine-related questions before receiving it. Upon receiving interprofessional and team-based CMM, the patient was able to reach their health care goals and establish a trusting relationship with the team.
Team-Based Care Strategy	■ **Interprofessional Team Roles:** ▪ Providers (including MD, NP, PA), RD/CDE and RNs are trained when to refer patients not meeting quality goals to the clinical pharmacist for CMM. Per practice site, there are a range of 4-12 providers, 1 RD/CDE and 2-4 RNs. ▪ Interprofessional communication occurs within the EHR, face-to-face or by telephone. ■ **Role of the Clinical Pharmacist:** ▪ Broad collaborative practice agreements allow for independent ordering of medications and labs. ▪ Patient outreach is completed by the clinical pharmacist based on unmet quality goals. ▪ The clinical pharmacist collaborates and communicates with care team members. ■ **Care Delivery Modality:** ▪ In-person, phone and video visits ▪ The length of the visit is variable and based on the individual clinic's scheduling practices: - 40–60-minute initial new patient visits - 30–40-minute return visits ▪ Patients average three visits with the clinical pharmacist until their medication-related needs were addressed and goals achieved, or they were lost to follow-up.
Patient Referral Criteria	■ All patients with any medications and conditions are eligible for CMM—per primary care provider and clinical pharmacist discretion. ■ **Primary Patients Recruited:** patients with A1c > 8.5% ■ **Secondary Patients Recruited:** patients receiving a home blood pressure monitoring device
Size of CMM Program	**Number of:** ■ **Clinical Pharmacists:** 1 ▪ FUHN Clinical Pharmacist FTE: 0.8 in direct patient care ▪ Additional clinical pharmacists are employed by other FUHN clinics; however, each site has an individual practice model. ■ **Current Practice Sites:** 3 ▪ Neighborhood HealthSource (2019-present) ▪ Native American Community Clinic (2020-present) ▪ Southside Community Health Services (2020-present) ■ **Unique Patients Served Across Three Practice Sites:** ▪ 161 patients and 546 visits (2020)

Program Success Factors	■ Broad collaborative practice agreements allow for patient-centered CMM provided by the clinical pharmacist. ■ Network-wide protocols allowed for consistent care process and follow up across clinic sites. ■ Patients most in need of CMM were identified using a population health approach. ■ Utilization of multiple care delivery modalities (e.g., in-person, telemedicine) improve access to CMM services. ■ The program's collaborative and team-based care approach.
Next Steps, Future Goals	■ Expand CMM services to additional FUHN sites. ■ Expand intentional recruitment for CMM. ■ Use contract shared-savings to support CMM services. ■ Incorporate learners (e.g., residents, students) into the CMM practice.
References	1. *Results.* Federally Qualified Urban Health Network. 2018. https://www.fuhn.org/blank-6. 2. *Integrated Health Partnerships.* Minnesota Department of Human Services. 2020. https://mn.gov/dhs/partners-and-providers/news-initiatives-reports-workgroups/minnesota-health-care-programs/integrated-health-partnerships/. 3. Grabner M, Abbott S, Nguyen M, Chen Y, Quimbo R. Estimated Cost Savings Associated with A1c Reductions in a Large US Commercial Health Plan. *Value in Health.* 2013;16(3):A160. 4. Pogach L. Glycemic Control and Health Care Costs for Patients with Diabetes. *JAMA.* 2001;285(2):182-9.
Program Contact Information	**Swetha Pradeep, Pharm.D.** Clinical Pharmacist, Federally Qualified Urban Health Network prade007@umn.edu https://www.fuhn.org
Developed by the Best Practices and Innovative Solutions Subgroup of the GTMRx Practice and Care Delivery Transformation Workgroup	