California Right Meds Collaborative

Fall 2020 Learning Session

Comprehensive Medication Management in Partnership with Health Plans

Steven Chen, PharmD, FASHP, FNAP

Associate Dean for Clinical Affairs

USC School of Pharmacy

California Right Meds
COLLABORATIVE

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Our Purpose Today…

To continue advancing a **proven framework** for delivering optimal results from medication therapy through **Comprehensive Medication Management** sustained by **value-based payments** for the most vulnerable high-risk patients

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Vassilios Papadopoulos, D.Pharm., Ph.D., D.Sc. (Hon)

Dean
USC School of Pharmacy
John Stauffer Dean's Chair in Pharmaceutical Sciences
Professor of Pharmacology & Pharmaceutical Sciences

CMM PROTE

MEDICATIONS MATTER

Adverse effects from medications are estimated to be the

4th leading cause of DEATH in the U.S.[1]

$528.4 BILLION

of avoidable spending annually is due to **MISUSE** or suboptimal use of medications[2].

75% of hospital readmissions among seniors in the U.S. are avoidable, primarily through better use of medications[3].

WHY?

50%

½ of the prescription medications taken every year in the US are used improperly[4].

WHAT can I do next to start benefitting from CMM?

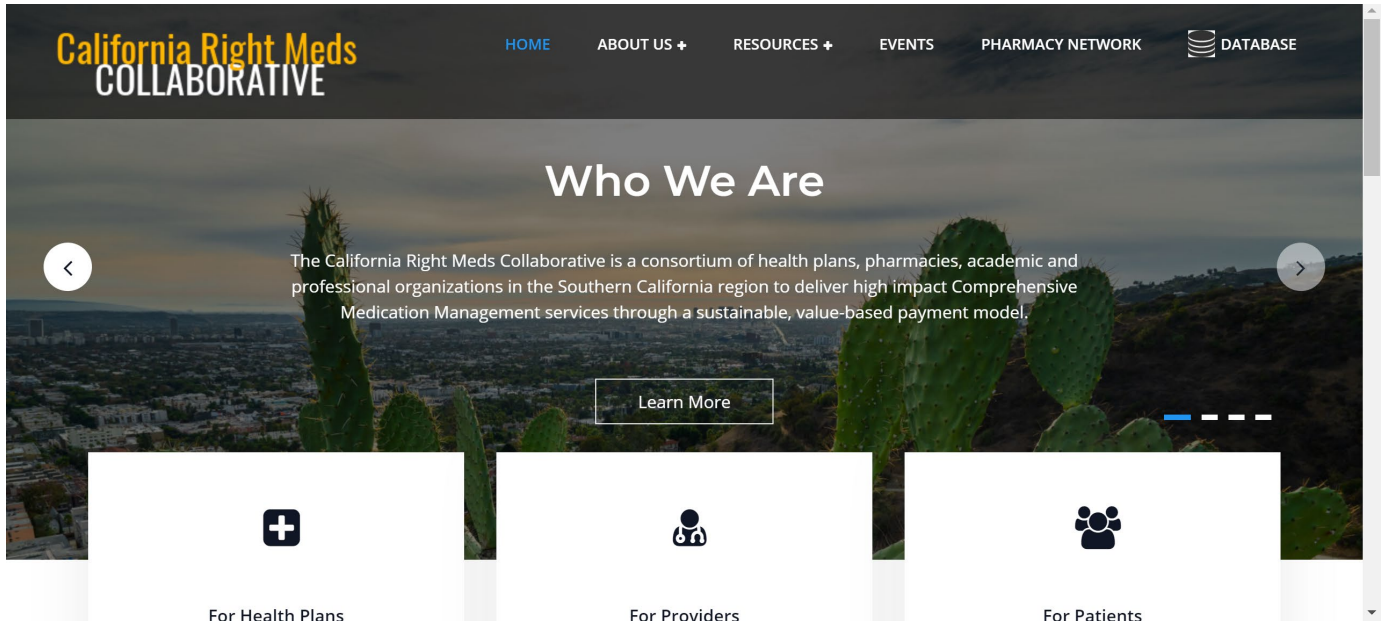
Healthcare professionals:
For more information, go to:

to include a one-stop-shop for CMM resources
http://calrightmeds.org/

High-Risk Patients:
Talk to your physician and ask for CMM

CDPH California Department of PublicHealth

USC School of Pharmacy



- **Vision:** Provide optimal medication therapy for high-risk patients in their communities

- **Mission:** Create a network of pharmacists in the community that provide sustainable high-impact Comprehensive Medication Management Services in alignment with health plan and health system population health priorities

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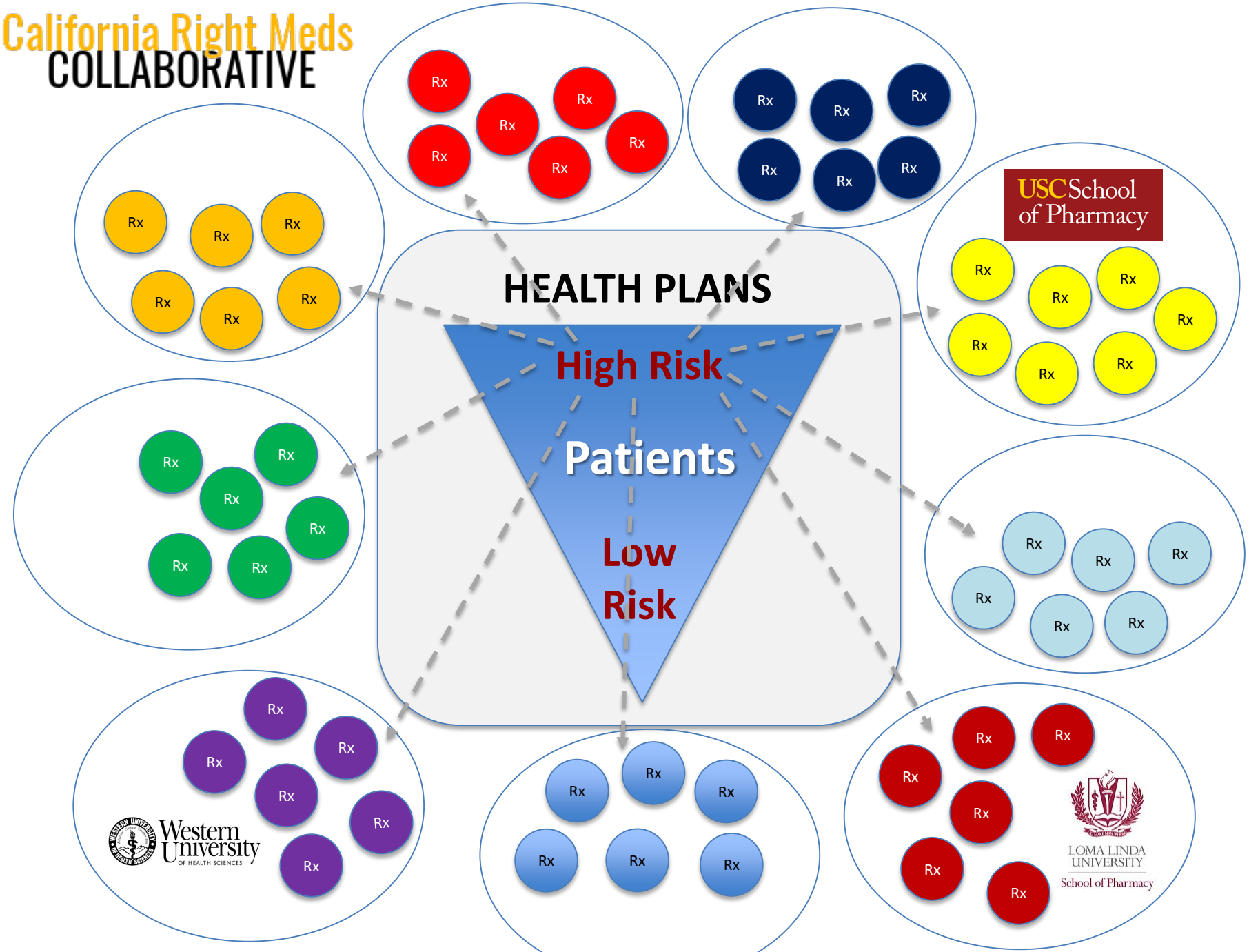


California Right Meds Collaborative: What Makes it Work?

L.A. Care Health Plan

Dr. Alex Kang
Dir. Clinical Pharmacy

Dr. Hanna Sung
Amb Care
Pharmacy Director

Cedars Sinai

Dr. Dri Wang
Psych Sr. MSL

Dr. Ron Victor

Dr. Florian Rader

Dr. William &
Josephine Heeres

IEHP
Inland Empire Health Plan

Dr Edward Jai
Sr. Director

Dr. Mike Blatt
Dir. Clinical Pharmacy

USC School of Pharmacy

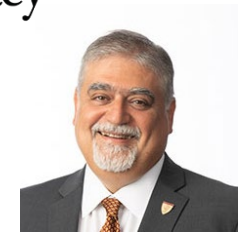
Dr. Jessica Abraham
Dir. Population Health

Dr. Connie Kang
CRMC LA Lead

Mariel Romero
QI Coordinator

Dr. Diane Yoon
Director of CPD

Jeff Shapiro
COO



Vassilios Papadopoulos
Dean

Dr. Kathy Johnson

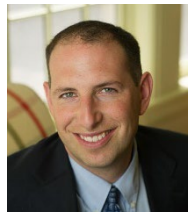
Dr. Pete Vanderveen

Cedars-Sinai

Dr. Rita Shane
Chief Pharmacist

Sang-Mi Oh
VP / Sr. Director

USC Gehr Family Center for Health Systems Science



Dr. Mike Hochman
Director

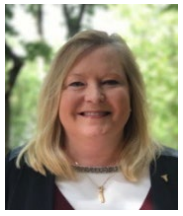
CDPH California Department of Public Health

Dr. Jessica Nunez
Chief, Chronic Disease
Control Branch

JWCH Institute, Inc. Health & Medical Services

Dr. Paul Gregerson
CMO

Right Care Initiative



Hattie Hanley
Founder

CMS Centers for Medicare & Medicaid Services

Dennis Wagner
Dir. iQI and
Innovation

County of Los Angeles Public Health

Dr. Tony Kuo
Dir. Chronic Disease
& Injury Prevention

Noel Barragan
Program Manager

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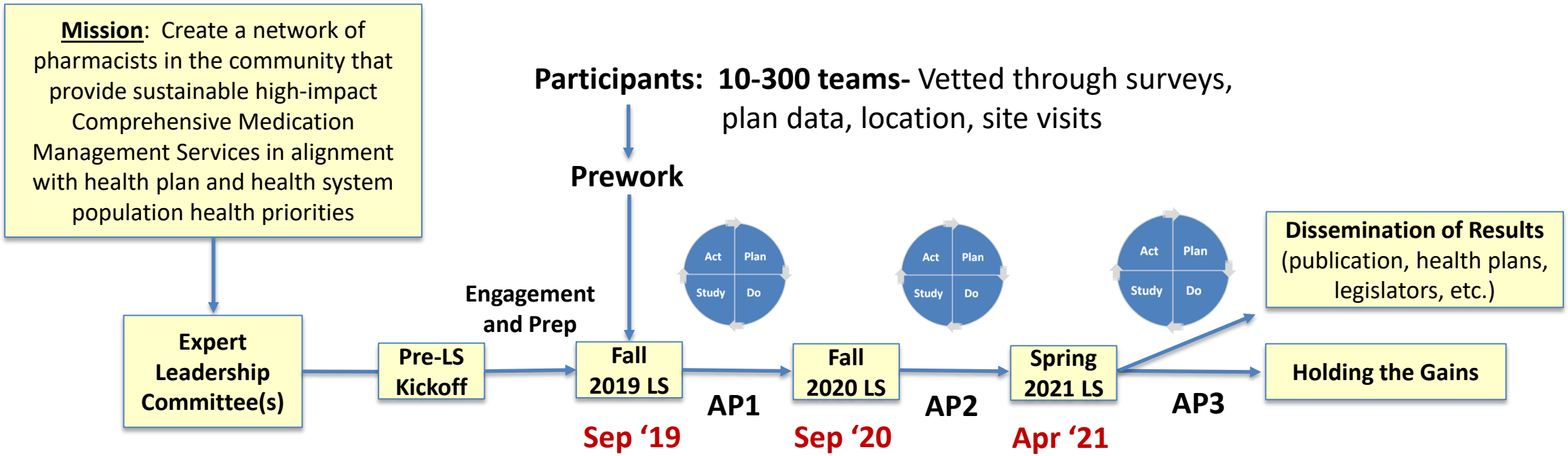
Calrightmeds.org

CRMC Progression Since Fall 2019 Learning Session

Milestone	Completed	Ongoing	Pending
Selection process for CRMC pharmacies			
Intensive training for pilot CRMC sites (live, patient actors, webinar)			
Patient and medical provider targeting and enrollment strategies			
Value-based payment models			
QI dashboard & tools for teams			
Learning Sessions, 1:1 Coaching			
Pilot program- PDSA, adaptive modeling, toolkit and resources			
Webinars / case reviews every 1-2 weeks			
Spread awareness of and engagement in CRMC (health plans, government, public)- 2020/2021			
Launch full rollout- Early 2021			

IHI Breakthrough Series Collaborative Process Adapted for CRMC



Ongoing Support:

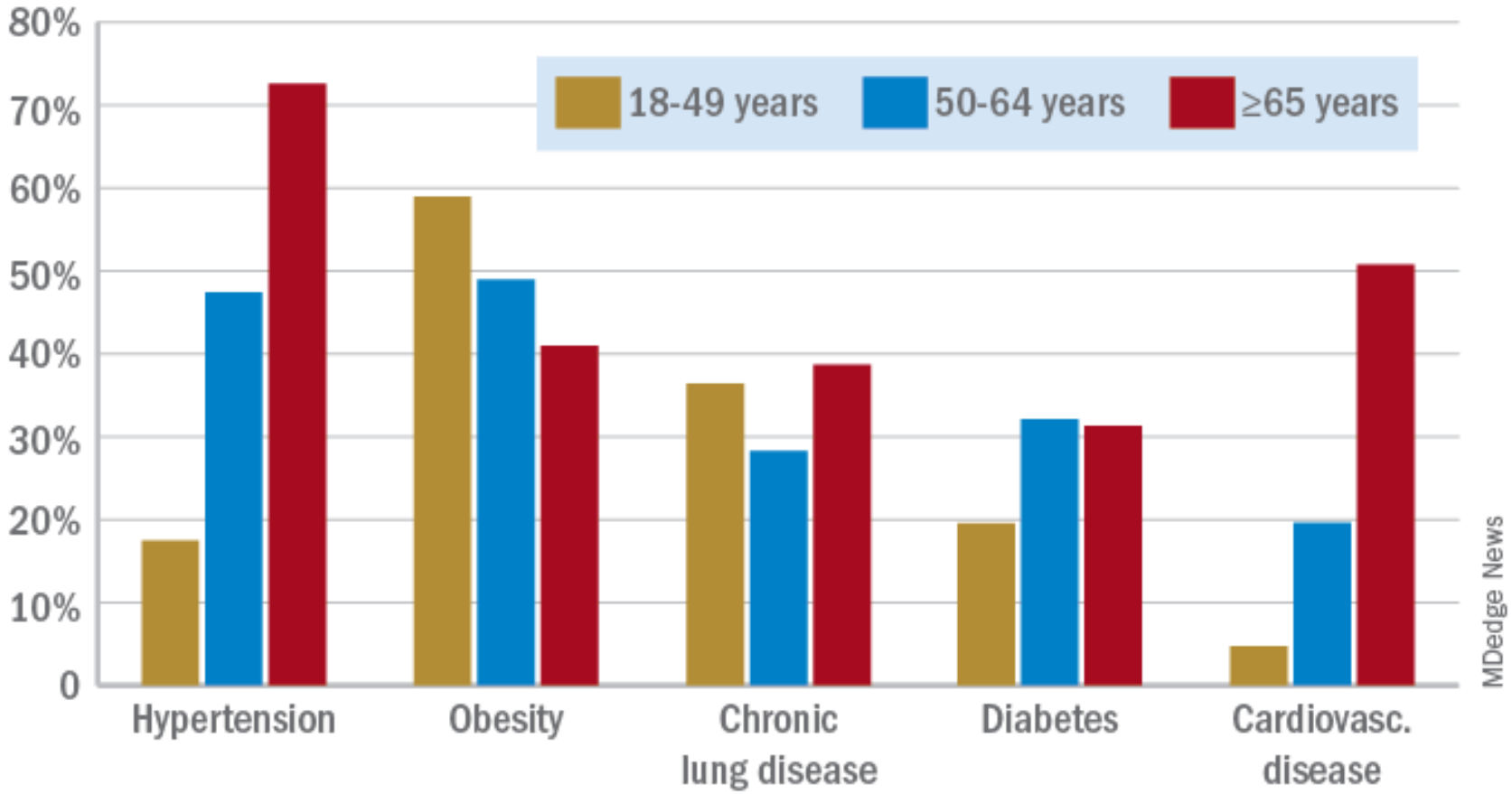
- Webinars (every 1-4 weeks)
- Local 1:1 coaching
- Support for meetings with potential medical / health system partners
- Data sharing for quality improvement and aggregation of impact measures

LS: Learning Session
AP: Action Period

The ~~new~~ normal brings new realities and challenges…

…and opportunities to do things better or differently

Underlying conditions among adults hospitalized with COVID-19



Note: Based on data from the COVID-19–Associated Hospitalization Surveillance Network for patients hospitalized in 99 counties in 14 states from March 1-30, 2020.

Source: MMWR. 2020 Apr 8:69(early release):1-7

http://dx.doi.org/10.15585/mmwr.mm6915e3
https://www.the-hospitalist.org/hospitalist/article/220575/coronavirus-updates/almost-90-covid-19-admissions-involve-comorbidities

Framing: What you will hear

- Keynote Session: Transformative Leadership
- The CRMC Journey: Progress, Challenges, Successes
- Advancing Community Pharmacy-based CMM
- Providing CMM for Homeless Patients
- Breakout Session:
    1. Session A (non-pilot sites): Promoting Patient Self-Management for Culturally Diverse Populations
    2. Session B (CRMC pilot sites): CMM Webinar Series- Keys to Providing Effective Follow-up Care
- Wrap-up

Question to run on…

What key insights will you bring back to your organization to advance optimization of medication therapy for your most vulnerable high-risk patients?

Our Request: How to “Be”

- Focused on our Purpose and Mission
- ‘Teaming’ and Interacting with One Another
- Actively Listening & Learning
- Grounded in Proven Methods
- Challenging Ourselves
- In Action, Making:
  - ✓ **Requests**
  - ✓ **Offers**
  - ✓ **Commitments**

This is what happens to your body over months in isolation, CNN 9/26/2020

Gretchen Goldman, PhD
@GretchenTG

Just so I'm being honest.

#SciMomJourneys

8:58 PM · Sep 15, 2020

281.4K

boredpanda.com

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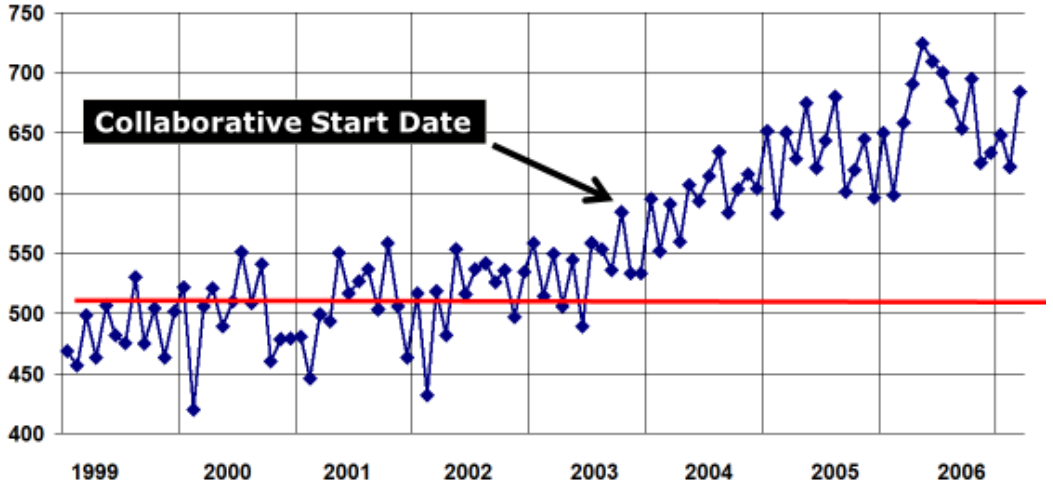
Choosing to Lead

Dennis Wagner, MPA
Former Director, iQuality Improvement & Innovation Group
Center for Medicare and Medicaid Services
Former Director, Office of Health Information Technology and Quality
Health Resources & Services Administration

Dennis Wagner
-- Choosing to Lead --



Increasing Organ Donation in USA
Jan 1999 – Apr 2007 (Monthly)

Learning Objectives

1. Explain how leadership is a self-accountability
2. Utilize bold aims to generate and evolve systems and results
3. Cultivate a powerful shared mindset through leadership speech acts

Thank You

- For your **hard work & commitment** to the patients and families we serve
- For your **leadership and contributions to the profession of pharmacy**
- For the **strategic thinking & active teaming** of everyone in the room
- For being part of the growing movement to **link healthcare payment to value**

What We'll Talk About Today

- Leadership as a Self-Accountability
- Using Bold Aims to Generate and Evolve Systems & Results
- Cultivating a Powerful Shared Mindset through Leadership Speech Acts

CONTRACT FOR RESULTS

"Committed to saving or enhancing thousands of lives a year by spreading known best practices to the nation's largest hospitals, to achieve organ donation rates of 75 percent or higher in these hospitals"

Secretary, Department of Health & Human Services

Executive Director, United Network for Organ Sharing

Chair, National Donor Memorial

Chairman, Institute for Healthcare Improvement

President, Association of Organ Procurement Officials

Executive Director, Coalition on Donation

Past President, North American Transplant Coordinators Organization

Incoming President, American Society of Minority Health and Transplant Professionals

OPO Co-Chair, Organ Donation Breakthrough Collaborative

Hospital Co-Chair, Organ Donation Breakthrough Collaborative

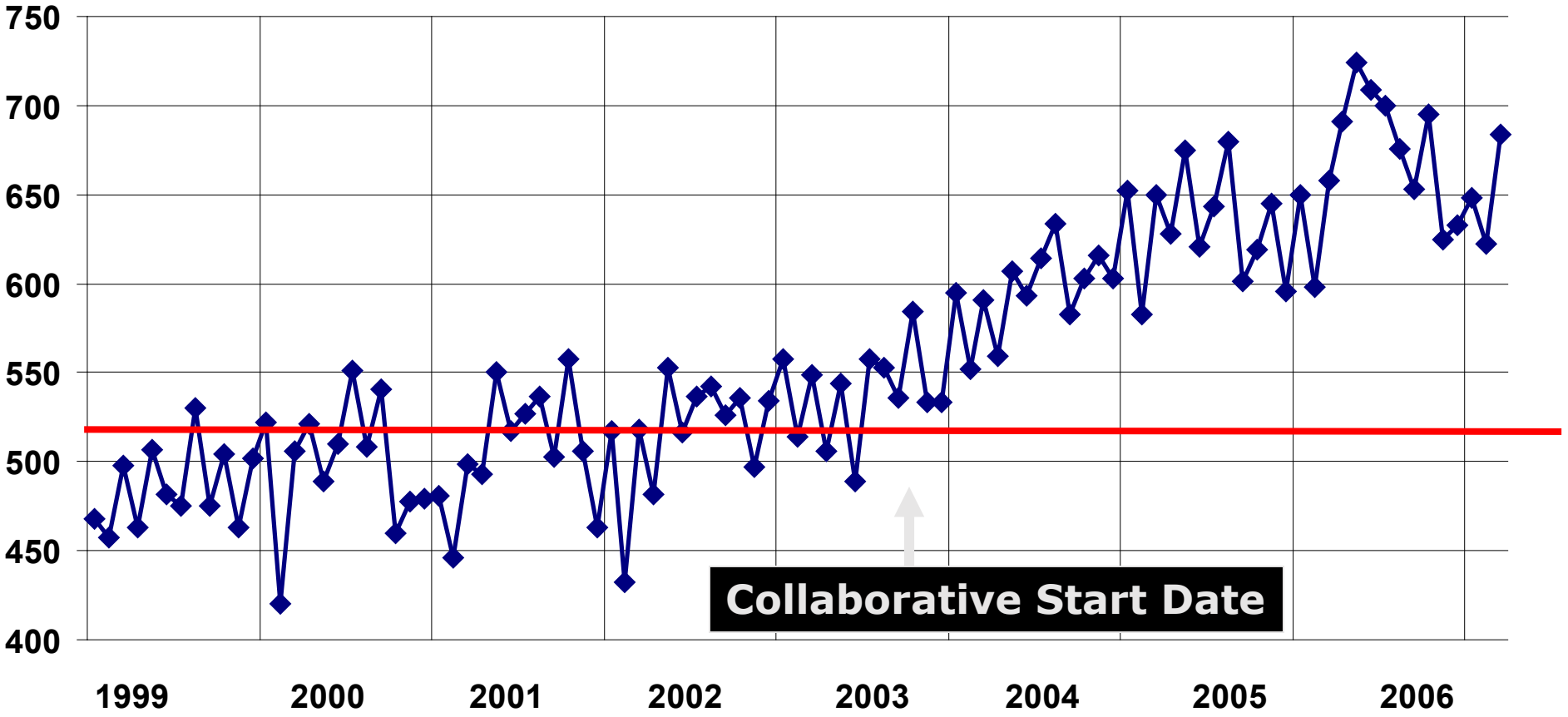
Deputy Surgeon General of the United States

President, Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)

DEPARTMENT OF HEALTH & HUMAN SERVICES · USA

DONATE LIFE

Organ Donation Breakthrough Collaborative
3 Years of Results



Increasing Organ Donation in USA
Jan 1999 – Apr 2007 (Monthly)

Recipient, Donor Mom, Procurement Leader, Transplant Surgeon

Photo taken in April 2002

Donation After Circulatory Death

- **Susan McVeigh Dillon Speaks to Collaborative Learning Session 2 in January, 2004…and Hospitals Throughout the Nation**

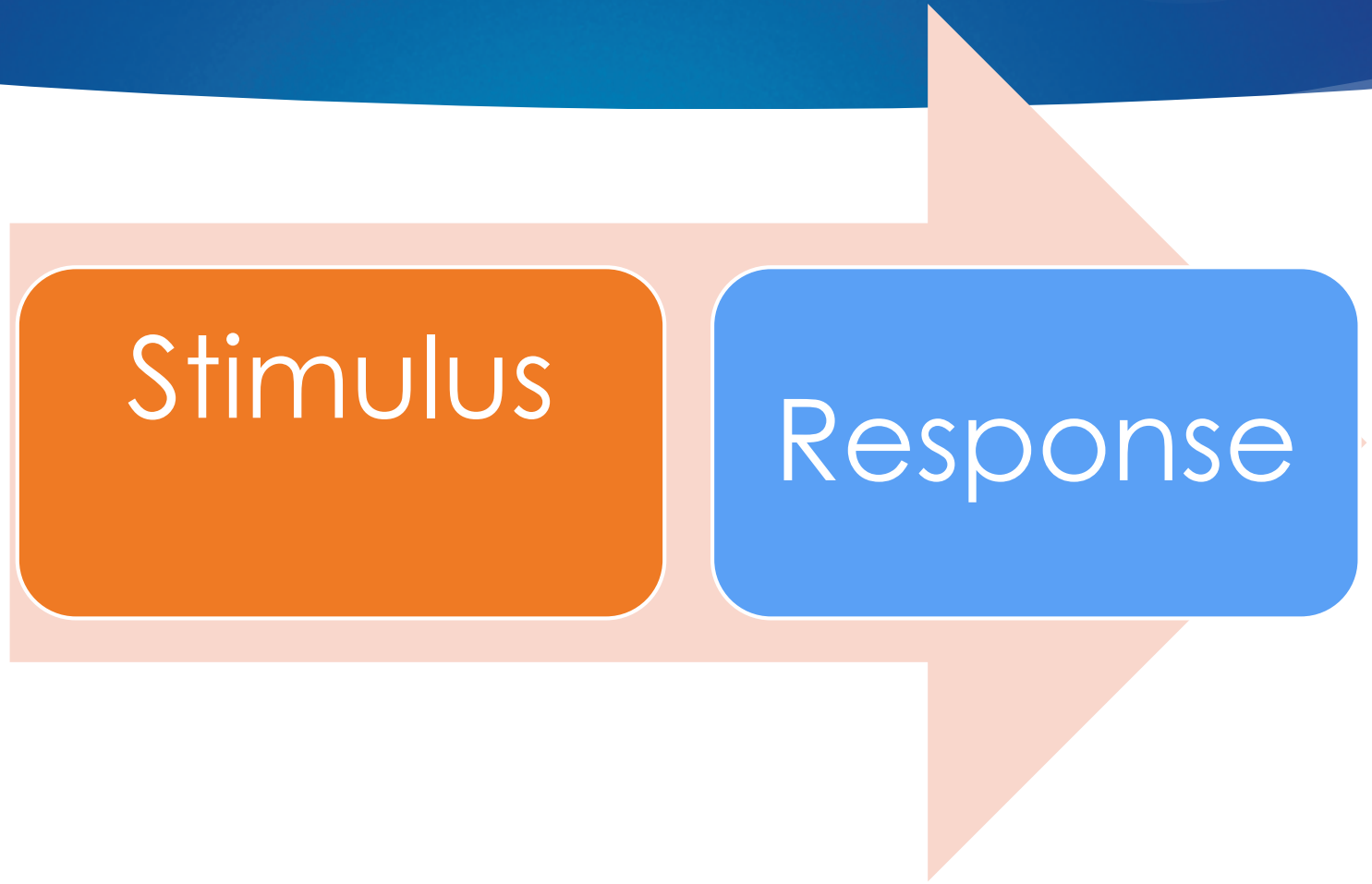
- **47% Increase in DCD in 2004**
- **More Big Increases in 2005**
- **Today 21% of Deceased Donors Nationally are from DCD**

A Key Mindset:

Leadership is a Self-Accountability

- You can not delegate leadership or make some one a leader.
- Leadership is a choice a person makes.
- People choose to lead from many different jobs and roles
- Leaders align with emerging leadership voices to move on strategic efforts.

A Powerful Model



Choice: The Most Powerful Model

Viktor E. Frankl Made Extraordinary Choices

Seminal Book: Man's Search for Meaning

Our Choices Matter Immensely

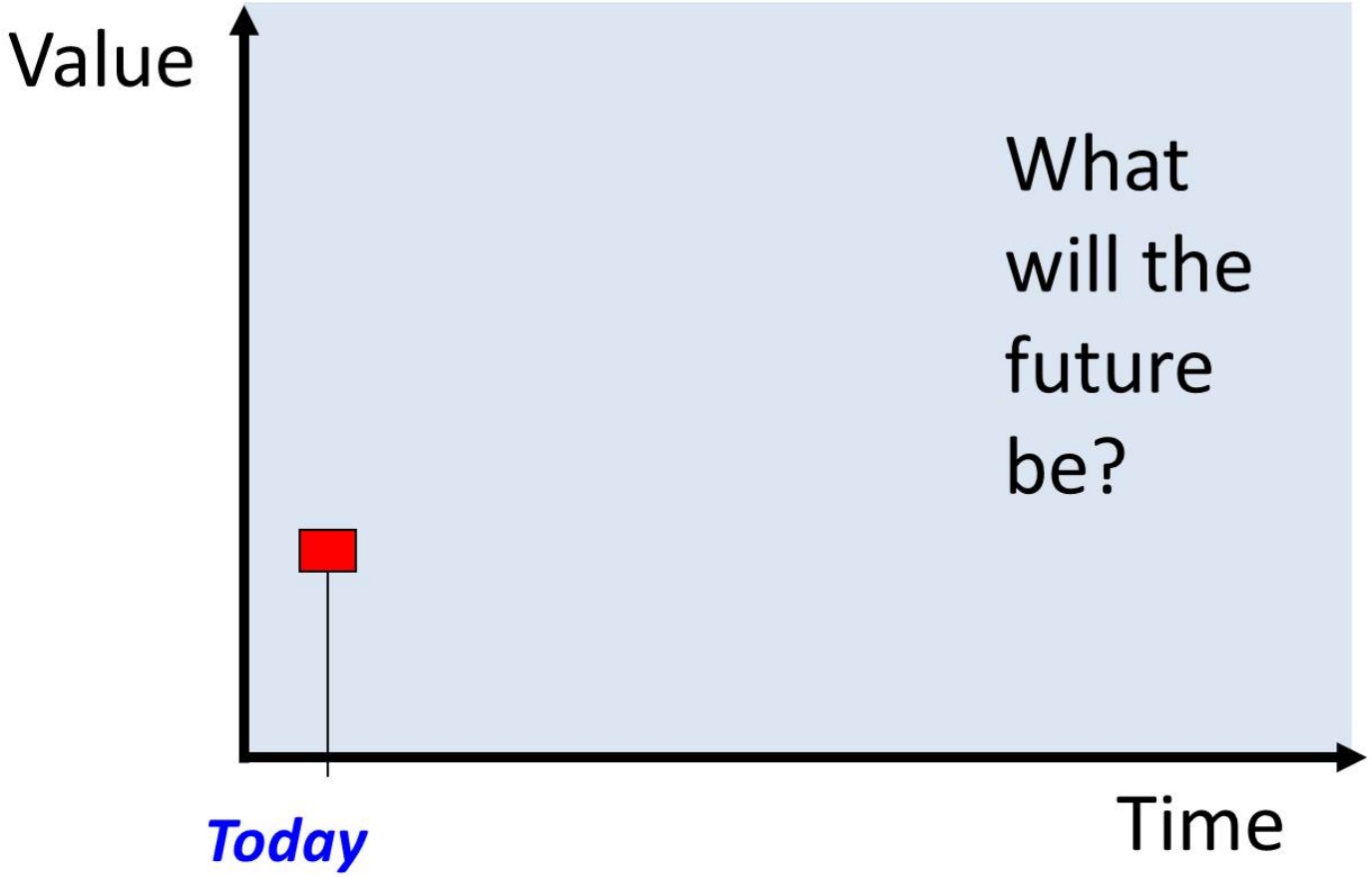
We Can Achieve Our Aims by first <u>Choosing</u> to Make Them Happen

Questions for Reflection & Action

- ***What are some of the most important leadership choices you have made in your career and in your life?***

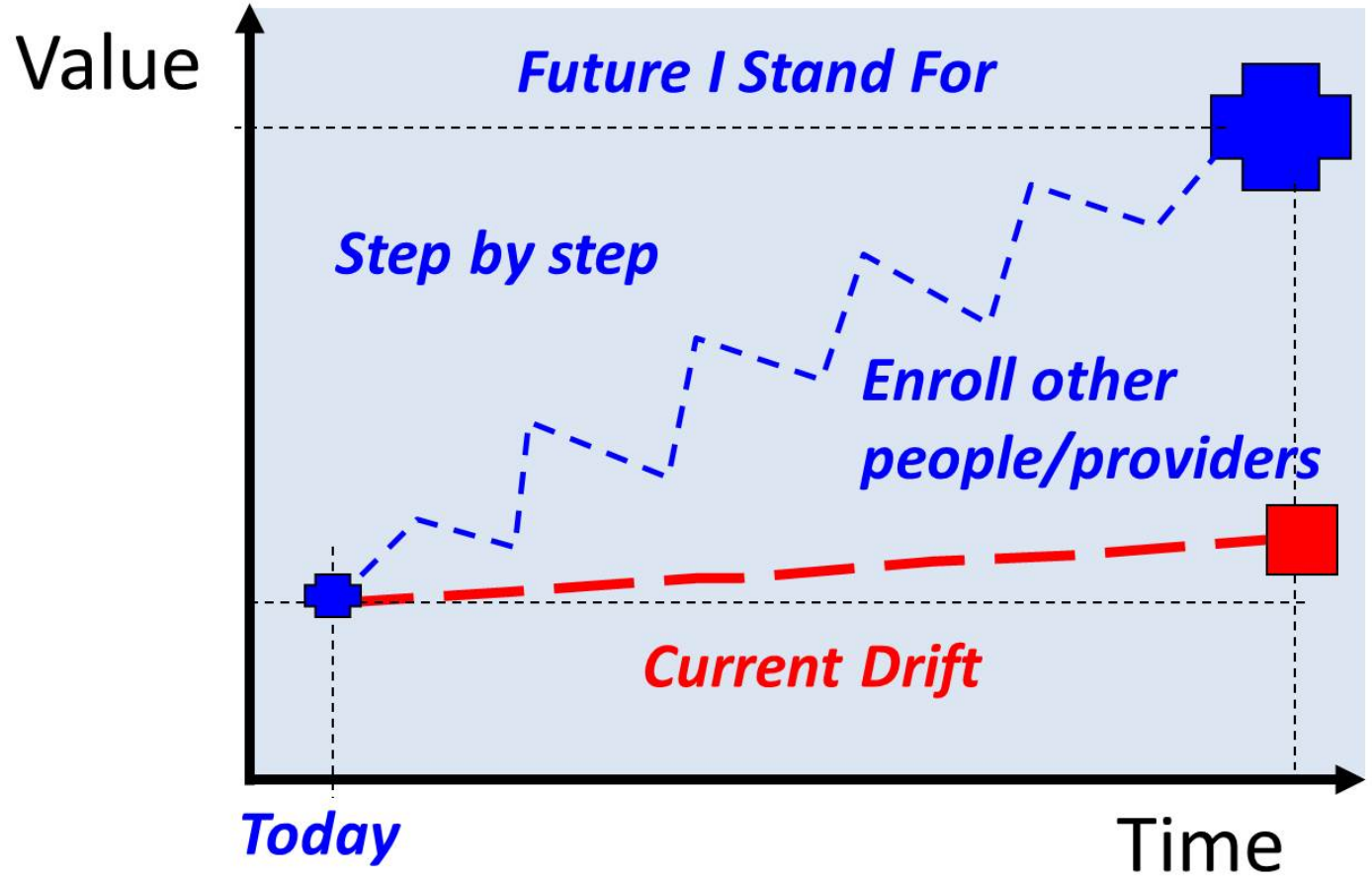
- ***What are some of the leadership choices you are contemplating or are making at this particular juncture in your career and your life?***

Aims & Results:
a choice we make every day



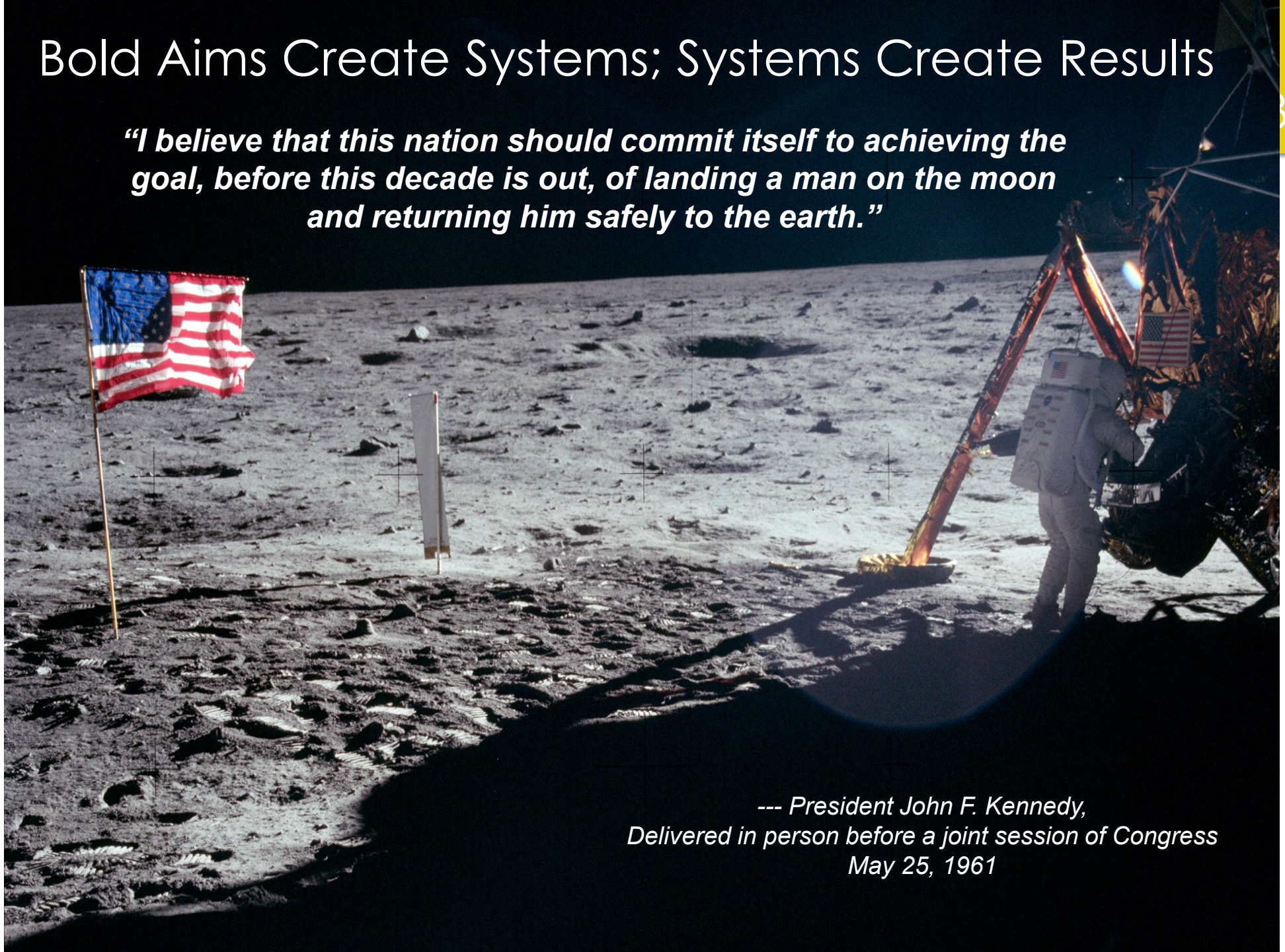
A Leadership Choice – Breakthrough Aims

Emergent Strategy: Stand For Bold Aims, Enroll Others, Persist, Learn, Evolve...Fast



Bold Aims Create Systems; Systems Create Results

"I believe that this nation should commit itself to achieving the goal, before this decade is out, of landing a man on the moon and returning him safely to the earth."



--- President John F. Kennedy,
Delivered in person before a joint session of Congress
May 25, 1961

Partnership for Patients Model Test Committed to Two Breakthrough Aims in 2011

GOALS:

40% **Reduction in Preventable Hospital-Acquired Conditions**

1.8 Million Fewer Injuries | 60,000 Lives Saved

20% **Reduction in 30-Day Readmissions**

1.6 Million Patients Recover without Readmission

Aims Create Systems---Systems Generate Results

Source: Partnership for Patients

A Bold Aim and Hard Work by Many Thousands of Clinicians Led to Major National Results 2010-2014

- 39% Reduction in Preventable Harm
- 87,000 lives saved
- $19.8B in cost savings
- 2.1M fewer harms

Source: Agency for Healthcare Research & Quality. "Saving Lives and Saving Money: Hospital-Acquired Conditions Update. Interim Data From National Efforts To Make Care Safer, 2010-2014." December 1, 2015.

A Clear Purpose: Get to Santiago de Compostela

St Jean Pied de Port in France to Santiago de Compostela in Spain:
799 kilometers -- 496.5 miles

Plan, Do, Study Act in Action on the Camino!

My family discovered and implemented many opportunities for PDSA cycles!

- Blister Prevention
- Blister Treatment
- Hydration
- Backpack Adjusting
- Managing & Minimizing Foot Pain
- Spouse Collaboration

A Powerful Shared Mindset: Leadership Speech Acts

- Assertions
- Declarations
- Requests & Offers
- Acknowledgements
- “Yes, and”
- Effective Questions

Leadership Happens Through Language

Leadership Speech Acts Are Not:

- Complaints
- Gossip
- Worries & Frets
- Ineffective Questions
- Excuses
- Blame

Leadership Happens Through Language

Questions for Reflection & Action

- ***What are your reactions and insights about Leadership Speech Acts?***
- ***What are your experiences with using Bold Aims to build systems & drive results?***
- ***What bold aims are you committing to now… in your work, in CRMC, and in your life?***

My Requests to Each of You

- Choose to Make & Stand for Bold Aims on Important Priorities like Improving the Health of Patients with Chronic Disease…and Getting Paid for Your Valuable Results
- Intentionally Use Leadership Speech Acts to Drive Progress, Results and Teamwork
- Lean In on the opportunity of the California Right Meds Collaborative
- Share these Concepts of Choice, Using Aims to Create Systems & Results, and Leadership Speech Acts -- in the Next 24 Hours

Together, we can achieve our bold Aims.

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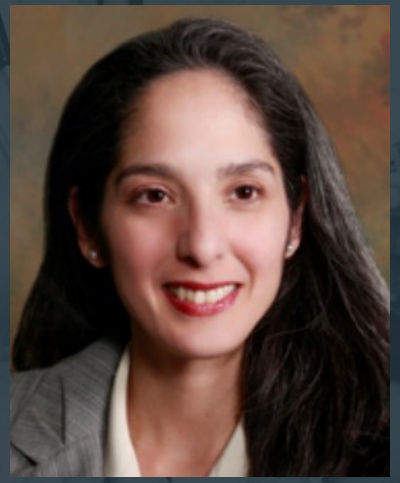
Chronic Disease Control Branch &
California Right Meds Collaborative Collaboration



Jessica Núñez de Ybarra, MD, MPH, FACPM
Chronic Disease Control Branch Chief
Public Health Medical Administrator
California Department of Public Health

Presentation Objective

- Summarize CDPH CDCB priorities that align with the work of California Right Meds Collaborative

Burden of Chronic Disease and Injury

- Most Californians die from chronic disease.
- Many Californians have multiple chronic diseases, lowering their quality of life and increasing medical costs.
- Not all Californians have the same opportunities for a healthy life.

***The Burden of Chronic Disease, Injury, and Environmental Exposure, California, Second Edition 2020*, Report**

Chronic Disease Control Branch

Mission

Prevent and optimally manage chronic disease

In collaboration with partners, CDCB strives to decrease the rate of chronic disease-related premature deaths and preventable disability by:

- monitoring the burden of chronic disease,
- promoting positive lifestyle modifications,
- improving chronic disease systems of care,
- sharing best health practices and innovative research, and
- training future public health leaders.

CDCB Programs and Initiatives

- California Alzheimer's Disease Program (research, local health department pilot, clinical center services)
- California Farmworker Health Study
- California Heart Disease, Stroke, and Diabetes Prevention
  - California Cardiovascular Disease Prevention Program
  - California Stroke Registry/California Coverdell Program
  - Prevention Forward
  - Well-Integrated Screening and Evaluation for Women Across the Nation (WISEWOMAN)
- California Preventive Health and Health Services Block Grant Prevention 2020
- California Sickle Cell Care Centers Network for Adults
- Workforce Development
  - California Epidemiologic Investigation Service Fellowship Program
  - Preventive Medicine Residency Program

Public Health

"Public Health is what we, as a society, do collectively to assure the conditions in which people can be healthy."

Institute of Medicine (IOM), The Future of Public Health. National Academy Press; Washington, D.C., 1988.

Pharmacists working everyday in these unprecedented times – THANK YOU!!!

- COVID-19 pandemic
- Heat wave and drought
- Wildfires and smoke
- Recession, Increasing job losses and salary reductions
- Increasing Home and Food Insecurity
- Social isolation, depression
- Domestic Violence
- Increasing Disparities – Income, Technology, Health, Education

Health Equity Definition

… attainment of the highest level of health for all people

Achieving health equity requires valuing everyone equally with focused and ongoing societal efforts to address avoidable inequalities, historical and contemporary injustices, and the elimination of health disparities.

U.S. Department of Health and Human Services. The Secretary's Advisory Committee on National Health Promotion and Disease Prevention Objectives for 2020. Phase I report: Recommendations for the framework and format of Healthy People 2020. Section IV. Advisory Committee findings and recommendations. Available at http://www.healthypeople.gov/hp2020/advisory/PhaseI/sec4.htm#_Toc211942917 (accessed 2/4/11).

Opportunities for Collaboration on CVD prevention

CDCB will partner to improve health outcomes and promote health equity

- Support delivery of prevention services to optimize healthy communities
  - Promote and share information about Comprehensive Medication Management (CMM) Collaborative Practice Agreements and adoption.
  - Host webinars on lifestyle modification/referral (via health information exchange), including self-measured blood pressure monitoring training.
- Connect community programs to clinical services
  - Promote adoption and implementation of team-based care approaches with the inclusion of non-physician team members (e.g., stroke coordinators, community health workers and pharmacists).
- Track and share chronic disease data
  - For hospitalized acute stroke patients, California Stroke registry will collect COVID-19 information.
  - Pilot acute stroke patient referral to CMM post hospitalization (blood pressure control, tobacco cessation, fall and injury prevention).
- Build capacity and future sustainability for prevention
  - Promoting telehealth capacity to link patients to health care services to reduce delayed care.

Thank you!

Jessica M. Núñez de Ybarra, MD, MPH, FACPM, Chief
Chronic Disease Control Branch

California Department of Public Health
jnunez2@cdph.ca.gov

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Better Blood Pressure Control Through Wider Use of CMM

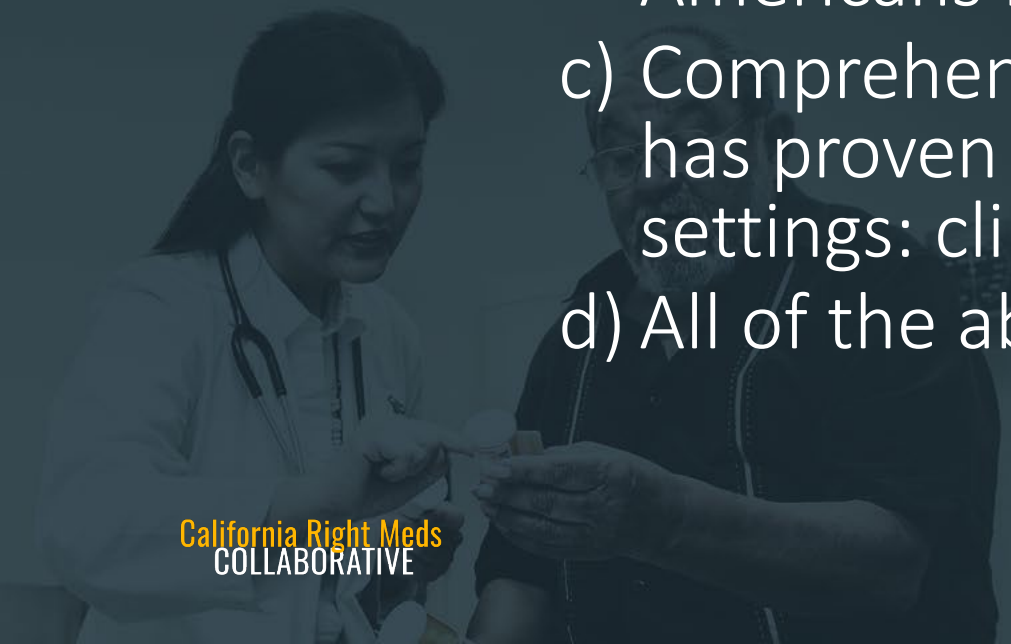
Tony Kuo, MD, MSH
Director, Division of Chronic Disease and Injury Prevention
Los Angeles Department of Public Health / Co-Program Leader
Population Health Program, UCLA Clinical and Translational Science Institute

Objectives

- Describe the current state of detection and control of risk factors associated with cardiovascular disease in Los Angeles County
- List LA County resources and programs to support better results for patients with hypertension, diabetes, and other common chronic diseases.

Which of the following is true regarding BP management in Los Angeles County?

a) BP control has improved from 25% to 75% between 1999-2006 and 2007-2014
b) American Heart Association's target BP for Americans is 70% by 2025
c) Comprehensive medication management has proven to be effective in multiple settings: clinical, community, urban, rural
d) All of the above



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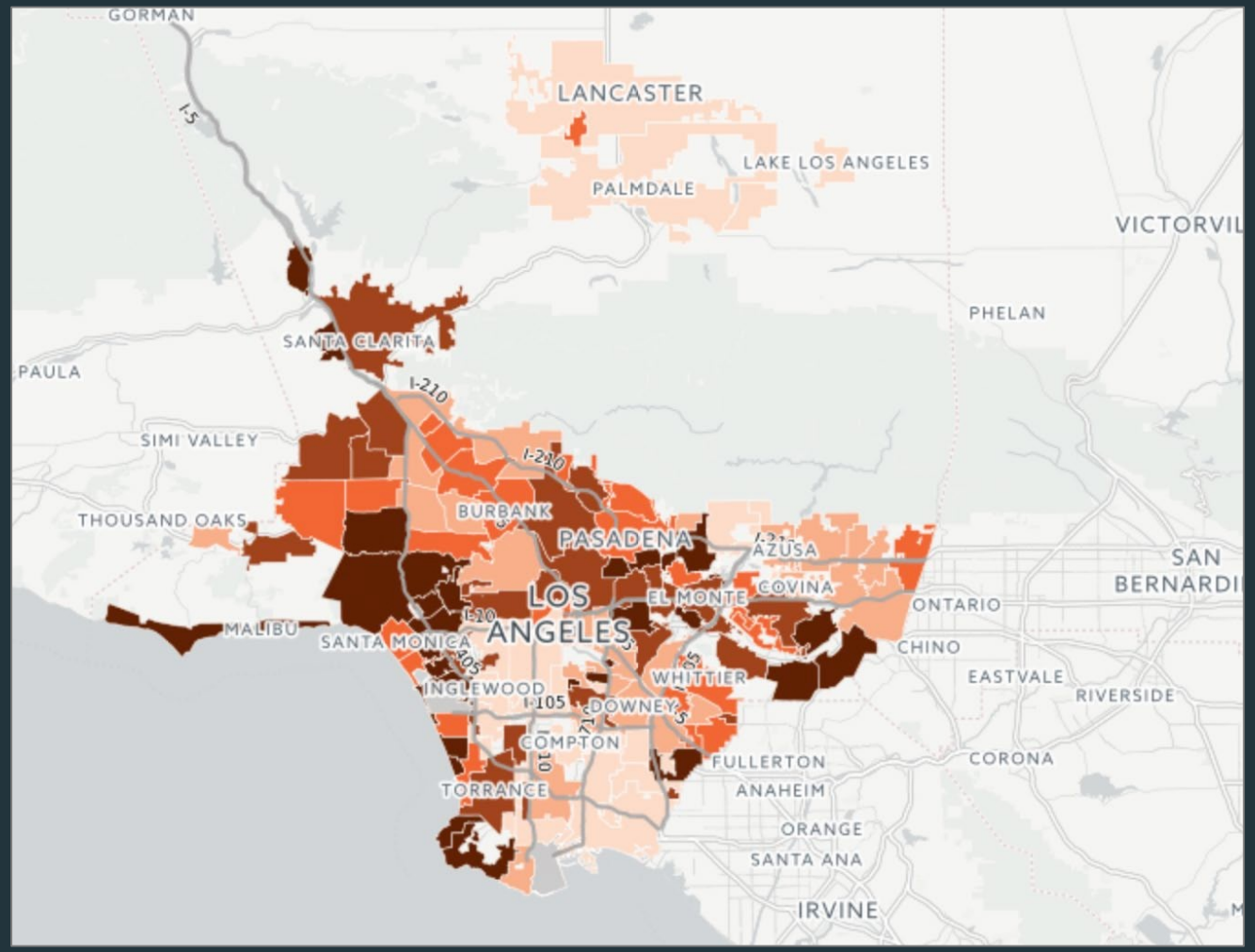
Los Angeles County: Overview

- >4,000 square miles
- 88 cities
- >100 unincorporated communities
- More than 10 million residents
- 1 of every 4 Californians lives in Los Angeles County
- >100 languages spoken

Life Expectancy in Los Angeles County by City/Community and Unincorporated Area



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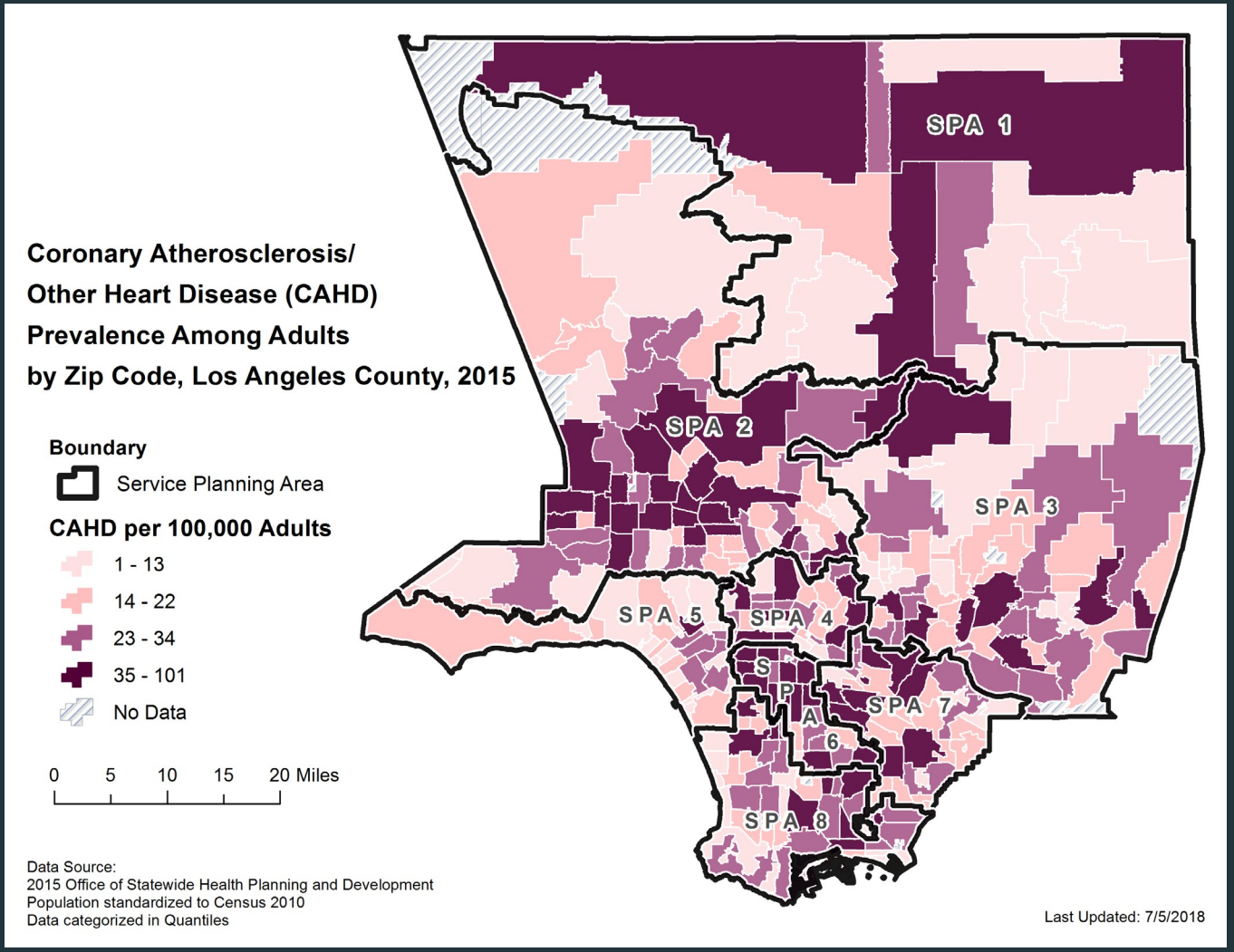
Cardiovascular Disease in Los Angeles County



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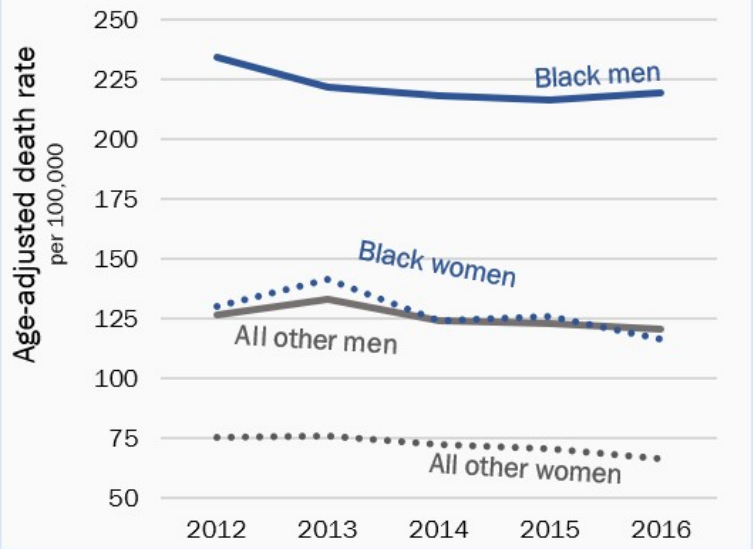
Heart Disease and Stroke in Los Angeles County

HEART DISEASE

Heart disease mortality has declined in recent years in Los Angeles County. However, among all groups, **Black men have the highest heart disease mortality rates.**[2]

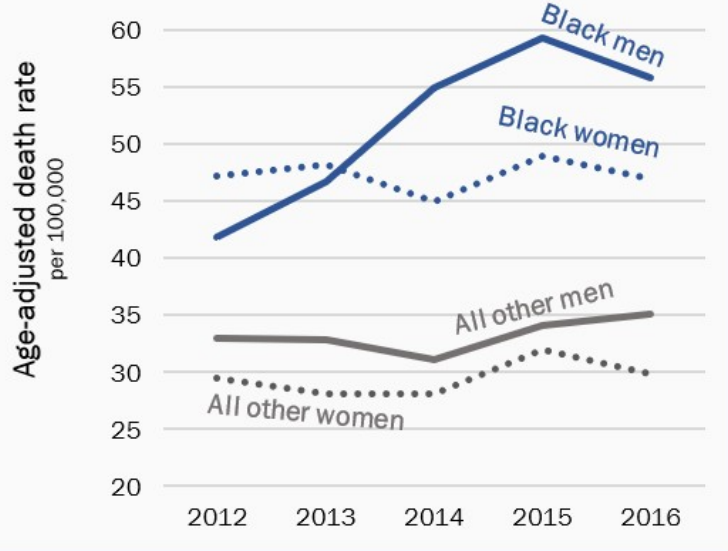
Heart disease mortality rate, Los Angeles County (2012–2016)



STROKE

Stroke mortality has been relatively stable between 2012 and 2016. However, Black men and Black women have higher stroke mortality rates than other racial or ethnic groups, and despite a recent decrease, **rates for Black men have gotten worse.**[3]

Stroke mortality rate, Los Angeles County (2012–2016)



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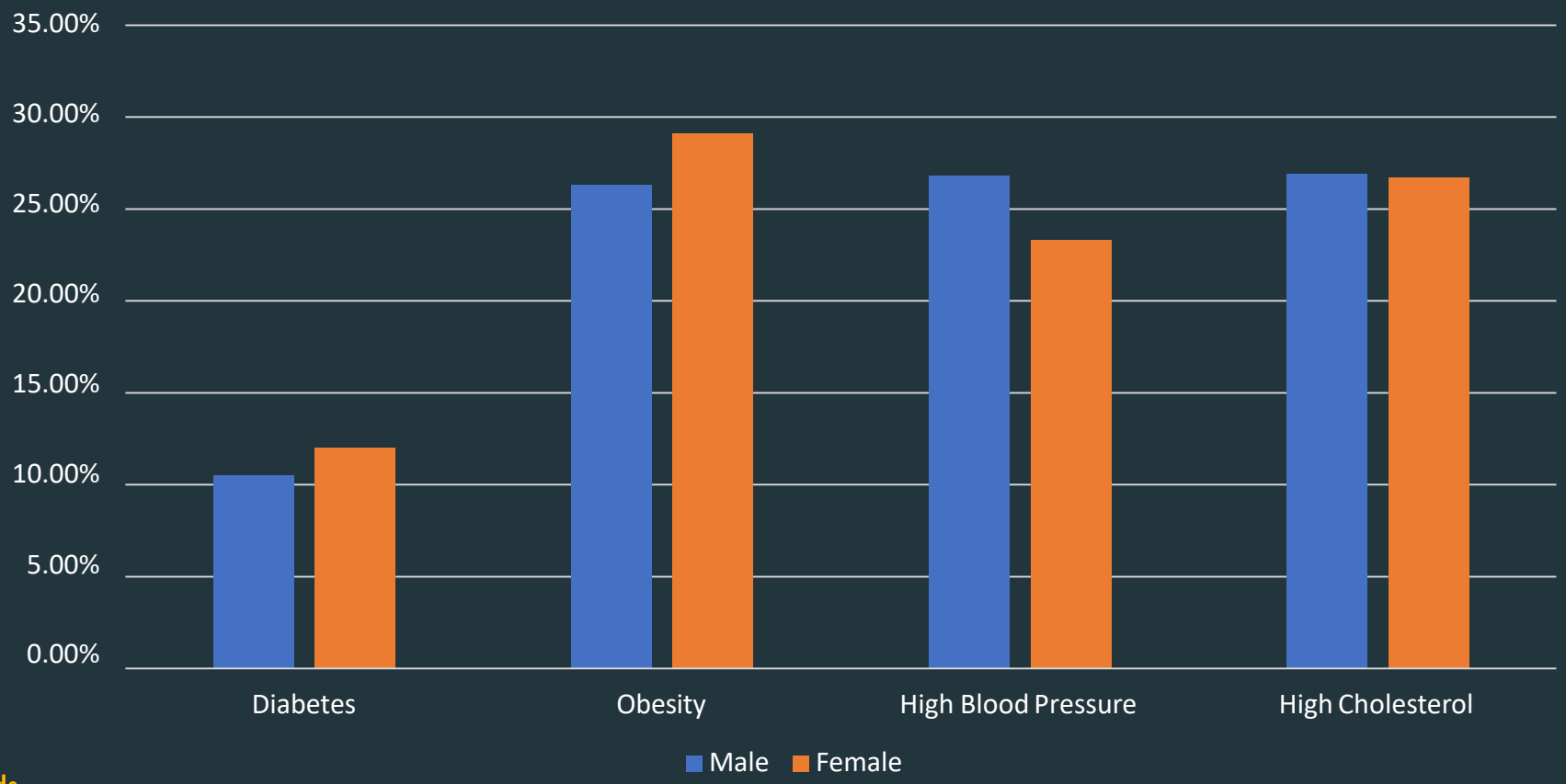
Chronic Disease Prevalence Among Adults in Los Angeles County, 2018



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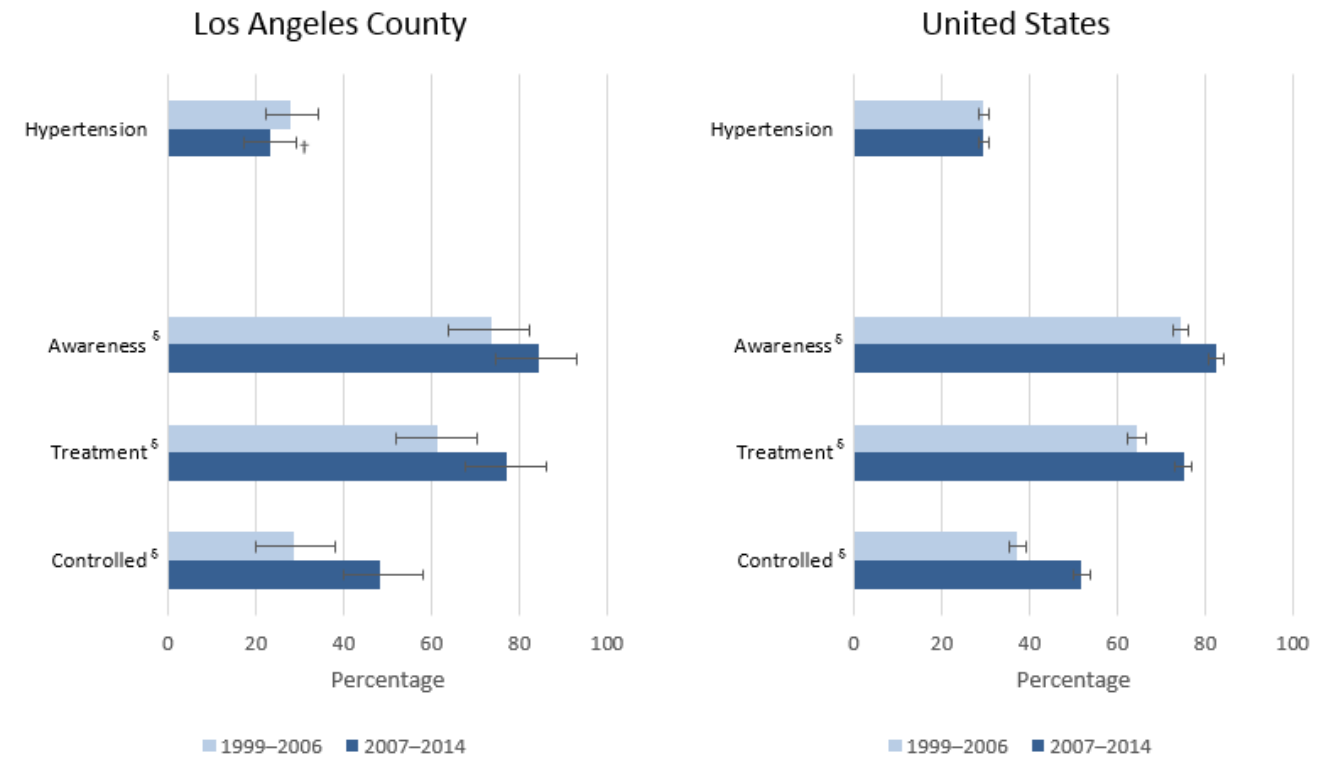
Age-adjusted prevalence of hypertension, and awareness, treatment, and control of hypertension* among adults aged ≥18 years — Los Angeles County and United States, 1999–2006 and 2007–2014



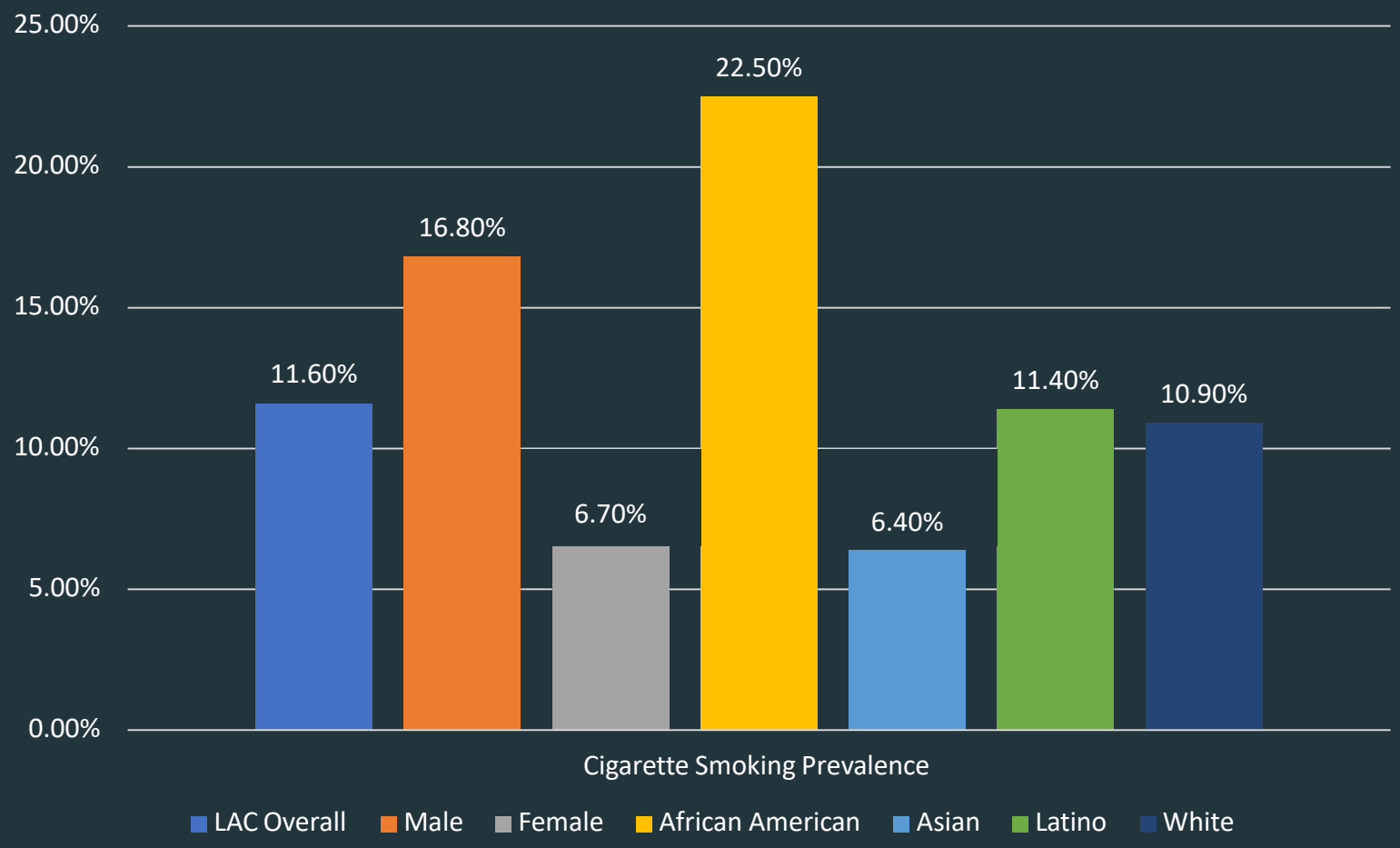
SOURCE: CDC/NCHS, National Health and Nutrition Examination Survey

*Hypertension prevalence estimates were age-adjusted by the direct method to the 2000 U.S. census population using the age groups 18–39, 40–59, and ≥60 years. Estimates for awareness, treatment, and control of hypertension were age-adjusted using the subpopulation of persons who have hypertension (age groups of 18–39, 40–59, and ≥60 years) in NHANES 2007–2008.

†Statistically significant at p<0.05 level between Los Angeles County and the United States.

§Statistically significant at p<0.05 level between 1999–2006 and 2007–2014

Adults Cigarette Smoking Prevalence in Los Angeles County, 2016



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Solutions for Healthier Communities (1817)

- Builds off of work done under CDC's 1422 Initiative (2014-2018)
- Strategies
  - "Explore and test innovative ways to engage non-physician team members (e.g., nurses, nurse practitioners, **pharmacists**, nutritionists, physical therapists, social workers) in hypertension and cholesterol management in clinical settings"
  - "Promote the adoption of MTM [includes CMM] between community pharmacists and physicians for the purpose of managing high blood pressure, high blood cholesterol, and lifestyle modification"

Solutions For Healthier Communities (SHC) Approach

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SHC's MTM/CMM Partners

Health Services
LOS ANGELES COUNTY

Scale and spread use of team care approach that incorporates use of Advanced Practice Pharmacists

Research and develop a model to effectively translate the Barbershop Research Project into a sustainable community-based model that engages pharmacists in medication management

CEDARS-SINAI

USC School of Pharmacy

Support the continued growth and development of the California Right Meds Collaborative

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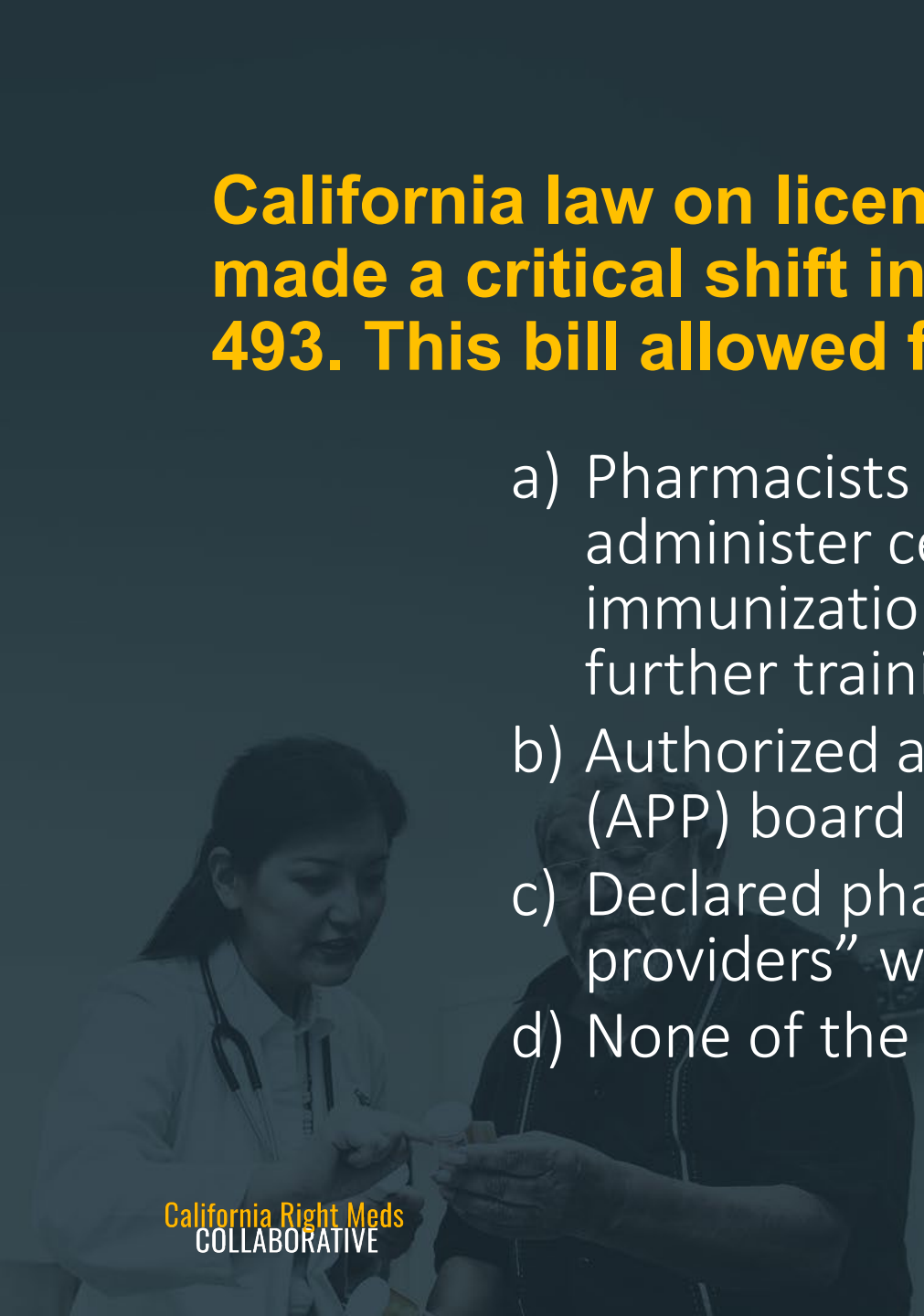
California law on licensed pharmacists' scope of practice made a critical shift in 2013 with the passing of Senate Bill 493. This bill allowed for all of the following except…

a) Pharmacists can independently initiate and administer certain medications and immunizations per state protocols without further training or certification
b) Authorized an advanced practice pharmacist (APP) board recognition program
c) Declared pharmacists to be "health care providers" who can bill for services
d) None of the above



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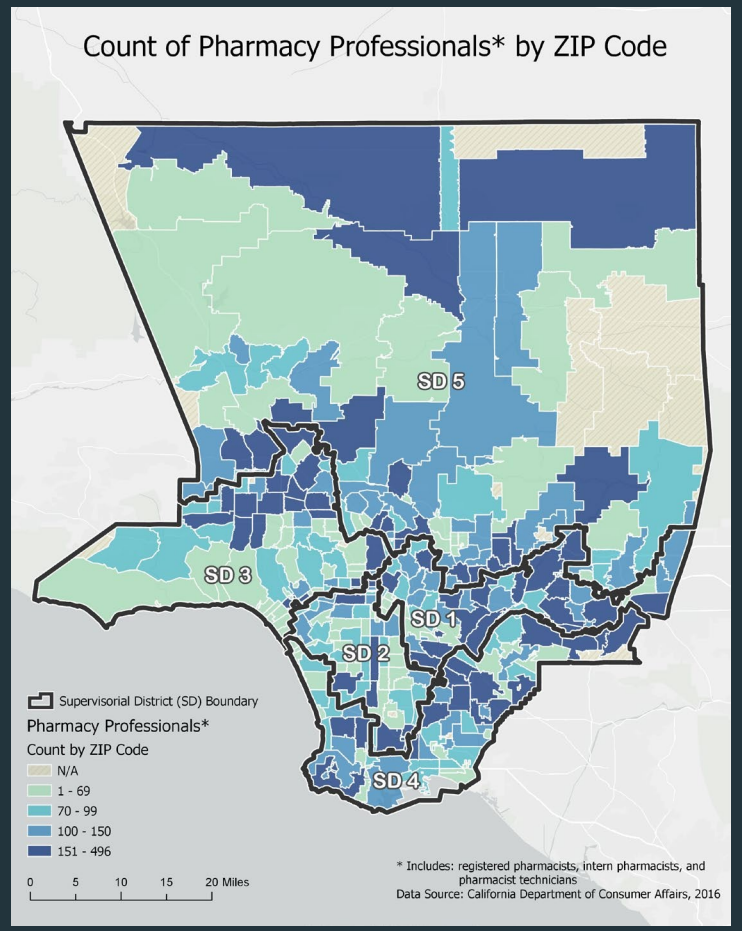
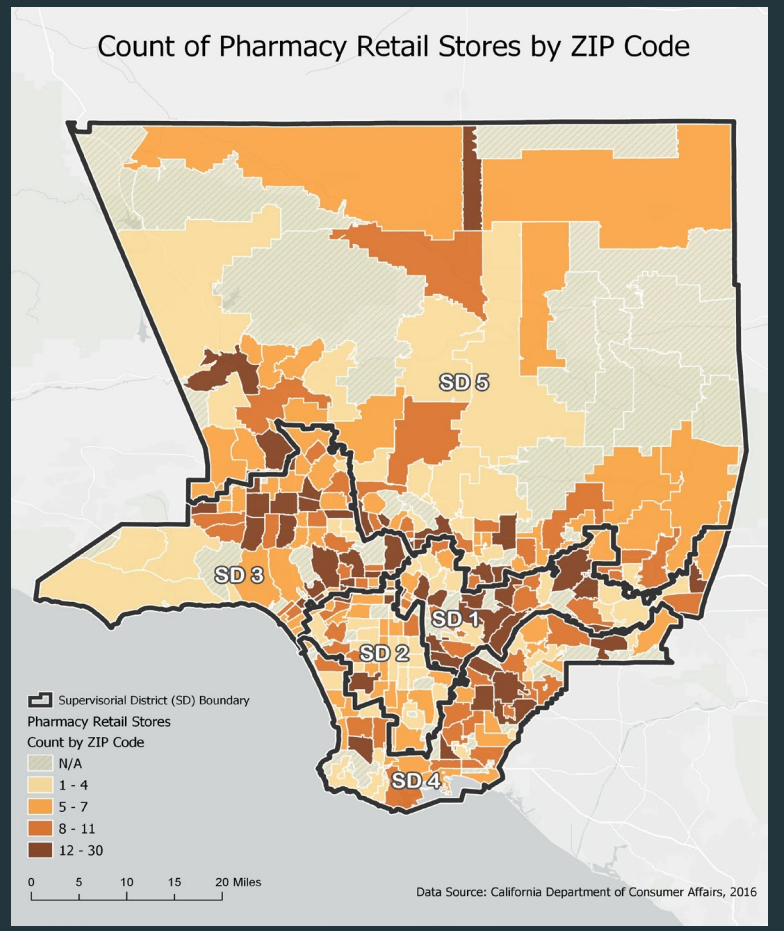
Considerations for Implementation

	Supportive Factors	Anticipated Challenges
Department of Health Services	• Building off of existing efforts • Physician and pharmacists champions • Flexible funding	• Large bureaucratic system • Competing priorities
Cedars-Sinai (Barbershop)	• Success of research project • National recognition (momentum)	• Expense of research project • Lack of sustainable reimbursement model
USC School of Pharmacy	• Building off of existing efforts • Trained workforce • Engaged partners • **Telehealth/ telecommunications**	• Lack of sustainable reimbursement model • Multiple platforms

Pharmacy Landscape in Los Angeles County





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Call to Action from the American Heart Association Western States Chronic Disease Prevention and Management Committee

The **nexus and synergy between pharmacy and public health**

The need and unprecedented opportunity to accelerate telehealth/telecommunications infrastructure due to COVID-19

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Coronavirus Disease 2019 (COVID-19)

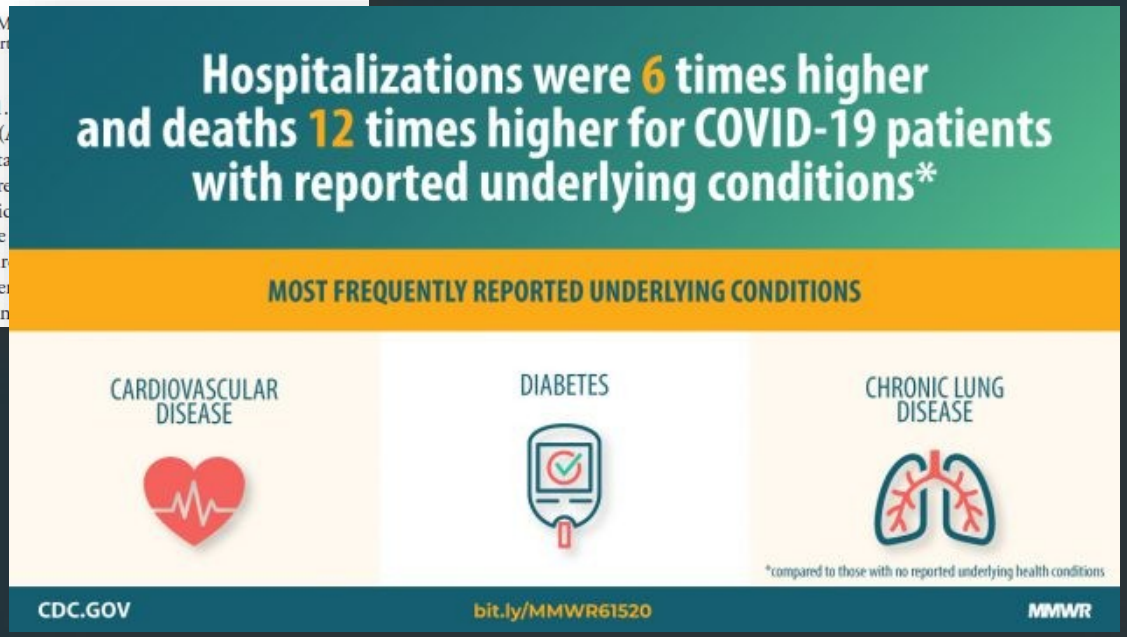
Centers for Disease Control and Prevention
MMWR
Morbidity and Mortality Weekly Report
Early Release / Vol. 69
June 15, 2020

Coronavirus Disease 2019 Case Surveillance — United States, January 22–May 30, 2020

Erin K. Stokes, MPH[1,*]; Laura D. Zambrano, PhD[1,*]; Kayla N. Anderson, PhD[1]; Ellyn P. M
Suad El Burai Felix, MPH[1]; Yunfeng Tie, PhD[1]; Kathleen E. Fuller

The coronavirus disease 2019 (COVID-19) pandemic resulted in 5,817,385 reported cases and 362,705 deaths worldwide through May, 30, 2020,[†] including 1,761,503 aggregated reported cases and 103,700 deaths in the United States.[§] Previous analyses during February–early April 2020 indicated that age ≥65 years and underlying health conditions were associated with a higher risk for severe outcomes, which were less common among children aged <18 years (*1–3*). This report describes demographic characteristics, underlying

black (black), and 1.
or Alaska Native (
with sufficient data
most common were
(30%), and chronic
(14%) patients were
to an intensive car
Hospitalizations we
a reported underlyin



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CRMC Practice Alignment Guide

Connie Kang, PharmD, BCPS, BCGP
Assistant Professor of Clinical Pharmacy
USC School of Pharmacy
September 27, 2020

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Practice Alignment Guide


Overview of guide
Select relevant resources
Continuous Professional Development Portfolio

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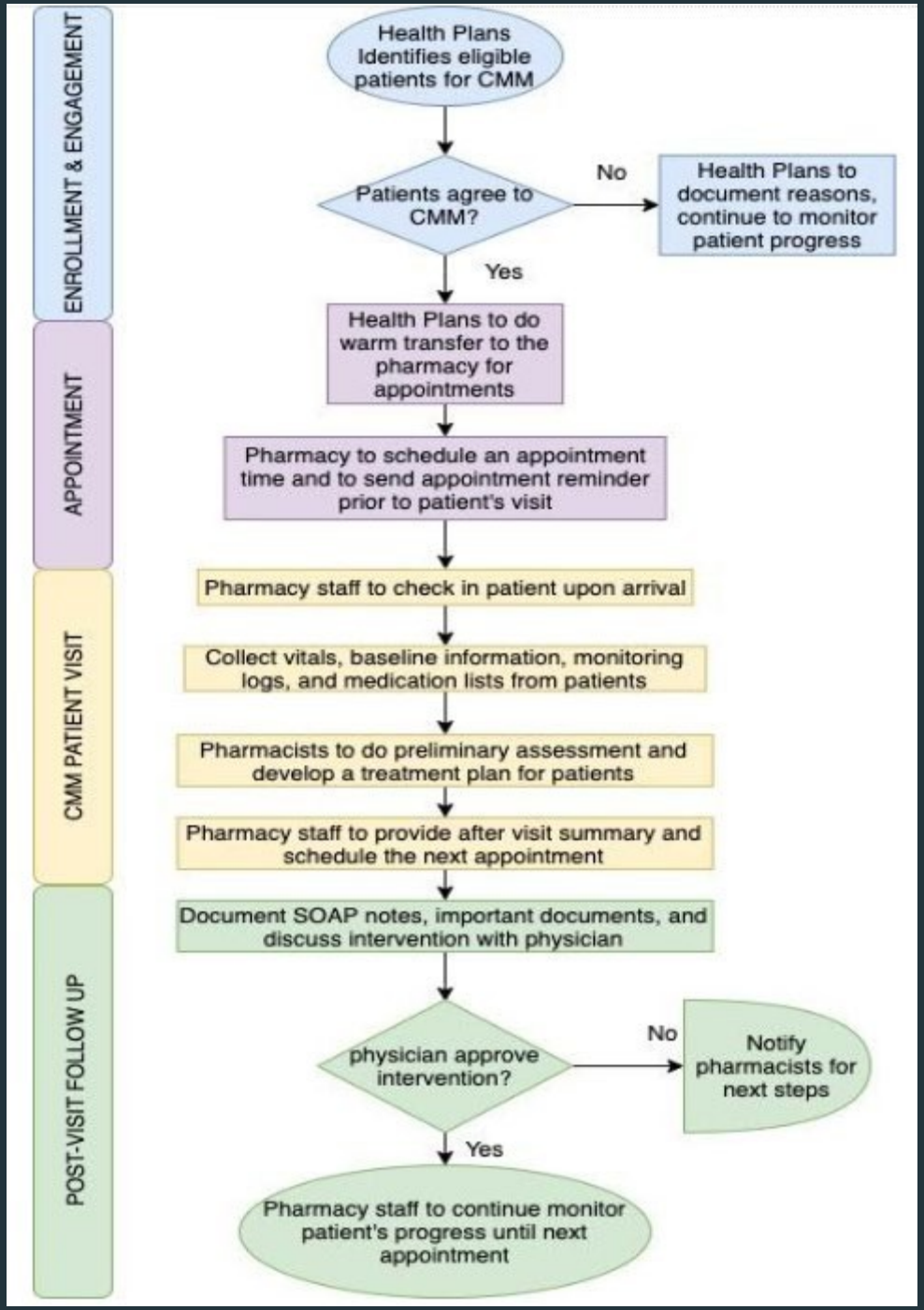
The Practice Alignment Guide contains

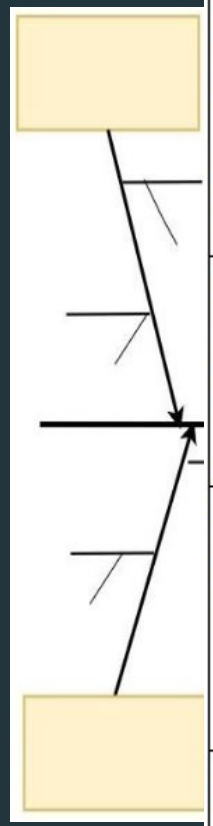
- What is CRMC, and why is it valuable
- Who is involved and why, and what's in it for them
- CMM steps
- CMM outcomes
- Quality assurance, and quality improvement
- Value proposition


Overview of guide
Select relevant resources
Continuous Professional Development Portfolio


Overview of guide
Select relevant resources
Continuous Professional Development Portfolio


ENROLLMENT & ENGAGEMENT
APPOINTMENT
CMM PATIENT VISIT
POST-VISIT FOLLOW UP
Health Plans Identifies eligible patients for CMM
Patients agree to CMM?
No
Health Plans to document reasons, continue to monitor patient progress
Yes
Health Plans to do warm transfer to the pharmacy for appointments
Pharmacy to schedule an appointment time and to send appointment reminder prior to patient's visit
Pharmacy staff to check in patient upon arrival
Collect vitals, baseline information, monitoring logs, and medication lists from patients
Pharmacists to do preliminary assessment and develop a treatment plan for patients
Pharmacy staff to provide after visit summary and schedule the next appointment
Document SOAP notes, important documents, and discuss intervention with physician
physician approve intervention?
No
Notify pharmacists for next steps
Yes
Pharmacy staff to continue monitor patient's progress until next appointment

Category	Method or Tool	Typical Use of Method or Tool	Aim & Assessment	Measures	Understand & change ideas	PDSA
I. **Viewing Systems & Processes**	Flow Diagram	Develop a diagram to represent a standardize workflow or a process in sequential order using an algorithm or a step-by-step approach to solve a task	x	x	x	
II. **Gathering & Organizing Information**	Surveys	Obtain information and organize data via a questionnaire. Record the data to identify patterns.	x	x	x	x
III. **Understanding Information & Relationships**	Force Field Analysis	Summarize forces supporting and hindering change toward a goal	x		x	
	Cause and Effect	Organize and identify potential factors and relationships causing an overall effect	x	x	x	
IV. **Understanding Variation**	Run Chart	Study variation in data over time and to assess the effectiveness of change	x	x	x	x
	Pareto Chart	Focus on areas of improvement with the greatest impact on a problem	x		x	x
V. **Team Decision Making**	Brainstorming	Generate a large number of ideas	x	x	x	
	Nominal Group	Generate a large number of ideas, gives silent time to list ideas, can use sticky notes	x	x	x	
	Multi-Voting	Narrow down a large list of ideas to fewer ideas through voting				
	Rank Order	Use to reduce a list of 10 or less, to the vital few ideas through ranking	x	x	x	
	Structured Discussion	Used to discuss the vital few ideas to arrive at a consensus decision	x	x	x	x
VI. **Projects Planning**	PDSA Cycle	Used to plan, organize, and keep track of testing, determine modifications made to the test				x



Plan	List your action steps	Person(s) responsibility	Timeline
• What is the objective of the test? • What change will you make? • Who will it involve (e.g. pharmacy, technician…)? • How long will it take to implement the change? • What resources will they need? • What data needs to be collected?			

Do	Describe what happened when the test was run
• Implement the change • Carry out the test • Document problems and unexpected observations. • Begin analysis of the data	

Study	Describe the measured results and how they compare to the predictions
• Complete the analysis of the data • Compare the data to your predictions • Summarize and reflect on what was learned. Look for: unintended consequences, surprises, successes, failures	

Act	Describe the modifications that will be made to the plan to improve for the next cycle
If the results were not what you wanted, try a new strategy. Refine the change based on what was learned from the test • Adapt – modify the changes and repeat PDSA cycle • Adopt – consider integrating the changes into the test • Abandon – change your approach and repeat PDSA cycle	

orces (-)

Date of Review_____ Pharmacy Site_____ Reviewing PharmD_____

Pharmacist_____ Patient ID#_____ Date of Note_____

Please note: For every boxed checked "No" please explain in the comments.

Subjective			
Is the primary referral reason and referral source clearly stated? Comment:_____	☐ Yes	☐ No	
Is the patient's past medical history (PMH), drug allergy, social history (SH) and family history (FH) documented? Comment:_____	☐ Yes	☐ No	☐ N/A
Objective			
Are the patient's medications (including OTC/supplements) accurately listed with name, dose, route, regimen, and indication? Comment:_____	☐ Yes	☐ No	☐ N/A
Are pertinent lab tests and vital signs being performed and documented? Comment:_____	☐ Yes	☐ No	☐ N/A
Assessment			
Are all the disease states evaluated and addressed? Comment:_____	☐ Yes	☐ No	☐ N/A
Are drug-related problems addressed? Comment:_____	☐ Yes	☐ No	☐ N/A
Is the treatment goal properly identified for each disease state? Comment:_____	☐ Yes	☐ No	☐ N/A
Is medication adherence being evaluated? Comment:_____	☐ Yes	☐ No	
Plan			
Is the pharmacist's interventions of medications, including initiating, adjusting, or stopping the medications documented? Comment:_____	☐ Yes	☐ No	☐ N/A
Are pharmacist interventions based on evidence-based practice (i.e., plans are justified with supporting evidence)? Comment:_____	☐ Yes	☐ No	☐ N/A
Is patient education and life-style modification provided? Comment:_____	☐ Yes	☐ No	☐ N/A
Is a follow-up appointment scheduled? Comment:_____	☐ Yes	☐ No	☐ N/A
Is the visit summary note sent to the physician and health plan within 24 hours of the patient's visit? Comment:_____	☐ Yes	☐ No	
Are the pharmacy interventions with the physicians followed-up and recorded? Comment:_____	☐ Yes	☐ No	☐ N/A

Additional Comments:


Overview of guide
Select relevant resources
Continuous Professional Development Portfolio

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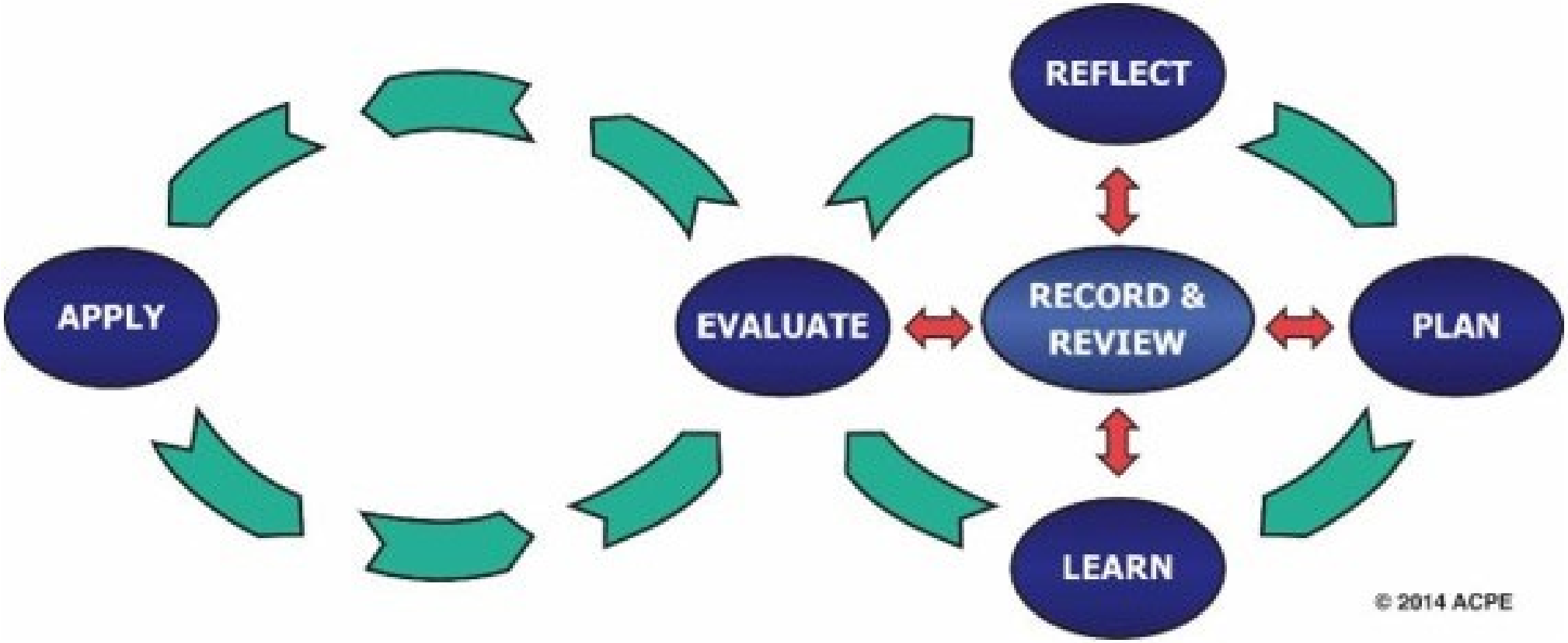
REFLECT
APPLY
EVALUATE
RECORD &
REVIEW
PLAN
LEARN
© 2014 ACPE

Request for completion

Portfolio Contents:

- ✓ REFLECT
- ✓ PLAN
- ✓ EVALUATE
- ✓ LOG (Learning Outcomes Growth)

California Right Meds Collaborative

Fall 2020 Learning Session

The CRMC Journey:

Progress, Challenges, and Successes

Steven Chen, PharmD, FASHP, FNAP

Associate Dean for Clinical Affairs

USC School of Pharmacy

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What you will hear…

- Stakeholder perspectives on the CRMC journey between the Fall 2019 LS and Fall 2020 LS (progress, challenges, successes)
  - Health Plans
  - CRMC Pharmacy Pilot Teams
  - CRMC Patient

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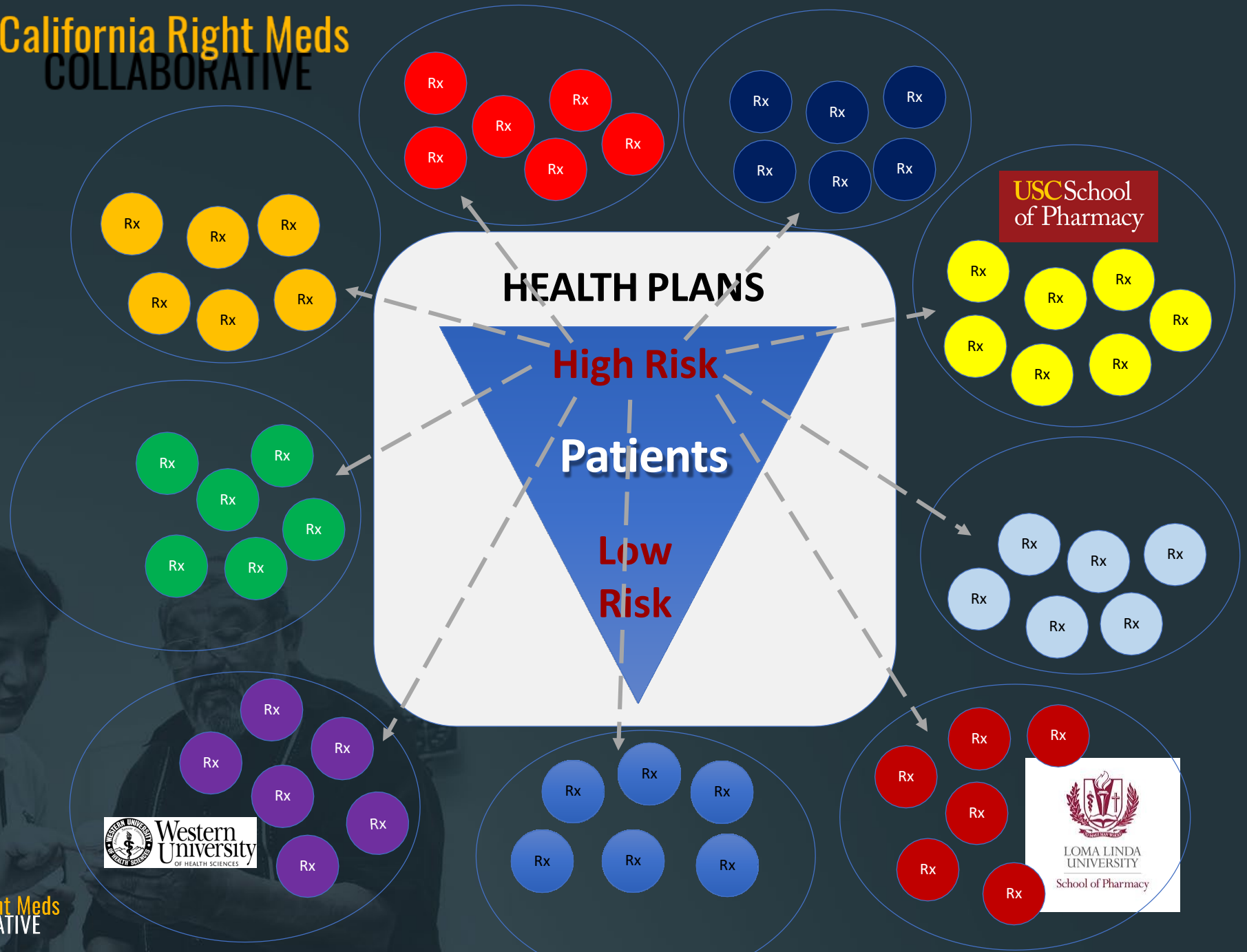

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CRMC Progression Since Fall 2019 Learning Session

Milestone	Completed	Ongoing	Pending
Selection process for CRMC pharmacies	✓		
Intensive training for pilot CRMC sites (live, patient actors, webinar)	✓		
Patient and medical provider targeting and enrollment strategies	✓		
Value-based payment models	✓		
QI dashboard & tools for teams	✓		
Learning Sessions, 1:1 Coaching		✓	
Pilot program- PDSA, adaptive modeling, toolkit and resources		✓	
Webinars / case reviews every 1-2 weeks		✓	
Spread awareness of and engagement in CRMC (health plans, government, public)- 2020/2021		✓	
Launch full rollout- Early 2021			✓


January
February
March
April
May
June

CRMC Progression Since Fall 2019 Learning Session

Milestone	Completed	Ongoing	Pending
Selection process for CRMC pharmacies	✓		
Intensive training for pilot CRMC sites (live, patient actors, webinar)	✓		
Patient and medical provider targeting and enrollment strategies	✓		
Value-based payment models	✓		
QI dashboard & tools for teams	✓		
Learning Sessions, 1:1 Coaching, special training (CMM, remote care)		✓	
Pilot program- PDSA, adaptive modeling, toolkit and resources		✓	
Webinars / case reviews every 1-2 weeks		✓	
Spread awareness of and engagement in CRMC (health plans, government, public)- 2020/2021		✓	
Launch full rollout- Early 2021			✓

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Health Plan Updates: Challenges, Opportunities, and Future Directions

Alex C. Kang, PharmD, APh, BCPS, BCACP, BCGP
Director, Clinical Pharmacy
Pharmacy and Formulary
L.A. Care Health Plan

L.A. Care Health Plan

Partners:

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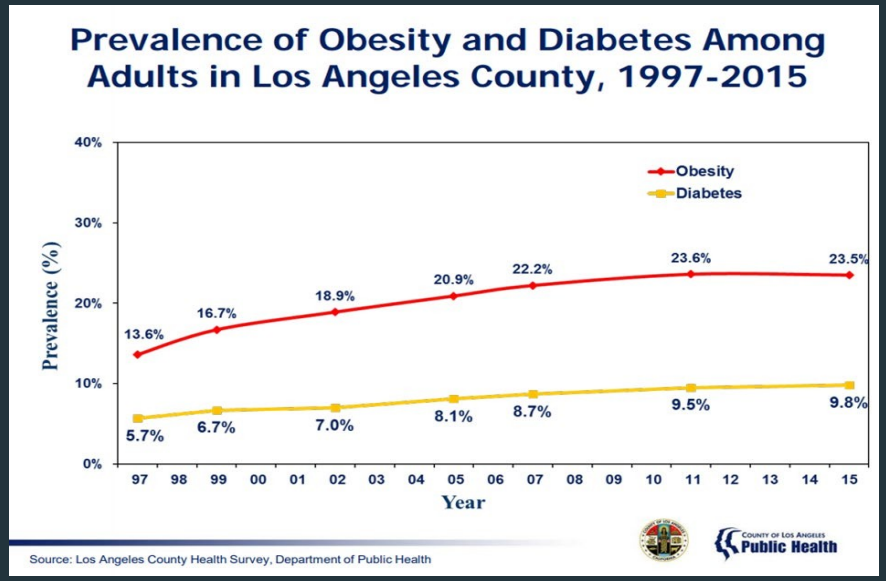
IEHP A Public Entity Inland Empire Health Plan

County of Los Angeles Public Health

ELEVATING HEALTHCARE IN LOS ANGELES COUNTY SINCE 1997

Health Disparities in Los Angeles County

- Social Determinants of Health
  - 22.4% of adults have less than a high school education
  - 18.4% of household incomes are less than 100% of the federal poverty level (FPL)
- Health Outcomes
  - 23.5% of adults are obese
  - 35.9% of adults are overweight
  - 9.8% of adults ever diagnosed with **diabetes**
  - 23.5% percent of adults ever diagnosed with **hypertension**
  - 25.2% of adults ever diagnosed with **high blood cholesterol**



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Current and Evolving Chronic Disease Control Challenges

Provider Partnerships

COVID-19 Contingency Plan

Health Plan Data Lag

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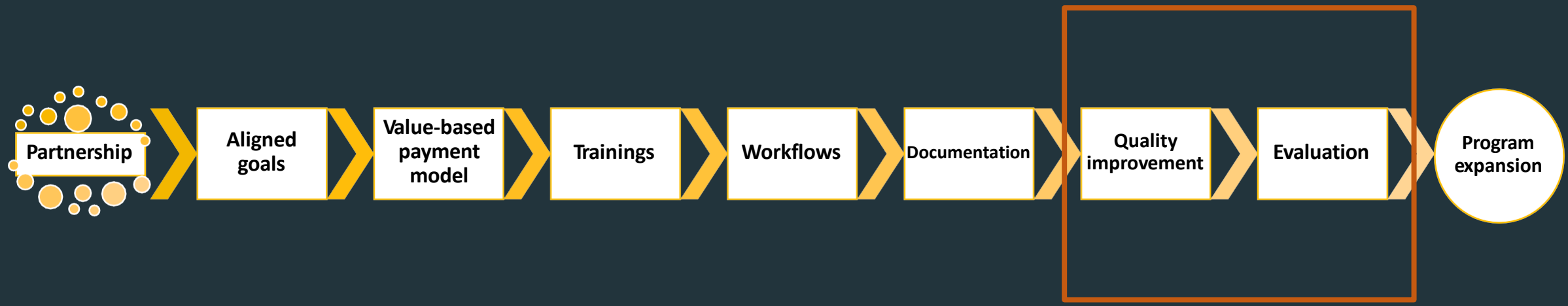
L.A. Care Programs

		Medi-Cal				Medicare			
HEDIS Measure	Sub Measure	2019 Rate	2018 Rate	2017 Rate	2016 Rate	2019 Rate	2018 Rate	2017 Rate	2016 Rate
Comprehensive Diabetes Care (CDC)	Blood Pressure Control <140/90	↑41.89%	17.86%	11.10%	11.77%	↓36.01%	36.65%	42.09%	25.75%
	HbA1c Poor Control >9%	↑46.37%	42.32%	43.39%	46.36%	↑32.45%	31.52%	38.23%	46.73%
	Medical Attention for Nephropathy	↑92.24%	91.00%	90.09%	90.91%	↑96.16%	95.24%	95.38%	94.27%
Asthma Medication Ratio (AMR)	Asthma Medication Ratio	↓53.10%	55.64%	56.65%	55.85%	N/A	N/A	N/A	N/A
Statin Therapy for Patients With Cardiovascular Disease (SPC)	Statin Adherence 80%	↑71.69%	69.72%	73.73%	68.63%	↑74.45%	72.67%	76.42%	69.89%
Statin Therapy for Patients With Diabetes (SPD)	Statin Adherence 80%	↑67.71%	66.73%	70.90%	63.57%	↑74.27%	72.13%	75.30%	69.75%

CRMC - Pathway to Success



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Alignments achieved through CRMC

- Alignment of Health Plan-Patient-Pharmacy-Physician
  - Clinical outcomes
  - PPG/Direct Network Involvement
  - Collaborative Practice Agreements
  - EHR access
- Continuity of chronic disease management
  - Telehealth

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Health Plan Updates:
Challenges, Opportunities, and Future Directions

Edward Jai, PharmD
Senior Director and Chief Pharmacist
Inland Empire Health Plan

Inland Empire Health Plan

Current Challenges

- Medi-Cal HEDIS Measures
- Medi-Cal Managed Care Accountability Set
- California Medicare-Medicaid Plan (MMP) HEDIS

Chronic Disease is a big problem

- Hypertension: CBP
- Diabetes: CDC-H9
- Asthma: AMR
- Depression: AMM x 2

Quality Withhold Measures

IEHP Inland Empire Health Plan

DY 6-8 (2020-22) Quality Withhold Measure Set

(Proposed Change)

CMS Core Measure Set

- Plan All-Cause Readmissions
- Controlling Blood Pressure
- Follow-Up After Hospitalization for
- Annual Flu Vaccine
- Medication Adherence for Diabetes
- Encounter Data

California-Specific Measure Set

- Members receiving Medi-Cal Speci
  Coordination with the Primary Me
- Reduction in Emergency Departme
  Substance Use Disorder Members
- Documentation of Care Goals (CA1
- Interaction with Care Team (CA1.1
- ***NEW** Core Measure 3.2 Percent of
  90 days of enrollment

California Department of Health Care Services
(Updated October 23, 2019)

Managed Care Accountability Set (MCAS) for Medi-Cal Managed Care Plans (MCPs)
Measurement Year 2019 | Reporting Year 2020

Based on Centers for Medicare & Medicaid Services (CMS) Adult and Child Core Sets for RY 2019

	MEASURE ACRONYM	MEASURE Total Number of Measures = 40 (13 Hybrid + 27 Administrative)	MEASURE TYPE METHODOLOGY	HELD TO MPL?
1	PCR[i]	Plan All-Cause Readmissions	Administrative	No
2	AWC	Adolescent Well-Care Visits	Hybrid	Yes
3	ABA	Adult Body Mass Index (BMI) Assessment	Hybrid	Yes
4	AMM-Acute	Antidepressant Medication Management: Acute Phase Treatment	Administrative	Yes
5	AMM-Cont	Antidepressant Medication Management: Continuation Phase Treatment	Administrative	Yes
6	AMR	Asthma Medication Ratio [ii]	Administrative	Yes [iii]
7	BCS	Breast Cancer Screening	Administrative	Yes
8	CCS	Cervical Cancer Screening	Hybrid	Yes
9	CIS-10	Childhood Immunization Status: Combination 10	Hybrid	Yes
10	CHL	Chlamydia Screening in Women [ii]	Administrative	Yes [iii]
11	CDC-HT	Comprehensive Diabetes Care: Hemoglobin A1c (HbA1c) Testing	Hybrid	Yes
12	CDC-H9	Comprehensive Diabetes Care: HbA1c Poor Control (>9.0%)	Hybrid	Yes
13	CBP	Controlling High Blood Pressure	Hybrid	Yes
14	IMA-2	Immunizations for Adolescents: Combination 2	Hybrid	Yes
15	PPC-Pre	Prenatal and Postpartum Care: Timeliness of Prenatal Care	Hybrid	Yes
16	PPC-Pst	Prenatal and Postpartum Care: Postpartum Care	Hybrid	Yes
17	WCC-BMI	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents: BMI Assessment for Children/Adolescents	Hybrid	Yes
18	W15	Well-Child Visits in the First 15 Months of Life: Six or	Hybrid	Yes

How are we doing?

- Some wins/losses…

Measure	DY 1 (2015)	DY2 (2016)	DY3 (2017)	DY4 (2018)		2018 Benchmark	2018 Goal Met?	Proposed 2020 Goal Changes
Plan All-Cause Readmissions Rate	21.87%	20.35%	19.99%	**21.06%**				
Plan All-Cause Readmissions Observed to Expected Ratio	1.0	0.88	0.8764	**0.8927↑**		<1.00	YES	<0.85
Controlling High Blood Pressure**NOT SCORED FOR 2018/2019	62.25%	62.75%	62.53%	**66.91%↑**		56%	YES	71%
Follow-up After Hospitalization For Mental Illness (FUH)	49.80%	60.20%	50.59%	**52.69%↑**		56%	NO	No change
Annual Flu Vaccine	58.9%	62.9%	60.0%	**66.0%↑**		69%	NO	No change
Medication Adherence For Diabetes Medications	72.4%	72.7%	74.6%	**76.4%**		73%	Yes	80%
Encounter Data Frequency-monthly	NA	63%	65.8%	**79.2%**	**63.1%**			
Encounter Data Timeliness-180 days	NA	63%	42.3%	**47.0%**		80%	NO	No change

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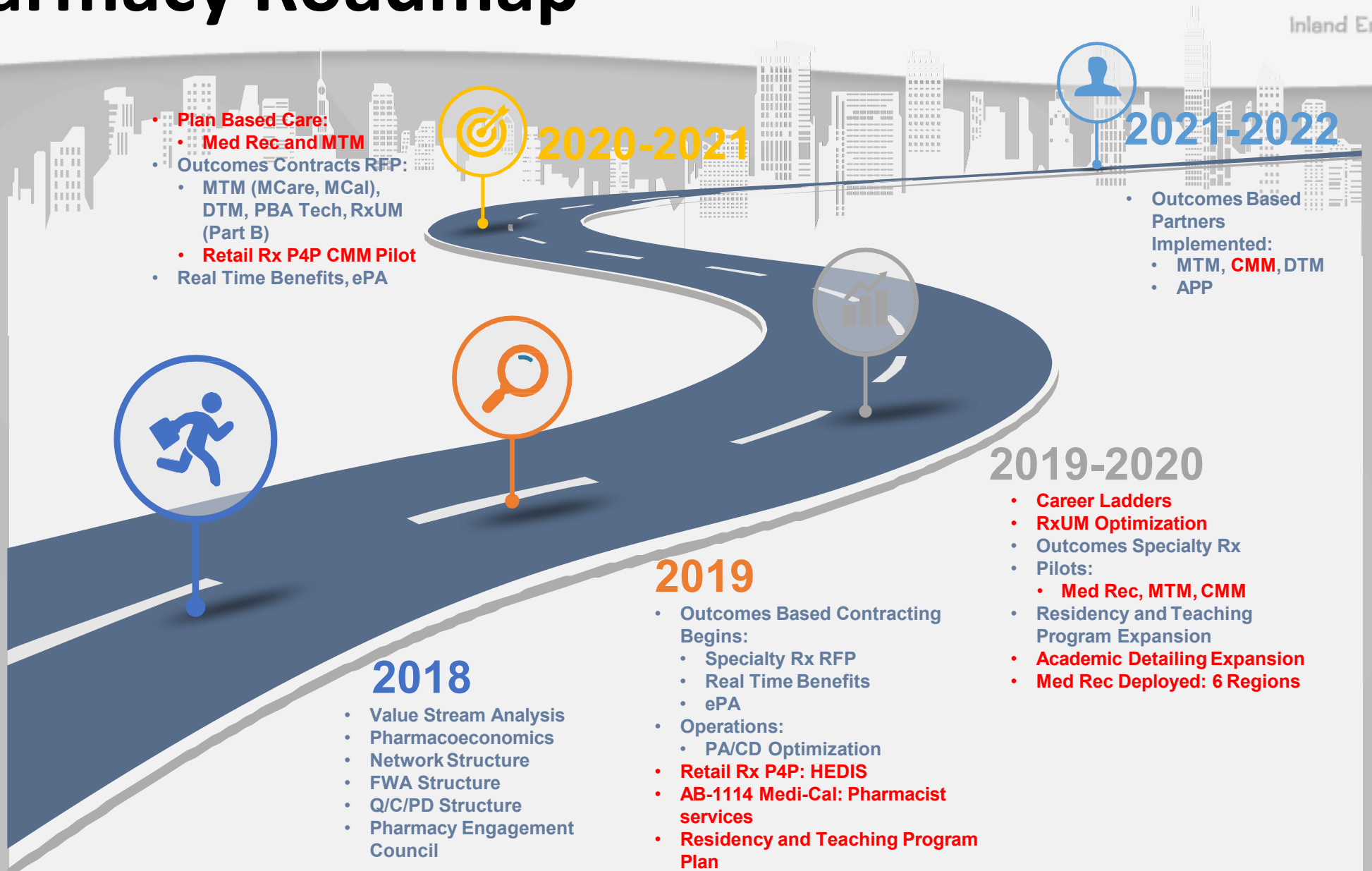
Where are we going?

- Medication Therapy Management
- Comprehensive Medication Management
- Telehealth/Remote Patient Monitoring

Pharmacy Roadmap



2018

- Value Stream Analysis
- Pharmacoeconomics
- Network Structure
- FWA Structure
- Q/C/PD Structure
- Pharmacy Engagement Council

2019

- Outcomes Based Contracting Begins:
  - Specialty Rx RFP
  - Real Time Benefits
  - ePA
- Operations:
  - PA/CD Optimization
- **Retail Rx P4P: HEDIS**
- **AB-1114 Medi-Cal: Pharmacist services**
- **Residency and Teaching Program Plan**

2019-2020

- **Career Ladders**
- **RxUM Optimization**
- Outcomes Specialty Rx
- Pilots:
  - **Med Rec, MTM, CMM**
- Residency and Teaching Program Expansion
- **Academic Detailing Expansion**
- **Med Rec Deployed: 6 Regions**

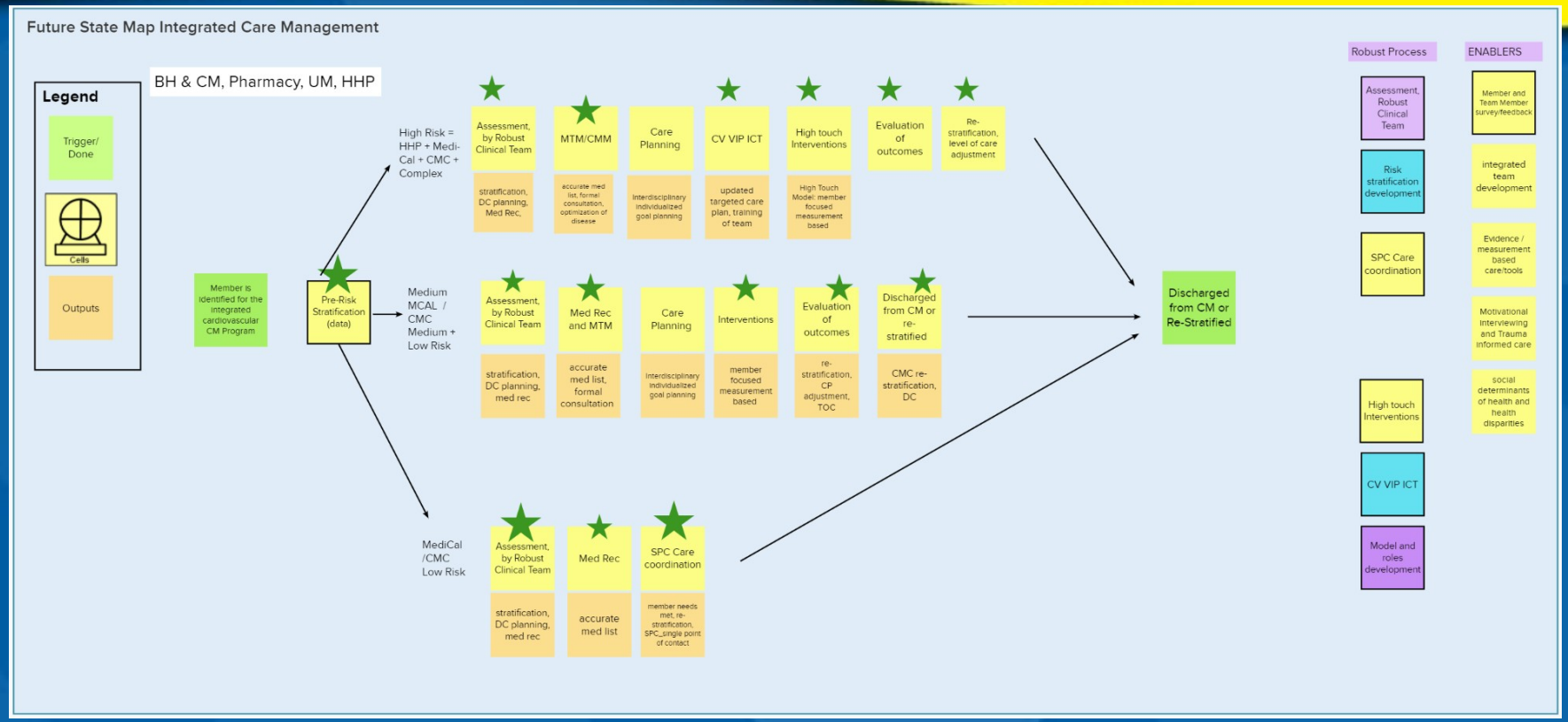
2020-2021

- **Plan Based Care:**
  - **Med Rec and MTM**
- Outcomes Contracts RFP:
  - MTM (MCare, MCal), DTM, PBA Tech, RxUM (Part B)
  - **Retail Rx P4P CMM Pilot**
- Real Time Benefits, ePA

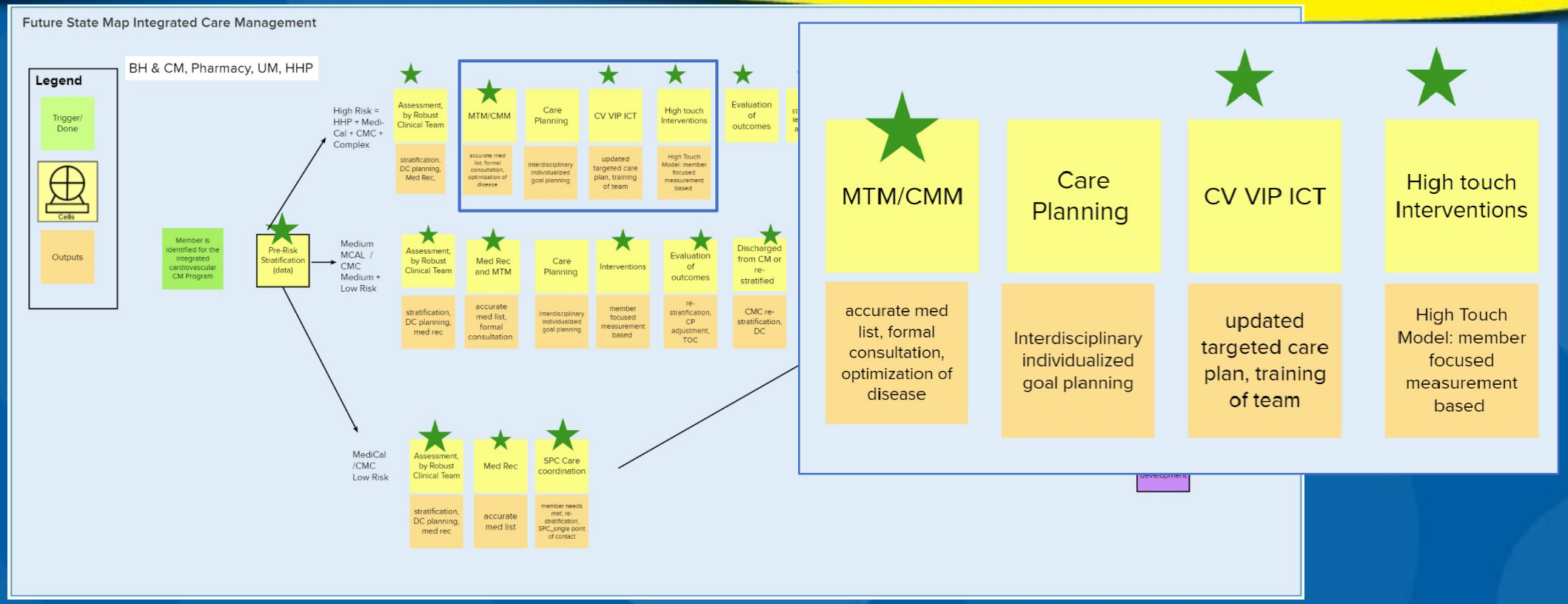
2021-2022

- Outcomes Based Partners Implemented:
  - MTM, **CMM**, DTM
  - APP

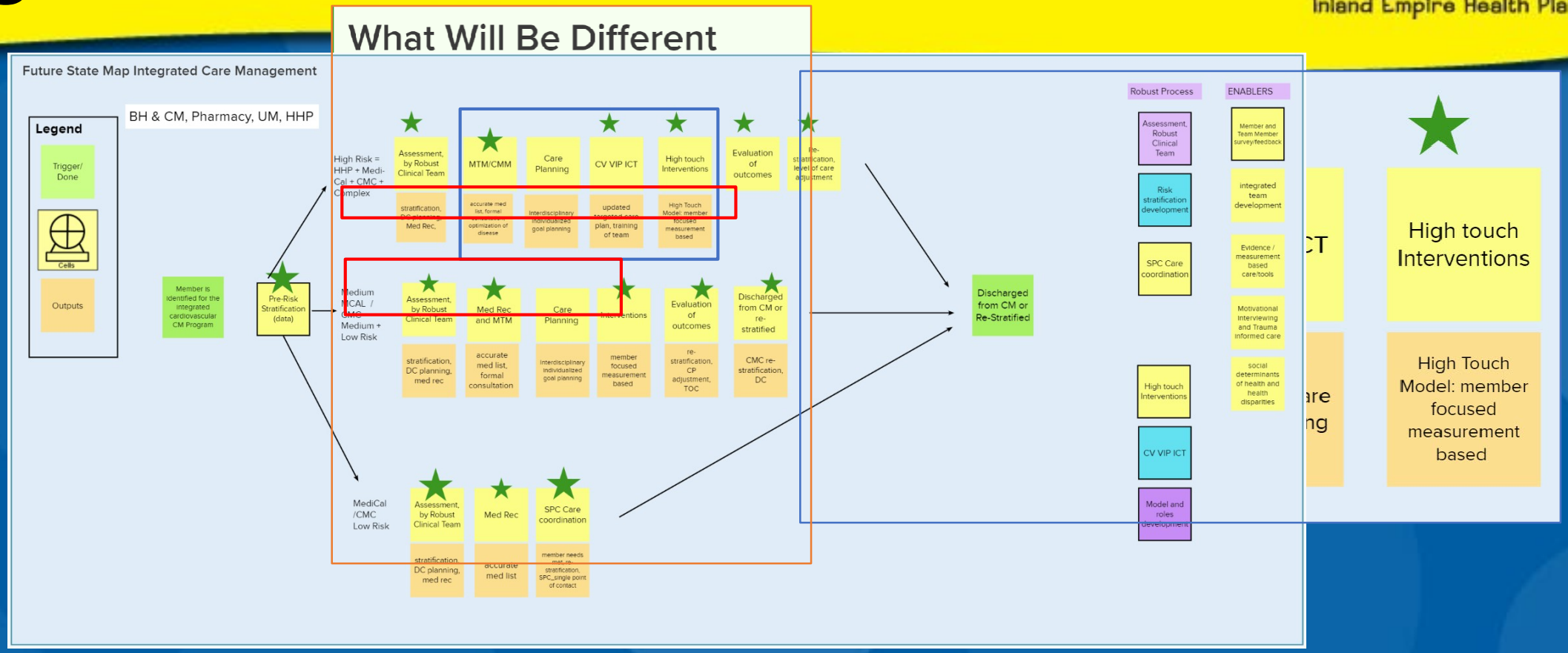
Integrated Care Value Stream



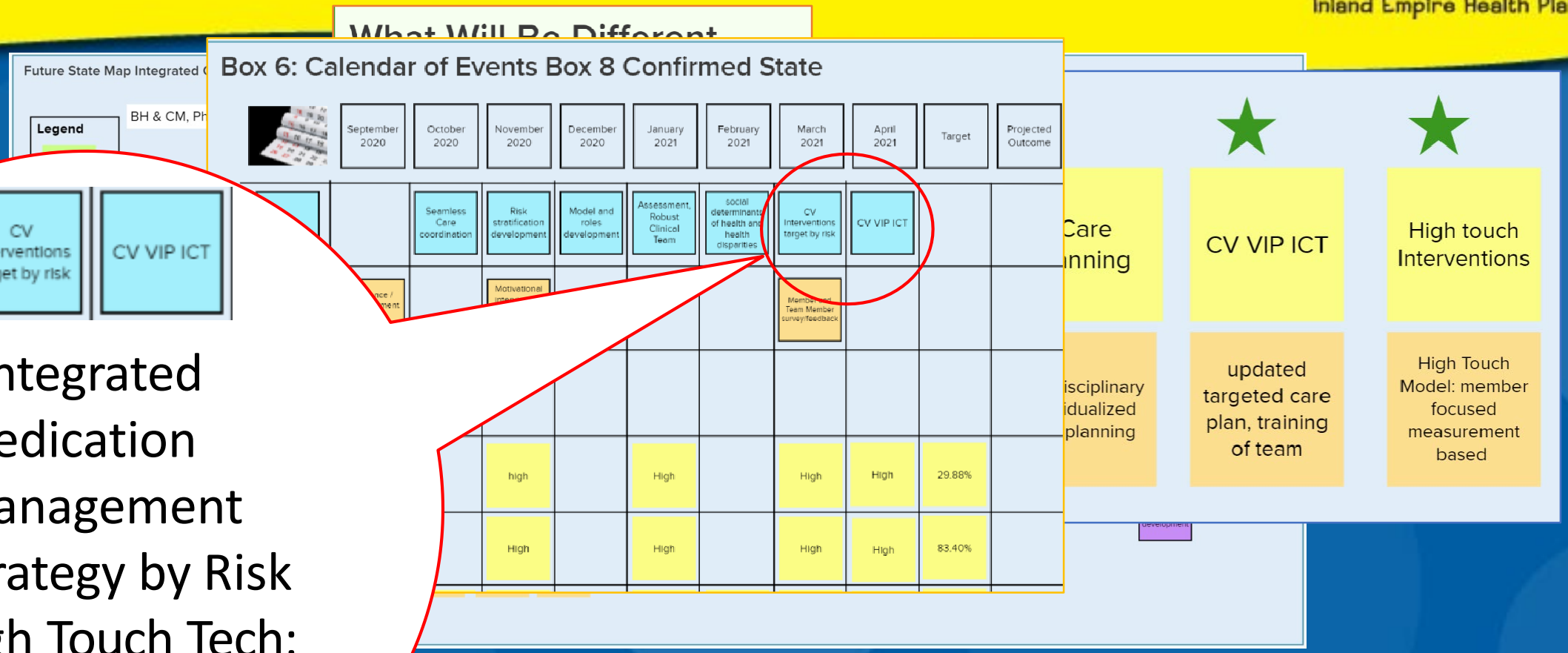
Integrated Care Value Stream



Integrated Care Value Stream



Integrated Care Value Stream VSA



1. Integrated Medication Management Strategy by Risk
2. High Touch Tech: Remote Monitoring

Telemedicine and Remote Monitoring

Inland Empire Health Plan

Telemedicine: “The delivery of any healthcare service or transmission of wellness information using telecommunications technology.”*

*Definition, The American Telemedicine Association (ATA)

What is Remote Patient Monitoring?

Inland Empire Health Plan

"Remote patient monitoring (RPM) is a digital health solution that captures and records patient physiologic data outside of a traditional health care environment.."*

*Definition, American Medical Association Digital Health Implementation Playbook, 2018

Remote Monitoring

Capabilities

- Bluetooth Biometric
  - BP, Wt, BG, Pulse Ox, Activity, Temp
- Real-time video, phone, texting
- Symptom Surveys
- Condition specific education:
  - DM, HTN, CHF, COPD, PN, etc.
  - Prevention and Wellness

CMS Now Reimburses

- **CPT 99453** reimbursement for **onboarding** a new RPM patient, set-up, education. Average national Medicare payment $19.46.
- **CPT 99454**: reimbursement for **providing** patient with **RPM device** for a 30-day period. Note can be billed each 30 days. $64.15.
- **CPT 99457**: **20 minutes** or more of clinical staff/physician/other qualified healthcare professional time in a calendar month requiring interactive communication. $32-$52
- **CPT 99091**: **30 minutes** of time every 30 days to bill. $58.38

Evidence in Growing Risk

IEHP
A Public Entity
Inland Empire Health Plan

Example: Hypertension and Telemonitoring

- 25-35% increased absolute BP Control vs Usual Care
- **BP Control in > 70% of patients** (UC: 45-57% control)
- Increased patient satisfaction

"Home BP telemonitoring and pharmacist case management achieved better BP control compared with usual care during 12 months of intervention that
persisted during 6 months of postintervention follow-up."

en.2018.1617

JAMA Network | Open

Original Investigation | Cardiology

Long-term Outcomes of the Effects of Home Blood Pressure Telemonitoring and Pharmacist Management on Blood Pressure Among Adults With Uncontrolled Hypertension
Follow-up of a Cluster Randomized Clinical Trial

Karen L. Margolis, MD, MPH; Stephen E. Asche, MA; Steven P. Dehmer, PhD; Anna R. Bergdall, MPH; Beverly B. Green, MD, MPH; JoAnn M. Sperl-Hillen, MD; Rachel A. Nyboer, BA; Pamala A. Pawloski, PharmD; Michael V. Maciosek, PhD; Nicole K. Trower, BA; Patrick J. O'Connor, MD, MPH

Abstract

Research

Original Investigation

Effect of Home Blood Pressure Telemonitoring and Pharmacist Management on Blood Pressure Control
A Cluster Randomized Clinical Trial

Karen L. Margolis, MD, MPH; Stephen E. Asche, MA; Anna R. Bergdall, MPH; Steven P. Dehmer, PhD; Sarah E. Groen, PharmD; Holly M. Kadrmas, PharmD; Tessa J. Kerby, MPH; Krissa J. Klotzle, PharmD; Michael V. Maciosek, PhD; Ryan D. Michels, PharmD; Patrick J. O'Connor, MD, MPH; Rachel A. Pritchard, BA; Jaime L. Sekelanski, BS; JoAnn M. Sperl-Hillen, MD; Nicole K. Trower, BA

IMPORTANCE Only about half of patients with high blood pressure (BP) in the United States have their BP controlled. Practical, robust, and sustainable models are needed to improve BP control in patients with uncontrolled hypertension.

OBJECTIVES To determine whether an intervention combining home BP telemonitoring with pharmacist case management improves BP control compared with usual care and to determine whether BP control is maintained after the intervention is stopped.

DESIGN, SETTING, AND PATIENTS A cluster randomized clinical trial of 450 adults with uncontrolled BP recruited from 14 692 patients with electronic medical records across 16 primary care clinics in an integrated health system in Minneapolis-St Paul, Minnesota, with 12 months of intervention and 6 months of postintervention follow-up.

INTERVENTIONS Eight clinics were randomized to provide usual care to patients (n = 222) and 8 clinics were randomized to provide a telemonitoring intervention (n = 228). Intervention patients received home BP telemonitors and transmitted BP data to pharmacists who adjusted antihypertensive therapy accordingly.

MAIN OUTCOMES AND MEASURES Control of systolic BP to less than 140 mm Hg and diastolic BP to less than 90 mm Hg (<130/80 mm Hg in patients with diabetes or chronic kidney disease) at 6 and 12 months. Secondary outcomes were change in BP, patient satisfaction, and BP control at 18 months (6 months after intervention stopped).

RESULTS At baseline, enrollees were 45% women, 82% white, mean (SD) age, 61.1 (12.0) years; mean systolic BP, 148 mm Hg; diastolic BP, 85 mm Hg. The proportion of patients with BP control at both 6 and 12 months was significantly greater in the telemonitoring group than in the usual care group.

BP control	Telemonitoring Intervention No.	Telemonitoring Intervention % (95% CI)	Usual Care No.	Usual Care % (95% CI)	Difference/Change From Baseline, % (95% CI)	P Value
6 and 12 mo	113	57.2 (44.8-68.7)	58	30.0 (23.2-37.8)	27.2 (13.4-40.0)	.001
6 mo	148	71.8 (65.6-77.3)	89	45.2 (39.2-51.3)	26.6 (19.1-33.1)	<.001
12 mo	141	71.2 (62.0-78.9)	102	52.8 (45.4-60.2)	18.4 (7.9-27.0)	.005
18 mo	135	71.8 (65.0-77.8)	104	57.1 (51.5-62.6)	14.7 (7.0-21.4)	.003

Compared with the usual care group, systolic BP decreased more from baseline among patients in the telemonitoring intervention group at 6 months (−10.7 mm Hg [95% CI, −14.3 to −7.3 mm Hg]; P<.001), at 12 months (−9.7 mm Hg [95% CI, −13.4 to −6.0 mm Hg]; P<.001), and at 18 months (−6.6 mm Hg [95% CI, −10.7 to −2.5 mm Hg]; P = .004).

CONCLUSIONS AND RELEVANCE Home BP telemonitoring and pharmacist case management achieved better BP control compared with usual care during 12 months of intervention that persisted during 6 months of postintervention follow-up.

TRIAL REGISTRATION clinicaltrials.gov Identifier: NCT00781365

JAMA. 2013;310(1):46-56.

Editorial page 40
Author Video Interview at jama.com
Supplemental content at jama.com

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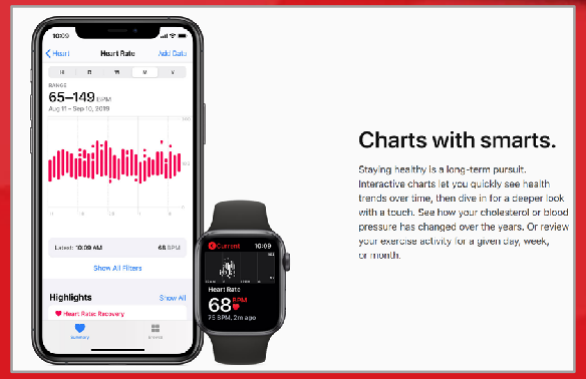
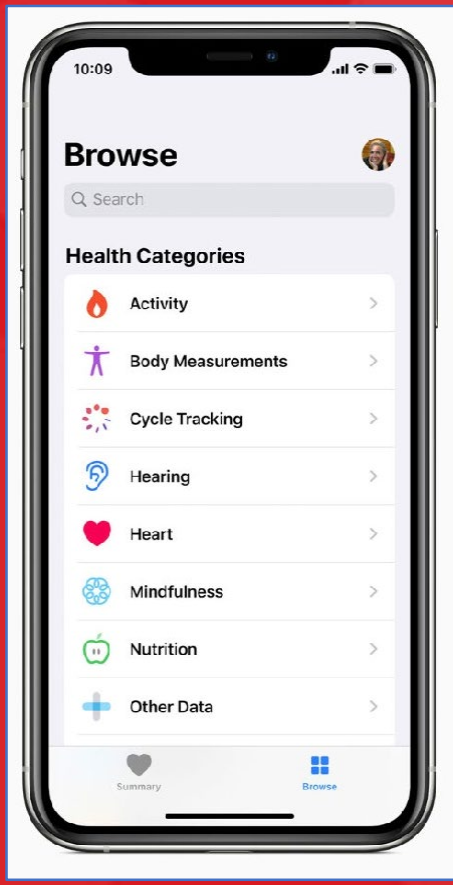
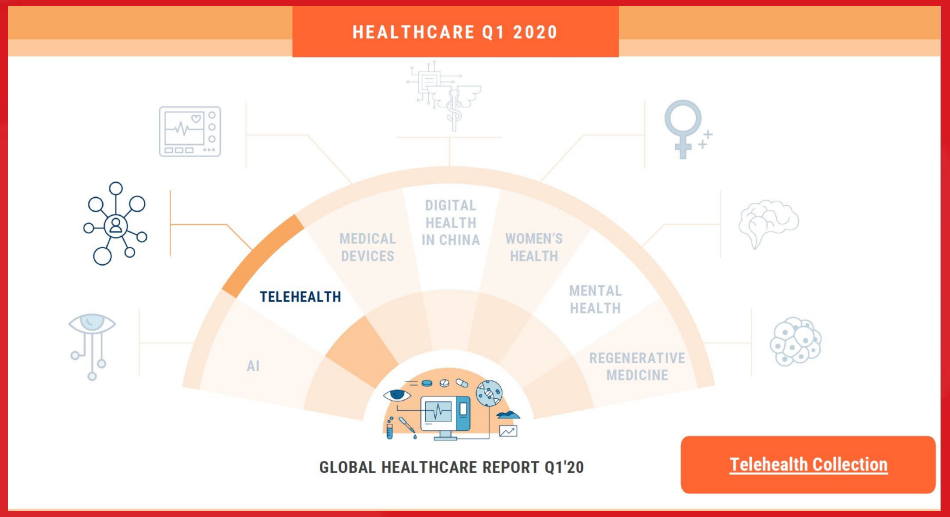
Part of a Larger Digital Strategy?

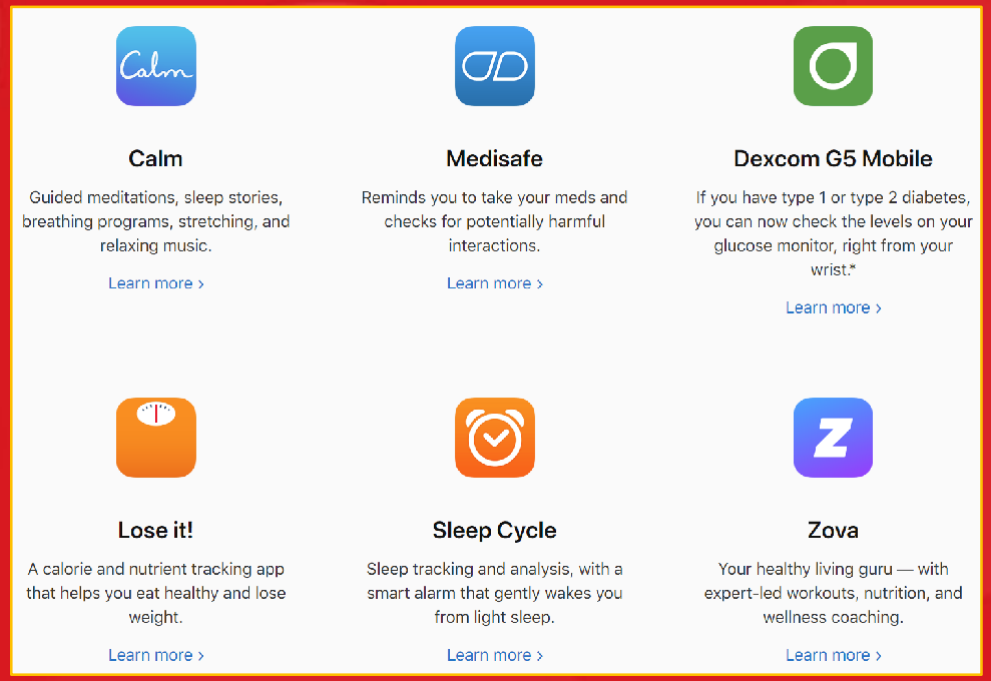
Internet of Things

- Smart Devices
- Apple Health

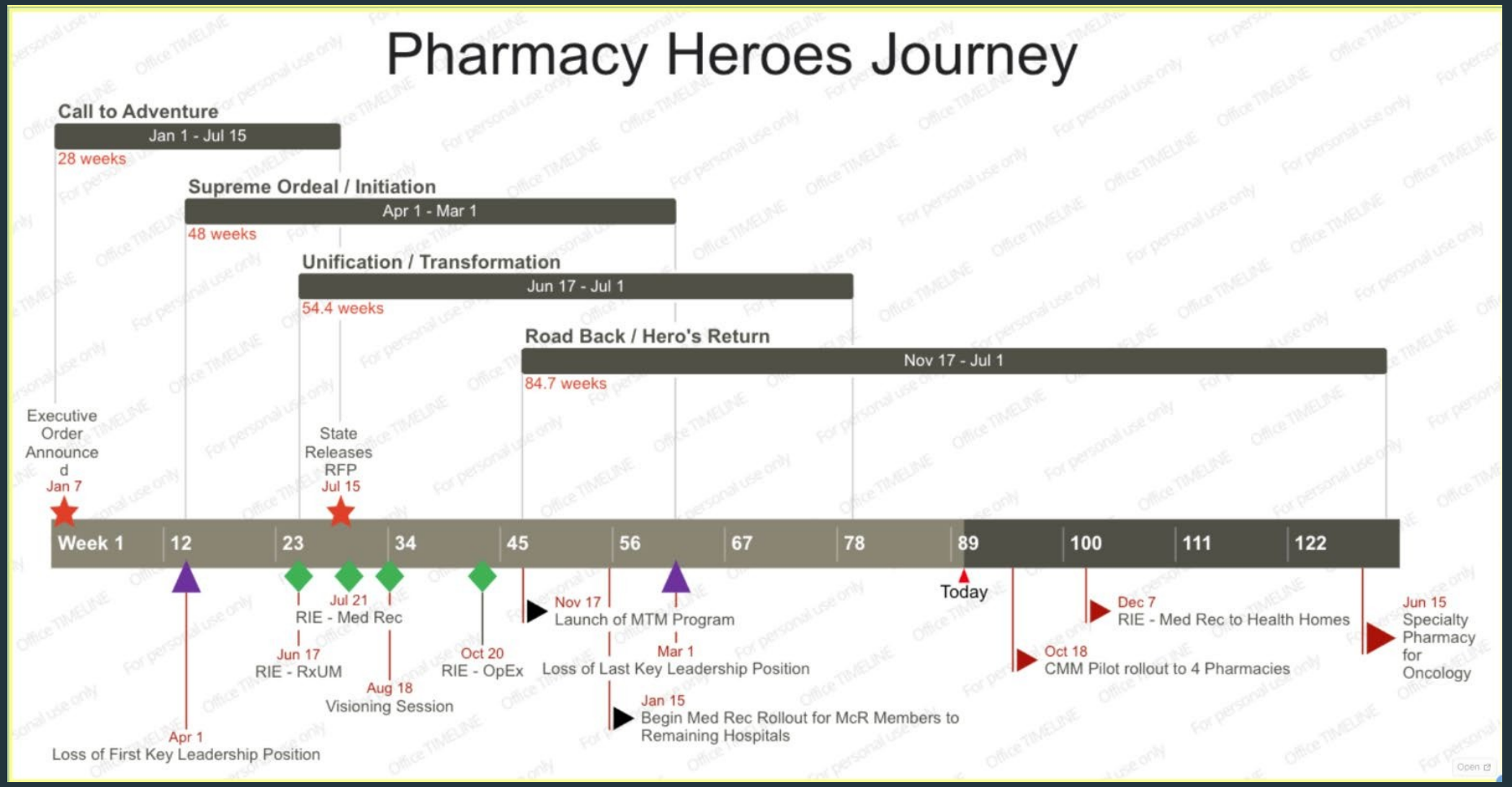








IEHP Pharmacy Transformation



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CRMC Boot Camp:
Implementation Experience from Pilot Teams

Annie Thai, PharmD
986 Pharmacy

Janice Cooper, PharmD, CDE, APh
Clinical Pharmacist
Manchester Professional Pharmacy
Hawthorne Professional Pharmacy

Christal Pham, PharmD, CDCES
Assistant Director of Clinical Pharmacy
Western University of Health Sciences

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Annie Thai, PharmD
986 Pharmacy

Why I Joined CRMC

- To be more involved with patient care as a pharmacist in the independent pharmacy setting
  - The goal is to establish trust and build strong relationships with physicians and patients

- Be a more proactive member of the healthcare team
  - PCPs are often too busy to manage patients with uncontrolled diabetes or asthma/COPD – Pharmacists can help!

Challenges of Initiating CMM Prior to CRMC

- It was difficult to work with physicians who are not aware of CMM services
- Many patients were skeptical of the services provided by pharmacies that they are not familiar with
- Patients often were not accountable for their own actions

CRMC Resources

- Resources provided by CRMC
  - Extensive trainings prior to the start of the program
  - Weekly webinars and case discussions
  - One-on-one coaching
  - Constant support from the CRMC team

Benefits of CRMC for Patients & Physicians

- Patients
  - Patients become more knowledgeable about their medications which can lead to increased adherence and improved quality of life
  - Increase access to health care for those who have trouble seeing their physicians
  - Detect and prevent costly adverse events

- Physicians
  - CRMC has helped establish partnerships between physicians and pharmacists to work collaboratively to manage patients' disease states
    - CPA established
  - Allow physicians to have more time to manage their more difficult patients

Commitment to Improving CMM Services

- Advertise program to current patients who may be eligible
- Inform more physicians about the program to foster partnerships between clinic and pharmacy
- Engage pharmacy staff to be more aware of the CMM services so they can educate potential patients about the program

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Janice Cooper, Pharm.D, CDE, APh
Clinical Pharmacist
Manchester Professional Pharmacy/Hawthorne Professional Pharmacy

Why Did I Join California Rights Meds Collaborative

- Aligned Goals
- Improve Patient Outcomes
- Integral Member of Healthcare Team
- Changing Future of Community Pharmacy and Pharmacist

What Challenges Have I Faced with Initiating CMM Prior to CRMC

- Time Constraints
- Patient and Healthcare Team Understanding
- Community Pharmacy Changing Role
- Role of Clinical Pharmacist In Community Pharmacy
- Compensation

What Works Well for California Rights Med Collaborative Work?

- 10 Step CMM Process
- Trainings
- Webinars
- Cases
- One-on-One Coaching
- Collaboration

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How Has CRMC Benefitted Patients and Physician Partners

Patient

- Education on Medication and Disease State
- Individualized Care Plan
- Actively Participates in Treatment Regimen
- Safe and Effective Use of Medications
- Improved Outcomes
- Collaboration

Physician Partners

- Dedication of Time to Patients
- More Effective in Reaching Treatment Goals
- Improved Outcomes
- Collaboration

What Actions Have I Committed to in Order to Improve My CMM Services?

- Utilizing the 10 Step CMM Process
- Additional Training to Meet the Educational Standards
- Developing CMM Skills
- Utilizing the Pharmacist Intervention and Medication Safety Documentation
- Learning Other Services That Are Offered

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Christal Pham, PharmD, CDCES
Assistant Director of Clinical Pharmacy
Western University of Health Sciences

WesternU Pharmacy Team

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Why did we join CRMC?

- Provided an INCENTIVIZED PAYMENT MODEL to engage all key stakeholder to obtain the Quadruple Aim with patient-centered care

PATIENT, PHARMACY, PHYSICIAN, L.A. CARE HEALTH PLAN

- Better patient engagement in health & reducing health risk
- Health metrics met by pharmacy, physician, health plan

L.A. CARE & PATIENT

- Less out of pocket expense for patient
- Less overall health cost for health plan due to hospitalization & other complications

PHYSICIAN & PHARMACY

- Obtained more patient info to better assess & manage
- Incentivized pharmacy & provider for positive work
- Better utilization of time spent for both provider & patient

PATIENT AND PHARMACY

- Able to express & address all health concerns and challenges
- Felt listened to by healthcare team (less playing telephone tag)
- Able to see immediate outcomes

What challenges have we faced with initiating CMM prior to CRMC?

- Payment:
  - Limited or no reimbursement for CMM services
  - Competing CMM services
  - CMM billing codes not accepted by CMS
- Communication:
  - Provider engagement from outside providers
  - Lag time between communication & recommendation

What's working well with CRMC?

- L.A. Care Health Plan
  - Patient recruitment through warm transfer
  - Providing patient list
  - Eligibility flowsheets
  - Reimbursement processing support
- USC
  - Resources (MRP chart, CRMC brochure, Physician letter, USC onsite disease states review)
- Pilot pharmacy
  - Learning from peers & getting new ideas. Great pharmacy community!

How has CRMC benefited patients & physician partners?

PHYSICIAN BENEFIT

- Assisting with pay for performance
- Reinforcing recommendation
- Assisting with med access through prior authorizations

PATIENT BENEFIT

- Patient appreciate weekly check in: Pandemic causing self-isolation
- Immediate outcome: Guided SMART goals established & modified
- Health coaching

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What actions have I committed to in order to improve my CMM services?

- Reviewing workflow / GOALS:
  - Reduce time spent on documentation and faxing
  - Increase efficiency in sharing info in timely matter
    - CRMC platform & physician letter within 24hrs
    - Our EHR within 2-3 days
    - L.A. Care Rx processing within 7-10 days
  - Improving communication with physicians
    - Simplify form? Ask what is best way of communication?
  - Creative ways to engage patients

Summary of Challenges & Successes!

CHALLENGES

- Provider engagement
- Patient recruitment
- Limited patient info
- Documentation

SUCCESSES

- Patient expressed gratitude & continued engagement
- Better assessment of SMBG with Freestyle Libre
- Doximity for telemedicine
- FQHC partnership
- Some provider engagement
- DM gift & coupon flyers

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Workflow Modification

Eddie Lee, PharmD
Vermont VO Pharmacy
L.A. Care CRMC Pilot Site

Ramesh Upadhyayula, PharmD, APh
Desert Hospital Outpatient Pharmacy
IEHP CRMC Pilot Site

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Eddie Lee, PharmD
Vermont VO Pharmacy
L.A. Care CRMC Pilot Site

Workflow

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- Eligible patient Scheduling
- Perform CMM with patient
- Document & Billing
- Schedule next appointment

Eligible Patient Scheduling

- Warm Hand off
- Schedule appointment (Calendar)
- Create patient profile
- Tell patient to have all their medications with them for the appointment

Perform CMM

- Pharmacist ± Technician goes into office to perform CMM
  - Pharmacy Student can input basic information

- What if patient does not answer. We call to reschedule

Documentation & Billing

- Documentation
  - Follow up with MD for Labs and medication background

- Billing
  - Fax LA Care for billing authorization
  - Bill through pharmacy management program

Schedule next appointment

Tricky

- Couple days
- Couple months
- Spontaneous

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Ramesh Upadhyayula APh
Director of Pharmacy/CEO
Desert Hospital Outpatient Pharmacy

Workflow Modification

- Repurposing the Pharmacy & Developing CMM Workflow
- Refining Workflow

Repurposing the Pharmacy & Developing CMM Workflow

- Workspace
- Time Allotment
- Staffing Needs

Workspace

- Identifying existing or potential
  - Quiet areas for CMM phone calls
  - Private areas with seating for in-person visits

Be creative and make the most of the space you have

Time Allotment

- Determine how much time is needed?
  - Intake
    - Appointment Scheduling
    - Creating Patient Profile
    - Preparing Patient for CMM Appt
  - CMM Appointments
  - Documentation
  - Billing
  - Patient Advocacy
    - Addressing Social Determinants of Health
    - Improving Access to Care
  - Incoming Faxes/Emails/Calls
- What times work best for each activity?
  - Down-time or between urgent dispensing tasks
    - Intake
    - Billing
    - Patient Advocacy
    - Incoming Faxes/Emails/Calls
  - Extra Coverage Time Periods
    - CMM Appointments
    - Documentation

Time Allotment

- Strategies to Improve Efficiency
  - Spreading out CMM appts
  - Alternating pharmacists
  - Using checklists
  - Sharing the workload
- CMM Appointment Design
  - Fixed Appt Times versus daily list of patients
  - Team approach to CMM appt versus solo approach
  - Using technology for patient monitoring

Staffing Needs

- Sharing Workload
  - Drop-Off
    - Intake
  - Call Room
    - Intake
    - Incoming Faxes/Emails/Calls
  - Lead Technician
    - Billing
  - Long-Term Care
    - Intake
  - Pharmacists/Interns
    - CMM Appointments
    - Documentation
    - Patient Advocacy

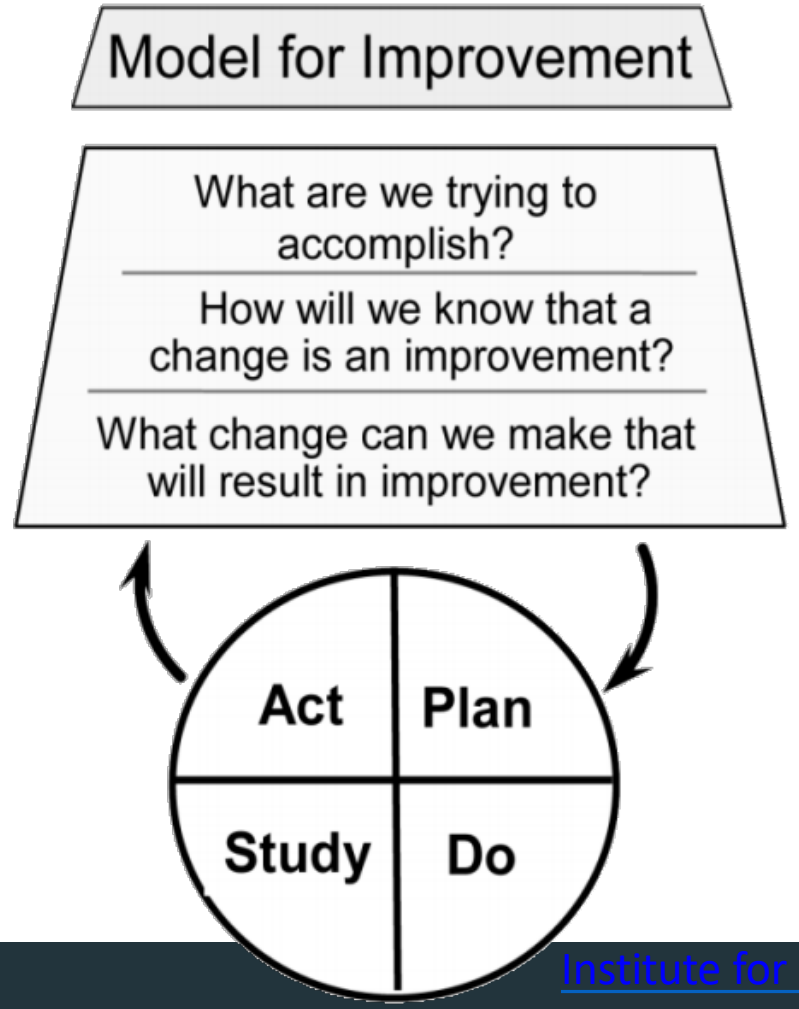
- Strategies for Sharing Tasks
  - Break Up Tasks into Smaller Tasks
  - Make CMM workload visible
    - Bin for CMM tasks
  - Lead tech to monitor CMM task bin & assign tasks as needed

Refining Workflow

- Quality Improvement
  - Goals
  - Results
  - Opportunities for Improvement

Rapid Cycle Quality Improvement

1. Plan
    a. Define what you do now
    b. Define areas for improvement
    c. How will changes be measured?
2. Do
    a. Do a trial-run of the change
3. Study
    a. Examine results
    b. Were the goals achieved?
4. Act
    a. Incorporate changes into workflow



Institute for Healthcare Improvement (IHI)

California Right Meds Collaborative

Fall 2020 Learning Session

Establishing Collaborative Practice Agreements

Steven Chen, PharmD, FASHP, FNAP

Associate Dean for Clinical Affairs

USC School of Pharmacy

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Learning Objectives

- Explain key differences between a Collaborative Practice Agreement and protocol
- Construct a collaborative practice agreement, protocol, etc., in accordance with legal and regulatory requirements that aligns with the risk tolerance of partnering organizations

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Definitions

Term	Definition	Authorized By:		
		State Legislature / Board of Pharm.	Health Plan	Health System
Scope of Practice	Boundaries within which a health professional may practice- *What am I LEGALLY PERMITTED to do*	✓		

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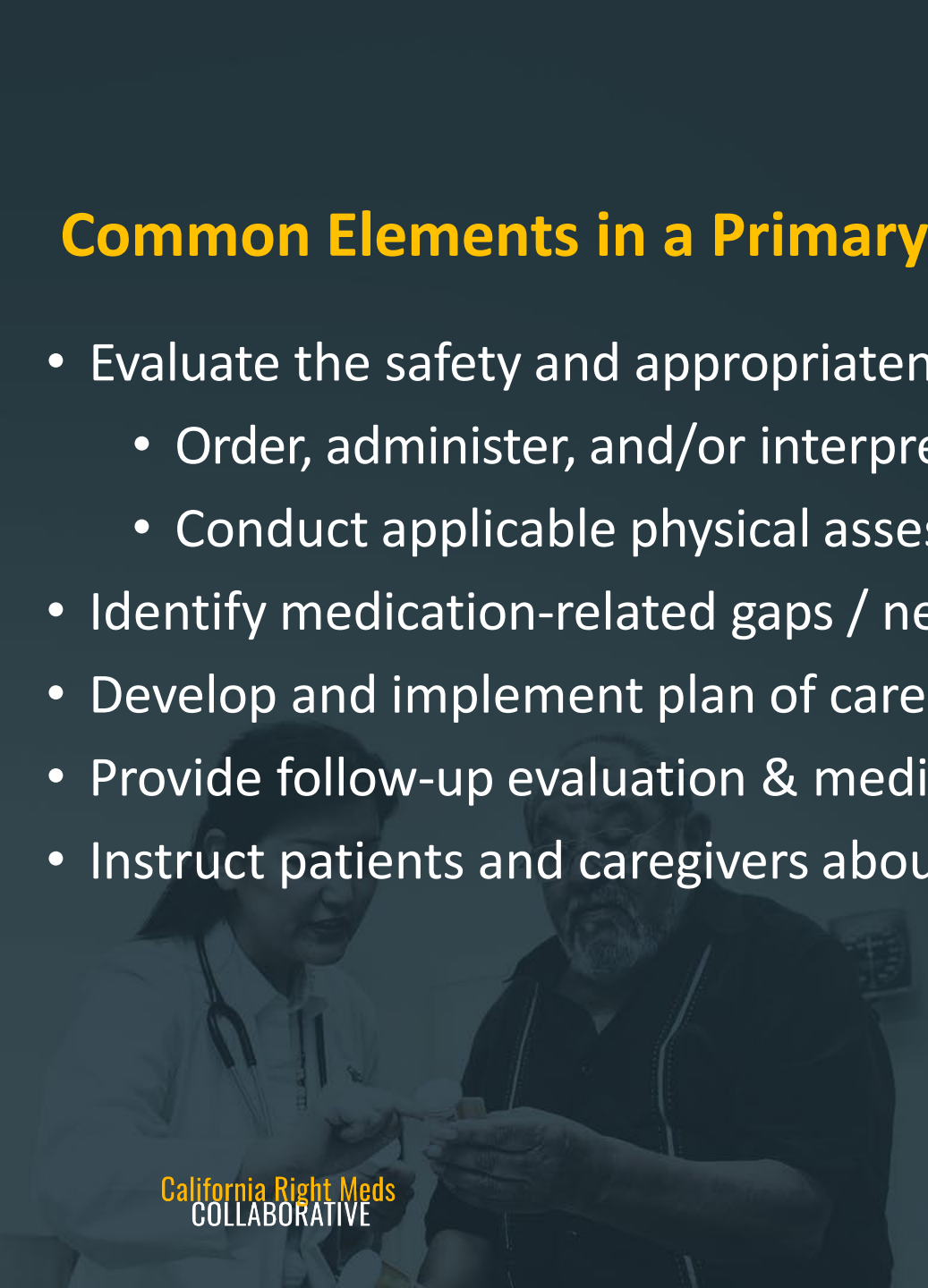
Common Elements in a Primary Care Pharmacist Scope of Practice

- Evaluate the safety and appropriateness of medication therapy
  - Order, administer, and/or interpret diagnostic and laboratory tests
  - Conduct applicable physical assessment
- Identify medication-related gaps / needs
- Develop and implement plan of care
- Provide follow-up evaluation & medication monitoring in collaboration with HC team
- Instruct patients and caregivers about medications and use of related devices



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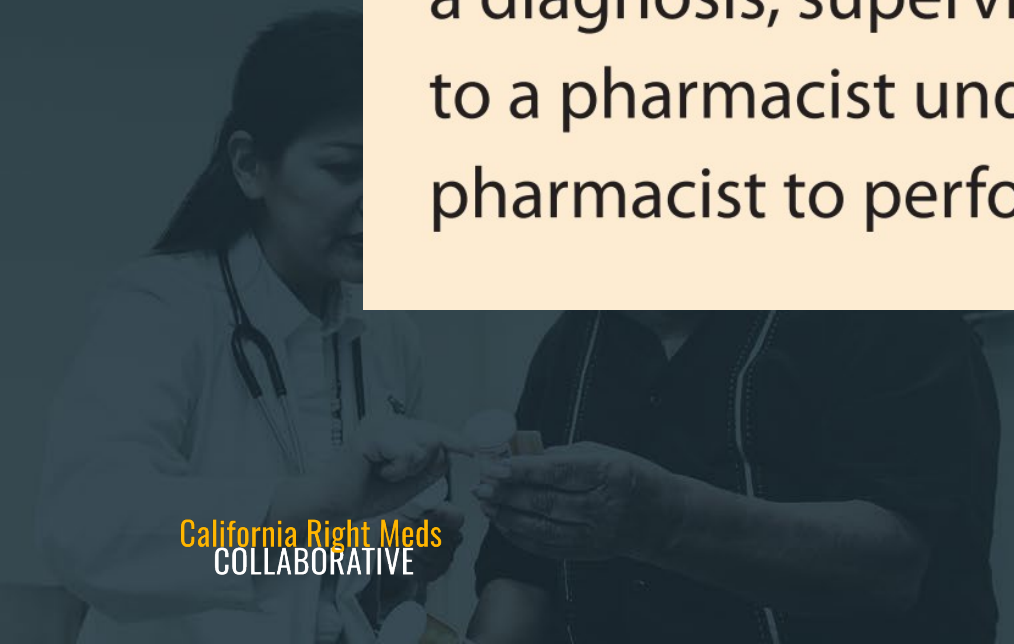
Credentialing	A process for confirming qualifications of an individual in a given subject or practice area- *What am I QUALIFIED to do?*		✓ ☐	✓ ☐
Privileging	Authorization granted by a specific facility or institution for a specific person to provide specific services or professional rights- *What am I ALLOWED to do HERE?*			✓ ☐

Pharmacist Collaborative Practice Agreement (CPA)

A formal agreement in which a licensed provider makes a diagnosis, supervises patient care, and refers patients to a pharmacist under a protocol that allows the pharmacist to perform specific patient care functions.



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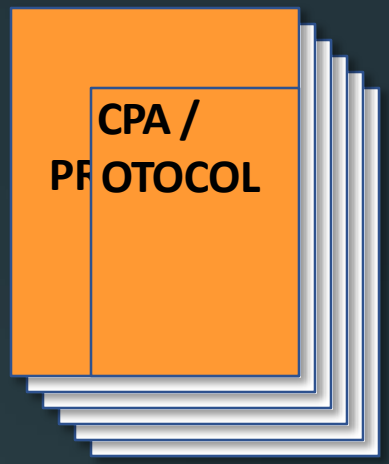
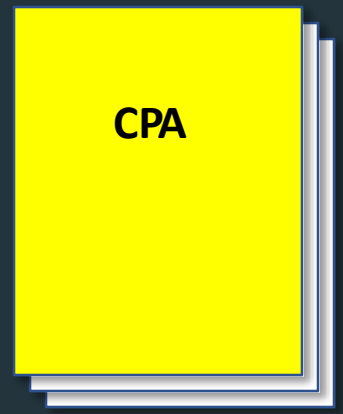
How is Privileging Translated into Practice?

- Goals
- Roles and responsibilities
- Supervision and staffing
- Enrollment and DC criteria
- Step-by-step decisions
- Condition or medication-specific



- Some protocol specificity
- + grant broad CPA permissions



- Permitted activities
- Not condition nor medication-specific
- May refer to guidelines / practice standards

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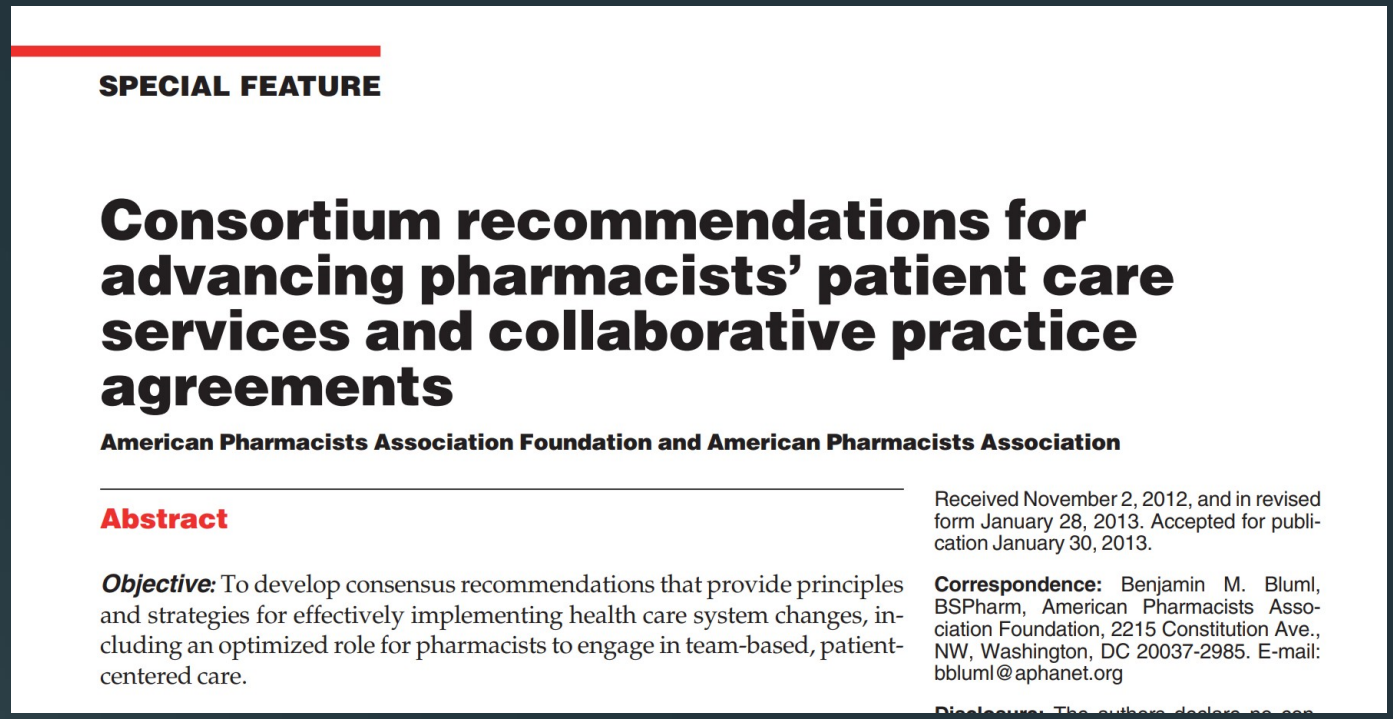
CPA Resources



SPECIAL FEATURE

Consortium recommendations for advancing pharmacists' patient care services and collaborative practice agreements

American Pharmacists Association Foundation and American Pharmacists Association

Abstract

Objective: To develop consensus recommendations that provide principles and strategies for effectively implementing health care system changes, including an optimized role for pharmacists to engage in team-based, patient-centered care.

Received November 2, 2012, and in revised form January 28, 2013. Accepted for publication January 30, 2013.

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J Am Pharm Assoc. 2013;53:e132–e141.

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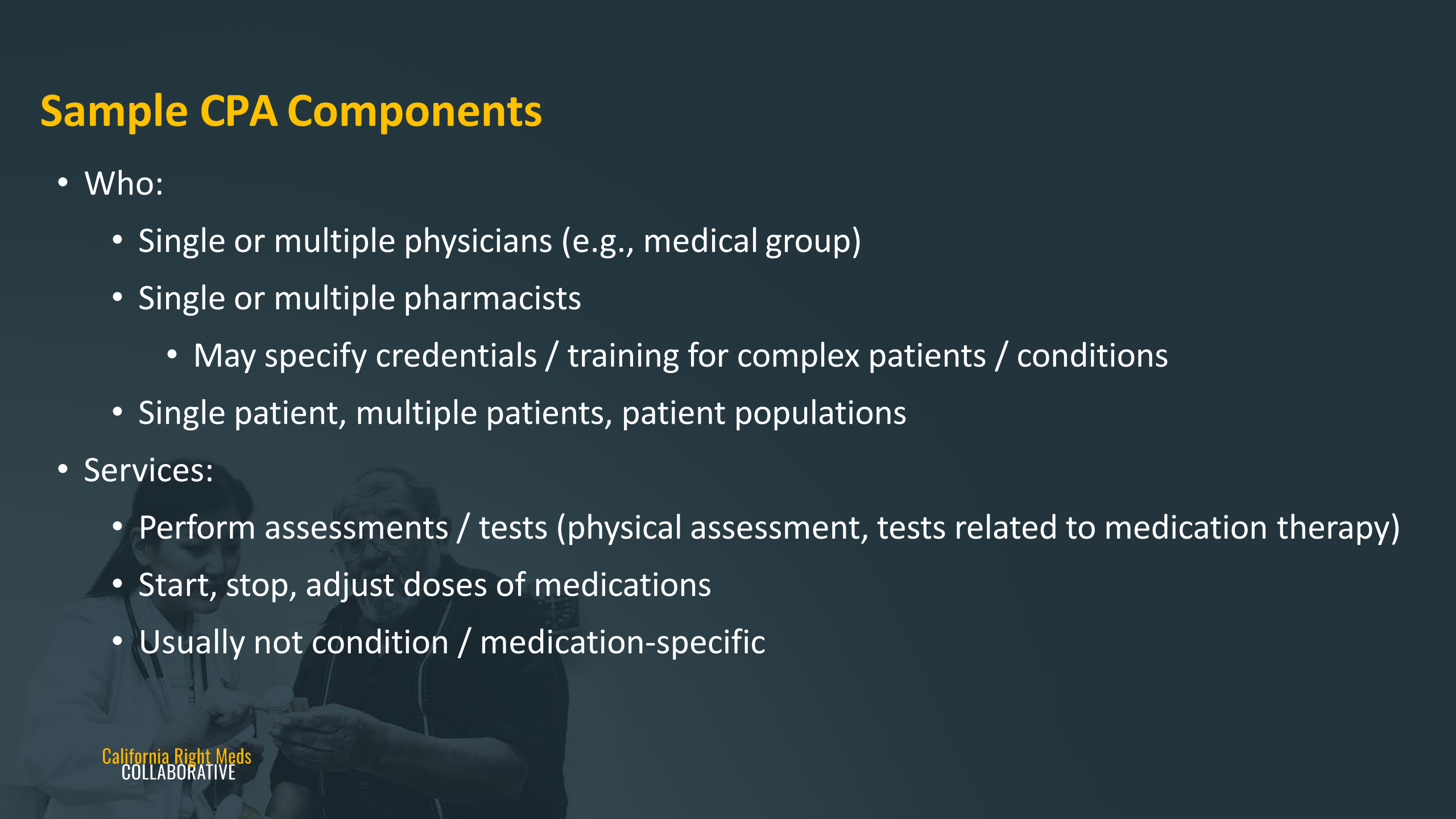
Sample CPA Components

- Who:
  - Single or multiple physicians (e.g., medical group)
  - Single or multiple pharmacists
    - May specify credentials / training for complex patients / conditions
  - Single patient, multiple patients, patient populations
- Services:
  - Perform assessments / tests (physical assessment, tests related to medication therapy)
  - Start, stop, adjust doses of medications
  - Usually not condition / medication-specific



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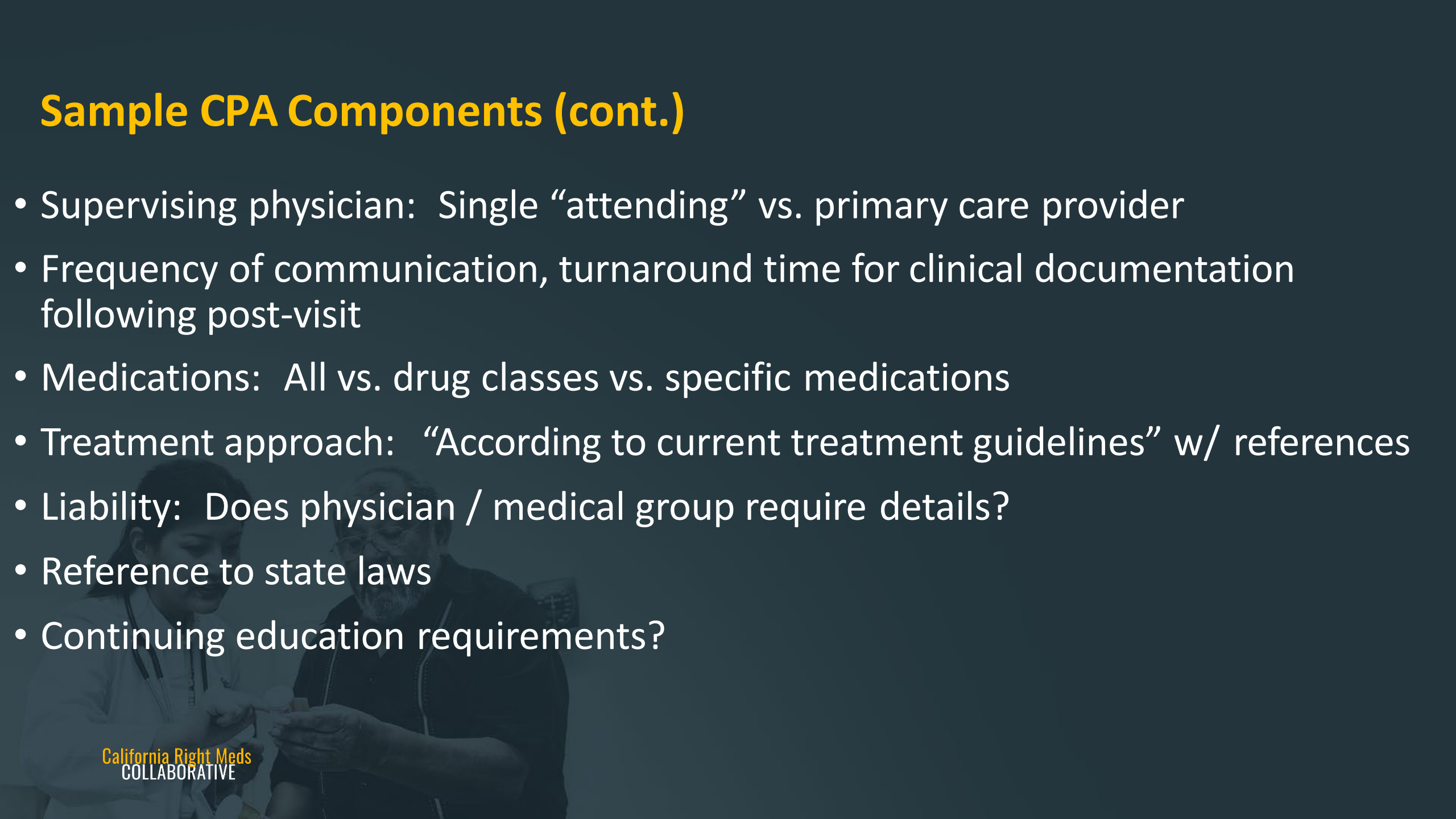
Sample CPA Components (cont.)

- Supervising physician: Single “attending” vs. primary care provider
- Frequency of communication, turnaround time for clinical documentation following post-visit
- Medications: All vs. drug classes vs. specific medications
- Treatment approach: “According to current treatment guidelines” w/ references
- Liability: Does physician / medical group require details?
- Reference to state laws
- Continuing education requirements?



Collaborative Practice Agreement for Comprehensive Medication Management (CMM)

USC University of Southern California

School of Pharmacy

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California Business and Professions Code section 4210 allows pharmacists to practice under a Collaborative Practice Agreement with individual physicians. Pharmacists may participate in the practice of managing, modifying, and monitoring medication therapy in collaboration with individual physician(s) who is/are responsible for the patient's care.

By signing this document, the named physicians agree that the named pharmacist may enter into a Collaborative Practice for their patients. As Medical Director and Residency Director of the clinic, all faculty and staff physicians and resident physicians fall under this agreement.

COLLABORATIVE AGREEMENT APPROVED BY:

PHARMACIST:

_____

[INSERT PHARMACIST NAME] R.Ph., Pharm.D.

PHYSICIAN:

_____ _____

Medical Director Residency Director (if applicable)

.

DATE OF IMPLEMENTATION: _____

DATES ANNUAL REVIEW COMPLETED:

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Collaborative Practice Agreement: Comprehensive Medication Management

PURPOSE

The purpose of the pharmacist-managed Comprehensive Medication Management (CMM) service is to work with patients and primary care team to ensure optimal results from chronic disease-related medication therapy. Optimal treatment outcomes can only be attained through a combination of medication, nutritional, educational, and follow-up interventions. The scope of the CMM service includes the management of major chronic diseases; any patient who is not meeting medication treatment goals can receive CMM. The objectives of the CMM service are as follows:

A. EDUCATION- Provide comprehensive education to all participating patients, enabling patients to:
   1. Explain the pathophysiology of the disease state and symptoms of worsening control.
   2. Describe the consequences of poorly-controlled disease.
   3. Guide patients in making lifestyle changes that are important for the management of chronic diseases including diet, exercise, and environmental control.
   4. Identify the purpose / general mechanism of action, dose, route of administration, frequency, and storage of all medications.
   5. If applicable, demonstrate proper use of a self-monitoring device.
   6. If applicable, demonstrate proper administration of medication (e.g. withdrawal, mixing, and administration of insulin and use of inhalers).

B. ADHERENCE- Identify and correct medication misuse, particularly nonadherence, through education and assistance devices / tools.

C. OPTIMIZE MEDICATION THERAPY – The pharmacist will be granted the authority to implement drug therapy adjustments (e.g., addition, substitution, discontinuation, dose adjustment) that will result in improved therapeutic outcome(s) consistent with current treatment

ORGANIZATION

A. Guidelines for referral: The provider can refer any patient they believe would benefit from pharmacy services. Patients can also self-refer if they would like to receive pharmacy services. Priority should generally be given to patients at highest risk for acute care utilization, patients with very poor measures of chronic disease control, and patients with medication safety concerns (adverse drug events or potential adverse drug events).

B. Clinic visits:

- Patients can be seen on the same day as the physician or on a separate day, depending on the availability of the pharmacist.
- If a patient referred by a "warm hand-off" from a physician cannot be seen on the same day in a reasonable amount of time, the pharmacist should at least make an introduction, explain the purpose of the CMM service, and assign the patient some "homework" prior to the first scheduled visit, e.g., use a medication organizer box, track SMBG readings, measure and record blood pressure or peak flow levels, etc.
- Patients will be scheduled for follow-up as often and as long as necessary to reach chronic disease treatment goal(s). Follow-up visits can be in-person, via telephone, or via video telehealth depending on the needs and resources of individual patients.
- The clinical pharmacy team will continue to provide surveillance of patients who are discharged from the CMM service after successfully reaching treatment goal(s). This surveillance will be primarily provided by clinical pharmacy technicians or student pharmacists, who will have a checklist of questions that will be administered to patients on at least a quarterly basis. The questions are disease-dependent and reflect control of disease as well as the safe use of medications. All responses will be reviewed by a clinical pharmacist and, if any concerns arise, patients may be re-enrolled in the CMM service. The purpose of this technician- and student-driven long-term follow-up is to ensure that patients' chronic conditions remain under control without medication-related complications.

C. Clinical activities provided by the clinical pharmacist under the primary care physician:

- ❑ Order labs and tests as appropriate for monitoring medication therapy (e.g., safety, efficacy, appropriateness)
- ❑ Refill authorization
- ❑ Therapeutic interchange
- ❑ Initiate, modify, or discontinue drug therapy in accordance with evidence-based clinical guidelines endorsed by national organizations including, but not limited to those listed in Appendix A.

D. Documentation and Quality Assurance

1. Documentation
   All visits will be documented in electronic health record and tasked to the patient's primary care provider within 24 hours of the encounter as specified above.

2. Quality Assurance
   Quality assurance reports will be generated at least quarterly focusing on key measures of healthcare quality that are aligned with National Quality Forum metrics, e.g., A1C for diabetes, blood pressure for hypertension, use of controller medications for asthma. If available, acute care utilization and medication therapy intervention data will also be aggregated.

E. Peer Review

Peer review of medical records will occur quarterly as follows:

Appendix A: National Treatment Guidelines for Common Chronic Conditions

1. **Anticoagulation:**
   CHEST Antithrombotic Guidelines (ACCP)

2. **Arthritis**
   - Guideline for the Treatment of Rheumatoid Arthritis (ACR)
   - Osteoarthritis Clinical Practice Guidelines (ACR)

3. **Asthma**
   - National Asthma Education and Prevention Program Expert Panel Report: Guidelines for the Diagnosis and Management of Asthma

4. **Chronic Heart Failure**
   - Guideline for the Diagnosis and Management of Chronic Heart Failure in the Adult (ACC / AHA)

5. **Cholesterol**
   - Guideline on the Treatment of Blood Cholesterol to Reduce Atherosclerotic Cardiovascular Risk in Adults (ACC / AHA)

6. **COPD**
   - Diagnosis and Management of COPD (GOLD)

7. **Diabetes**
   - American Diabetes Association Clinical Practice Guidelines, Diabetes Care (ADA)

Hypertension Medication Management Program Collaborative Practice Agreement

USC University of Southern California

School of Pharmacy

Version 5.0 (last updated 8/28/2018)

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III. Staffing and Duties / Responsibilities

HMMP services will be provided by a clinical pharmacist. Other pharmacy-related personnel may include pharmacy residents, clinical pharmacy technicians, and student pharmacists. Primary care providers will be updated and consulted as outlined below. The expertise of all allied health will be utilized, including but not limited to occupational therapists, nurses, nutritionists/dieticians, and case managers. The clinical pharmacist is responsible for ensuring that the elements of care described in this agreement are accurately provided by all pharmacy-related personnel.

A. Clinical pharmacist functions (In accordance with California State Pharmacy Law, Section 4052.1)

1. Evaluation: The clinical pharmacist may perform routine drug therapy-related patient assessment procedures including vital sign measurement and physical exam (e.g., foot exam, check for peripheral edema, lung sounds, etc.)
2. Treatment: The clinical pharmacist may initiate, discontinue, and adjust doses of medications for hypertension. Examples of these agents include but not limited to: diuretics (loops, thiazides, potassium sparing), beta blockers, alpha blockers, mixed alpha + beta blockers, calcium channel blockers, renin inhibitors, ACE inhibitors, angiotensin II receptor antagonists, aldosterone antagonists, vasodilators, combination antihypertensives, and alpha-2 agonists.
3. Monitoring: The clinical pharmacist may order laboratory tests in accordance with guideline recommendations and as necessary for monitoring the safety and efficacy of blood pressure

B. Technician duties and responsibilities (In accordance with California State Pharmacy Law, Section 4115): The clinical technician will function under the direct supervision of the pharmacist in performing duties and responsibilities that does not require the professional judgment of a pharmacist, which may include, but not limited to:

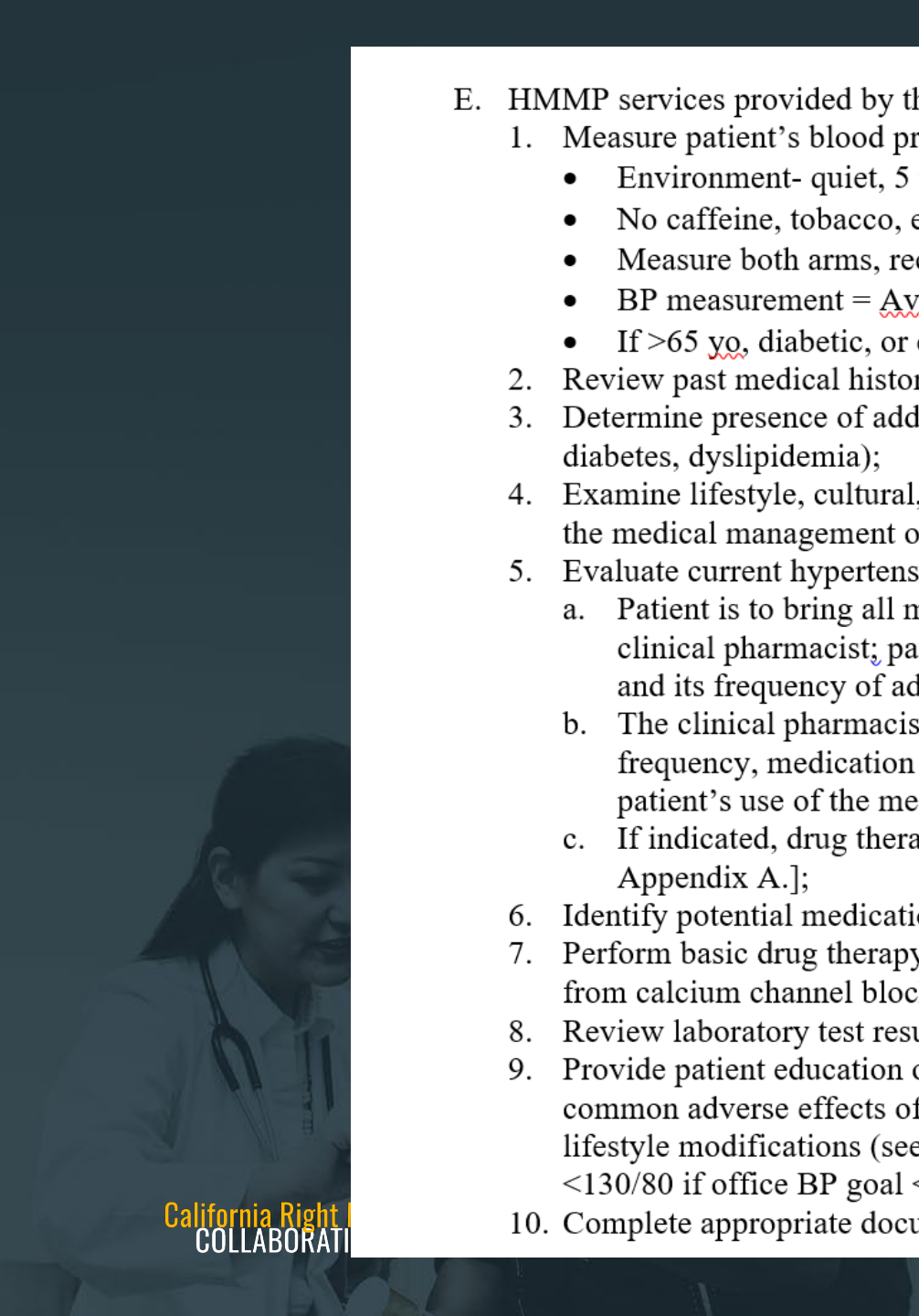
1. Administrative and clerical duties
    a. Assist in front end activities pertaining to the patient work flow as necessary
    b. Prepare and gather relevant information that the pharmacist may need during the patient visit
    c. Schedule the patients for appointments
    d. Perform other related duties as assigned
2. Clinical support duties
    a. Assist in back end activities such as vital sign measurement, weight and height
    b. Gather patient's prescriptions (if available) and pharmacy information
    c. Follow-up with patients via telephone to collect information about medication use, monitoring, symptom frequency, etc.
    d. Perform other related duties as assigned

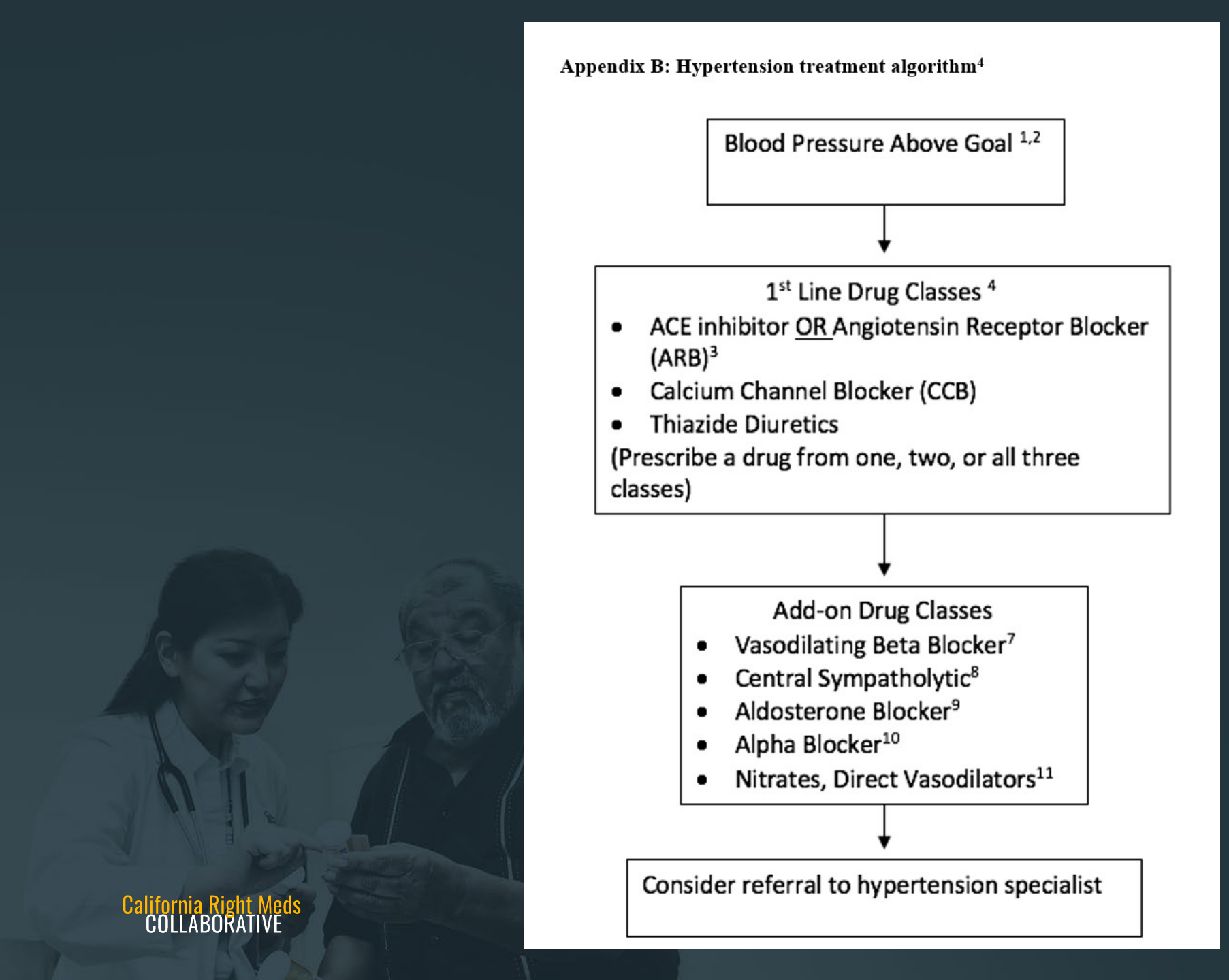
C. Blood Pressure Goals[1]

According to current national standards, blood pressure goal is <130/80mmHg for all patients.

E. HMMP services provided by the Clinical Pharmacist may include the following:

1. Measure patient's blood pressure and heart rate according to AHA standards, including:
   - Environment- quiet, 5 minutes of rest
   - No caffeine, tobacco, exercise x 30 min. prior
   - Measure both arms, record / treat higher arm
   - BP measurement = Avg of 2 readings taken ~ 1-2 min. apart that are within 5 mmHg
   - If >65 yo, diabetic, or c/o dizziness: Check standing BP at 0 and 2 minutes
2. Review past medical history;
3. Determine presence of additional cardiovascular risk factors (eg, family history, tobacco, obesity, diabetes, dyslipidemia);
4. Examine lifestyle, cultural, psychosocial, educational, and economic factors that might influence the medical management of hypertension;
5. Evaluate current hypertension drug treatment regimen and patient's adherence to regimen
   a. Patient is to bring all medications (prescription and over-the-counter) to every visit with the clinical pharmacist; patient will be asked to identify each medication, its purpose, its dose, and its frequency of administration.
   b. The clinical pharmacist will attempt to identify causes (e.g., inconvenience of dosing frequency, medication access issues, etc.) and solutions for any discrepancies between the patient's use of the medication and the prescribed regimen.
   c. If indicated, drug therapy adjustments may be initiated in order to reach treatment goals [see Appendix A.];
6. Identify potential medication-related problems;
7. Perform basic drug therapy-related physical assessment (e.g., check for ankle edema resulting from calcium channel blockers, HR for beta-blockers);
8. Review laboratory test results and order tests if indicated;
9. Provide patient education on the following topics: interpretation of blood pressure readings; common adverse effects of prescribed medications; importance of adherence to medications; lifestyle modifications (see chart below); self-monitoring of blood pressure (home BP goal of <130/80 if office BP goal <130/80, home BP goal of <135/85 if office BP goal <140/90)[1]
10. Complete appropriate documentation as discussed in Section I.





Appendix B: Hypertension treatment algorithm[4]

Blood Pressure Above Goal [1,2]

↓

1st Line Drug Classes [4]

- ACE inhibitor OR Angiotensin Receptor Blocker (ARB)[3]
- Calcium Channel Blocker (CCB)
- Thiazide Diuretics

(Prescribe a drug from one, two, or all three classes)

↓

Add-on Drug Classes

- Vasodilating Beta Blocker[7]
- Central Sympatholytic[8]
- Aldosterone Blocker[9]
- Alpha Blocker[10]
- Nitrates, Direct Vasodilators[11]

↓

Consider referral to hypertension specialist

Request:

Utilize resources from the CRMC website and CRMC Practice Alignment Guide to develop a strategy for proposing initiation or advancement of a CPA

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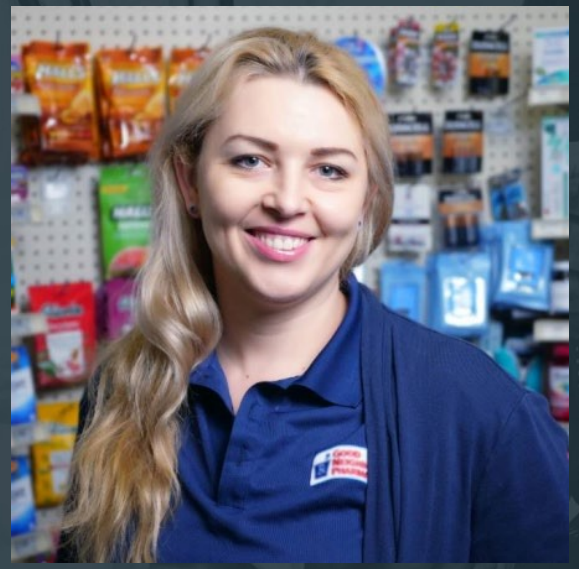
Personal Branding:

Promoting Advanced Clinical Services Through Community Pharmacies



Adelina Ardelean

Advertising Manager

Good Neighbor Pharmacy

Branding Basics

Define Your Brand Identity

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What Is Your Pharmacy's Brand?

Your brand is your promise to patients.

It's the perception patients have when they hear or think about your business.

- It conveys your **purpose** and **values**.
- It establishes your **personality** and **tone**.
- It **differentiates** you from the competition.

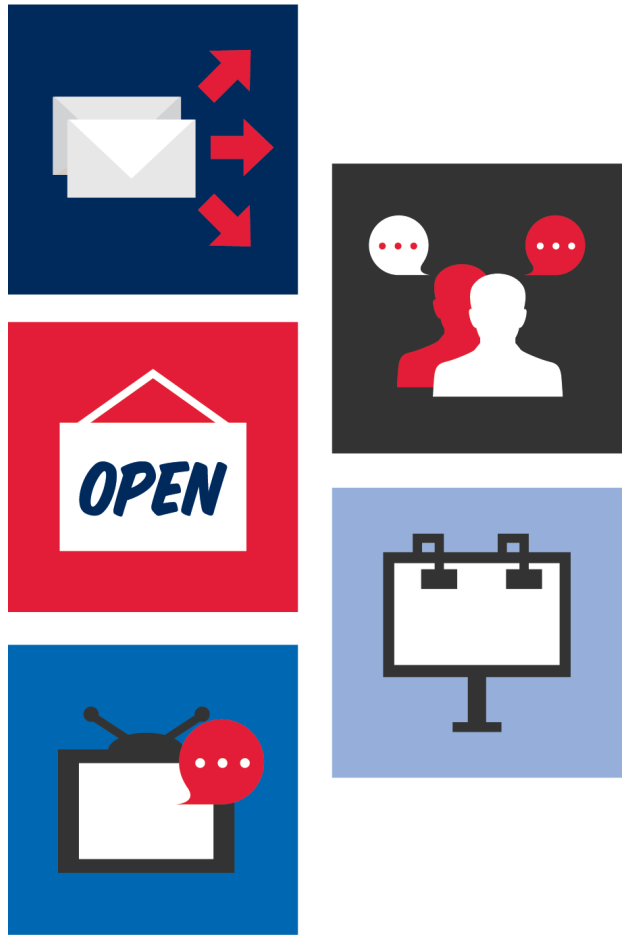
Define Your Brand Identity

Consider the following questions to help build your pharmacy's brand identity:

- Is there a unique story behind your pharmacy?
- What does your pharmacy do better than anyone else? What sets you apart from the competition?
- What services do you offer?
- What beliefs and values are most important to your pharmacy?
- What is your pharmacy's mission?
- What are the top 5 adjectives or words you would use to describe your pharmacy?

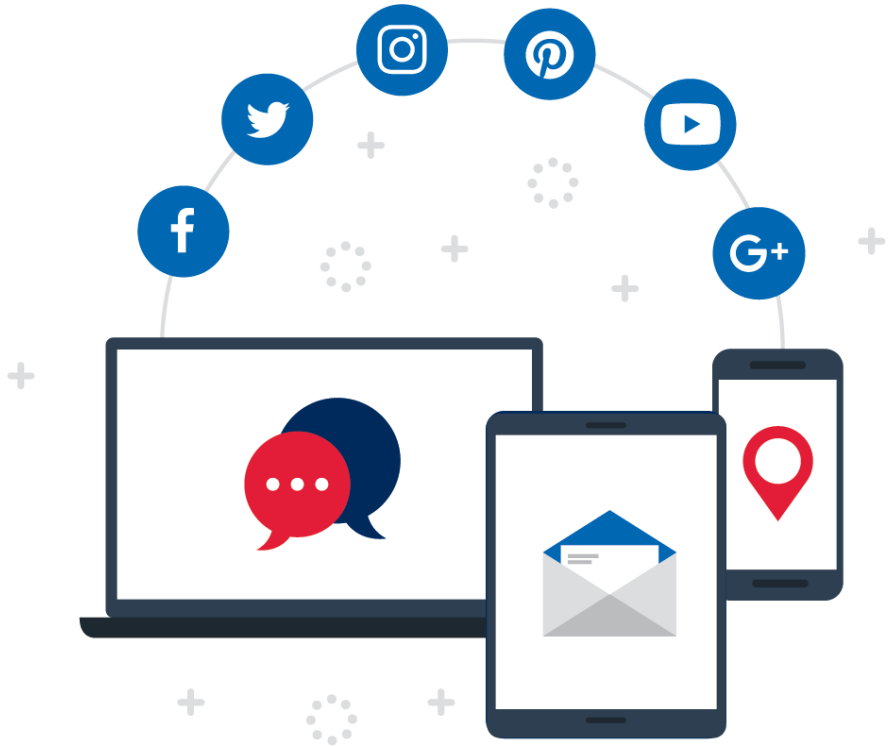
Offline Brand Channels

- Face-to-face (and phone) interactions
- In-store experience
- Signage
- Print marketing
- Direct mail
- TV/radio/print ads
- Word of mouth



Online Brand Channels

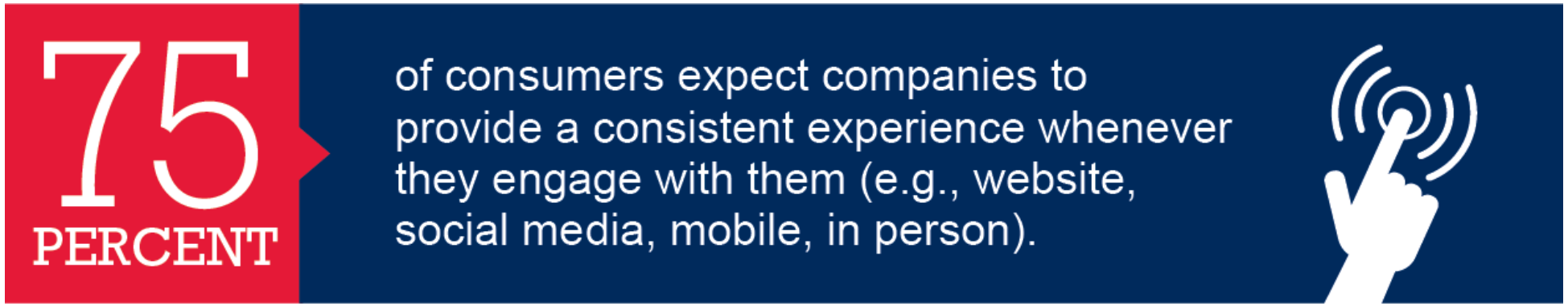
- Social media
- Website/blog
- E-mail
- Mobile
- Local business listings
- Ratings and reviews
- Search engine optimization (SEO)



Creating a Seamless Brand Experience

Consumers want to feel a real **human connection** with brands and want technology to enhance this connection. An important aspect of true human connection to a brand is **familiarity**.

Familiarity at every touch point defines brand commitment.



Impact of Digital Technology

Digital technology has changed the way we live.

What we eat
We find recipes and nutrition advice from Pinterest and watch cooking videos on Facebook.

Where we go
We rely on our mobile phones for directions to get us to our destination.

Who we marry
Thanks to dating apps and websites, 1/3 of today's marriages begin online.

What we wear
We see clothing from influencers and ads on social media and we add it to our wardrobe in a few clicks.

How we talk
We are connected to everyone we need to reach – all from a small device in our pocket.

Consumer Trends Snapshot

The following trends have been observed during the COVID-19 pandemic:

- **16%** growth in global web traffic from April-June 2020.
- **200 billion hours** globally spent on apps in April 2020 and **40%** total YoY growth April-June.
- **82 minutes** per day spent on social networks in the U.S., a **7%** increase from 2019.

Building Your Digital Brand

It's All About Content

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Identify Your Digital Champion

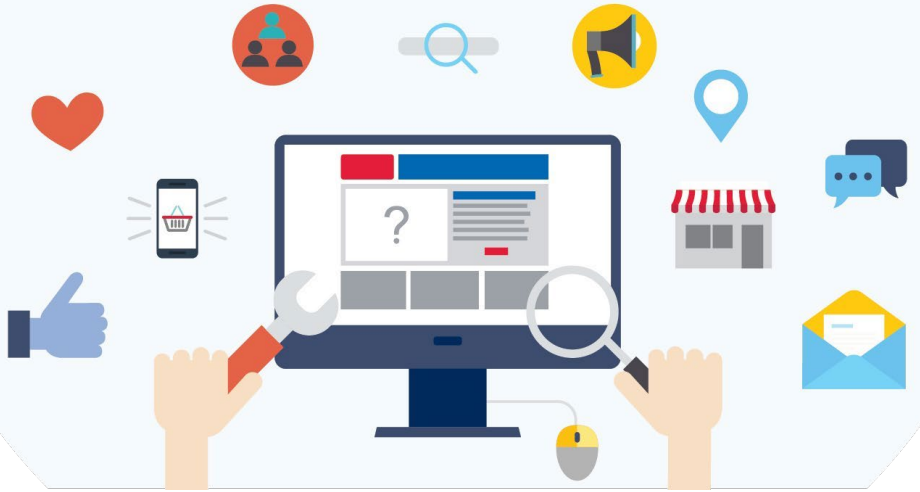
- Who from your pharmacy is going to build and manage your online brand?
- Do they have the proper tools and resources?
- Are you in alignment about your brand identity?

Creating Your Online Brand

Define your brand identity.

Choose your channels.

Create content and tell your story.

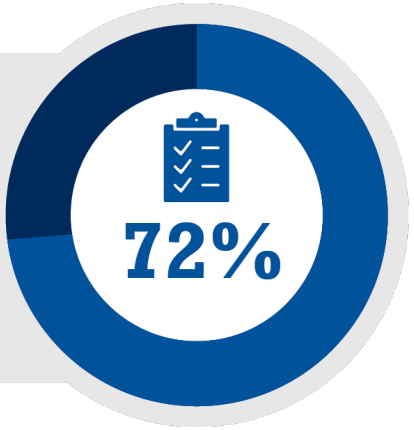


Tell Your Story with Content Marketing

Content marketing allows you to create a narrative and explain to people how your business fits into their lives and addresses their needs. Patients, prescribers and legislators are key audiences to consider.

- Does your audience find it interesting?
- Is it relevant to their needs, wants and goals?
- Is it original?
- Does it provide value?

Seventy-two percent of consumers agree they expect companies to understand their needs and expectations.



Social Media Content & Strategy

1. **Share a variety of content.**
   - Promote clinical services
   - Feature product and patient educational content
   - Highlight information about pharmacy events / programs
   - Other (make it fun!)

2. **Be consistent.**
   - Recommended post frequency: three to five times per week
   - Don't become "out of sight, out of mind"

3. **Show patients what makes your pharmacy special.**

4. **Plan ahead by creating a content calendar and pre-scheduling posts.**

5. **Use visuals like photos, graphics and videos.**

6. **Stay engaged, especially with feedback.**

Putting Ideas Into Practice

Best Practices from Independent Pharmacies

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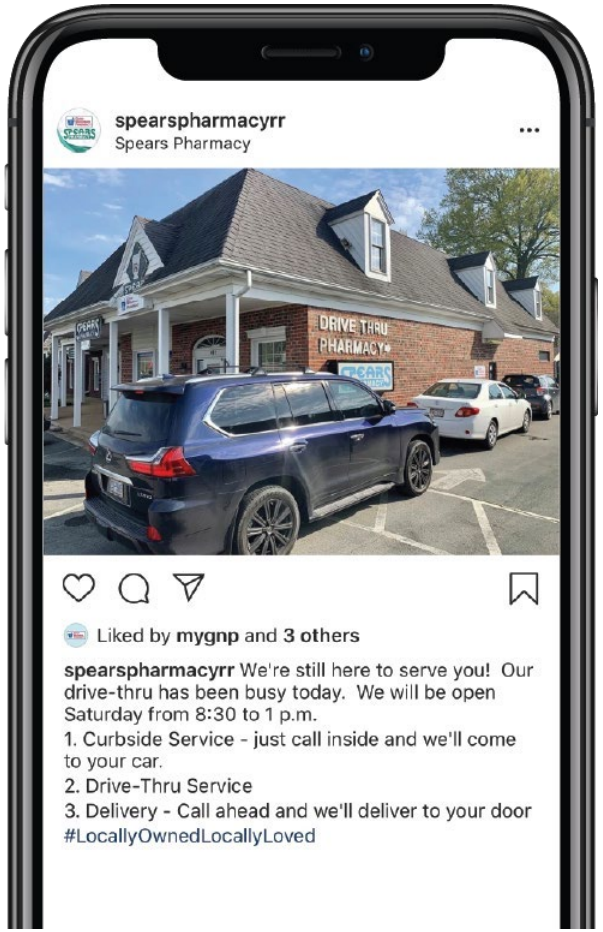
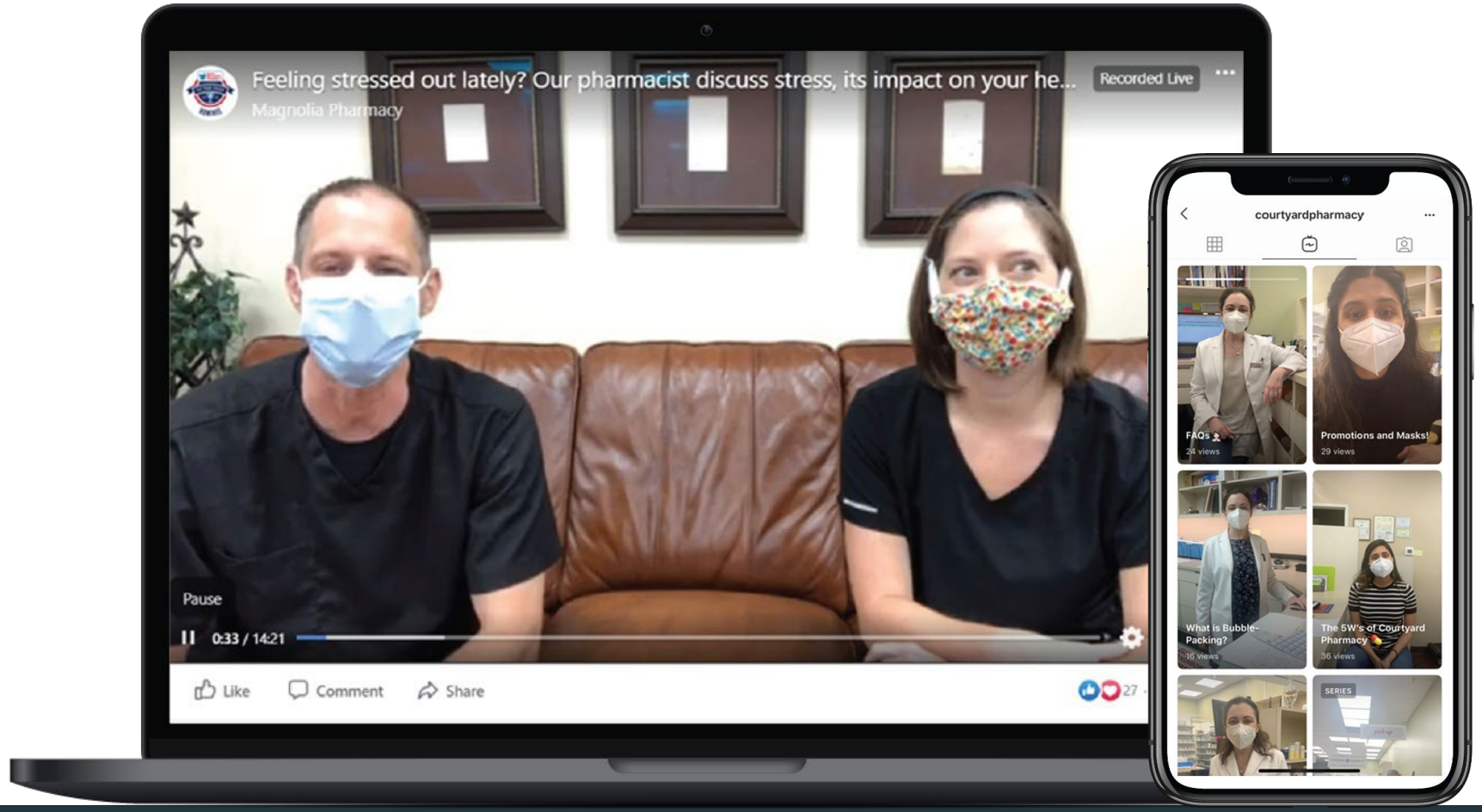
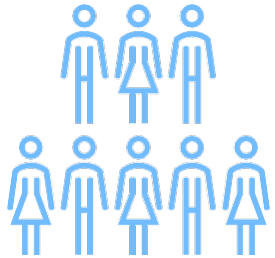
Social Media



Social Media

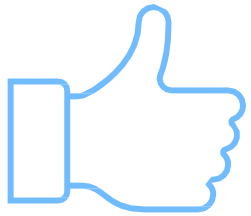


Key Performance Indicators to Measure Brand Awareness on Social



Impressions

How many people are seeing the content that you are publishing?



Engagements

How many people are reacting to your posts with likes, comments or shares?

Share of Voice

How much engagement are you generating on social relative to the engagement your competitors are generating?

Sources

Hubspot.com

Appannie.com

Emarketer.com

Pbahealth.com

Hbr.org

Socialmediatoday.com

Inc.com

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Providing Optimal CMM for Homeless Patients: Challenges and Solutions

Michelle Chu, PharmD, BCACP, APh
Assistant Professor of Clinical Pharmacy
USC School of Pharmacy
Director, PGY1 Pharmacy Residency-Ambulatory Care

Working with Homeless Population

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Learning Objectives

- List challenges unique to homeless patients while providing CMM
- Develop solutions to overcome medication treatment success barriers for homeless patients
- Apply strategies for acquiring medications for patients who have very limited disposable income
- Compare different approaches to engaging homeless patients as a healthcare provider
- List critical variables and barriers to consider in order to successfully improve health outcomes for homeless patients

Homeless and healthcare[1,2]

- Approx. 50% utilize ER as a primary source of health care
  - 64% due to poor management of chronic conditions
  - Psychiatric illness (depression 70%, schizophrenia 27%)
  - Substance use disorders (81% alcoholics, 36% heroin users, 35% cocaine users)
  - Cardiovascular complaints and injuries (mostly adults aged 50 and older)
  - Multiple ED visits within 30 days

1. Salhi et al. Academic emergency medicine 2018;25:577-593
2. White et al. BMC Health Services Research 2014;14:511

Homeless and healthcare[1,2]

- Multiple barriers to healthcare access
  - Less knowledge and poor understanding
    - Access
    - Insurance
  - Poverty
  - Permanent housing

1. Salhi et al. Academic emergency medicine 2018;25:577-593
2. White et al. BMC Health Services Research 2014;14:511

Center for Community Health (CCH), JWCH

- Skid Row
- Various services provided
  - Primary care, dentistry, optometry, behavioral health, social work, dispensary, clinical pharmacy

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http://www.city-data.com/neighborhood/Skid-Row-Los-Angeles-CA.html, accessed 9/16/20

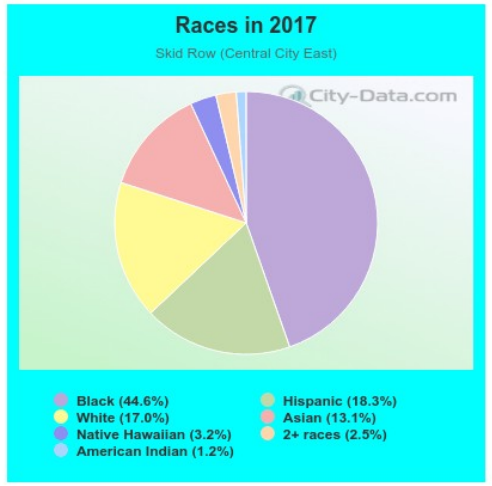
Center for Community Health (CCH), JWCH

- Skid Row
- Various services provided
  - Primary care, dentistry, optometry, behavioral health, social work, dispensary, clinical pharmacy

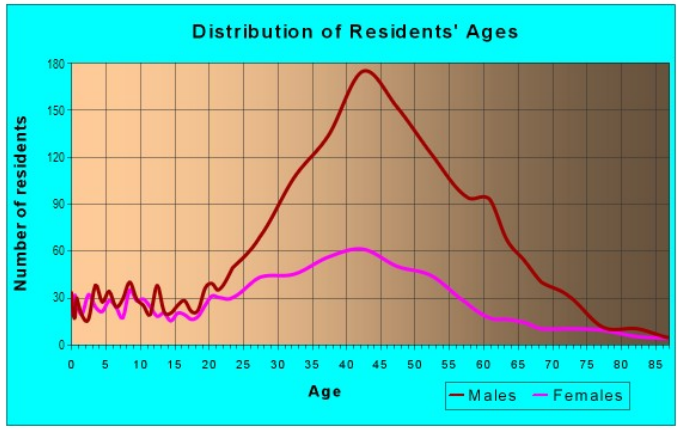
Area: 0.392 **square miles**

Population: 9,294

Population density:
Skid Row (Central City East): 23,717 people per square mile
Los Angeles: 8,477 people per square mile



Black	44.6%	4,262
Hispanic or Latino	18.3%	1,747
White	17.0%	1,628
Asian	13.1%	1,253
Native Hawaiian and Other Pacific Islander	3.2%	302
Two or more races	2.5%	243
American Indian	1.2%	116



Median household income in 2016:
Skid Row (Central City East): $12,926
Los Angeles: $54,432

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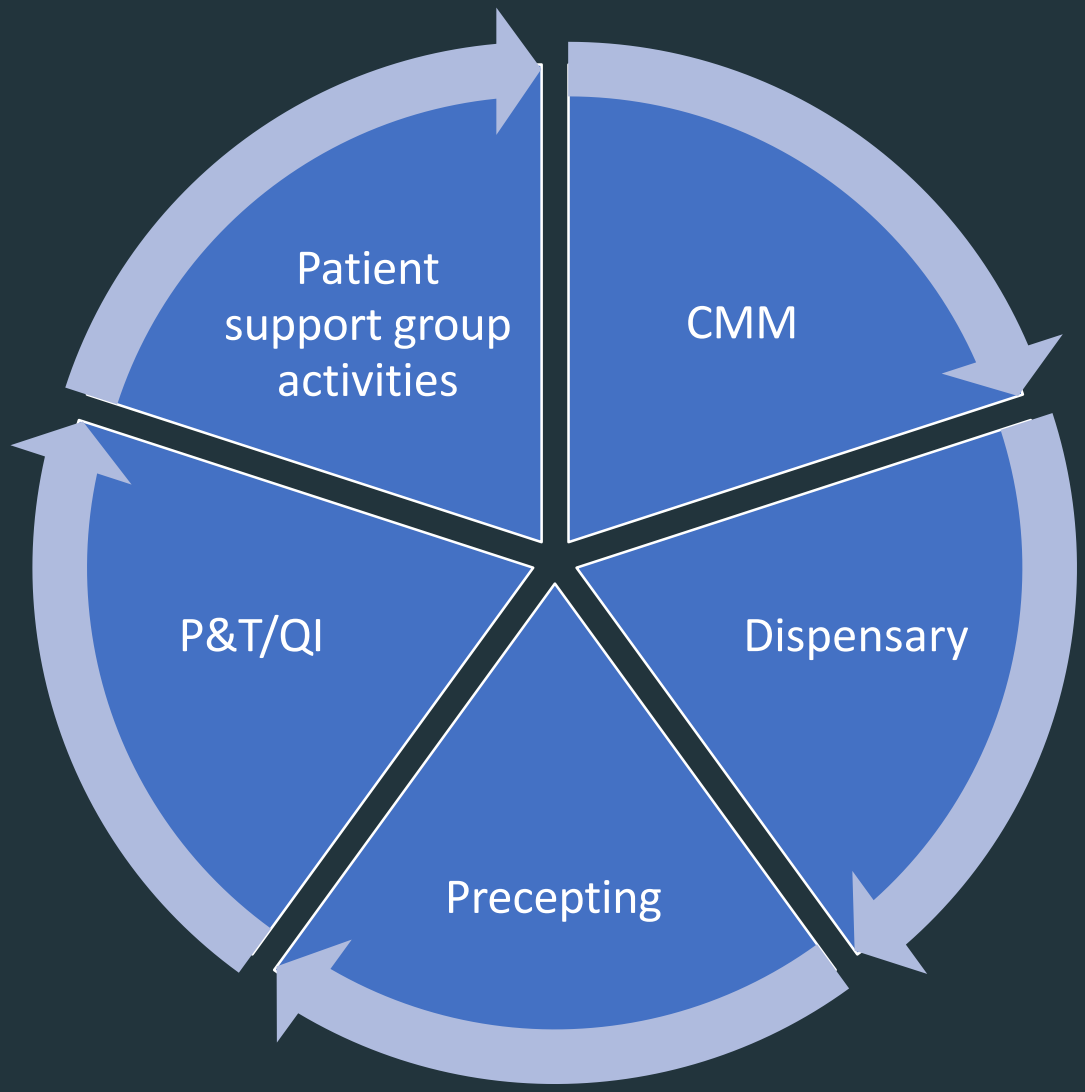
http://www.city-data.com/neighborhood/Skid-Row-Los-Angeles-CA.html, accessed 9/16/20

How I started here

- Residency training
- Patient interactions
- Strong physicians' support



Partnership and collaboration

- Champion Physician → other physicians, clinic staff, clinic operation
- Needs of the clinic/physicians/medical teams
  - Quality/performance metrics
  - Medication safety needs
    - Drug therapy needing close monitoring
    - Patients with polypharmacy/multiple providers
  - Medication access needs
    - 340B medications, Formulary, PAP
    - Flu vaccine voucher

Partnership and collaboration

- Care coordination and case management
  - Team huddle
- Other specialists and allied healthcare providers
  - Patients with mental disorder

Partnership with patients

- DM health fairs and support group
- Smoking cessation program by USC student group
- Monthly presentations on disease awareness by USC student group

Partnership with patients

Earn their trust and respect	Understand and accept their lifestyle	Identify and accommodate individual needs
Social factors	Shared decision making	Be flexible at times

Poor health literacy

- Mid 40's AAM with DM and mental illness
- Incarcerated all his childhood/adulthood
- Education level: 2nd grade
- Can't read or write
- No family members except aunt (mom's friend)

- Mid 40's Middle Eastern male with DM and mental illness
- New to Skid Row
- BG 300-400's
- Full adherence to meds
- Eating 1 loaf of bread every meal


WEINGART CENTER ASSOCIATION
Leavey Building
Center for
Community Health
Downtown Los Angeles
512-522

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Keys to Success in Providing Healthcare to Homeless Patients

Paul Gregerson, MD, MPH

Chief Medical Officer

Internal Medicine Specialist

John Wesley Community Health Institute Coordinator

National Health Care for the Homeless Council

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Lisa Goldstone, PharmD, BCPP
Associate Professor of Clinical Pharmacy
USC School of Pharmacy

Psychiatry for Population Health Pharmacists (PPHP)

- Mild to moderate mental health conditions commonly treated in primary care*

Number of BCPPs is relatively small/not adequate to cover both psychiatric and primary care settings

Care provided by non-BCPPs in primary care has resulted in improved outcomes

Non-BCPPs with adequate training, could fill this gap in care and assist with the referral of patients to BCPPs as needed

* = primary care as well as other non-psychiatric outpatient, ambulatory, and community-based settings

Psychiatry for Population Health Pharmacists (PPHP)

- Increase access to sustainable, equitable, and high-quality medication management services for patients with mental health conditions
- Equip pharmacists in non-psychiatric settings with the skills necessary to provide medication management and triage/referral services for patients with mental health conditions in alignment with whole person care and population health goals of health plans and health systems
- Anticipated launch date: Spring 2021 (lwgoldst@usc.edu)

Upcoming CRMC Events

Webinars

[Ongoing]

Case Discussions

[Ongoing]

Journal Clubs

[Ongoing]

Pilot Meetings

[Ongoing]

Clinical Pharmacy Technician Trainings

[Spring 2021]

CRMC Spring 2021 Learning Session