Quality is not an act, it is a habit.
~Aristotle
**MMG** is a Foundation Medical Group affiliate (DHMF) in the Greater Sacramento Division of *Dignity Health* and now *Common Spirit Health*.

Using the patient centered medical home (PCMH) model we put the patient at the center of their health care experience and everyone work collaboratively to achieve the best outcomes for the population we serve.
Our Care Transformation Journey

Impetus for Change

• 2009: Primary Care Crisis
  – Lost one-third of the primary care workforce
  – Burden of work carried heavily by the primary care physician (1 MD, 1 MA)
    • Variable support across clinic sites
    • EMR burden
Our Care Transformation Journey

Primary Care Excellence Team

• Primary care leadership team formed in December 2010
• Vehicle for primary care re-design and eventual PCMH recognition
• Goals:
  – Reduce burnout
  – Promote stronger relationships with patients
  – Leverage skills of licensed support staff
  – Address patient needs more comprehensively
  – Support care management
Patient's Support Network

Informatics

Clinical Specialist: Pharmacists, Social workers, CDE, etc

Clinic Process Improvement teams: All Staff

Specialty Clinical Champions: endo, cardio

Primary Care Site Managers & RN's

Primary Care Site Clinical Champions: Physicians, NP, PA

Primary Care Leadership
## MMG/DMHF Excellence Team Structure

<table>
<thead>
<tr>
<th>Team</th>
<th>Members</th>
<th>Role</th>
<th>Meeting schedule</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care Excellence Leadership Committee</td>
<td>Executive clinical and operational leadership</td>
<td>Strategy</td>
<td>Monthly</td>
</tr>
<tr>
<td>Primary Care Excellence Team</td>
<td>Executive leadership, clinic leadership, support services leadership</td>
<td>Communicate strategy, education, clinic collaboration</td>
<td>Monthly</td>
</tr>
<tr>
<td>Primary Care Site Teams</td>
<td>Clinic manager, clinician champion, MA, RN, LVN, front desk, referrals</td>
<td>Review clinic performance, execute local process and quality improvement efforts</td>
<td>Monthly</td>
</tr>
</tbody>
</table>
| Improvement Workgroups            | Variable                                          | Specialized quality improvement projects  
*Ex: Diabetes management, TCM* | Variable          |
| MMG Excellence Team               | Primary care and specialty care leadership         | Cross-specialty collaboration                            | Quarterly        |
Our Team in Action (Monthly Excellence Team)
Primary Care Excellence Initiatives (2010-2019)

- APP support model (TC)
- Huddles (TC)
- Accountable care teams (TC)
- Team and culture building (TC)
- Annual Wellness Visits (KM)
- Medication reconciliation (KM)
- Problem list management (KM)
- Access initiatives (AC)
- HCC improvement efforts (CM)
- Transitions of care (CM)
- Patient experience projects (QI)
- Diabetes management (QI)
- Blood pressure control (QI)
- Point of care tools (QI)
- Pre-visit planning (QI)
- Registries & physician dashboards (QI)

Related PCMH 2017 concept in parentheses
Project Leadership

Diabetes Intensive Management: HbA1C >9%

PC Excellence Leadership Committee
- Review results and approve for org wide implementation

Diabetes Improvement Team:
Physician, RN, Pharmacist, Operational Leadership
- Set direction and accountability for pilot teams

PC Excellence Team / Site Teams
- Implement approved processes locally

Pilot Clinics:
Downtown Internal Medicine
Downtown Family Medicine
- Pilot processes and track results
Evidence Base

Diabetes Intensive Management: HbA1C >9%

- AMGA initiative to improve care for people with Type 2 diabetes
- Guided by 11 campaign planks

1. Build Accountable Diabetes Team
2. Measure HbA1c Every 3-6 Months
3. Contact Patients Not at Goal & with Therapy Change within 30 Days
4. Use a Patient Registry
5. Embed Point-of-Care Tools

HbA1c: Hemoglobin A1c
Together 2 Goal Campaign Toolkit [PDF]
Workflow & Tools Development

Diabetes Intensive Management: HbA1C >9%

- Accountable Diabetes Team
- Measure HbA1c
- Contact Patients Not at Goal

Pilot Process

- Run monthly HbA1c >9% report from registry
- Round with each clinician monthly
- New T2G: schedule appointment with PCP & RN
- Continuing T2G: Bi-weekly follow up (phone or clinic)

All: POCT HbA1C measurement every 6 weeks

- Refer to Endocrine or continue with PCP

HbA1c: Hemoglobin A1c  T2G: Together 2 Goal  PCP: Primary Care Physician  RN: Registered Nurse
POCT: Point of Care Test
Workflow & Tools Development

<table>
<thead>
<tr>
<th>Diabetes Registry</th>
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<tbody>
<tr>
<td>Mercy Medical Group</td>
</tr>
<tr>
<td>A Service of Dignity Health Medical Foundation</td>
</tr>
<tr>
<td>Data refreshed on Saturday, July 13, 2019</td>
</tr>
</tbody>
</table>

**Performance Report**
- Diabetic Patients by PCP
- Diabetic Patients by Endocrinologist
- Diabetic Measurements between Primary Care and Endocrinologist

**Diabetes Patient Pursuit List**
- Patients with Diagnosis of Hypertension and CHF
- Patients by A1C (Value, # of Tests) during different Period
- Chasing List by Metric for Endocrinologist
- Type I Patients by Endocrinologist
### Patient Pursuit List

**Metric:** Diabetes: HbA1C > 9% for

<table>
<thead>
<tr>
<th>MRN</th>
<th>Patient Name</th>
<th>In Performance</th>
<th>Screening Date</th>
<th>Result</th>
<th>Last Appt</th>
<th>Next Appt</th>
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<td>10.4</td>
<td>03/15/19</td>
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Workflow & Tools Development (Cont.)

Keys to Success

- Utilize diabetic registry report
- Maintain tracking mechanism
- Huddle with physicians
- Consistent patient outreach
- Know when to refer to endocrinology
- Consistent HbA1c Testing

Diabetes Intensive Management:
HbA1C >9%
Results

Diabetes Intensive Management: HbA1C >9%

- 39 patients tested in 2017 (9%)

- Frequency of Labs in 2018:
  - 43% tested once
  - 23% tested twice
  - 34% tested three or more

Average Drop in HbA1c:
- 2017: 11.0
- 2018 Avg: 9.0

- 2017 is the average of patient results >9 (429 patients)
- 2018 is the average of same patients that tested at least 1 time in 2018
Project Evolution

**Diabetes Intensive Management:**

- **HbA1C >9%**

- **Jan-Sept 2018:** Pilot

- **Nov 2018:** Leadership review/approval for organization wide implementation

- **Dec 2018:** Present process to remaining clinics

- **Jan 2019:** Clinic implementation begins
CA Integrated Healthcare Association Quality Comparison HbA1c Control

Score: 74.48%

Legend:
- Green: Better than current year’s 75th percentile of all participating POs
- Yellow: Current year’s 50-75th percentile of all participating POs
- Red: Worse than current year’s 50th percentile of all participating POs

Diabetes Care: HbA1c Control < 8.0%

Statewide Ranking

Organization Ranking

Mercy Medical Group
A Service of Dignity Health Medical Foundation
CA Integrated Healthcare Association Quality Comparison HbA1c Control

The percentage of members 18-75 years of age with diabetes (type 1 and type 2) whose most recent HbA1c level is above 9.0% (or is missing a result), or if an HbA1c test was not done during the measurement year.

Score: 17.04 %

Legend:
- Better than current year's 75th percentile of all participating POs
- Current year's 50-75th percentile of all participating POs
- Worse than current year's 50th percentile of all participating POs

Diabetes Care: HbA1c Poor Control > 9.0%

Statewide Ranking

Organization Ranking

Diabetes Care: HbA1c Poor Control > 9.0%

Other Organization
Score: 48.86
Together, we will

Ready, Set, Goals!

FY2020 Ambulatory Quality Goal: Hypertension Improvement Management
Let’s Work Together to Cross the Finish Line.

CommonSpirit

1. Re-check patient’s blood pressure after 5 minute rest period if initial reading elevated ($\geq 140/90$)
2. Inform provider of out of range readings ($\geq 140/90$)
3. Schedule appointment with patient’s PCP or affiliated PCP (if none designated) prior to departure
4. Educate patient on risks of HTN and importance of keeping scheduled PCP appointment

to lower high blood pressure!

Mercy Medical Group
A Service of Dignity Health Medical Foundation

CommonSpirit
Clinic Embedded Ambulatory Pharmacy Service Line

DHMF Pharmacy Services
Organizational Chart by Department

Greg Light
Director
Pharmacy Services

Tim Zane
Lead Supervisor
Pharmacy Services

Mar Aikman
Supervisor
Clinical Pharmacy MMG

Kitty McVey
AC Service Supervisor

Peter Phan
Oncology Pharmacist Specialist

Jonathan Miano
Supervisor Clinical Pharmacy

Mercy Medical Group
A Service of Dignity Health Medical Foundation
Foundation Pharmacy Services Team White Paper recently published internally to Dignity showcases how quality is achieved utilizing interprofessional teams to provide care and highlights the power of pharmacy services specifically.

Ambulatory Care Pharmacy Services: Description, Impact on Patient Care and Physician Practices within Dignity Health Medical Foundation, 2020

January 15, 2020

Abstract

Launched in 2007, the Institute of Healthcare Improvement created the Triple Aim framework with the goal for healthcare to create system improvement. The goal of the framework is to simultaneously improve individual healthcare and experience along with that of communities and populations, while reducing overall costs. To use the framework successfully, providers and organizations need to understand population management; scale services to care for patients; and build a system to support and expand best practices within new models of care. The Triple Aim has created a shift in the way patient care is provided. Successful practices are best achieved when interprofessional teams provide care. This model of care delivery is transforming multiple aspects of ambulatory pharmacy care and physician-office practices, resulting in expansion of the scope of pharmacist and medication management-related services.

Authors

Greg Light, Pharm.D; Margherita Aikman, RN, BSN, Pharm.D, BCPS, CACP, CDE, APh; Jonathan Miano, Pharm.D., Timothy Zane, Yessenia Chavarria, Kitty McVey, Pharm.D.
The Triple Aim is an approach to optimizing health system performance, proposing that health care institutions simultaneously pursue 3 dimensions of performance: improving the health of populations, enhancing the patient experience of care, and reducing the per capita cost of health care.
Ambulatory Pharmacy Services Examples

• Formulary Management and Integration
• Disease State Management
• Enhanced continuity of care across the continuum of practice settings, and geographically dispersed facilities, particularly for newly discharged patients inclusive of the complex care patients
• Drug Product Procurement and Inventory Management
• Focus on Comprehensive Patient Care; The addition of clinical pharmacy services:
  – Creates significant cost savings to the healthcare system
  – Improves patient satisfaction
  – Increases medication safety
  – Delivers appropriate cost conscientious therapy
  – Improves patients’ access to care with more frequent patient touches to get patient’s to therapeutic goals faster and help solve treatment inertia
  – Enhance focused improvement on quality-related outcomes such as MIPS and Medicare Stars
The Ambulatory Clinical Pharmacy Team

Mid-Town & Natomas:
Navi Atwal, RPh, BCACP, BCGP, APh

San Juan, Roseville, Folsom, Rocklin:
Erin Falconer, Pharm.D., BCGP, BCACP, APh

San Juan, Eldorado Hills, Fair Oaks:
Thu Le, Pharm. D, BCGP, BCACP, APh

Mid Town 50% & Woodland/Davis 50%:
Chloe Parra, Pharm. D., BCPS

Woodland:
Moje Moradi, Pharm D., CGP, FASCP, BCADM

Elk Grove Area:
Amy Diep, Pharm.D., BCPS, BCGP, APh

Pharmacy Coordinators
(Our Team Support Staff Float to all locations)

Mavile Hernandez  Vanny Kongmany  Whendy Thao
Ambulatory Clinical Pharmacy Services

Our Purpose and Goal

• Serve Dignity physicians, advanced practice clinicians and patients by improving cost, quality, and satisfaction
• Assist in giving physicians and advanced practice clinicians more time to see higher acuity patients by allowing the Ambulatory Clinical Pharmacists to help manage routine chronic disease states and fill clinical gaps related to medication issues
• Increase patient access for routine chronic disease states
• Contribute to better patient outcomes and increase performance report metrics for physicians, and the organization
• Part of the Transition of Care (TOC) & Care Coordination patient support continuum
Ambulatory Clinical Service: What Should You Send Us?

- Chronic disease state management patients
  - **Hypertension** patients (new starts—we titrate to goal quickly! But all patients are appropriate)
  - **Diabetes** patients (not already referred to endocrinology)
  - **Lipid** management (Is your patient on the right intensity of statin? Let us check and titrate)
  - **Gout** management (We will check uric acid levels and titrate medications)
  - Anything **CLINICAL related to medication management**
  - Medication cost issues and non-adherence due to cost or side effects
Team Approach

CDE & Pharm.D. Patient Collaboration Plan

Identify patient

CDE ↔ Pharm.D.
CERTIFIED DIABETES EDUCATOR
(Lifestyle management and education related to diabetes)

Refer from Pharm.D. to CDE when:
- Patient requires dietary education
- Patient needs carb counting review
- Patient could benefit from lifestyle interventions
- Patient needs a more comprehensive review of diabetes management

AMBULATORY CLINICAL PHARMACIST
Pharm.D.:
(Medication management, chronic disease state comorbidity management)

Refer from CDE to Pharm. D. when:
- HTN not at goal
- No Statin or LDL not at goal
- Polypharmacy
- Titration or change of more than one oral diabetic medication

Merck\ Medical Group
A Service of Dignity Health Medical Foundation
Leveraging all Available Clinicians

MMG Measure Up Pressure Down Blood Pressure Control Pathways

- **PCP Visit:** HTN noted, medication started, added or titrated
- **Cardiology visit:** Uncomplicated HTN noted, medication started, added, or titrated
- **Active Pursuit Metrics list:** MA, RN refers patient or makes PCP appointment

**Clinician, or Nurse Refers Patient:** Patient to be seen within 2 weeks for follow-up

- **Pathway Option:**
  - APC to follow up
  - Ambulatory Clinical Pharmacist

- **Systolic BP > 180**
- **Systolic BP < 179**

- **Follow up appointment with patient**
  - PCP: HTN noted medication started, added, or titrated. Patient referred and seen within 2 weeks for follow-up

- **Patient will be seen within 2 weeks with 2-3 week follow up appointments for medication management, medication titration and monitoring, and lifestyle coaching and education. See MMG Ambulatory Clinical Pharmacist HTN protocol for clinic visit details**

- **Patient still not at goal after patient’s maximum dose of three BP medication consult with PCP, and or Cardiologist or Nephrologist**
What you need to Know:

The Ambulatory Clinical Pharmacy Team Manages & Treats Blood Pressure!

What to Do
When you have a patient with an elevated BP—start or modify therapy, order follow up labs & SEND US A REFERRAL via a Center message to our pool.

Search: “pharmacist” and you will find our pools.

Main Center Pool for Pharmacy referrals:
DHF-MMG- Pharmacist

We will contact the patient, make an appointment for follow up within two weeks and QUICKLY titrate to goal

What to Share
- The Ambulatory Clinical Pharmacists are advanced pharmacy practitioners who are board certified and know blood pressure management!
- We are available to help manage your patients with a hypertensive diagnosis.
- We believe in a team approach to foster patient engagement, reduce the care management burden on physicians and improve clinical outcomes.
- A referral to our blood pressure management is a comprehensive service that includes:
  - Correct & Calm BP Monitoring
  - Ongoing Lifestyle Counseling
  - Medication Reconciliation
  - Patient/Specific Medication Adjustments, Titration and Monitoring Based on National Guidelines
  - Monitoring Medication Adherence
  - Frequent Ongoing Patient Visits Until Stable at Goal
  - Shared Decision Making & Communication back to Referring Clinician

Yes you:
- Travel to your clinical site
- Have the training and legal authority to help with chronic disease states WITH YOUR PERMISSION & Collaboration
- Have a detailed blood pressure clinic visit workflow we can share with you—just ask!
Clinicians have the option of using “Pre-Visit” Report listing health care information and items the patient may be due for or might be of interest for the clinician to be aware of. We included potential medication non-adherence for the following medication categories:

- Diabetes medications
- RAS antagonists
- Statins
Leveraging the E-Fill Team

• Group of trained pharmacy technicians that refill patient prescriptions is based on standing orders
• Allowed to change patients from a 30 day supply to a 90 days supply for all stable appropriate refills on medications that meet the metrics:
  • Diabetes medications
  • RAS antagonists
  • Statins
• Receive referrals from clinicians for **CLINICAL** medication issues

• Partner with payers. Strong relationship with local Blue Shield to weekly hand off patients related to:

  Statin Use in Persons with Diabetes (SUPD)
  Statin Therapy for the Prevention and Treatment of Cardiovascular Disease (SPC)

Example of email I get from Blue Shield weekly letting us know of new patients to work up:

Hi Mar,

No new SUPD or SPC cases to escalate this week.

Happy Friday!
SUMMARY AND NEXT STEPS

• Optimal Team-based care drives quality, promotes a great culture and helps decrease clinician burnout
• With shortage of physicians, leveraging allied health professionals who work at their highest level of expertise improve quality and drive the cost of care down
• Outcomes is the responsibility of the entire team – it takes a medical neighborhood to take care of the population entrusted to us
  – Address the continuum of care and social determinants of health
• Expand Performance Excellence work to the Medical and Surgical Specialties
  – Working on Patient Centered Specialty Practice Recognition