Collaborating with Health Care Workers

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Jessica Abraham, PharmD, APh
Director of Population Health
USC School of Pharmacy
Agenda

• Background of the Clinical Pharmacy Services

• Collaboration with Community Health Care Workers
$12 Million USC / AltaMed CMMI Project: Specific Aims

OUTCOME MEASURES

- Healthcare Quality
- Safety
- Total Cost / ROI
- Patient & provider satisfaction
- Patient access

10 teams
Pharmacist + Resident + Clinical Pharmacy Technician

Telehealth clinical pharmacy

Resident and technician training for expansion

Web-based pharmacist training and credentialing

UNIVERSITY OF SOUTHERN CALIFORNIA
National Conference on Best Practices and Collaborations to Improve Medication Safety and Healthcare Quality
Feb 2014 & 2016
USC Patient Targeting and Management Strategy

High cost patients

Frequent and recent acute care utilizers

48 EHR-embedded triggers to detect high risk patients

MD referrals

Comprehensive Medication Management

Treatment Goal Reached?

No

Yes

Clinical pharmacy tech “check-ins” every 2 months

Unstable
Patient Selection Outcome: Recruit high risk patients

- Enrolled 6,000 patients since Oct 2012
  - Predominantly Hispanic, non-elderly women
- 3/4ths have hypertension, 36% uncontrolled
- 2/3rds have diabetes, 60% uncontrolled
- High rates of hospitalizations
Clinical Services During Visits

• Comprehensive medication review, evaluation of drug treatments for chronic conditions
  — Adherence, appropriateness, effectiveness, safety
• Monitoring home vitals and laboratory results
• Modifying drug therapies / recommending treatment plans
• Ordering labs and medications
• Patient education
• Coordinating post-discharge care including medication reconciliation post-discharge (MRP)
Why Promotoras?

• Training/Background
  — Self management of chronic conditions
  — Evidence based information on chronic conditions
  — Well connected to community agencies, businesses and organizations

• Frequently culturally aligned with patient population
  — Improve health disparities, increase cultural sensitivity
Collaboration with Promotoras at AltaMed

• Assess the participants’ health through a simple risk assessment of diabetes, cardiovascular disease and other chronic diseases
  — Referral source for USC CMM Services
  — Communicate with care team regarding patients’ identified teams (IDT meetings)

• Coordinating and managing outreach activities/classes relating to disease management programs (e.g. diabetes, asthma, CVD, and other chronic diseases)
  — Deliver comprehensive self management training for patients with chronic conditions to move them towards change, engagement and empowerment to become better managers of their chronic condition
Collaboration with Promotoras at AltaMed Cont.

• Follow up on high risk patients (face to face group setting or one on one or phone visits)
• Distribute educational materials and administer health assessments
• Conduct lay education sessions on the risk factors, intervention strategies and community resources
• Coordinate outreach activities with community-based organizations and businesses
thank you