

# Medication Optimization Use Case

<b>COMMUNITY CARE PHYSICIANS—Albany, New York</b>	
<b>Focus Area</b>	Primary care chronic disease model that incorporates comprehensive medication management (CMM) provided by the clinical pharmacist in collaboration with the interprofessional primary care team to optimize therapeutic outcomes.
<b>At-a-Glance</b>	<ul style="list-style-type: none"> <li>■ <b>Organization Type:</b> Independent multispecialty medical group</li> <li>■ <b>Launch Date:</b> 2015</li> <li>■ <b>Payment and Funding Sources:</b> <ul style="list-style-type: none"> <li>▪ Organizational funding from Community Care Physicians</li> <li>▪ Private insurance payer, national, state and local primary care value-based, as well as patient-centered medical home initiatives</li> <li>▪ Local college of pharmacy provides funding for 0.5 FTE pharmacist and 0.5 FTE pharmacy resident</li> </ul> </li> </ul>
<b>Organization Details</b>	Community Care Physicians (CCP) is a multispecialty medical group with more than 2,000 employees, 420 practitioners, 80 practices and 30 specialty offices across 8 counties in upstate New York’s Capital District.
<b>Brief History of CMM Program</b>	<p>Medication management services were first implemented in 2015 and initially focused on quality improvement initiatives and CMM for chronic conditions (e.g., cardiovascular disease, type 2 diabetes mellitus, respiratory disease). Patients were identified for CMM through a primary care provider referral or by manual enrollment by the clinical pharmacist based on internal reporting for metrics such as A1c &gt;10% and blood pressure greater than 140/90 in office.</p> <p>By 2018, quality improvement and cost saving data from national, state and local primary care value-based initiatives allowed the program to expand to consist of 4.5 FTE pharmacists providing whole-person centered CMM. Pharmacists continue to assist with patient-centered CMM within interdisciplinary teams that align with organizational goals.<sup>1,2</sup> In 2019, the department expanded further with the launch of the ASHP-accredited PGY-2 residency.</p>
<b>Results &amp; Achievements</b> <b>Focus on the Quadruple Aim:</b> <ul style="list-style-type: none"> <li>▪ <i>Better Outcomes</i></li> <li>▪ <i>Cost Savings</i></li> <li>▪ <i>Patient Satisfaction &amp; Engagement</i></li> <li>▪ <i>Clinician Satisfaction</i></li> </ul>	<p><b>Better Outcomes</b><sup>1-3</sup></p> <ul style="list-style-type: none"> <li>■ Post CMM intervention, identification of medication-related problems led to increased safety and better care. The clinical pharmacists completed 1,119 CMM reviews in 953 unique patients, from March 2021 to June 2022, the following outcomes were identified: <ul style="list-style-type: none"> <li>▪ A medication-related problem (MRP) was identified in 78% of reviews <ul style="list-style-type: none"> <li>- Most common identified MRP was therapy needed, not currently prescribed (21%), followed by patient not taking medication due to cost (19%)</li> </ul> </li> </ul> </li> </ul> <p style="text-align: right;"><i>continued</i></p>

<p><i>continued</i> <b>Results &amp; Achievements</b></p>	<ul style="list-style-type: none"> <li>■ In a population of 196 patients receiving CMM from March 2021 to June 2022, the following diabetes-related outcomes were identified:             <ul style="list-style-type: none"> <li>- A1c was reduced in 94.6%</li> <li>- Average reduction in Hemoglobin A1c was 2.4%</li> <li>- Indicated therapy (statin, ACE inhibitor) was recommended to be added in 52 patient cases</li> <li>- Diabetic retinopathy screenings were recommended 91 times and microalbumin screening were recommended 53 times</li> </ul> </li> </ul> <p><b>Cost Savings</b><sup>1-3</sup></p> <ul style="list-style-type: none"> <li>■ Lower cost medications were recommended in 158 of 1,119 CMM reviews</li> </ul> <p><b>Clinician Satisfaction</b><sup>1-3</sup></p> <ul style="list-style-type: none"> <li>■ Of the 975 total CMM review recommendations, 97.2% were accepted by providers and 2.8% were declined</li> </ul>
<p><b>Patient Success Story</b></p>	<p>At CCP, a 56-year-old male was referred to the clinical pharmacist for CMM by his primary care provider. The patient had a past medical history of type 2 diabetes, hyperlipidemia, non-alcoholic steatohepatitis and obesity. The patient’s A1c at time of referral was 16.1%, and he was on a diabetic regimen of metformin IR 500 mg twice daily. This was a new diagnosis of diabetes and the patient had not previously taken any diabetic medications.</p> <p>Through CMM visits, the clinical pharmacist educated him on medication use, lifestyle modifications (diet/exercise) and worked with the physician to adjust the medication regimen over time to a final regimen of metformin IR 1000 mg twice daily and insulin glargine 35 units daily. He was also initiated on a statin and an angiotensin converting enzyme inhibitor (ACEi) for cardiovascular risk reduction. In three months, his A1c decreased by 6.7% and he demonstrated an improved adherence to his medication plan.</p>
<p><b>Team-Based Care Strategy</b></p>	<ul style="list-style-type: none"> <li>■ <b>Interprofessional Team Roles:</b> <ul style="list-style-type: none"> <li>■ Clinics are staffed by physicians, physician assistants, nurse practitioners, behavioral health specialists, nurses and clinical pharmacists</li> <li>■ Learners in the clinics include medical residents, nursing students, pharmacy residents and pharmacy students</li> <li>■ An integrated care team consisting of pharmacists, nurse care managers and care coordinators cover clinics on site or remotely</li> <li>■ Practitioners collaborate with clinical pharmacists to identify and enroll medically complex patients for CMM</li> </ul> </li> <li>■ <b>Role of the Clinical Pharmacist:</b> <ul style="list-style-type: none"> <li>■ Pharmacists are currently unable to enter collaborative practice agreements (CPAs) due to current New York State Pharmacy Law, but this has not inhibited medication optimization through CMM because of the high medication recommendation acceptance rates</li> <li>■ Direct collaboration with practitioners and standardized protocols allows the clinical pharmacist to provide CMM services</li> <li>■ Pharmacists also identify and address targeted HEDIS measure gaps (e.g., statins for those with type 2 diabetes)</li> </ul> </li> </ul> <p style="text-align: right;"><i>continued</i></p>

<p><i>continued</i></p> <p><b>Team-Based Care Strategy</b></p>	<p>■ <b>Care Delivery Modality</b></p> <ul style="list-style-type: none"> <li>▪ Visits are conducted in-person and via telehealth for approximately 15-30 minutes</li> <li>▪ Care plans and practitioner communication are documented via electronic health record</li> <li>▪ Patient interactions and outcomes are tracked in a third-party data management application</li> <li>▪ Clinical pharmacist ensures scheduling of patients for follow-up visits with the appropriate clinician (e.g., physician, pharmacist)</li> <li>▪ Appointments are scheduled at various frequencies depending on clinical appropriateness (e.g., weekly, bi-weekly, monthly) increasing patient access to clinical services</li> </ul>
<p><b>Patient Referral Criteria</b></p>	<p>■ <b>Eligible Patients:</b> Patients are referred for CMM by their primary care provider or they are identified by the clinical pharmacist as high-risk based on internal reports identifying patients based on key factors (A1c &gt;10% or blood pressure &gt;140/90 mmHg).</p> <ul style="list-style-type: none"> <li>▪ The clinical pharmacist meets with patients who do not meet disease state marker goals (e.g., A1c, blood pressure) to provide CMM, and works with the physician and interprofessional care team as the medication expert focusing on improving therapeutic outcomes and quality of life.</li> </ul>
<p><b>Size of CMM Program</b></p>	<p><b>Number of:</b></p> <ul style="list-style-type: none"> <li>■ <b>Clinical Pharmacists:</b> 4             <ul style="list-style-type: none"> <li>▪ Clinical Pharmacist FTE: 3.5</li> </ul> </li> <li>■ <b>Pharmacy Residents:</b> 1</li> <li>■ <b>Nurse Care Managers:</b> 10</li> <li>■ <b>Care Coordinators:</b> 3</li> <li>■ <b>Practice Sites:</b> 28 primary care clinic sites</li> <li>■ <b>Support Staff:</b> Clerical staff and students assist with both physician and pharmacist appointments</li> <li>■ <b>Unique Patients Using Services:</b> 294 patients (as of June 16, 2022)</li> </ul>
<p><b>Program Success Factors</b></p>	<p>■ <b>Convenient Patient Access and Simple Program Entry</b></p> <ul style="list-style-type: none"> <li>▪ Identification of high-risk patients to benefit from CMM services (e.g., comorbid conditions, polypharmacy/medication complexity, physician selection, referral)</li> <li>▪ Multiple care delivery modalities (e.g., in-person, telemedicine)</li> <li>▪ In-person and telehealth appointments for patients at no-cost</li> </ul> <p>■ <b>Demonstrate Efficiency and Effectiveness of Interprofessional Team-Based Care</b></p> <ul style="list-style-type: none"> <li>▪ High-risk patients are identified either by practitioners or pharmacist review of medical records</li> <li>▪ Collaboration between the interdisciplinary care team (including the clinical pharmacist) eases primary care provider workload</li> </ul> <p style="text-align: right;"><i>continued</i></p>

<p><i>continued</i> <b>Program Success Factors</b></p>	<ul style="list-style-type: none"> <li>■ <b>Demonstrate and Articulate CMM's Value</b> <ul style="list-style-type: none"> <li>▪ Continued return on investment studies with positive results</li> <li>▪ Meaningful and experiential learning opportunities for advanced pharmacy practice experience students</li> <li>▪ Measuring and reporting outcomes to sustain program viability</li> </ul> </li> <li>■ <b>Expanded Roles and Responsibilities of the Pharmacist</b> <ul style="list-style-type: none"> <li>▪ Organization-approved treatment workflows and protocols</li> <li>▪ Consistent care process and follow-up</li> <li>▪ Utilization of all staff effectively for interdisciplinary collaboration so the practitioner can focus on patient care</li> </ul> </li> </ul>
<p><b>Next Steps, Future Goals</b></p>	<ul style="list-style-type: none"> <li>■ <b>Next Steps</b> <ul style="list-style-type: none"> <li>▪ Expand interprofessional collaboration throughout more primary care offices within CCP to resolve medication therapy problems targeting populations not achieving therapeutic goals (e.g., weight loss, asthma controller inhalers)</li> <li>▪ Provide CMM services within specialty care (e.g., pediatrics, endocrinology, rheumatology, OBGYN)</li> <li>▪ Administration and interpretation of professional continuous glucose monitoring which may open opportunity for billing for services and closer diabetes management</li> <li>▪ Completion of annual Medicare wellness visits</li> </ul> </li> <li>■ <b>Opportunities for Program Improvement</b> <ul style="list-style-type: none"> <li>▪ Align financial incentives</li> <li>▪ Improve practitioner awareness of CMM</li> <li>▪ Standardize efficacy measurements for non-diabetes conditions</li> </ul> </li> </ul>
<p><b>References</b></p>	<ol style="list-style-type: none"> <li>1. Acuitas Health, LLC. (2022). Pharmacy Services Diabetes Management 2022-4-1. Internal Community Care Physicians report: unpublished</li> <li>2. Acuitas Health, LLC. (2022). Pharmacy Services Assessment 2022-4-1. Internal Community Care Physicians report: unpublished</li> <li>3. Acuitas Health, LLC. Pharmacoeconomics 2022-4-1. Internal Community Care Physicians report: unpublished</li> </ol> <p>At this time, the data shared is not yet published. Feel free to reach out to those listed in the 'program contact information' if you have any questions.</p> <p style="text-align: right;"><i>continued</i></p>

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<p><i>continued</i> <b>References</b></p>	<p>Additionally, below are papers and posters that came out of Community Care Physicians that may be of interest to you:</p> <ul style="list-style-type: none"><li>▪ Crocetta N, Guay K, Watson A. Evaluation of a pharmacist's impact on the use of glucagon-like peptide-1 receptor agonists for weight management in a family medicine setting. <i>Fam Pract</i>. October 2022. doi: 10.1093/fampra/cmac110.</li><li>▪ Murray B, Watson A. Reimbursement for clinical services provided by ambulatory care pharmacists via telehealth. <i>JACCP</i>. June 2021. <a href="https://doi.org/10.1002/jac5.1483">https://doi.org/10.1002/jac5.1483</a>.</li><li>▪ Palazzolo C, Urakath J, Watson A, Yonosko P. 6-126 - Review of low dose aspirin use for primary prevention in patients 70 years and older. <i>ASHP Midyear: Student Posters</i>. 2019. <a href="https://www.eventscribe.com/2019/midyear/fsPopup.asp?efp=TOhGUU9FTKY2NDg0&amp;PosterID=251638&amp;rnd=0.348738&amp;mode=posterinfo">https://www.eventscribe.com/2019/midyear/fsPopup.asp?efp=TOhGUU9FTKY2NDg0&amp;PosterID=251638&amp;rnd=0.348738&amp;mode=posterinfo</a>.</li><li>▪ More information on the clinical pharmacy team at Community Care Physicians: <a href="https://communitycare.com/practices/clinical-pharmacy/">https://communitycare.com/practices/clinical-pharmacy/</a>.</li></ul>
<p><b>Author</b></p>	<p><b>Nicholas Crocetta, Pharm.D.</b> PGY2 Ambulatory Care Pharmacy Resident <a href="mailto:ncrocetta@communitycare.com">ncrocetta@communitycare.com</a> (518) 713-8644</p>
<p><b>Program Contact Information</b></p>	<p><b>Alexandra Watson, Pharm.D., BCACP</b> Ambulatory Care Clinical Pharmacist <a href="mailto:awatson@communitycare.com">awatson@communitycare.com</a> (518) 713-8293</p>
<p><i>Developed by the Best Practices and Innovative Solutions Subgroup of the GTMRx Practice and Care Delivery Transformation Workgroup</i></p>	