MTM IN FQHCS:
Improving Chronic Disease Outcomes
Objectives

- Highlight the value a pharmacist can bring to chronic disease management
- Offer various models of pharmacist engagement in FQHCs
- Describe a coalition being formed across the state to improve chronic disease management in FQHCs through MTM
Medication Therapy Management

Otherwise known as “MTM”
Medication Therapy Management

A service or group of services that optimizes therapeutic outcomes for individual patients. The service is provided by pharmacists, the medication experts on the health care team.
Integrated Medication Management

10 Elements for Integrated Medication Management

Patient Safety and Clinical Pharmacy Services Collaborative supported by HRSA and The Alliance for Integrated Medication Management 2009-2014
Why MTM

- An estimated 15% of the U.S. population (some 46 million people) are high-risk, high-cost, medically complex patients:
  - multiple chronic health conditions
  - multiple and sometimes dangerous medications
  - multiple health care providers
  - experience barriers to accessing care
  - poorly adhere to medication regimens.

Why MTM

- **Uncoordinated** medication management accounts for more than 30% of total health care costs.

- Reform efforts aimed at these high-risk patients could save over $240 billion per year.

To Err is Human: Building a Safer Health System, The Institute of Medicine Nov 1999  [http://www.IOM.edu](http://www.IOM.edu)
Ohio Population Improvement with MTM

Data Source: Self-reported data.

ADE Project: 5 Ohio Teams, CMS Patients
Supporting MTM

- Caresource
  - Pharmacist Providing Services
  - Direct Reimbursement
  - Healthier Patients
  - Lower Overall Healthcare Spending

Shared Savings = PATIENT WINS
MTM in Ohio FQHCs
Patient Story

Impact of the Pharmacist in Patient Care

VIDEO
Project Overview
Role of Public Health in MTM

- CDC publication released in August 2012
- Identified opportunities for public health to engage new partners to improve management of HTN and diabetes
- In February 2013, CDC issued new RFP to fund state public health chronic disease programs
Domain 3: Health System Interventions

- Increase use of team-based care in health systems
  - Increase engagement of non-physician team members, i.e., nurses, pharmacists, and patient navigators, in HTN and diabetes management in the health care system

- 34% of Ohioans have HTN. Control rates not optimal. Only 50% of diagnosed patients are <140/90.

- 10% of Ohioans have diabetes; 14% of African-Americans;

- Prevalence and mortality from HTN and diabetes higher in minority populations

- Heart disease, stroke and diabetes are among leading causes of death in Ohio
Forming MTM Collaborative

- Initial meeting with OPA in February 2013
- Quickly engaged OSU College of Pharmacy, Ohio Association of Community Health Centers and FQHCs, Ohio KEPRO
- Submitted application to CDC mid-March, funded beginning 6/30/13
- MTM Collaborative began meeting in July 2013 to develop framework for Collaborative
Purpose & Goals

To expand medication therapy management (MTM) provided by pharmacists to patients cared for in Federally-qualified Health Centers (FQHCs) in Ohio to reduce the burden of chronic disease.

- **Primary aims** include increasing the number of FQHC patients with a/an:
  - A1C in control, defined as <9%
  - Blood pressure in control, defined as <140/90 mmHg
  - Diabetes composite control, defined as A1C, BP, and LDL in control

- **Secondary aims** include increasing the number of FQHC patients:
  - Seen by pharmacists and details on Medication-related Problems (MRPs), Adverse Drug Events/potential Adverse Drug Events (ADEs/pADEs), including cost avoidance
  - With access or referral to chronic disease or diabetes self-management education programs
# Project Timeline

<table>
<thead>
<tr>
<th>Dates</th>
<th>Activities</th>
</tr>
</thead>
</table>
| Fall 2013            | • Identify pilot sites  
                       |      • Connect with colleges of pharmacy                                     |
| January 2014         | • Gather baseline data from sites                                           |
|                      |      • Conduct orientation                                                  |
|                      |      • All sites enroll in PSPC                                              |
| February-March 2014  | • Finalize model at individual sites                                        |
|                      |      • Present to individual site staff                                     |
|                      |      • Identify patient population                                           |
| April-December 2014  | • Recruit and engage patients                                               |
|                      |      • Report data monthly to PSPC                                           |
|                      |      • Participate in monthly conference calls and quarterly in-person meetings|
| Phase II             | • Share optimized models and data from pilot sites & encourage adoption of these models statewide |
The Patient Safety and Clinical Pharmacy Services Collaborative

**PSPC AIM:**
Inter-professional teams that improve the health outcomes and safety for high medication risk populations through patient-centered, cost-effective medication management services aligned with quality national standards.

**PSPC’s vision:**
To engage 3,000 communities in the US who will have integrated care teams that will ensure optimal health outcomes and safety for every patient.

*In our 5th year (2012-2013), we had over 380+ community based teams from 49 states + DC, PR and VI participate!*
Over 25,000 Patients are in PSPC PoF’s with 57% of Teams Showing Improvement on the Health Status Marker Thru August 2013. Over 17,000 patients have achieved goal on their health status.

<table>
<thead>
<tr>
<th>Condition</th>
<th># of Teams</th>
<th># of PoF's</th>
<th># of Patients in PoF</th>
<th>Average Size of PoF</th>
<th>Number of Patients Under Control</th>
<th>% of PoF Under Control</th>
<th># of PoF's Showing Improvement</th>
<th>% of PoF's Showing Improvement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticoagulation</td>
<td>124</td>
<td>151</td>
<td>7,828</td>
<td>51.8</td>
<td>5,196</td>
<td>66.4%</td>
<td>80</td>
<td>53.0%</td>
</tr>
<tr>
<td>Antipsychotic</td>
<td>140</td>
<td>140</td>
<td>6,224</td>
<td>44.5</td>
<td>4,376</td>
<td>70.3%</td>
<td>73</td>
<td>52.1%</td>
</tr>
<tr>
<td>Asthma</td>
<td>1</td>
<td>1</td>
<td>50</td>
<td>50.0</td>
<td>25</td>
<td>50.0%</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Depression</td>
<td>2</td>
<td>2</td>
<td>15</td>
<td>7.5</td>
<td>1</td>
<td>6.7%</td>
<td>1</td>
<td>50.0%</td>
</tr>
<tr>
<td>Diabetes</td>
<td>150</td>
<td>177</td>
<td>8,784</td>
<td>49.6</td>
<td>6,442</td>
<td>73.3%</td>
<td>113</td>
<td>63.8%</td>
</tr>
<tr>
<td>Dyslipidemia</td>
<td>7</td>
<td>7</td>
<td>566</td>
<td>80.9</td>
<td>287</td>
<td>50.7%</td>
<td>3</td>
<td>42.9%</td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td>1</td>
<td>1</td>
<td>14</td>
<td>14.0</td>
<td>10</td>
<td>71.4%</td>
<td>1</td>
<td>100.0%</td>
</tr>
<tr>
<td>Hypertension</td>
<td>10</td>
<td>10</td>
<td>1,776</td>
<td>177.6</td>
<td>1,067</td>
<td>60.1%</td>
<td>7</td>
<td>70.0%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>435</strong></td>
<td><strong>489</strong></td>
<td><strong>25,257</strong></td>
<td><strong>51.7</strong></td>
<td><strong>17,404</strong></td>
<td><strong>68.9%</strong></td>
<td><strong>279</strong></td>
<td><strong>57.1%</strong></td>
</tr>
</tbody>
</table>

Note: Individual Teams may be managing multiple populations of focus. 1 Team managing 3 Populations of Focus will be counted as 3 Teams. 1 Team also be submitting data for CMS PoFs and PSPC PoFs.
Support & guide the Collaborative Teams in their work

Support a platform (the Healthcare Communities Portal) for teams and provide other communication strategies to keep teams connected to and learning from the faculty and other teams

Offer coaching to organizations at Learning Sessions and the Action Periods through telephone and conference calls, email, and listserv communications

Provide information on subject matter, application of that subject matter, & methods for process improvement both during and between Learning Sessions

Mobilize state and national quality, safety, health, pharmacy and other organizations to support the work of teams
Data Reporting

- pADE/ADE reporting

**MEDICATION RELATED PROBLEM (MRP)**

**Appropriateness and Effectiveness**
- Untreated medical problem
- Drug dosing not adequate for treatment goals (dose, interval, or duration)
- Treatment not optimal based on current evidence/guidelines
- Monitoring standards not being followed

**Safety (pADE / ADE)**
- Drug dosing excessive for treatment goals (dose, interval, or duration)
- Incomplete/improper directions
- No indication for medication prescribed
- Polypharmacy (Rx not needed)/duplication
- Contraindication
- Adverse drug reaction (ADR)
- Allergy
- Drug interaction
- Lab/diagnostic test indicated, not ordered
- Abnormal lab result not addressed
- Pharmacy/dispensing error
- Medication overdose or misuse
- Dose discrepancy between patient use & prescribed therapy
- Using expired medication

**Nonadherence and Patient Variables**
- Medication underuse/poor adherence
- Dosage form is not reasonable for patient
- Inadequate patient self-management of lifestyle and other non-drug variables
- Patient disinterested or refuses treatment
  - No rational reason given

**Miscellaneous**
- Drug not available in prescribed strength
- Inadequate referrals between scheduled visits
- Nonformulary/no cost effective drug choice
- Illegible prescription
- No follow-up appointment with PCP
- Other

**ADE / pADE CLASSIFICATION**

**Potential Adverse Drug Event (pADE)**
- No med error/event, but potential for ADE identified
- Med error/event did NOT reach patient
- Med error/event reached patient, but no harm
- Med error/event reached patient, monitoring or intervention required to confirm no harm

**Adverse Drug Event (ADE)**
- Event occurred, resulting in temporary harm and requiring intervention
- Event occurred, resulting in temporary harm and requiring hospitalization
- Event occurred, resulted in permanent harm/diability
- Event occurred, life-threatening
- Event occurred, resulted in death

**pADE SEVERITY RATING**

- Potential for minimal (would require patient self-management) or no harm
- Potential for moderate harm (would require healthcare professional intervention or hospitalization to resolve)
- Potential for severe harm (permanent disability or death)

**ACTION / INTERVENTION**

1. DC drug(s)
2. Substitute drug(s)
3. Add drug(s)
4. Change dose/dose interval
5. Change duration of rx/qty
6. Change PRN to schedule
7. Change schedule to PRN
8. Order lab/diagnostic test
9. Educate patient
10. Refer to other service
11. Clarify Rx
12. Substitute dosage form
13. Make apt w/provider
14. Provide Rx compliance box
15. Other

State Pilot Support
Our Team

Alexa Sevin, PharmD
Clinical Pharmacist, CNHC
PGY2 Resident, The Ohio State University

Kelly Wright, PharmD, BCACP
Clinical Pharmacist, CNHC
Assistant Professor, Cedarville University

Parminder Bajwa, MD, MBA, DBA
Director of Clinical Excellence & Performance Improvement, CNHC

Aditi Ghose, PharmD
Clinical Pharmacist, CNHC

Clinton Scott, CPhT
Pharmacy Technician, CNHC
**PoC:** # patients at the service site (FQHC site):

24, 941

**PoS:** # patients in PoC diagnosed with HTN and/or T2DM:

5,733

<table>
<thead>
<tr>
<th># patients with HTN:</th>
<th>4756</th>
</tr>
</thead>
<tbody>
<tr>
<td># patients with T2DM:</td>
<td>2794</td>
</tr>
</tbody>
</table>

**PoS Out of Control:**

2,527

<table>
<thead>
<tr>
<th># Diabetic Patients with A1C &gt; 9%:</th>
<th>600</th>
</tr>
</thead>
<tbody>
<tr>
<td># HTN Patients with BP &gt; 140/90:</td>
<td>2088</td>
</tr>
</tbody>
</table>
Pharmacy Services:
- Medication Therapy Management
- Disease management (diabetes, hypertension, dyslipidemia, asthma, COPD, tobacco cessation)
- Pain management
- Monthly CME in-service
- Spirometry
- Medication Access Program
- 340B pharmacy & contracted pharmacies
- Vaccination
- In progress: transition of care
AxessPointe Team

- Magdi Awad, PharmD
  - Director of Pharmacy Services

- Nicole Stone, PharmD
  - PGY1 Resident
Population of Focus

PoC: # Population of Care

PoS: # Population of Service

High Risk PoS: # PoS out of control

PoF: # Population of Focus

All patients served by organization
12663

Patients (18-75) with
HTN 2686
T2D 814

Patients in PoS out of control
BP≥140/90: 587
A1C>9: 337

Study Population
Health Partners of Western Ohio
Dr. Gene Wright Community Health Center

“To eliminate gaps in health outcomes for all members of our community by providing access to quality, affordable, preventive and primary health care.”

Jennifer Clark, RPh, Director of Pharmacy Services
Kyle Glasgow, PharmD, BCACP, Clinical Pharmacy Manager
Josh Ebbing, PharmD, PGY1 Pharmacy Resident

University Partners:
University of Findlay College of Pharmacy
Ohio Northern University Raabe College of Pharmacy
Risk: CPS Consult
Chronic Disease Managed w/Meds

PoF=controlled w/risk or uncontrolled w/low risk
• Med reconciliation
• Group education
• Enabling services
• Care transitions
• Evaluate Relative Risk (=>5 meds, =>2 CC, >1 Provider)

1 CPS visit per year

High Risk: CPS Triage

PoF=high risk
(=>5 meds, =>2 CC, >1 Provider)
• Highlighted in team huddle
• Intervention w/ PCP visit
• CPS Action Plan
• Integrated follow-up

3 CPS visits per year

Very High Risk: CPS Clinic

PoF=uncontrolled high risk / high utilization
• Disease Management
• CPS Care Plan
• Integrated Team Review
• Continued Follow Up

8 CPS visits per year
OHIO Consortium

Faculty/Colleges of Pharmacy

Students, Residents
Trainees

Pharmacists/Pharmacies

MEDICATION THERAPY
MANAGEMENT (MTM)

FQHCs

Ohio Department of Health Programs
Community Health Resources

Improve Chronic Disease Outcomes for Ohioans
MTM IN FQHCS:
Improving Chronic Disease Outcomes