Primary Care and Community Health Reforms (PCCHR) Workgroup Meeting

February 23, 2021

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Agenda

Welcome, Roll Call, and Housekeeping Items	Lesley Bennett, Chair	1:00 PM
Public Comment	Members of Public	1:05 PM
Approval of the January 26th Meeting Minutes—Vote	Members of PCCHR	1:10 PM
Connecticut's Healthcare Benchmark Initiatives	Michael Bailit, Bailit Health	1:15 PM
Chronic Medication Management Models	Marie Smith, PharmD, FNAP University of Connecticut	1:50 PM
Facilitated Discussion—Guiding Principles	Don Ross, CedarBridge	2:20 PM
Next Steps	Don Ross, CedarBridge	2:50 PM
Meeting Adjournment	All	3:00 PM

Roll Call

Public Comment

(2 minutes per person)

Approval of January Meeting Minutes

Connecticut's Healthcare Benchmark Initiative
Presentation to the Primary Care and Community Health Reforms Work Group
February 23, 2021

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Welcome Remarks

Agenda

Topics
Background
Healthcare Affordability and Quality in Connecticut
Connecticut's Healthcare Benchmark Initiative
Advisory Body Guidance for PCCHR
OHS' Charge to the PCCHR
Questions and Discussion

Background

Connecticut's Executive Order #5

1	**Cost Growth Benchmark**	Recommendations for a cost growth benchmark that covers all payers and all populations for 2021-2025.
2	**Primary Care Spend Target**	Recommendations for getting to a 10% primary care spend as a share of total healthcare expenditures by CY 2025, applied to all payers and populations.
3	**Data Use Strategy**	A complementary strategy that leverages the state's APCD, and potentially other sources, to analyze cost and cost growth drivers, and more.
4	**Quality Benchmarks**	Recommendations for quality benchmarks applied to all public and private payers, effective 2022.

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Technical Team Members

- **Rebecca Andrews –** American College of Physicians CT
- **Zack Cooper –** Yale University
- **Judy Dowd –** Office of Policy and Management
- **Paul Grady –** Connecticut Business Group on Health
- **Angela Harris –** Phillips Metropolitan CME Church
- **Paul Lombardo –** Insurance Department
- **Pat Baker –** Connecticut Health Foundation (retired)
- **Luis Perez –** Mental Health Connecticut
- **Rae-Ellen Roy –** Office of the State Comptroller
- **Vicki Veltri –** Office of Health Strategy

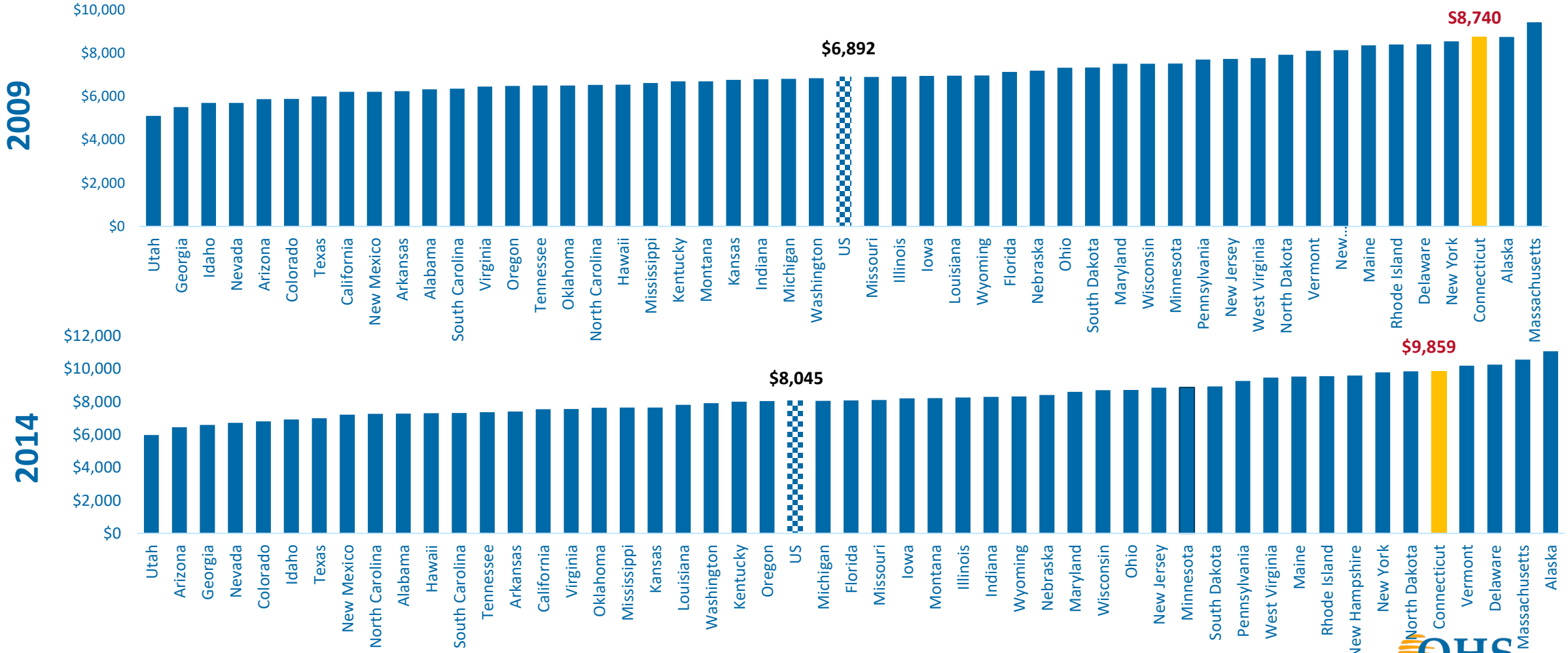
Stakeholder Advisory Board Members

- **Vicki Veltri –** Office of Health Strategy
- **Reginald Eadie –** Trinity Health of NE
- **Kathy Silard –** Stamford Health
- **Theresa Riordan –** Anthem BCBS of CT
- **Rob Kosior -** ConnectiCare
- **Richard Searles –** Merritt Healthcare Sol.
- **Ken Lalime -** CHCACT
- **Margaret Flinter –** Community Health Ctr
- **Karen Gee –** OptumCare Network of CT
- **Marie Smith –** UConn School of Pharmacy
- **Tekisha Everette –** Health Equity Solutions
- **Pareesa Charmchi Goodwin –** CT Oral Health Initiative
- **Howard Forman –** Yale University
- **Nancy Yedlin –** Donaghue Foundation
- **Fiona Mohring –** Stanley Black and Decker
- **Lori Pasqualini –** Ability Beyond
- **Sal Luciano –** CT AFL-CIO
- **Hector Glynn –** The Village for Fam & Children
- **Rick Melita –** SEIU CT State Council
- **Ted Doolittle –** Office of the Healthcare Adv
- **Susan Millerick -** patient representative
- **Kristen Whitney-Daniels -** patient representative
- **Jonathan Gonzalez-Cruz -** patient representative
- **Jill Zorn -** Universal Health Care Foundation

Healthcare Affordability and Quality in Connecticut

Connecticut is one of the states that spends the most on healthcare…

Personal healthcare spending, per capita, by state, 2009 and 2014



Source: Centers for Medicare and Medicaid Services, State Health Expenditure Accounts, 2009 and 2014

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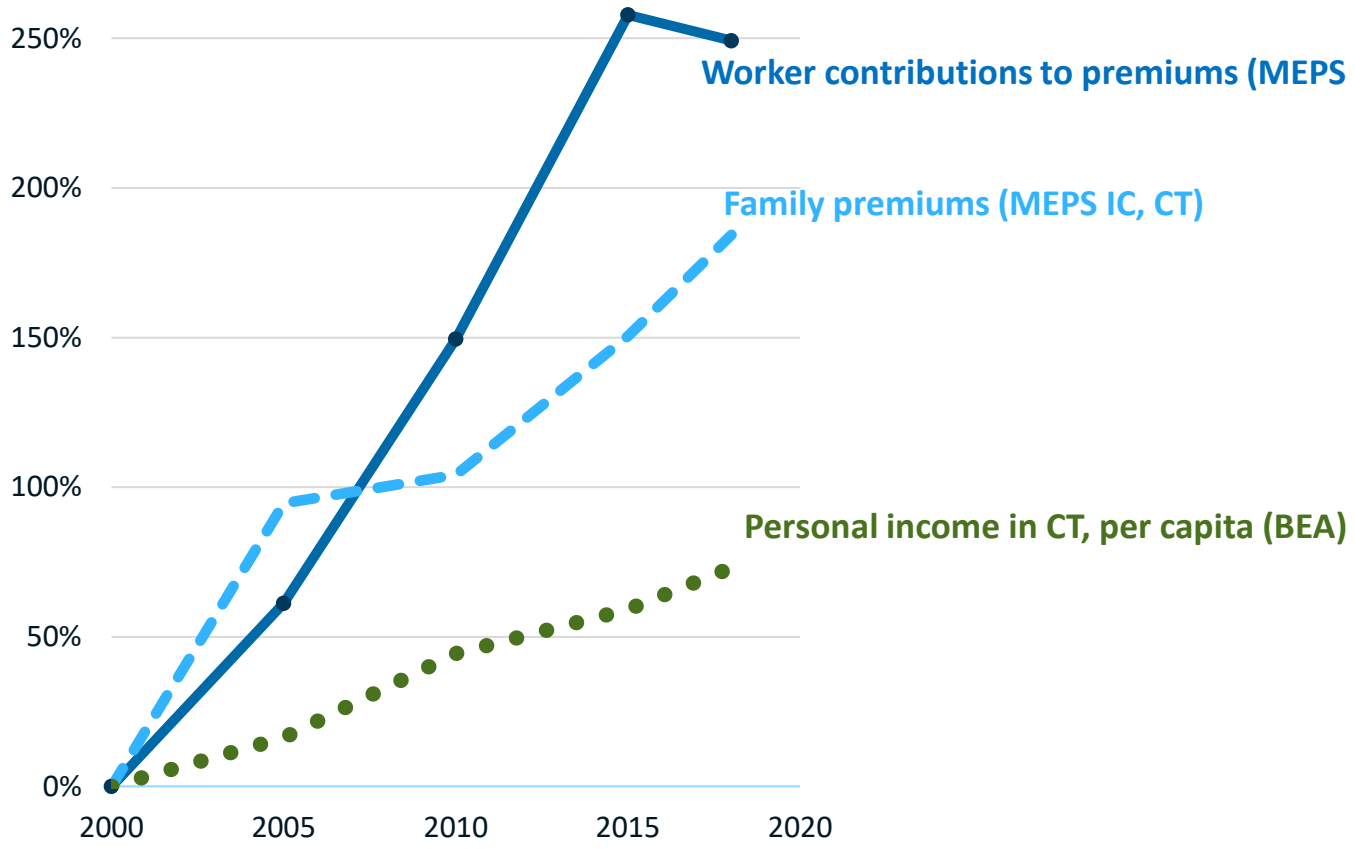
Healthcare remains unaffordable to many

Since 2000, Connecticut employer-sponsored insurance premiums have grown **two and half times** faster than personal income



Source: Medical Expenditure Survey, Tables D.1 and D.2 for various years

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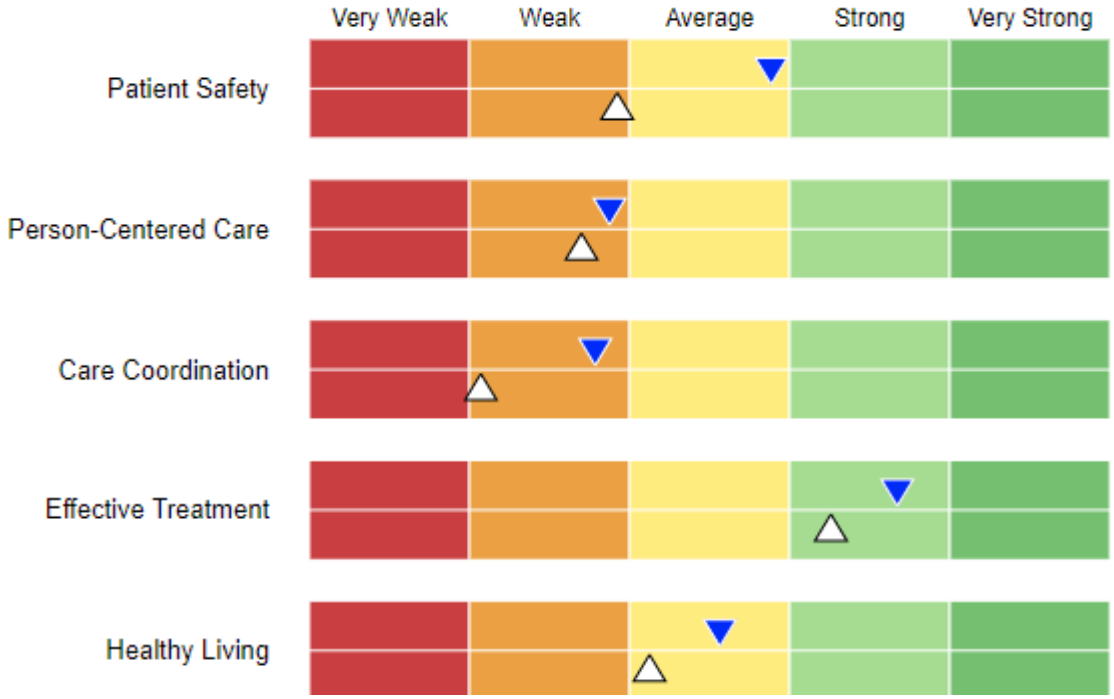
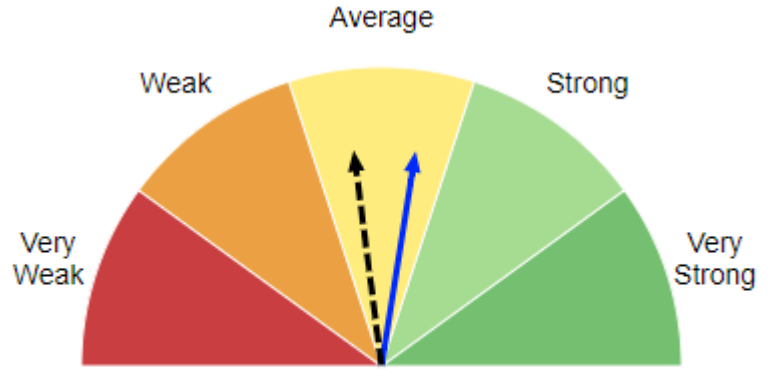
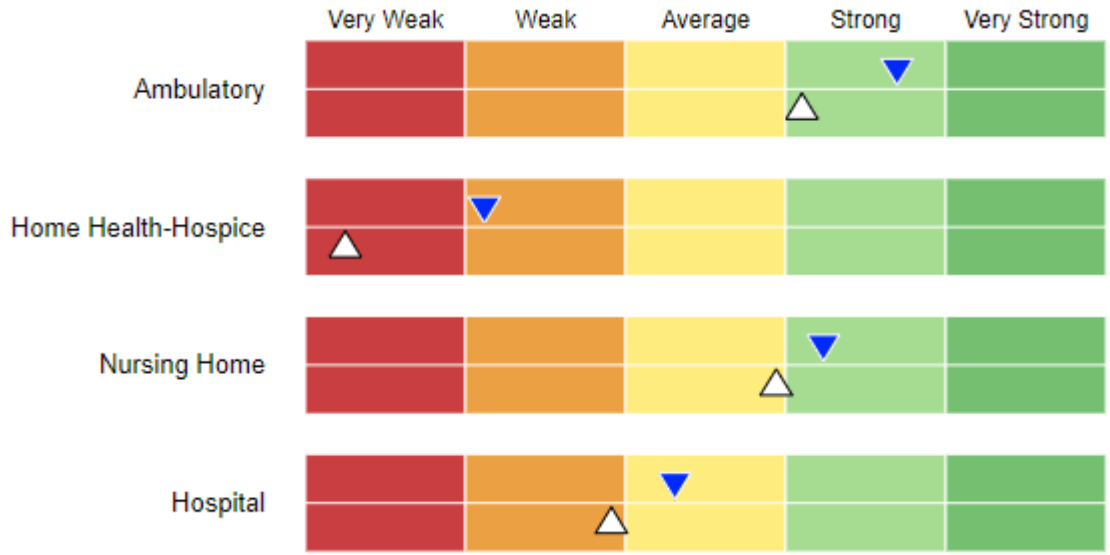
National Healthcare Quality and Disparities Report

Overall, Connecticut's quality is in the "average" range compared to other states and has opportunity for improvement in several key categories of quality measurement.



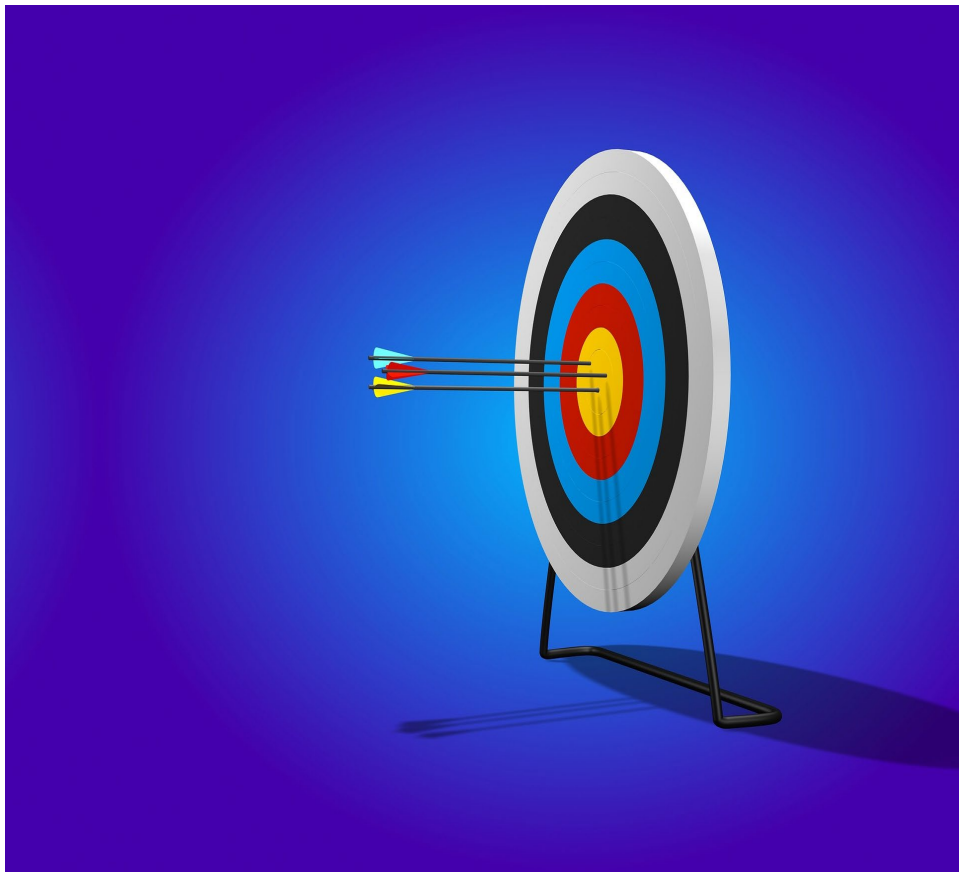




Source: AHRQ. Measurement time period varies by measure. Blue arrows indicate performance most often between 2015-2017 and white arrows indicate performance from 2000-2012. https://nhqrnet.ahrq.gov/inhqrdr/Connecticut/dashboard

Healthcare Cost Growth Benchmark

Healthcare Cost Growth Benchmark



- A per annum rate-of-growth target for healthcare costs in a state. Captured spending includes:
  - Insurer and consumer-paid spending for all covered services, including pharmacy
  - Non-claims spending made to providers from health plans
  - Net Cost of Private Health Insurance (insurer admin and margin)

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Alignment with Other States

- While customized for Connecticut, the recommended cost growth benchmark methodology is aligned with those adopted by Delaware, Massachusetts, Oregon and Rhode Island.

Setting Connecticut's Cost Growth Benchmark

The Technical Team recommended that the cost growth benchmark use a **20/80 weighting of the growth in CT Potential Gross State Product and growth CT Median Income**.

The resulting benchmark value was **2.9%**.

The Technical Team recommended increasing the benchmark value for the first two years, before settling at 2.9% for the latter years.

2021 (Base Value + 0.5%)	3.4%
2022 (Base Value + 0.3%)	3.2%
2023–2025 (Base Value)	2.9%

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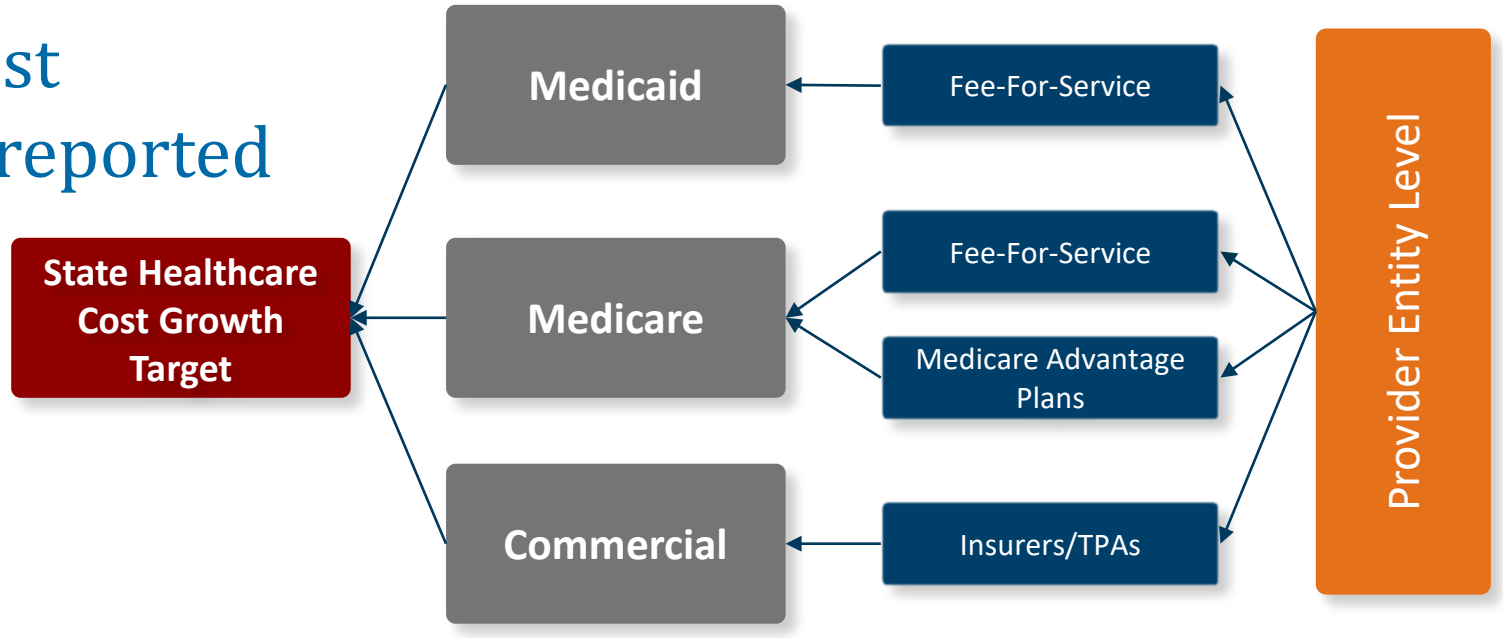
Connecticut's Cost Growth Benchmark

- The Technical Team recommended that aggregate spending data be **collected from payers** because the APCD lacks self-insured data, non-claims-based payments, and drug rebate data. This is the approach that has been taken by all other states.
- The Technical Team responded to Stakeholder Advisory Board concerns about a potential risk of future underservice by recommending the development of additional **monitoring strategies**.
  - OHS has developed a set of recommended monitoring measures with stakeholder input.

Cost Growth Benchmark Reporting Levels

As in DE, MA, OR and RI, performance against the cost growth benchmark will be reported at four levels:

1. State
2. Market
3. Insurer
4. Provider Entity



OHS will report per capita change in spending from one calendar year to the next, along with any contextual information that highlights known reasons spending was above or significantly below benchmark.

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Quality Benchmarks

What are Quality Benchmarks?

- Quality benchmarks are targets which all public and private payers, providers and the State must work to achieve to maintain *and improve* healthcare quality in the state.
- Quality benchmarks may include clinical quality measures, under- and over-utilization measures, and patient safety measures.
- Connecticut will be the second state to have statewide quality benchmarks. (Delaware was the first.)
- OHS' Quality Council will develop recommendations during the summer for 1-1-22 adoption.

Data Use Strategy

Data Use Strategy

- OHS contractor Mathematica recently delivered its initial data use strategy analysis of commercial insurance market cost drivers and cost growth drivers in Connecticut (2015-2018) using APCD data.
- The purpose of the analysis was to understand patterns in Connecticut health care spending, and thereby perhaps identify potential opportunities to slow spending growth and meet the benchmark (3.4% for 2021).
- OHS will conduct ongoing and additional analyses that are in the Data Use Strategy but were not part of Mathematica's scope of work.
- OHS will make findings public, and then begin to engage stakeholders in leveraging data analysis to inform strategies that will support benchmark and target success.

Primary Care Spending Target

Why Establish a Primary Care Spending Target?

- The U.S. healthcare system is largely specialist-oriented. Research, has demonstrated that greater relative investment in primary care leads to better patient outcomes, lower costs, and improved patient experience of care.

- Some states are strengthening their healthcare systems by:
  - ***supporting improved primary care delivery*** (e.g., expanding the primary care team, supporting advanced primary care model adoption)
  - ***increasing the percentage of total spending that is allocated towards primary care***.

What is a Primary Care Spending Target?

- A primary care spending target is an **expectation for what percentage of healthcare spending should be devoted to primary care.**
- Executive Order 5 establishes the expectation that Connecticut will **increase primary care spending as a percentage of total healthcare spending to 10%** by **2025**.
- There is no penalty for not reaching the annual target.
  - OHS does intend to report on performance at the market and individual payer levels, however.

Connecticut's 2021 Primary Care Spending Target

On the recommendation of its advisory body, OHS has set **the 2021 primary care spending target at 5.0%** for the following reasons:

OHS does not yet have baseline data from payers to identify current primary care spending.

Its best estimate for current spending using prior analyses of APCD data is 4.8%.

COVID-19 has negatively impacted primary care utilization in 2020, and this is likely to continue into early 2021.

Recommendation for the Primary Care Spend Target

- The Technical Team recommended that OHS defer setting targets for 2022-2024 until after it has: a) collected baseline payer data, and b) consulted with the PCCHR Work Group.
- Consistent with the cost growth benchmark, the Technical Team also recommended that OHS report performance against the primary care spending targets for all five years at four levels:
  1. State
  2. Market
  3. Insurer
  4. Provider Entity*

*For entities of a sufficient size.

Advisory Body Guidance on How to Increase Primary Care Spending (1 of 2)

- The Stakeholder Advisory Board expressed interest in the approach undertaken by Rhode Island.
  - Rhode Island wanted its target to encourage innovative contracting and payment as well as primary care system investment.
  - It did not want insurers to simply change rates of reimbursement for specific codes in order to meet its target.
  - Therefore, Rhode Island specified insurers could not increase premiums or engage solely in fee service manipulation to meet the primary care spend target.

Advisory Body Guidance on How to Increase Primary Care Spending (2 of 2)

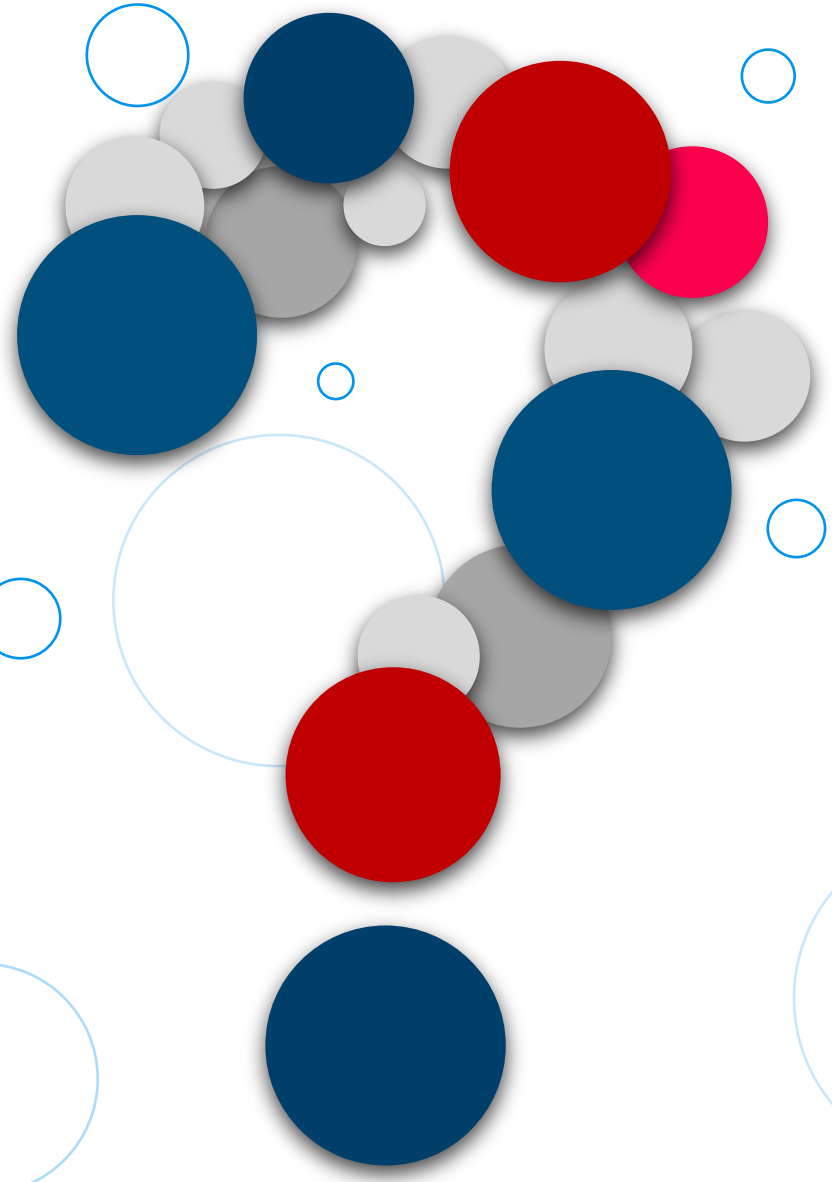
- The Technical Team offered the following suggestions for PCCHR's consideration:
  - Increase spending (1) in alignment with existing statewide initiatives and policies, (2) through increased utilization of value-based incentives and (3) in a way that provides value.*
  - Leverage the increased spending to enhance how primary care is delivered, perhaps guided by the National Alliance of Health Care Purchaser Coalitions recommendations on advancing primary care.**

*Value can be defined as improved quality, increased utilization and access and improved outcomes.
**Includes: enhanced access for patients, more time with patients, realigned payment methods, organization and infrastructure backbone, behavioral health integration, disciplined focus on health improvement and referral management

PCCHR Work Group's Charge and Timeline

- Charge
  - The Technical Team asked the Primary Care and Community Health Reforms Work Group to recommend primary care spend targets for 2022-24.
  - The Technical Team also asked that the PCCHR to consider strategies for investing in primary care that improve access, quality and patient and provider experience.
  - Finally, the Technical Team requested that the PCCHR consider how to approach the creation of a PCP selection requirement.
- Timeline
  - During Q1-Q2 2021, the PCCHR should consider and recommend strategies for investing in primary care, and the creation of a PCP selection requirement.
  - During Q3 2021, the PCCHR should recommend to the Technical Team primary care spend targets for 2022-2024, following completion of the pre-benchmark analysis of 2018-2019 payer spending data.

Questions and Discussion



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Chronic Medication Management Models:
Pharmacists on Expanded Primary Care and Population Health Teams

CT OHS Primary Care and Community Health Reform Work Group

February 23, 2021

UCONN | SCHOOL OF PHARMACY

Introductions

Marie Smith, Pharm.D., FNAP
Henry Palmer Professor - Pharmacy Practice
Assistant Dean - Practice and Policy Partnerships
Email: marie.smith@uconn.edu

Mary Mulrooney, Pharm.D., MBA
Assistant Research Professor
Former Primary Care Pharmacy Transformation Fellow
Email: mary.mulrooney@uconn.edu

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Agenda

Background Info

- Comprehensive Medication Management (CMM)
- Clinical Pharmacist Training/Credentials
- Pharmacist Practice Models

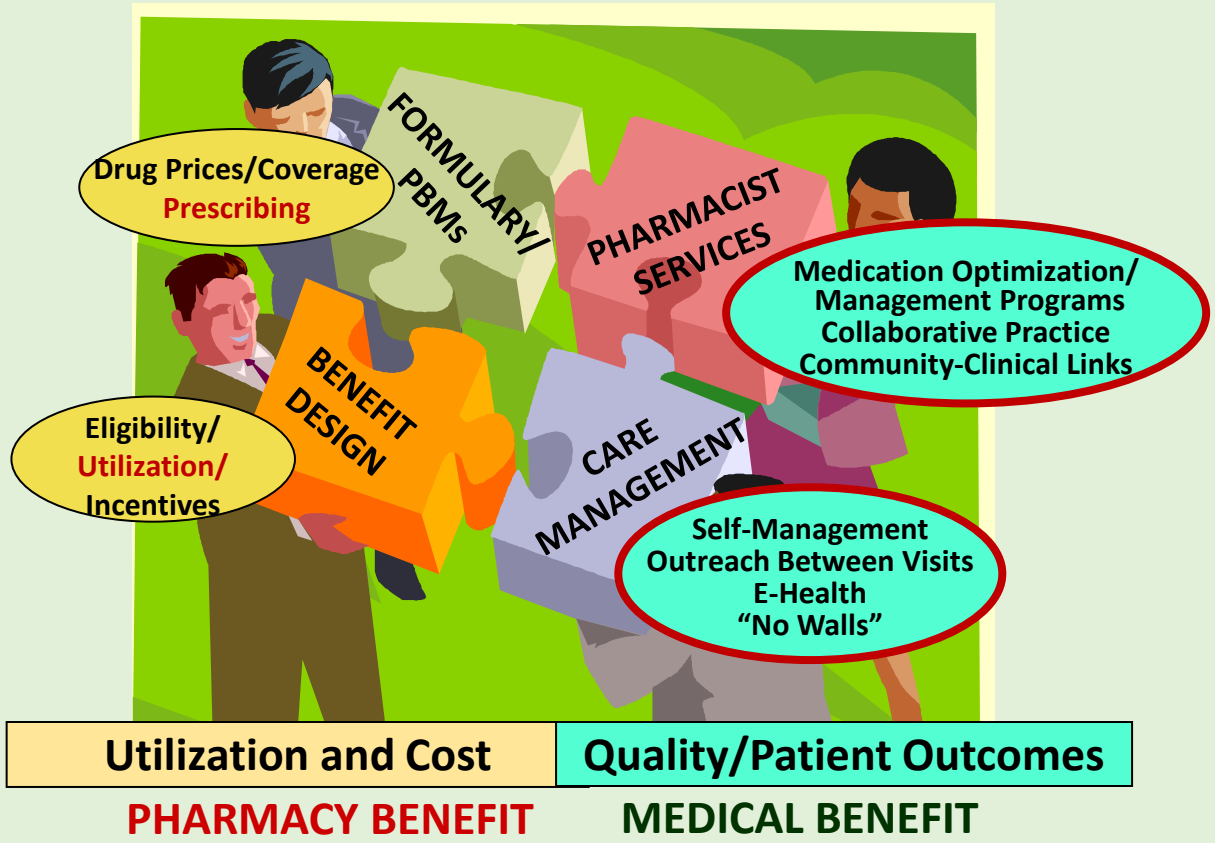
CMM Practice Models in CT

- NEMG: Expanded Primary Care Team Model
- CHC: Population Health Team Model

Lessons Learned

Discussion/Q&A

Value-Based Program Components for Medication Use, Safety, Lower Costs



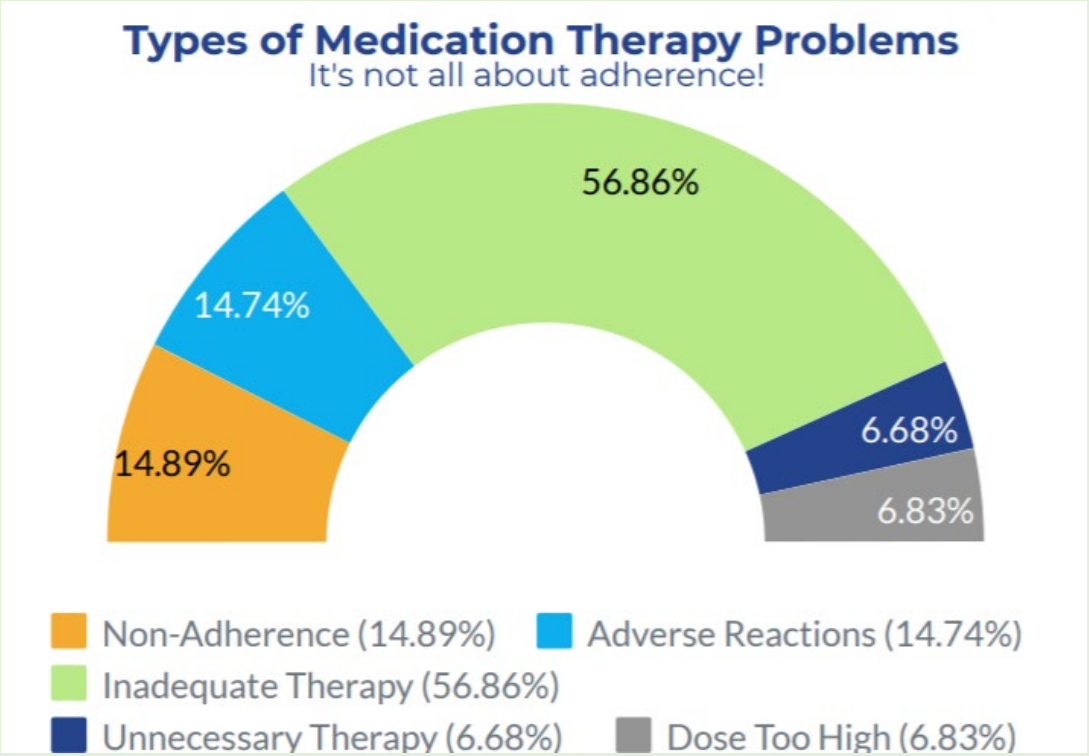
VALUE = [PATIENT OUTCOMES + JOY OF PRACTICE] / TOTAL COST of CARE

- **Value-based programs must incorporate <u>all 4 components</u>**
- **Focus on only Rx costs misses the <u>compounded value</u> of managing appropriate, safe, and cost-effective medication use (team-based care, collaborative practice, patient medication outcomes)**

The Problem:
Non-Optimized Medication Therapy in Primary Care

65% of U.S. adults take **≥1 med**;
22% take **≥5 meds**

Outpatient preventable medication adverse events cost **~$3 billion** annually in the U.S.



Key Message: Suboptimal medication use= 275,000 lost lives and $528B wasted every year!

Sources: National Center for Health Statistic. Prescription Drug Use in the United States, 2015-2016. https://www.cdc.gov/nchs/data/hus/2018/038.pdf
Burton, M.M., Hope, C., Murray, M.D., et al. (2007). The cost of adverse drug events in ambulatory care. AMIA Annu Symp Proc, 90-93.

Get the Medications Right Institute: https://16bvl028dn7zhgp35k7rzh5c-wpengine.netdna-ssl.com/wp-content/uploads/2020/11/Employer-Infographic-11192020.pdf

The Solution: Comprehensive Medication Management (CMM)

A systematic approach to medications where **physicians and pharmacists** ensure that all medications (prescription, nonprescription, alternative, traditional, vitamins, or nutritional supplements) are individually assessed to determine that **each medication is appropriate** for the patient, **effective** for the medical condition, **safe** given the comorbidities and other medications being taken, and **able to be taken** by the patient as intended.

GOAL

Source: Get the Medications Right Institute: https://16bvl028dn7zhgp35k7rzh5c-wpengine.netdna-ssl.com/wp-content/uploads/2020/11/Employer-Infographic-11192020.pdf

Source: Adapted from ACCP Comprehensive Medication Management in Team-Based Care: https://www.pcpcc.org/sites/default/files/event-attachments/CMM%20Brief.pdf

Pharmacist Clinical Training and Expertise

PharmD Education and Training

- **Entry-level 6 or 7-yr degree (PharmD)**
  - ✓ 2 yrs Pharmacotherapeutics
  - ✓ 1.5 yr Drug Info/Lit Eval'n
  - ✓ 3 yrs Pharmacy problem-solving
  - ✓ 4 yrs Patient-care exp + clinical rotations
- **Postgraduate Residencies and Fellowships**
- **Board-certified Pharmacy Specialties (12)**
  - ✓ Ambulatory Care, Cardiology, Critical Care, Geriatrics, Infectious Disease, Nuclear Pharmacy, Nutrition Support, Oncology, Pediatrics, Pharmacotherapy, Psychiatric, Sterile Compounding, Organ Transplantation
  - ✓ **CT (as of Feb 2021) = 462 pharmacist specialists**
    - **71% in Amb Care/Geriatric/Pharmacotherapy**
- **Medication Management Certificate Programs**
- **Advanced Pharmacy Practitioner Credentials**

Pharmacist's Expertise

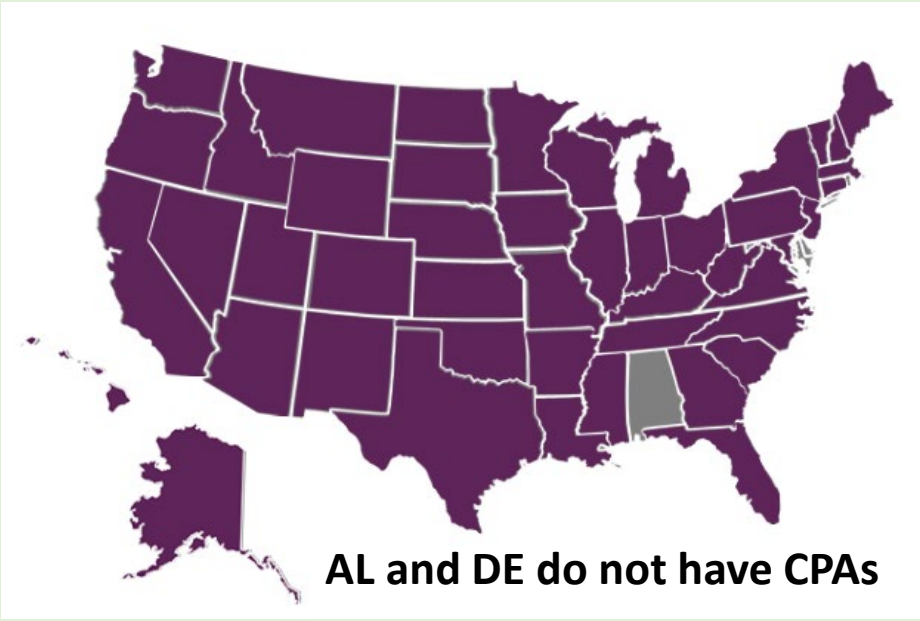
- Pharmacology/ Pharmacotherapeutics
- Pharmacokinetics
- Pharmacogenomics
- Drug Toxicity: Adverse Drug Events, Interactions
- Drug Information and Evaluation
- Patient Medication Safety
- Medication Management
  - Identify, Resolve, and Prevent Med Problems
- Medication Adherence Assessment
  - Compliance and Persistence
- Pharmacoeconomics
- Outcomes Research
- Patient Communications/Health Literacy
- Pharmacy Practice Systems

Pharmacists' competencies are SYNERGISTIC (not duplicative) with those of other health professionals

Collaborative Practice Agreements (CPA)

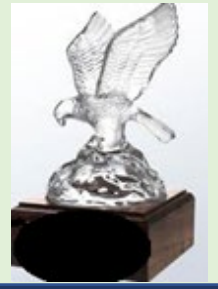
CT Collaborative Practice Agreements (CPA)
(known as Collaborative Drug Therapy Management (CDTM)

- Formal, written agreement between pharmacists and providers that increases the efficiency of team-based care
- **2012:** pharmacists + physicians (DPC: Collaborative Drug Therapy Management: Sec. 20-631-1— 20-631-3)
- **2019:** expanded to pharmacists + both physicians and APRNs (Public Act 19-98-sSB921)
- **Not restricted to specific drugs or conditions or practice settings**
- **Allows pharmacist to:**
  - **Add, adjust, and discontinue medications**
  - **Order lab tests**



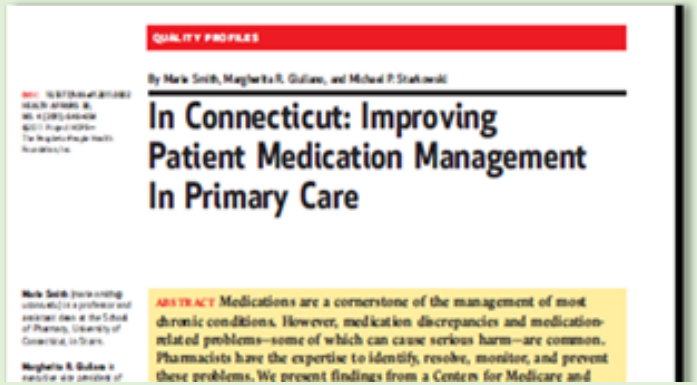
Source: CDC: https://www.cdc.gov/dhdsp/pubs/docs/cpa-team-based-care.pdf as of 12/2015

CT Medicaid Comprehensive Medication Management (CMM) Project



2012 APhA Foundation PINNACLE Award

PARTNERS:
UConn School of Pharmacy
CT Dept of Social Services (Medicaid)
CT Pharmacists Association


QUALITY PROFILES

By Marie Smith, Margherita R. Giuliano, and Michael P. Starkowski

In Connecticut: Improving Patient Medication Management In Primary Care

ABSTRACT Medications are a cornerstone of the management of most chronic conditions. However, medication discrepancies and medication-related problems—some of which can cause serious harm—are common. Pharmacists have the expertise to identify, resolve, monitor, and prevent these problems. We present findings from a Centers for Medicare and

Key Findings (2010)

CT Medicaid beneficiaries have complex medication regimens

- Medical conditions ~9-10/ptnt , chronic medications ~ 15-16/ptnt
- Pain, GI, Dyslipidemia, High BP, Asthma/COPD, Diabetes, Depression
- Mean Age – 51 yrs, Female – 71%
- 410 patient visits, 88 patients, 20 providers in 5 primary care sites

Medication Therapy Problems (MTPs) = 917, mean = 10.4/ptnt

- **Medication appropriateness (30%)**
  Needs additional medications using evidence-based guidelines
- **Effectiveness (23%) -** Dose too low
- **Safety (21%) -** Adverse drug events, drug interactions
- **Patient non-adherence (26%)**
  Patient doesn't understand med use instructions – esp. inhalers

74% MTPs relate to clinical decision-making/team-based care
26% MTPs relate to patient health beliefs, adherence behaviors

Avg Medical Cost Savings: $472/yr (fewer emergency room visits)

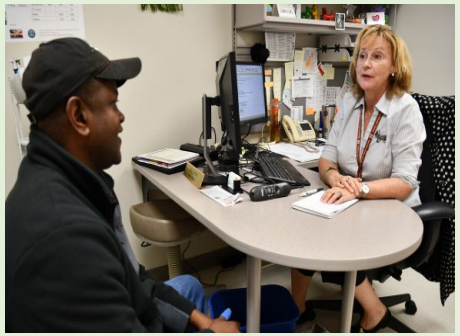
Avg Drug Cost Savings: $1,123/yr (decreased waste: meds not taken, duplicates, cancelled, less costly)

Source: Smith M, Giuliano MR, Starkowski MP. In Connecticut: improving patient medication management in primary care. Health Aff (Millwood). 2011. doi: 10.1377/hlthaff.2011.0002.

2 CT Exemplar Pharmacist Practice Models

OHS CT SIM Pharmacy Technical Assistance Project (2019)

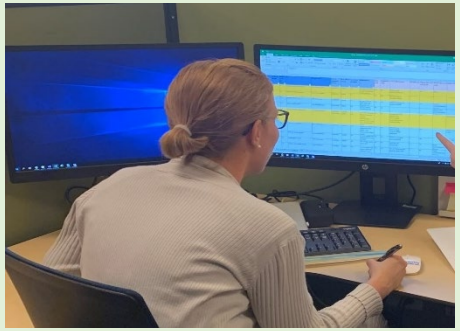
Participating Entities	Pharmacist Practice Models	
	Expanded Care Team	Population Health Team
Yale NewHaven Health Northeast Medical Group	✓	
Community Health Center, Inc.		✓



EXPANDED CARE TEAM MODEL

Use of Collaborative Practice Agreement (MD, APRNs)

- Pharmacist meets one-on-one with patients
- Pharmacist provide comprehensive med management
- Pharmacist implements med changes + orders lab tests
- Pharmacist see patients until therapy goals are met

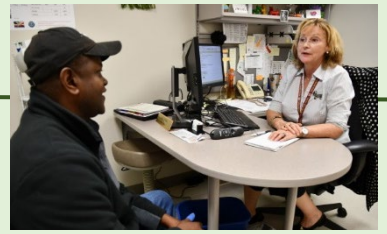


POPULATION HEALTH TEAM MODEL

- Pharmacist does NOT meet with patients
- Pharmacist reviews and assesses med regimens
- Pharmacist sends targeted med optimization recommendations (i.e. high blood pressure, diabetes) to PCPs for implementation

Comprehensive Medication Management Process

Expanded Care Team



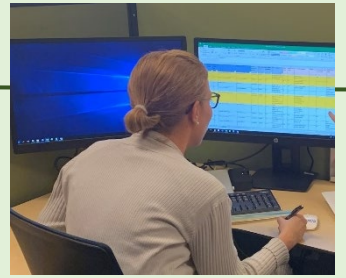
2

Patient Provides Info
- Personal medication experience, history, preferences, beliefs

3

Patient Explains Actual Use
- Actual use of all meds (Rx, OTC, supplements)

Population Health Team



2

Pharmacist Reviews EHR
- Med history and notes documented in EHR

3

Pharmacist Analyzes Patterns
- Med use patterns in EHR (Rx, OTC, supplements)

1

Patient Identified
- Has not achieved med therapy goals

4

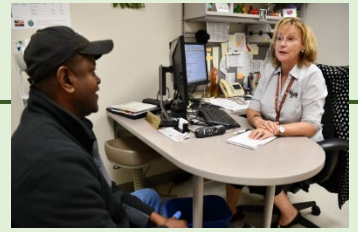
Pharmacist Assesses Each Med
- **Appropriateness**
- **Effectiveness**
- **Safety**
- **Adherence**

5

Pharmacist Identifies MTPs
Medication therapy problems such as:
- **Inadequate therapy**
- **Unnecessary Therapy**
- **Duplicate therapy**
- **Dose too high/low**
- **Adverse Events**
- **Drug Interactions**

Comprehensive Medication Management Process (cont'd)

Expanded Care Team



6

Develops Care Plan
- Pharmacist creates plan + therapeutic changes to achieve optimal outcomes

7

Patient Agrees with Plan
- Patient understands care plan which is communicated to PCP

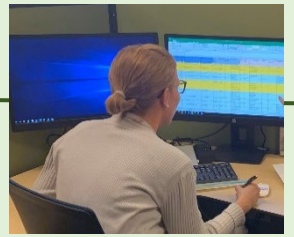
8

Pharmacist Documents in EHR
- Documents all steps & current clinical status vs. goals of therapy

9

Pharmacist Implements Plan
- **(<u>Collaborative Practice Agreement</u>:** Pharmacist implements med changes to achieve optimal outcomes

Population Health Team



6

Develops Recommendations
- Pharmacist recommends therapeutic changes to achieve optimal outcomes

7

Pharmacist Documents in EHR
- Documents all steps & current clinical status vs. goals of therapy

8

Sends Recommendations to PCP
- Pharmacist recommends therapeutic changes to the PCP to achieve optimal outcomes

9

PCP Reviews/Implements Plan
- **<u>Without CPA</u>**, PCP must review and implement changes (adds workload, inertia)

10

Follow-up Evaluations
- Pharmacist determines effects of changes, reassesses outcomes, recommends further changes
- CMM is an iterative process!

Source: Adapted from Get the Medications Right: https://16bvl028dn7zhgp35k7rzh5c-wpengine.netdna-ssl.com/wp-content/uploads/2019/04/GTMRx-CMM-10-steps-PDF.pdf

Expanded Primary Care Team Model:
Northeast Medical Group (NEMG)

https://kaltura.uconn.edu/media/1_1so2j7xb

- Pharmacist in **3 NEMG Practices (~3 years)**
  - New Haven, North Haven, and Trumbull
- **Highly credentialed and skilled** pharmacist
  - Residency training in primary care
  - 4 years of ambulatory care work experience within a large integrated health system in Oregon
  - Board certified pharmacotherapy and ambulatory care specialist
- **6 Collaborative Practice Agreements** with MDs/APRNs
- PCP **referrals for high-risk**, complex patients
- Pharmacist sees patients **between PCPs visits**
- Pharmacist Impact on PCPs
  - **Reduced clinical workload burden** and improve provider satisfaction
  - **Improved patient outcomes** and satisfaction
- NEMG leaders **pursuing pharmacist scalability**

NEMG: Pharmacist Impact on Diabetes Outcomes (A1c)

Pharmacist Visits:

- Meet with patients between PCP visits
- Intensive medication optimization and management using CPA
  - Average of 4 patient visits in 5 months

Poor Diabetes Control

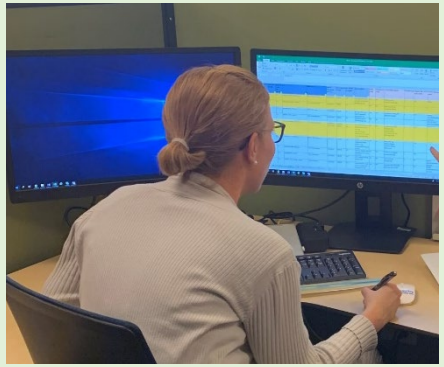
Good Diabetes Control

NEMG Pharmacist's Diabetes Patients (N=73)					
A1c Ranges	Average A1c (%)			Average #	
	Before	After	Change	Pharmacist Visits	Months
≥11%	12.4	9.4	-3.0	4	5
10%-11%	10.3	9.4	-0.9	3	4
9%-10%	9.4	8.8	-0.6	5	6
8%-9%	8.5	7.7	-0.8	3	5
<8%	7.4	7.1	-0.3	4	5
Total	9.9	8.6	-1.3	4	5

Findings:

- Average A1c reduction of 1.3%
- **Patients that started with an A1c ≥11% had an average reduction of 3.0%**
- Positive physician and patient feedback

Population Health Team Model:
Community Health Center, Inc. (CHC)



Pilot Project

- Centralized pharmacist with no direct patient interaction nor CPA
- 41 **high-risk, uncontrolled** patients with BOTH high blood pressure + type 2 diabetes
- **Pharmacist reviewed and assessed** high blood pressure and diabetes medications
- **Pharmacist sent PCPs recommendations** for med optimization via e-messaging

Type of Recommendation (N= 47)	# of Recommendations	% of Total (% of MRPs)
Medication Therapy Problems	**28**	**60%**
Indication/Appropriateness	3	(11%)
Effectiveness	6	(21%)
Safety	9	(32%)
Adherence	10	(36%)
Care Coordination for Medication Optimization	**19**	**40%**

64% were clinician-influenced

Population health pharmacist spends **substantial time on care coordination for medication optimization** interacting with multiple providers, pharmacies, and other health professionals.

Pharmacist Value & Impact Calculators

PharmValCalc – Pharmacist FTE & ROI Calculator

PCImpact –

1. Forecast Pharmacist Patient Capacity
2. Impact of Pharmacist Services on:
   - PCP time/workload
   - Improved patient access to PCP appointments

NEMG Findings:

- NEMG pharmacist is at capacity due to high patient referrals from PCPs

- **Each additional pharmacist FTE opens up 1,120 more patient appointments per year**

PHARMACIST MODEL TYPE		
PHARMACIST PRACTICE MODEL		
• Clinical activities • Type of patient (new vs follow-up) • Approach (Targeted vs comprehensive)		• Frequency (One-time vs longitudinal) • Need for patient contact- Y/N
PHARMACIST TIME REQUIRED		
Step 1: Pre-visit EMR Med/Lab Review and Assessment		
Minutes per patient (pp)		
Step 2: Performs Clinical Visit and Develops Recommendations		
Minutes per patient		
Step 3: Present recs to PCP and Participates in Plan Development		
Minutes per patient		
Step 4: Educates Patient and Determines Follow-up Frequency/Type		
Minutes per patient		
Step 5: Post-visit Documentation and Update Med List		
Minutes per patient		
Total minutes per patient		
PCP TIME AND IMPACT		
PCP Time With Team-Based Pharmacist:		
Reviewing pharmacist recs (minutes per patient)		
Developing med action plan (minutes per patient)		
Ordering labs/eRx (minutes per patient)		
Total minutes per patient		
PCP Time Without Team-Based Pharmacist		
Usual Care (minutes per patient)		
Difference in PCP Minutes Spent per patient		
Impact on PCP Clinical Workload (hours) in year		
PHARMACIST WORKLOAD CAPACITY		
# of patient reviews/visits per year		
PATIENT IMPACT		
Uptake rate for implementing pharmacist recs		
# of patient reviews/visits **impacted** by pharmacist rec in year [Stratified by Pharmacist Clinical Time]	1 FTE 2 FTE 3 FTE 4 FTE	

ROI	8.48
Total Cost Avoidance	$ 411,453.90
Costs of adding an RPH	$ 125,000.00
FTE's required	0.35
Hospital Readmission Cost Avoidance	
Percent of Patients who stay overnight in hospital per year	5.5%
Patients admitted per year	1100
Hospital readmission rate	13.90%
Estimated Number Patients Readmitted per Year	153
Cost of Hospital Readmission	$13,800
% Drug Related Hospital Readmissions	26%
Patients Readmitted from Medication Related Cause	40
% Reduction in Med Related Readmissions from RPh Intervention	75%
Potential Reduction in Patient Readmission from Med Related Cause	30
Total Cost Avoidance RPh Performing Med Recs High Risk Patients	$ 411,453.90
New 30-day Hospital Readmission Rate	11.19%
Reduction in Readmission Rate	2.71%

Sacro K, Smith M, Swedberg C, Lee YJ, Hunt M, Mulrooney M. PharmValCalc: A calculator tool to forecast population health pharmacist impact. Res Social Adm Pharm. 2020 Sep;16(9):1183-1191. doi: 10.1016/j.sapharm.2019.12.012. Epub 2019 Dec 20. PMID: 32147460.

Mulrooney M, Smith M. PCImpact: A modeling tool for forecasting impact of primary care pharmacist services. *Research in Social and Administrative Pharmacy*. February 2021. doi: https://doi.org/10.1016/j.sapharm.2021.02.001.

Lessons Learned from SIM TA Program

Pharmacist Success Factors

Leading factors in the success of TA projects

- **Well-defined** pharmacist role
- Pharmacist **training, work experience, and credentials**
- Pharmacist skills in building **trusted relationships with patients and clinicians**
- Pharmacist experience in developing and using **collaborative practice agreements** for Direct Patient Care practice models

Organizational Success Factors

Influenced the focus, commitment and pace of integration of clinical pharmacist services

- **Medical leadership buy-in** to integrate and/or enhance clinical pharmacist services
- The **availability of data/**reports to identify high-risk, high-value patients for pharmacist interventions
- **Culture of team-based care** for better access and continuity of care, improve patient outcomes and quality measures, and reduce PCP clinical workload burden (only applies to Direct Patient Care Model)

Major Barrier: NO payer reimbursement for pharmacist-provided CMM services

Resources

GTMRx Learning Center: https://gtmr.org/learning-center/
GTMRx Blueprint for Change Tools: https://gtmr.org/blueprint-for-change-tools/
GTMRx Blog: https://gtmr.org/evidence/blog/
For Consumers: https://gtmr.org/consumers/
For Employers: https://gtmr.org/home/get-involved/employers/
For Policy Makers: https://gtmr.org/policy-solutions/
For Providers: https://gtmr.org/providers/

CDC Collaborative Practice Advancing Team-Based Care Through Collaborative Practice Agreements A Resource and Implementation Guide for Adding Pharmacists to the Care Team - 2017

AMA Steps Forward- Embedding Pharmacists Into the Practice - 2017

Pharmacists Belong in ACOs/Integrated Care Teams – Nov 2013
Marie Smith, David Bates, Tom Bodenheimer

In Connecticut: Improving Patient Medication Management In Primary Care - April 2011
Marie Smith, Margherita Giuliano, Michael Starkowski

Why Pharmacists Belong in the Medical Home – May 2010
Marie Smith, David Bates, Tom Bodenheimer, Paul Cleary

PCImpact: A modeling tool for forecasting impact of primary care pharmacist services. RSAP 2021.
Mary Mulrooney and Marie Smith

PharmValCalc: A calculator tool to forecast population health pharmacist impact- RSAP 2020
Kathryn Sacro, Marie Smith, Colleen Swedberg, Yeo Jung Lee, Michael Hunt, Mary Mulrooney

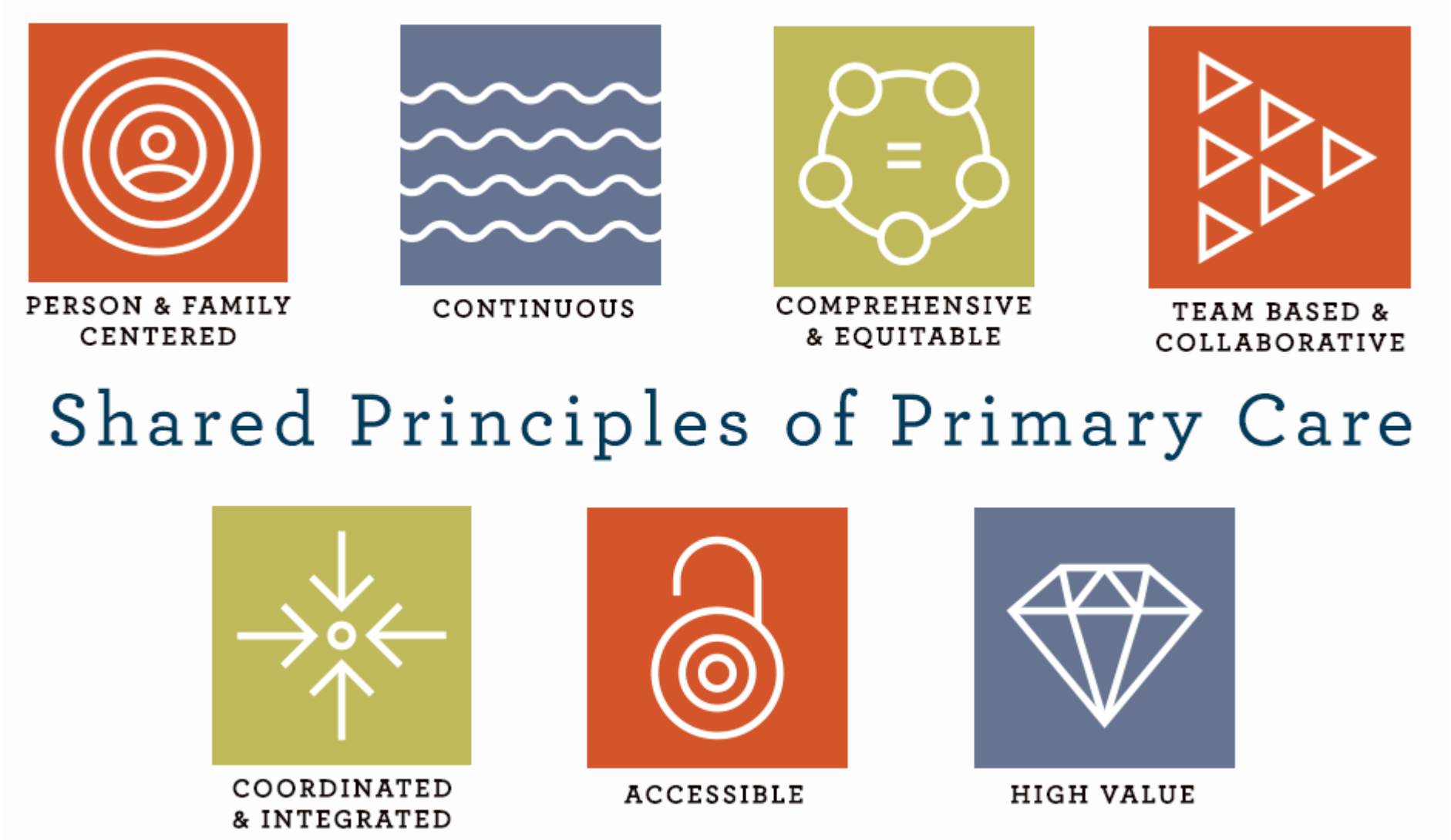
Variability in state Medicaid medication management initiatives – RSAP 2016
George Neyarapally and Marie Smith

Strategies for community-based medication management services in value-based health plans RSAP 2016
Marie Smith, Susan Spiggle, Brody McConnell

Consumer physician, payer perspectives on primary care medication management services with a shared resource pharmacists network. *RSAP* – September 2013
Marie Smith and Michelle Breland

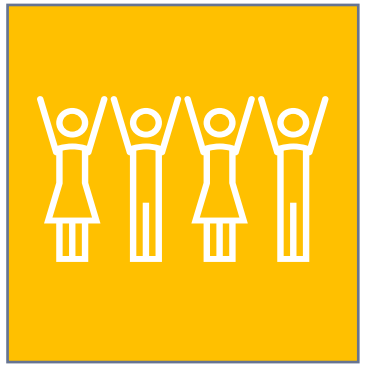
Follow-up Discussion on Revised PCCHR Guiding Principles

The Shared Principles of Primary Care



Feedback Process

- Based on your feedback at the meeting, we added two additional principles for your consideration
  - **Improved Clinician Experience**
  - **Community-Focused**
- OHS then asked for additional review and comments in between meetings
- 8 total commenters
- Our Guiding Principles, based on workgroup input and feedback, will be used to guide development of models for reform



IMPROVED CLINICIAN & STAFF EXPERIENCE

COMMUNITY-FOCUSED

- Highlights of Incorporated Feedback:
  - More emphasis on addressing health disparities/implicit biases and clarifying related terms
  - Inclusion of care partners when referring to families
  - Addressing administrative burden in relation to health information technology
  - Eliminating redundancies
  - Word choice/clarity issues

Substantive Changes: Principle 3

Comprehensive & Equitable*

- Primary care addresses the whole person with appropriate clinical and supportive services that include acute, chronic and preventive care, behavioral and mental health, oral health, health promotion, education and more. Each primary care practice will decide how to provide these services in their clinics and/or in collaboration with other clinicians outside the clinic.
- Primary care clinicians seek out the impact of social determinants of health and societal inequities. Care delivery is tailored accordingly.
- Primary care clinicians and staff partner with health and community-based organizations to promote population health and health equity, including making inequities visible and identifying avenues for solution.
  - **Models apply a data-driven approach to identifying historical, current, and potential health disparities in all populations, including racial health disparities.**
  - **Proactive interventions in care planning reduce or eliminate identified inequities.**
  - **Care models promote awareness of organizational and individual implicit biases and utilize evidence-based practices to eliminate discrimination and prejudice from the provision of care.**

Substantive Changes: Principle 3

Comprehensive & Equitable* - Footnote Added

*Throughout the principles, references to health disparities or health inequities include, but are not limited to, disparities or inequities based on race, ethnicity, religion, national origin, sex, gender identity or expression, sexual orientation, mental disability, physical disability, blindness, or status as a veteran.

Substantive Changes: Principle 8

Improved Clinician and Staff Experience

- Primary care models emphasize enhanced efficiency and payer alignment, while minimizing the administrative burden on clinicians and practices.
- ~~Through multi-disciplinary team-based care, clinicians are empowered to routinely work at the top of their healthcare licensure and scope of practice.~~
- Clinicians and staff are adequately funded for required services and rewarded for the quality and value of care provided. Volume-driven incentive structures are phased out where possible.
- **Clinical health information technology and data sharing tools prioritize useability and value to clinical decision-making and care through rigorous pilot testing with practicing clinicians.**

Substantive Changes: Principle 9

Community-Focused

- 'Community health' means that the social, economic, and physical conditions within a geographic community enable individuals and families to meet their basic needs and achieve their health and well-being goals throughout their lives.
- Reforms aim to **achieve** the integration of community health and **wellbeing with person and family/care partner centered** healthcare to **address health inequities and** socioeconomic risk factors in order to transform all Connecticut neighborhoods into healthy communities.
- Interdisciplinary team members have clear roles and shared accountability for agreed-upon goals and services, collaborate effectively toward shared outcomes, and commit to actively identifying solutions or alternative pathways when barriers to implementation arise. Sustainable financing is linked to community health, equity and wellbeing.
- ~~Stakeholders work to achieve the systematic integration of community health and wellbeing with person and family centered healthcare.~~

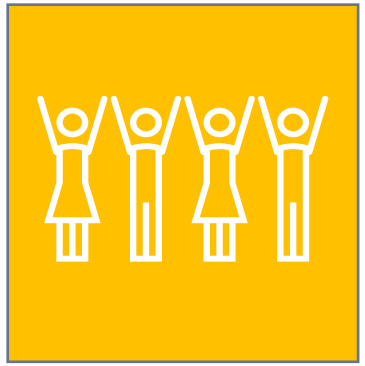
Proposed Guiding Principles

PERSON & FAMILY CENTERED

CONTINUOUS

COMPREHENSIVE & EQUITABLE

TEAM BASED & COLLABORATIVE



IMPROVED CLINICIAN & STAFF EXPERIENCE

Shared Principles of Primary Care

COORDINATED & INTEGRATED

ACCESSIBLE

HIGH VALUE

COMMUNITY-FOCUSED

OHS CONNECTICUT Office of Health Strategy

Next Steps

Meeting Adjournment