California Right Meds COLLABORATIVE

Hanna Sung, PharmD, BCACP, BC-ADM, APh

June 27, 2021

An initiative of

USC School of Pharmacy

Statement of Disclosure

- Hanna Sung has no financial relationships that apply to the educational content presented.

Objectives

- Develop strategies for overcoming common challenges in management of diabetes and hypertension in Comprehensive Medication Management (CMM)
- Discuss clinical instances to consider exceptions to strict glycemic control
- Consider health plan priorities in clinical decision making when providing CMM to patients with diabetes and hypertension

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Common Challenges

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Common Challenges in CMM

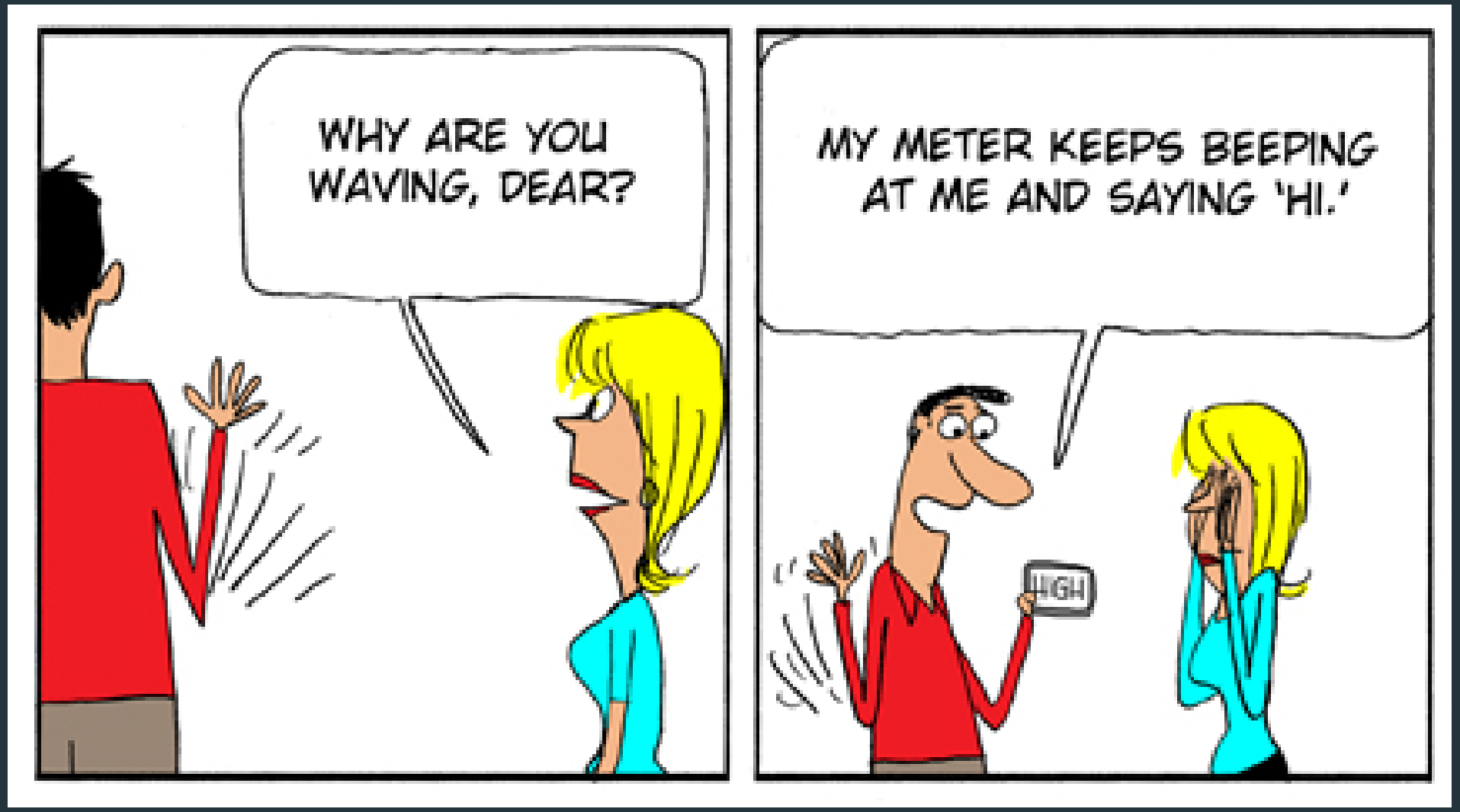
- Relationship and Communication
  - Primary Care Provider-Pharmacist Provider
    - Lack of use of risk-specific therapies
    - Lack of integrated care
    - Clinical inertia
  - Pharmacist Provider-Patient
    - Medication and lifestyle adherence issues
    - Patient Education Gaps: Disease state, monitoring techniques, barriers to care, stigmas associated with medication
    - Lost to follow-up
    - Access

Overcoming challenges in CMM

- Evidence-Based
- Build rapport
  - In-services
  - Electronic Medical Record Access
  - Collaborative Practice Agreement
  - Board certification
- Communicate regular follow-ups
- No “I” in Team

Overcoming challenges in CMM

- Evidence-Based
- Build rapport
  - Motivational Interviewing
  - Things remembered
  - Regular follow-ups
- Coach the patient
- Involve family members
- No “I” in Team


WHY ARE YOU WAVING, DEAR?
MY METER KEEPS BEEPING AT ME AND SAYING 'HI.'
HIGH

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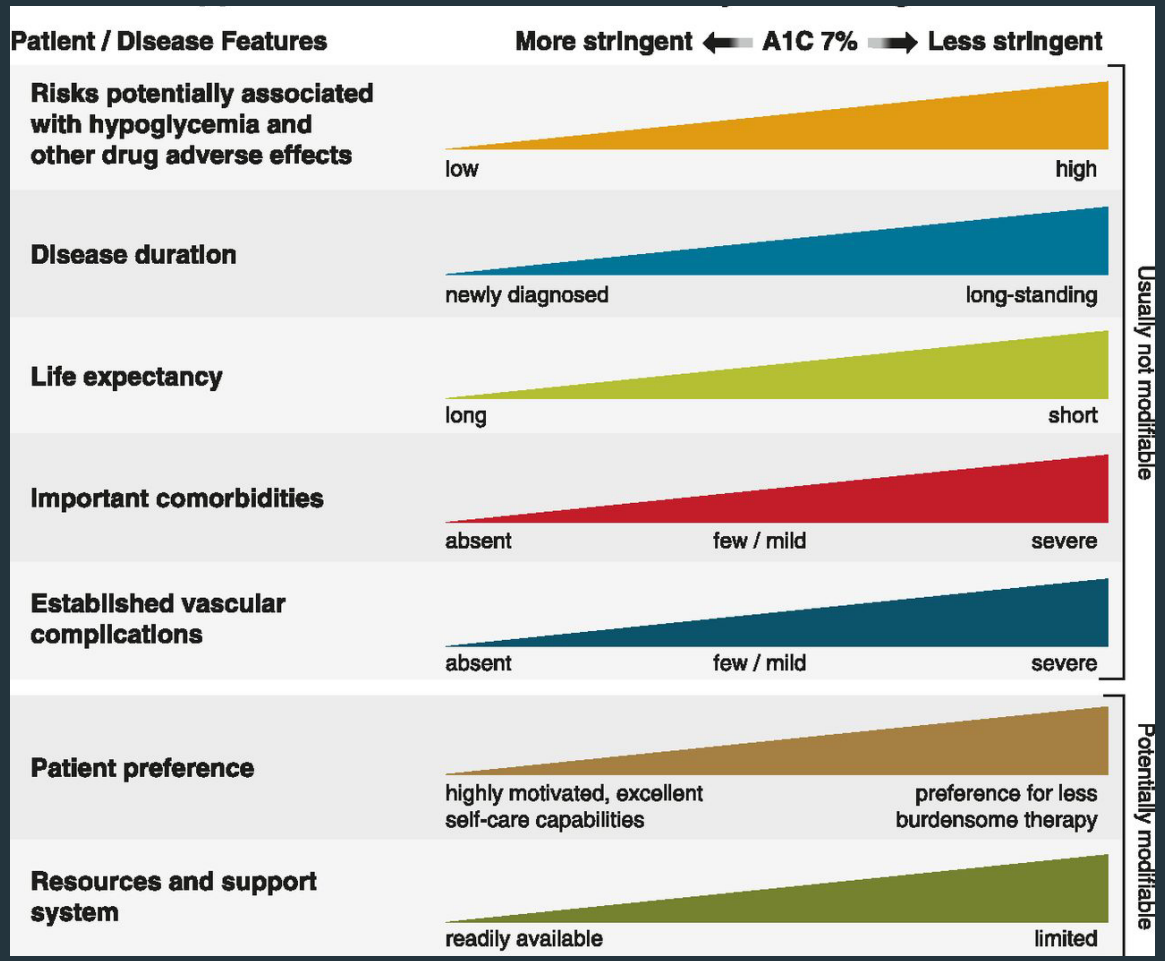
In the beginning…

- Origins of A1c <7% glycemic target

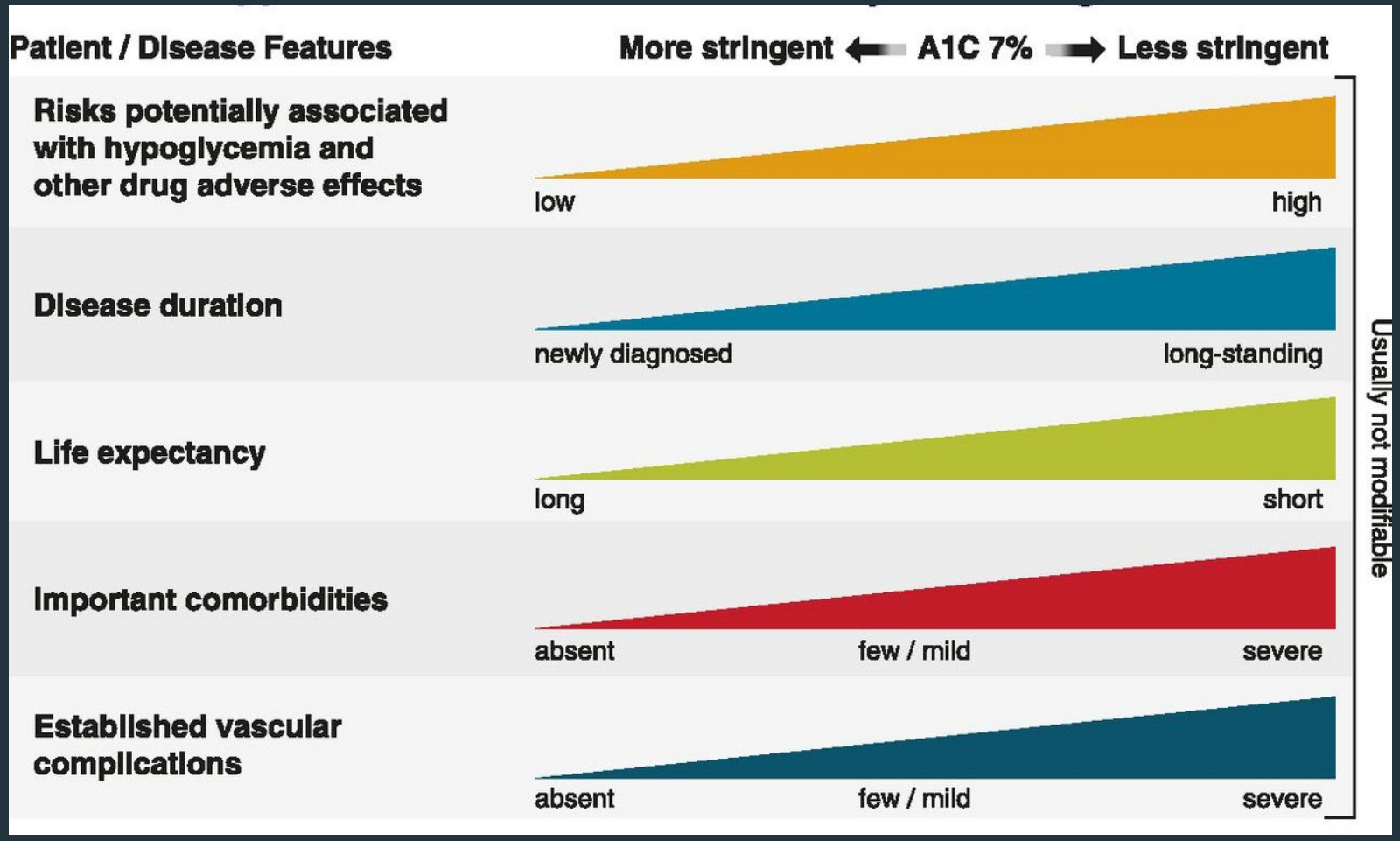
- Body of evidence: Improved glycemic control associated with significant reductions microvascular and macrovascular disease
  - UKPDS
  - ACCORD
  - ADVANCE
  - VADT

Approach to Glycemic Targets

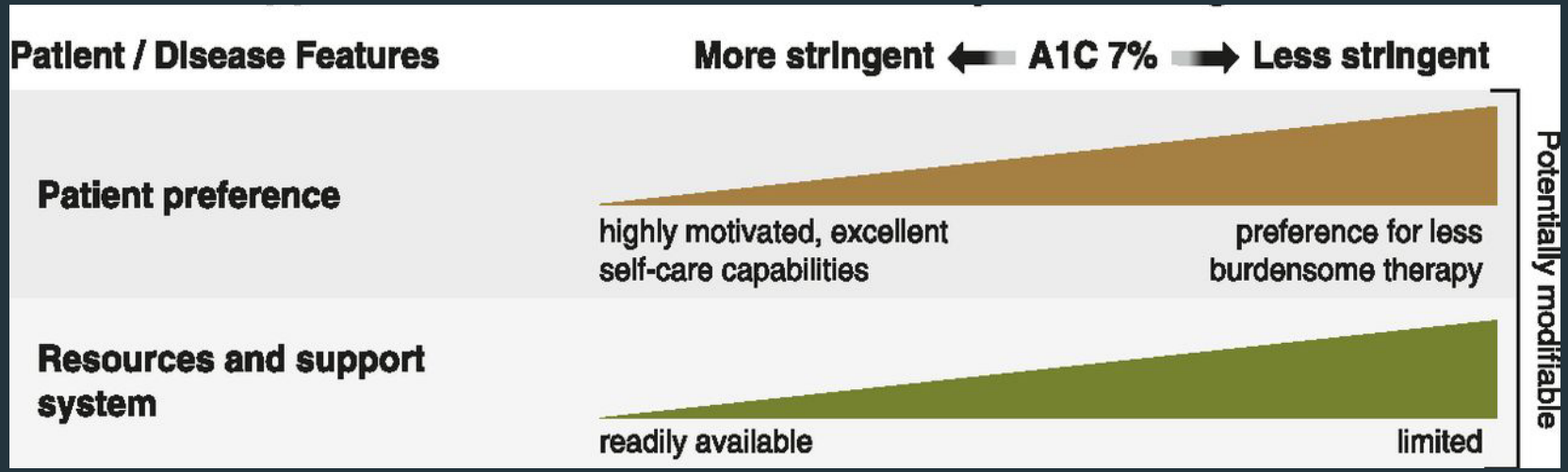
- Individualized
- Shared decision making
- Clinical decision making
- Fluid



Factors: Not modifiable



Factors: Modifiable



Less stringent goal

- A1c <8%
- Factors to consider:
  - History of severe hypoglycemia
  - Limited life expectancy
  - Advanced microvascular or macrovascular complications
  - Extensive comorbid conditions
  - Long-standing diabetes in which A1c goal has been difficult to obtain despite intensive efforts
  - Harm>Benefit

Case Discussion

- Ms. MD is a 52 yo female with Type 2 diabetes, hypertension, and hyperlipidemia. She has had T2DM x 2004. She is currently taking Basaglar 40 units at bedtime, Admelog 8 units before meals, and linagliptin 5mg once daily. Pt endorses full adherence to her medications. You've worked with her in the past 6 months to bring down her blood sugars from 9% (12/2020) to 7.5% (5/2021).
- Pt states on the phone that she was recently discharged from UCLA-Harbor post PE and DVT. During the hospitalization, pt was also diagnosed with pancreatic cancer.

Breakout rooms

Discuss this case in your groups:

- What modifiable and non-modifiable factors did you identify to individualize the patient's goal?
- What are additional considerations to address when discussing with the patient?
- What A1c goal would be appropriate for Ms. MD?

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DOC- CAN YOU SEE THE PROBLEM?
I'M AFRAID SO
INSURANCE COMPANIES

Cost of disease

- Economic Burden in the US
  - Diabetes: $327 billion/ year
  - Hypertension: $131 billion/ year

- Clinical Implications

  -Identify effective strategies to improve control of chronic diseases associated with high annual expenditure

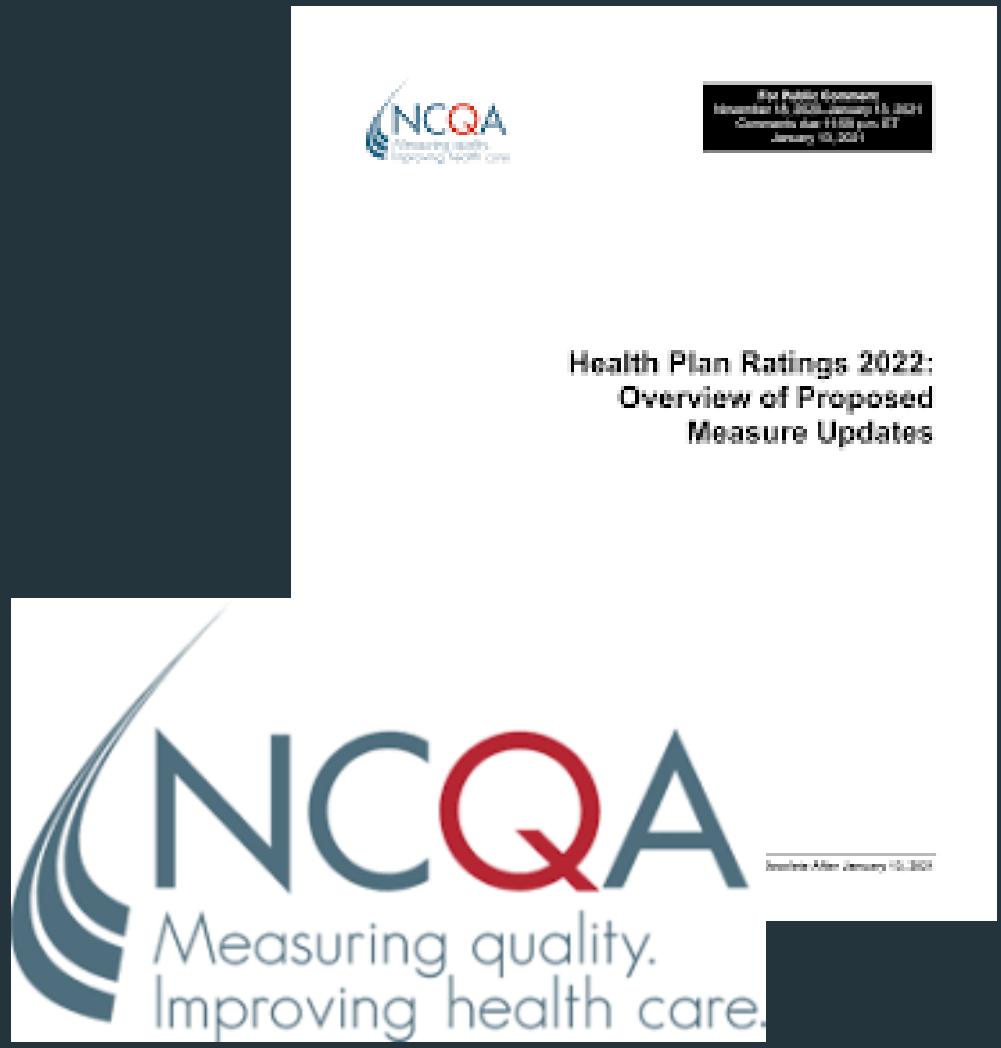
Quality Metrics

- Clinical decision making in Diabetes and Hypertension are in alignment with health plan priorities
  - Clinical guidelines: Providers
  - Quality metrics: Health Plans

- Quadruple Aim

Quality Measures

- Quality of Healthcare
  - HEDIS (Healthcare Effectiveness Data and Information Set)
  - CAHPS (Consumer Assessment of Healthcare Providers and Systems)



Quality Metrics: Diabetes

- Comprehensive Diabetes Care
  - HbA1c control (<8%)
  - Retinal eye exam
  - Medical attention for nephropathy
    - At least 1 ACE inhibitor or ARB dispensed
    - Visit with nephrologist
    - Evidence of ESRD or Dialysis
    - Evidence of stage 4 chronic kidney disease
    - Nephropathy screening or monitoring test

Quality Metrics: Hypertension and more

- Controlling Blood Pressure
- Adequate Control defined by:
  - Systolic <140
  - Diastolic <90
- Standards of Care

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Question 1

What are some strategies for overcoming challenges in comprehensive medication management?

a. Autonomously make clinical decisions without communicating information to healthcare team
b. Emphasize to patients who are non-adherent to their medications that insulin will have to be used if they do not improve
c. Regularly communicate clinical information to health care team regarding mutual patient
d. Demand that provider sign a collaborative practice agreement, as you feel that it'd be more efficient

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Question 2

Ms. MC is a 56 yo female who was recently discharged from the hospital after a deep vein thrombosis and pulmonary embolism. During the hospitalization, pt was also diagnosed with pancreatic cancer. Pt has had type 2 diabetes, obesity, hyperlipidemia since 2004. Pt states that her appetite has decreased, and she is feeling tired/less motivated. Her recent A1c went down from 9% to 7.4%. What would be an appropriate goal A1c for this patient?

a. A1c <9%
b. A1c <8%
c. A1c <7%
d. A1c <6.5%

Question 2

Ms. MC is a 56 yo female who was recently discharged from the hospital after a deep vein thrombosis and pulmonary embolism. During the hospitalization, pt was also diagnosed with pancreatic cancer. Pt has had type 2 diabetes, obesity, hyperlipidemia since 2004. Pt states that her appetite has decreased, and she is feeling tired/less motivated. Her recent A1c went down from 9% to 7.4%. What would be an appropriate goal A1c for this patient?

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Question 3

What is the health plan priority/measure for diabetes control?

a. Hemoglobin A1c
b. Comprehensive Diabetes Care
c. Blood Pressure
d. Retinal Eye Exam Completion

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Sahar Dagher, PharmD, APh

June 27, 2021

An initiative of

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Video Telehealth: Best Practices

Objectives

- Discuss the background of telehealth
- Discuss the types of telehealth
- Identify solutions to select telehealth platforms for the delivery of CMM
- Review implementation via USC Virtual Pharmacist Care
- Develop or refine a video telehealth **workflow** process that optimizes delivery of CMM services.
- Share **solutions** for ensuring that telehealth services are simple and comfortable for patients to use.

Learning Objectives

1. Identify free and low cost video telehealth platforms for the delivery of CMM
2. Develop or refine a video telehealth workflow process that optimizes delivery of CMM services.
3. Share solutions for ensuring that telehealth services are simple and comfortable for patients to use.

History of Telehealth

- Mid to late 19th century
  - ECG data transmitted over telephone wires
- Modern telemedicine started in the 1960s
  - Military and space technology sectors
  - The use of television

Development of telehealth

- Early advancements information and communication technologies (ICTs)
  - Digital replacing analogue
  - Rapid drop in the cost of ICTs
  - Internet, Web-based applications
  - Multimedia approaches

Telehealth Policy

- Federal Health Resources and Services Administration (HRSA)[1]
  - *"..use of electronic information and .. technologies to support long-distance clinical health care, ..health-related education, ..health administration."*
- The National Telehealth Policy Resource Center, Center for Connected Health Policy
  - "*The mode of delivering health care services …via information and communication technologies to facilitate the diagnosis, consultation, treatment, education, care management, and self-management of a patient's health care..*"

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1. http://www.hrsa.gov/ruralhealth/telehealth/
2. http://cchpca.org/telehealth-advancement-act

What is Telehealth?

- The use of electronic information and telecommunication technologies to support and promote long-distance clinical health care, patient and professional health-related education, public health and health administration.

- Technologies include video conferencing, the internet, store-and-forward imaging, streaming media, and terrestrial and wireless communications.

https://www.hrsa.gov/rural-health/telehealth

Telehealth vs telemedicine?

- Telemedicine
  - Use of electronic communication and information technologies to provide clinical services[1]
- Telehealth
  - Equal quality of care delivery in-person vs via electronic communication, including non-clinical services
  - Broader application of technologies through various health care disciplines[2]
    - Dentistry
    - Counseling
    - Physical and occupational therapy
    - Home health
    - Chronic disease monitoring and management
    - Disaster management
    - Consumer and professional education

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1. The American Telemedicine Association, *Telemedicine, Telehealth, and Health Information Technology.* May 2006.
2. Center for Connected health Policy. Telehealth Definition Framework. http://cchpca.org/sites/default/files/uploader/Telehealth%20Definintion%20Framework%20for%20TRCs_0.pdf.

Key Components of Telehealth

- Live Video
- Store and Forward
- Remote Patient Monitoring
- Mobile Health

Live Video

- Synchronous care
- Two-way interaction between patient and provider using audiovisual telecommunications technology
  - “Real-time” care which may substitute for an in-person encounter
- Health Education
- Consults
- Emergency Room/Intensive Care Unit Support

Center for Connected health Policy. What is telehealth? https://www.cchpca.org/what-is-telehealth/?category=live-video

Store and Forward

- Asynchronous telehealth
- Electronic transmission of medical information, such as digital images, documents, and pre-recorded videos, to a practitioner, usually a specialist, who uses the information to evaluate the case or render a service outside of a real-time or live interaction.
- X-Ray, MRIm photos, patient data, video exam clips
- Benefits to patients and providers
  - Timely specialty care without travel, lessened wait times, providers/specialists can review cases simultaneously, overcome language and cultural barriers
- eConsults: sharing of PHI between PCP and specialists

Remote Patient Monitoring

- Personal health and medical data collection from an individual in one location, which is transmitted via electronic communication technologies to a provider in a different location for use in care and related support.
- Monitoring programs can collect health data to transmit to monitoring centers
  - Vitals, weight, blood pressure, blood sugar, blood oxygen, heart rate, electrocardiograms
- This type of service allows a provider to continue to track healthcare data for a patient once released to home or a care facility, reducing readmission rates.

Mobile Health (mHealth)

- Health care and public health practice and education supported by mobile communication devices such as cell phones, tablet computers, and PDAs.
- Applications can range from targeted text messages that promote healthy behavior to wide-scale alerts about disease outbreaks.
- The Food and Drug Administration (FDA), the Federal Trade Commission (FTC), the Federal Communication Commission (FCC), and the Department of Health and Human Services (HHS) all have some jurisdiction oversight in this area.

mHealth and the FDA

- Regulated medical devices are healthcare products intended for diagnosis, cure mitigation, treatment, or prevention of a medical condition intended to affect the structure or any function of the body
- Not all devices are created equal
  - Class I: Low Risk and subject to less regulatory control
    - Apps used for self-management, track medication usage or DDDI, perform calculations used in clinical practice, medical device data systems
  - Class II: Requires greater regulatory controls to provide reasonable assurance of safety and effectiveness
  - Class III: Highest risk and subject to highest regulatory control

mHealth and the FDA

- Do apps need FDA regulatory oversight?

✓If they are extensions of a medical device for the purposes of controlling the device or displaying, storing, analyzing or transmitting patient specific medical device data (i.e CGM)

✓Transform mobile platform into a regulated device by using attachments, display screens or sensors

✓Uses patient specific information to analyze, diagnose and/or treat a patient

✓Involved in active patient monitoring

- Apps NOT considered medical devices
  - Medical flashcards, Finding medical facilities, track and review medical bills, medical textbooks and educational materials

Starting and Sustaining Telehealth

- Select a telehealth vendor
- Prepare for telehealth implementation
- Conduct a telehealth visit

https://telehealth.hhs.gov/providers/getting-started/#types-of-telehealth

Telehealth Solutions: Selecting a Vendor

- Basic business overview
- Free or low cost
- Technology needs
  - Integrate into your EMR
- Cybersecurity and privacy (i.e HIPAA compliant)
- System Usability
  - Advanced features
    - Virtual waiting room
    - Scheduling future visits
  - Simplicity for patient and provider
    - No special equipment for patients required
    - Do patients need to download the app?
- Vendor Support Services
- Clinical Validation

1. BUSINESS:

- Organizational overview – tenure, funding source, financial stability, affiliations, notable customers, etc.
- Impact to program ROI— product cost, business model, reimbursement rates, risk sharing, support payment program participation, etc.
- Expertise in offering telehealth to your specialty
- Knowledge of federal and private payer requirements

2. INFORMATION TECHNOLOGY:

- Ability to integrate with your current IT landscape, particularly your EHR system
- Cost, process, and timeline associated with integration and product updates
- Ability to capture data important to care team and patient[20]
- Patient geolocation for licensure
- Customization capabilities
- Patient access to data
- Ability to maintain patient identity across platforms
- Biometrics/RPM integration capability
- Information blocking and interoperability requirements (as applicable)
- Impact analysis on your internet and local network usage

3. SECURITY: (APPENDIX D.3)

- Supports compliance with HIPAA rules, such as willingness to sign a Business Associate Agreement (BAA)
- Third-party audits (SOC 2, HITRUST)
- Liability structure for managing potential security breaches
- User authentication and authorization
- Transparency on collected data use processes
- Local regulatory compliance (i.e., State Medical Board)
- In-platform consent capabilities

4. USABILITY:

- User experience of platform for patients and care team members
- Patient and care team engagement metrics
- Dashboard/workflow assimilation
- Multi-specialty application
- Platform launch process and timing
- Ease of billing/payout for patients and health systems/practices

5. CUSTOMER SERVICE:

- Level of support available to practice during and after implementation— staff training, patient education, project management, data analysis and insights, etc.
- What technology does the patient need and does the vendor support this?
- Degree of technical support available to patients
- Access to existing procedures and templates

6. CLINICAL VALIDATION:

- Documented clinical outcomes
- Published peer-reviewed research

-assn.org/system/files/2020-
n-quick-guide-appendix-d1-
r-guide.pdf

Preparing for telehealth

- Identify a private room
- Establish a telehealth workflow and protocols
- Telehealth appointments
  - When you'll be available for appointments, how patients will schedule appointments
- Patient onboarding
- Patient consent
- Language barriers
- On Call IT support

Preparing Patients for Telehealth

- Share the benefits of telehealth pertinent to patient
- Explain that their personal information is protected
- Offer audio-only visit if equipment is an issue
- Encourage patient to check with their payer on telehealth coverage. If Medicare, explain that CMS has expanded coverage of telehealth for Medicare beneficiaries
- Patient pushback is normal

Preparing Providers for telehealth

- Schedule training with software vendor for all relevant staff
- Create FAQs for staff to reference later
- Encourage “practice runs”
- Patient interaction trainings
- Be patient
- Provide additional training sessions
- Educate staff on the presence of security risks as well as best practices for safe remote work
- Provide on-call IT support

Conduct a telehealth visit

- Introduce yourself and confirm the patient's identity via drivers license or photo ID for new patients
- Discuss purpose of the visit and what to expect
- Obtain the patient's consent to the purpose of the visit, chart the consent
- Determine who is in the room with the patient
- Assure the patient that their information is secure
- Outline the session for the patient
- Discuss what to do if the patient loses connectivity, get their best phone number
- Maintain the same standard as an in-person visit
  - Patient's health history and clinical data
- Provide a plan for the patient at the end of the visit, same as in-person

Evaluate your telehealth program

- Measuring a program's impact and providing information on where to make improvements.
- Evaluation findings can facilitate sustainability and ensure goals and objectives of the program are being achieved.
- Evaluation Strategies
- Evaluation Measures

https://www.ruralhealthinfo.org/toolkits/telehealth/5/strategies-and-considerations

https://telehealth.hhs.gov/providers/direct-to-consumer/

https://www.cms.gov/About-CMS/Agency-Information/OMH/resource-center/hcps-and-researchers/Improving-Access-to-Care-for-People-with-Disabilities

Evaluation Strategies

- Assess and define
  - Define service needs, define a program model, create a business model
- Develop and plan
  - Develop a quality improvement process
  - Communication plan
  - Technology implementation plan
  - Identify data needs, methods for data collection, frequency of data analytics
- Implement and Monitor
  - Identify potential point of improvement via PDSA cycle
  - Patient and Provider satisfaction surveys

Evaluation Measures

- Access to Care
  - Affordability, Availability, Accessibility, Accommodation and Acceptability
- Financial Impact/Cost
  - Consider all parties involved: patients/caregiver, the care team and the larger health system
  - Measures include: Patient travel miles saved, Cost per visit, ROI
- Experience
  - Determines user-friendly and effectiveness of the program
  - Patient and Provider satisfaction surveys
- Effectiveness
  - Clinical, operational and technical aspects
  - Considerations: socioeconomic and environments setting, technology used, type of care being delivered

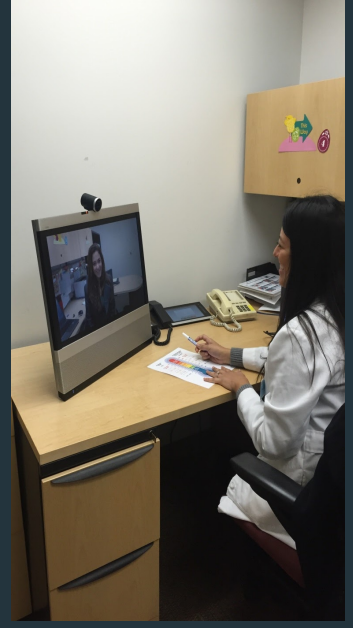
Who will pay?

- The COVID -19 public health emergency reimbursements may be extended or become payment
- Medicare, Medicaid expanded payment to include:
  - Audio-only phone visits
  - Services furnished to homebound patients (no restrictions to geographic location)
  - Expanded list of provider types
  - Expanded list of services
- Private Payers

https://www.cms.gov/files/document/telehealth-toolkit-providers.pdf

USC
Virtual Pharmacist Care

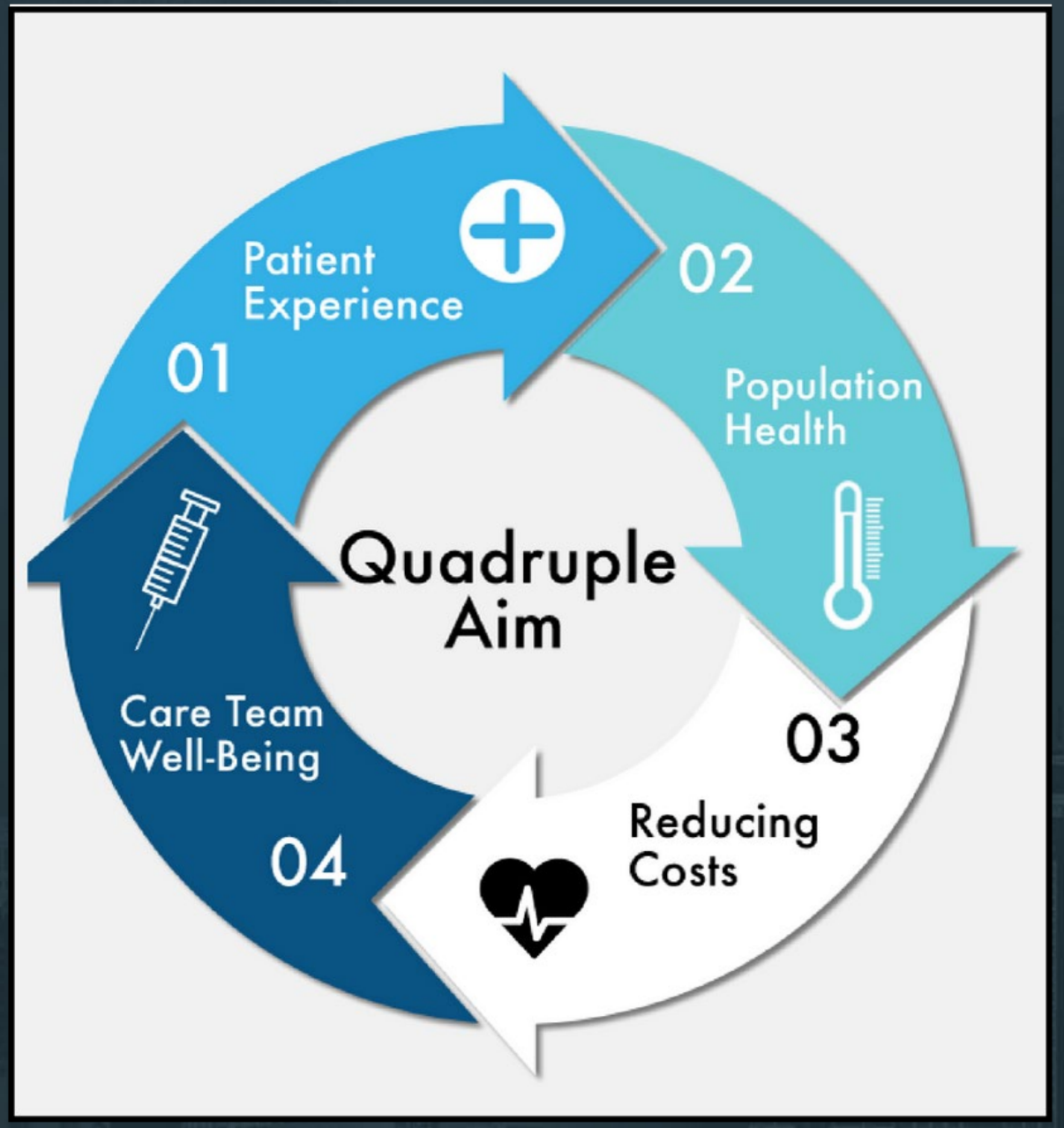
Virtual Pharmacist Care (VPC)



- USC Virtual Pharmacist Care (VPC)
  - Established in 2012
  - Mission Statement: Provides remote Comprehensive Medication Management (CMM) services for high-risk patients in alignment with payer and health system priorities
  - Remote medication management services tailored to population health priorities of its partners
  - Improve quality of care and reduce total healthcare costs
  - Services offered using telehealth and/or video-telehealth

VPC Quadruple Aim

Focus on high cost / high risk / complex chronic diseases



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VPC Post Discharge Pharmacy Service (Video-telehealth)

Setting: Keck Medical Center of USC

Goal

Minimize medication-related gaps during transition from hospital to outpatient clinics

Needs assessment

Poor readmission data & medication therapy adherence

Lost recognition with Get with the Guidelines

Initiation: Advanced Heart Failure Patients July 2017

Expansion

May 2018: General Medicine

July 2018: Endocrinology

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Virtual Care Post-Discharge management in the HF population

Goal

- To study the impact of virtual care post-discharge management service on clinical and service outcomes

Objectives

- Implement virtual care pharmacy services to provide 30-day ToC to HF patients
- Determine the service impact on all-cause readmission, provider and patient satisfaction
- Analyze medication related problems identified in the post-discharge HF patient population
- Facilitate comprehensive care transition between hospital and patients' primary care physicians

Virtual Care Post-Discharge Workflow

INPATIENT

- PharmD performs daily review of patient list/chart
- Assess patient list for discharge planning
- Patient referral from physicians at least 1 day prior to discharge

UPON DISCHARGE

Patient/ primary caregiver contacted within 48-72 hours to schedule initial telehealth pharmacy appointment

POST-DISCHARGE

-Initial visit: within 72 hours

-Subsequent visits for 30 days (at least 2 visits*)

*Visits conducted via phone or video

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Pharmacist Clinical Services During Visits

Medication reconciliation, evaluation of drug treatments for chronic conditions	Adherence, appropriateness, effectiveness, safety
Monitoring home vitals and laboratory results	
Modifying drug therapies / recommending treatment plans	i.e. HF protocol
Ordering labs and medications	
Patient education	
Coordinating post-discharge care	

First Year Review: JULY 2017-JUNE 2018

Medication Related Problems

30-day Readmission

Provider and Patient Satisfaction

Patient Comorbidities *(Majority had 6)*

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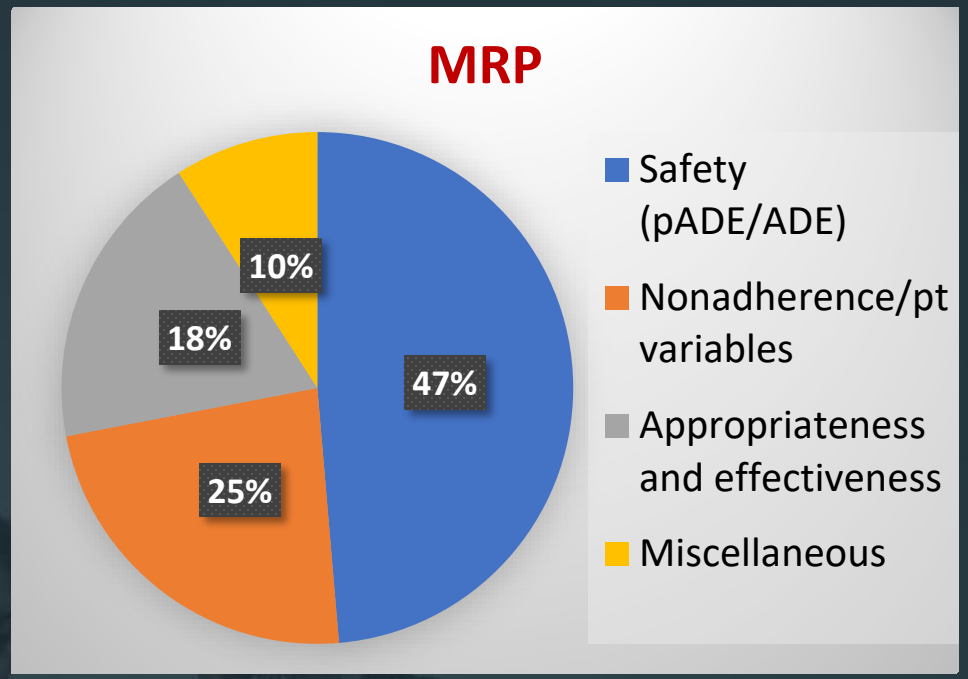
Characteristics	Received service (No. of patients based on initial admission) (n=67)
Clinical features of heart failure	
Ischemic cardiomyopathy, n (%)	38 (56.7)
Mean LVEF ± S.D., median (range)	25.1 ± 10.1, 23.0 (8–45)
Considered for heart transplant, n (%)	13 (19.4)
Mean BNP ± SD, median (range), n=71	1889 ± 1588, 1320 (118-5000)
Mean N-terminal Pro-BNP ± SD, median (range), n=35	10456 ± 17482, 5162 (828-70000)
Medical history, n (%)	
CKD, Stage 3 or higher	63 (94.0)
Hypertension	45 (67.2)
Diabetes	40 (59.7)
Dyslipidemia	33 (49.3)
CAD (other than MI)	37 (55.2)
Atrial fibrillation/arrhythmia	32 (47.8)
AKI during hospitalization	31 (46.3)
Anemia	24 (35.8)
MI	23 (34.3)
ICD	22 (32.8)
S/P CABG	16 (23.9)
S/P PCI	14 (20.9)
OSA or any sleep apnea	13 (19.4)
COPD	12 (17.9)
Depression	11 (16.4)
Stroke	9 (13.4)
Dialysis	7 (10.4)
CRT-D	6 (9.0)
Other conditions[c]	43 (64.2)

Medication Related Problems Identified

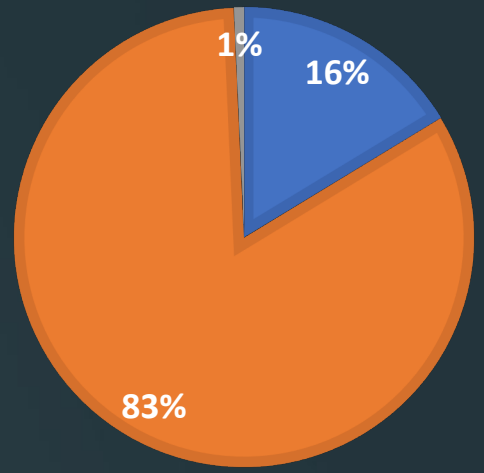


Total MRPs identified: 316

Average MRPs per admission ~5

SAFETY

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



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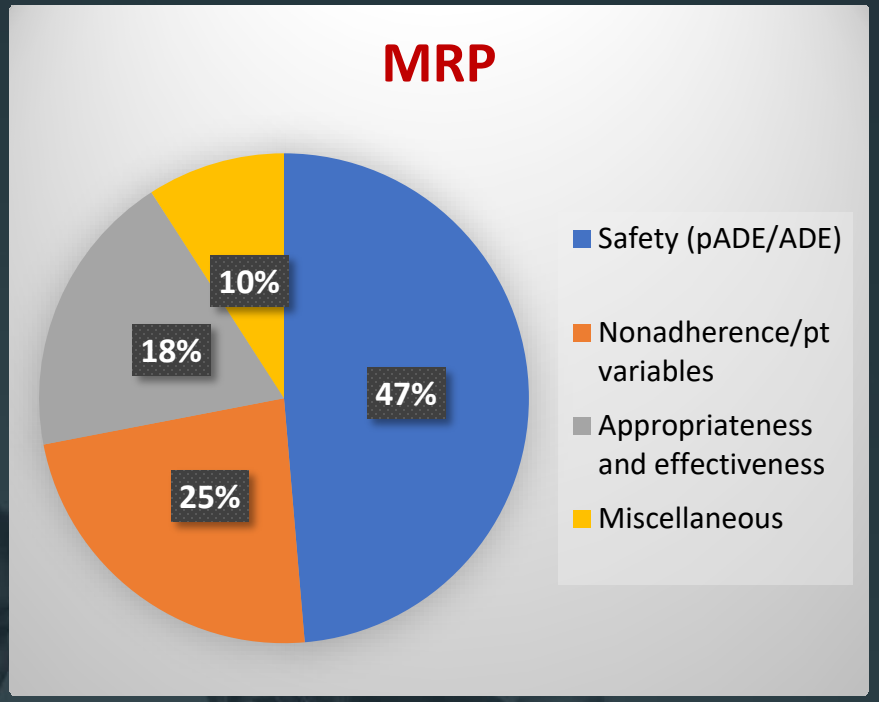

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Average MRPs per admission ~5

Medication	Count
Heart failure (Total n= 163)	
Loop diuretic	41
ACEi/ARB/Entresto	40
Aldosterone antagonist	27
Beta blocker	16
Hydralazine/nitrate	7
Digoxin	1
Diabetes (Total n= 49)	
Injectable DM agents	33
Oral DM agents	14
Other	62

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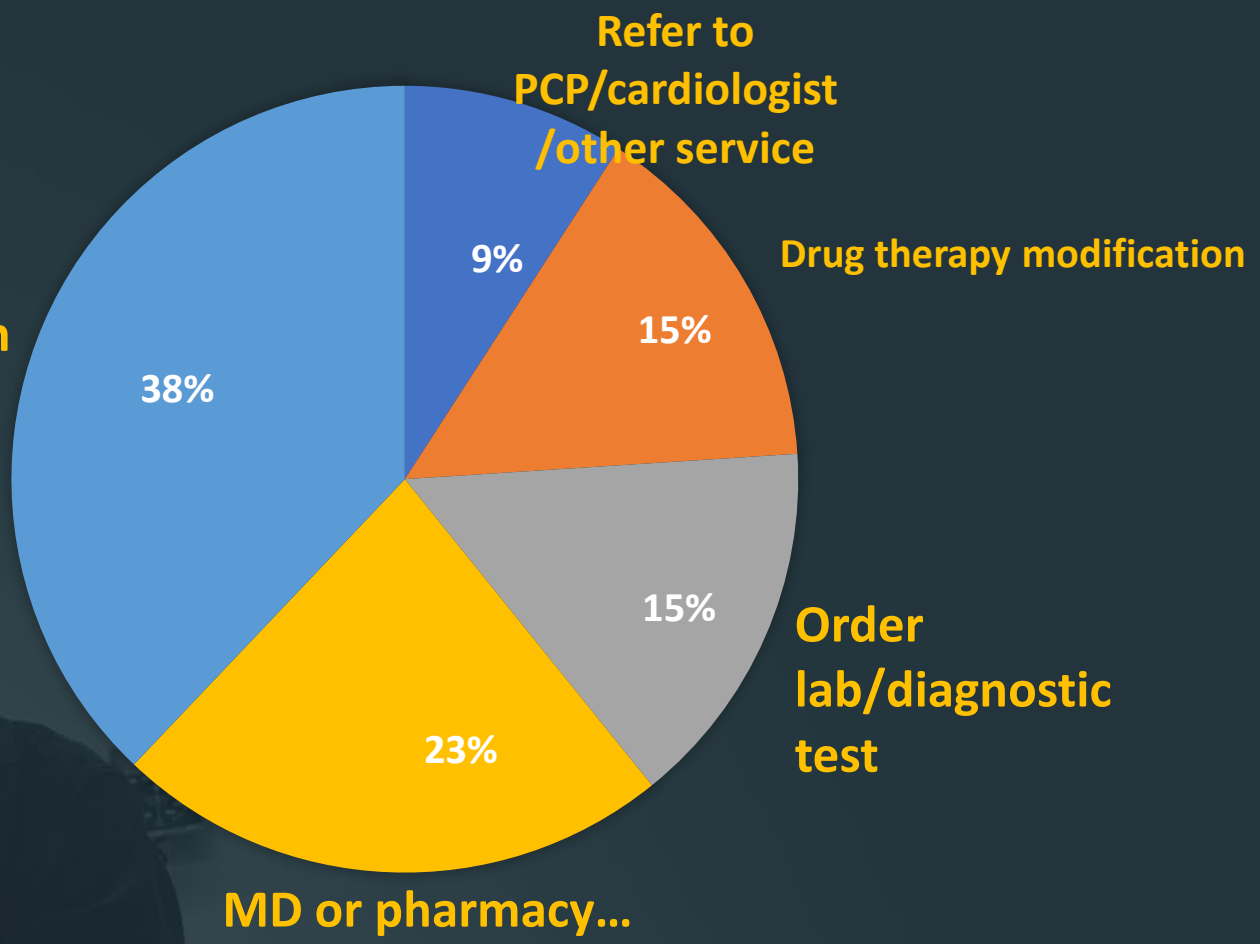
Interventions and recommendations



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Video-Telehealth Patients with 30-day Readmissions

	Total n=67
Patients readmitted within 30 days of the last hospitalization, n (%)	7 (10.4)
Mean days to readmission median (range)	11.75 13 (4–18)
Reasons for readmission, n (%)	
Reasons not related to HF	4 (57.1)
Heart failure exacerbation	3 (42.9)

One case of 30-day readmission prevented decreases cost by ~$50,000

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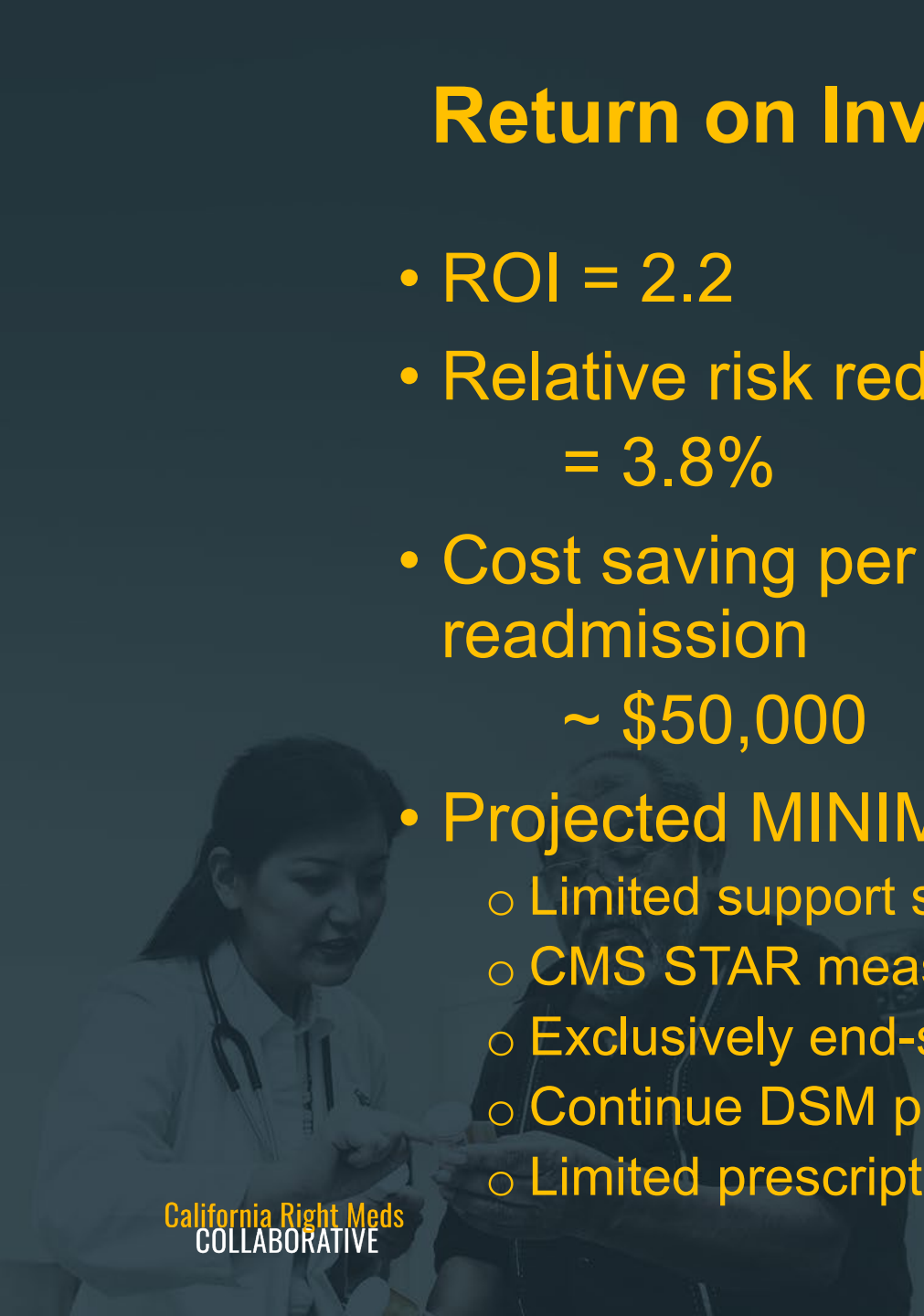
Return on Investment (ROI)

- ROI = 2.2
- Relative risk reduction of 30-d readmission
  = 3.8%
- Cost saving per 1 prevented 30-day readmission
  ~ $50,000
- Projected MINIMUM cost savings considering
  - Limited support staff
  - CMS STAR measure improvement
  - Exclusively end-staged diseased patients
  - Continue DSM post 30-day TOC period
  - Limited prescriptive authority



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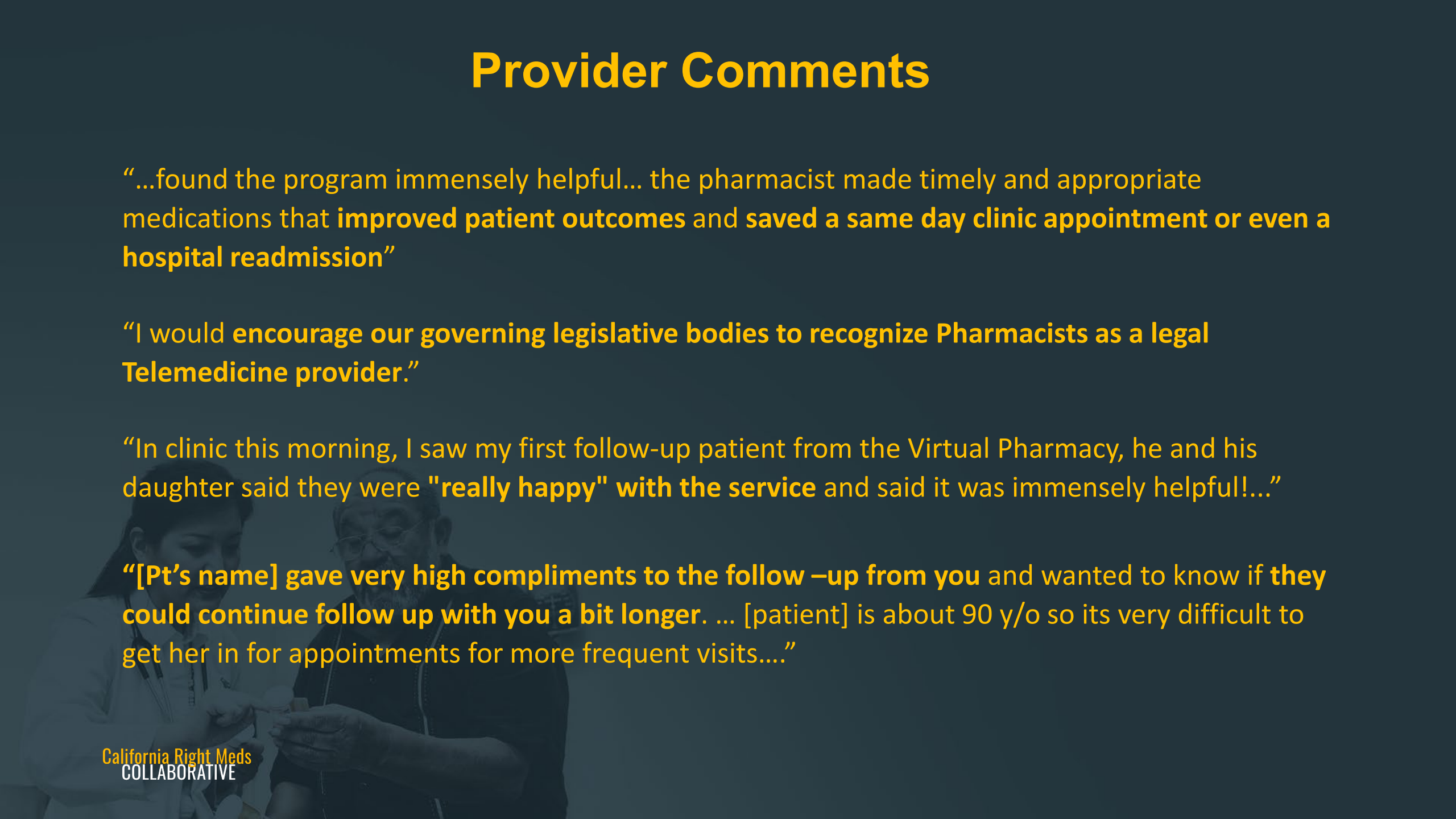
Provider Comments

"…found the program immensely helpful… the pharmacist made timely and appropriate medications that **improved patient outcomes** and **saved a same day clinic appointment or even a hospital readmission**"

"I would **encourage our governing legislative bodies to recognize Pharmacists as a legal Telemedicine provider**."

"In clinic this morning, I saw my first follow-up patient from the Virtual Pharmacy, he and his daughter said they were **"really happy" with the service** and said it was immensely helpful!..."

"[Pt's name] gave very high compliments to the follow –up from you and wanted to know if **they could continue follow up with you a bit longer**. … [patient] is about 90 y/o so its very difficult to get her in for appointments for more frequent visits…."



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Patient Comments

Avg. satisfaction score 9.88

"… **very helpful** in terms of **clarifying any questions/concerns/ issues** and found it **very beneficial**…"

"Brings **closer monitoring for critical patients** like my husband…"

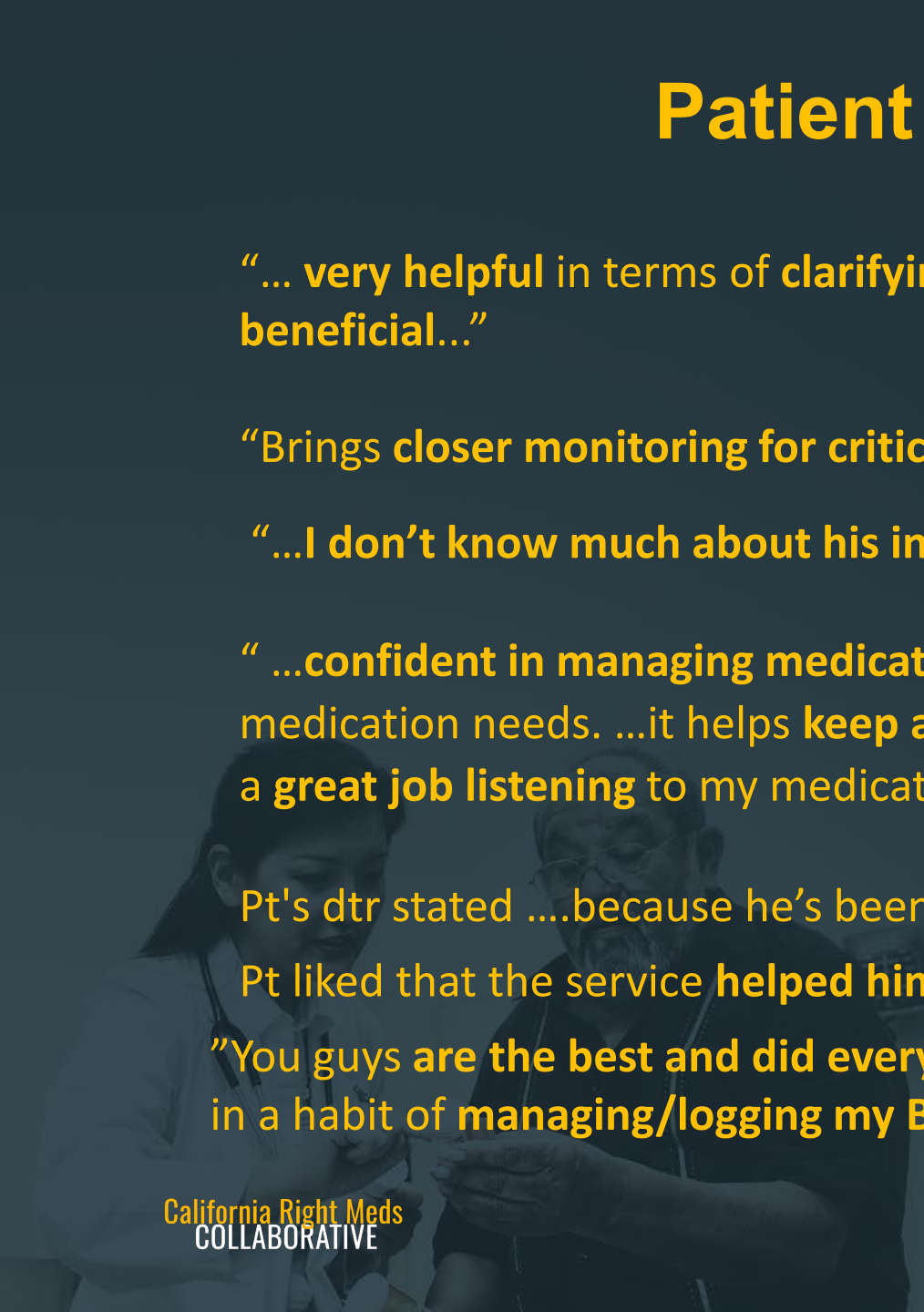
"…**I don't know much about his insulin** and it is excellent this service to **understand better**…

" …**confident in managing medications** after talking to someone who knew and understood his medication needs. …it helps **keep all of his providers on the same page**. …**very thorough** and did a **great job listening** to my medication needs…"

Pt's dtr stated ….because he's been to other hospitals and **no one has ever done this**.

Pt liked that the service **helped him take control of his health**….

"You guys **are the best and did everything right**. I liked that it was **at my convenience** and put me in a habit of **managing/logging my BPs**"



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Benefits Associated with USC VPC Video-Telehealth

1. Improves patient safety
2. Lowers 30-day all-cause readmission rate
3. Increases patient retention
4. High satisfaction with program

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Using Virtual Care to achieve Triple Aim

- Improve factors that are known to cause frequent hospital readmissions
  - Optimize medication therapy
    - Initiate/titrate to the target dose to achieve quality care
    - Reduce adverse events related to uncontrolled DM in HF patients
- Patient and provider acceptability of telehealth programs
  - Provider survey on clinical appropriateness of pharmacy interventions
  - Patient satisfaction survey (externally validated and meaningful ex: QoL)
- Identify key pharmacists activities during comprehensive care transition
  - Categorize clinically meaningful pharmacy interventions and actions to resolve problems
  - Identify level of clinical significance if no interventions made

Discussion

- What services could your pharmacy(ies) offer via virtual care?
- What population of patients would benefit from this service at your pharmacy(ies)?
- What barriers do you foresee to implementing a virtual care program?

Thank you!

Any questions?

sataii@usc.edu