Event ID: 2641181
Event Started: 6/11/2015 2:52:24 PM ET

Please stand by for real-time captions.

Ladies and gentlemen thank you for continuing to hold. Your pharmacist transforming care and patient centered medical home and accountable care organization will begin momentarily. Thank you for your patience.

Welcome to the pharmacist transforming care and patient centered medical home and ACO conference call. My name is Richard and how beer operator for today's call. At this time all participants or listen only mode percolated we will conduct a question-and-answer session. Please note this conference is being recorded. I would not turn the call over to Ms. Gloria.

Good afternoon and welcome to our summer. Are webinars been presented by the Lake superior quality innovation network which is comprised of three organizations. The state of Michigan, meta-start in Wisconsin and Stratis health in Minnesota supporting the centers for Medicare and Medicaid services, parties for healthcare quality improvement. I would like to introduce you to today's speaker, Dr. -- to 11. Completed her Dr. of pharmacy from University of California, San Francisco. She completed her pharmacy practice residency at Kaiser Permanente and after her residency she moved overseas and developed and implemented an anti-regulation service in admin service for the first time in South Korea. After five years Dr. Chow joined us in the United States at the University of Michigan health system to develop ambulatory clinical services. She was the first pharmacist evaluated and endorsed by the committee at the University of Michigan health service and was granted special privileges and patient care. Dr. Choe the -- practice model it Michigan as per the patient centered medical home and has but it across 14 health centers. She is also developing new reimbursement process for clinical pharmacy services. Dr. Choe has been recognized and awarded nearly year after year for state and national organizations for her innovative programs for best practices and their excellence in teaching and experiential education. 2011 Trent water collects EC stated national recognition from the Michigan pharmacy Association innovative practice, pharmacy practice award in the ASHP best practice award for the group practice model in the patient centered medical home's. Most recently she has received the 2014 American pharmacists Association pinnacle award for individual career achievements. At this time it is my privilege to introduce you and turn it over to Dr. Hae Mi Choe Afternoon everyone. Thank you for joining us today for the webinar. I wanted to briefly review the learning objectives for our webinar and then I will proceed with the presentation.

We're going to define the patient centered medical home in terms of the characteristics and components of a medical home. Identify the potential roles for pharmacist of possible barriers to the inclusion of pharmacist on the patient centered medical home team. Outline strategies for demonstrating the value of pharmacist involved on a patient's medical home and also describing emerging opportunities for pharmacist in the accountable care organization.

I know most of you on the call probably already know the concept of patients at her medical home but those that may or may not be as familiar with that I would give a definition as I interpret what the patient centered medical home means to me. The patients that are medical home and bodies a new care delivery model that replaces episodic care was coordinated care so rather than waiting for patients to seek medical help when there is urgency or there is something wrong with the patient, really replacing that with coordinated and more proactive care. Patients have a team that takes a collective responsibility for meeting patients healthcare needs so meaning that it is no longer just physicians who are taking care of the patient and working and managing patients but they now have a team that takes the accountability and responsibility for taking care of the patient's chronic needs. It really centers around ongoing relationship with primary care providers and where primary care providers is really providing the foundation for building that patient care team.

Some of the joint principles for patients of the medical home I know the different domains out there depending on which entity that you look at in terms of principles for patient centered medical home but I think they all have common themes that it is centered around patient team-based care. There is a robust care management component to the patient centered medical home, customer referral tracking, patient management support, really empowering the patient to take more ownership of managing their health care rather than those of us in healthcare to tell the patient what to do and how to do. Measure and improve performance in cognitive of what our metrics are and being able to track that and see how we are doing in terms of improving in our performance. Patient tracking and registry functions and advanced electronic communications as well as enhancing access and communication with the patient.

University of Michigan health system we have patient this to members that are comprised of physicians, pharmacists, nurses, social workers, dietitians, medical assistance, panel managers and office assistance. Julie all disciplines are represented in our patient centered medical home team and we work very cohesively together to improve the care of the patients with chronic conditions.

Wanted to focus today on the role the pharmacist contributed the patient centered medical home while the disciplines contribute in a meaningful way to improve the care of the patients. Thought it would spend the rest of the afternoon focusing on the pharmacist contribution to the model.

At the University of issue have 10 embedded pharmacist and all of our primary care clinics. Even though I have 10 pharmacist in the clinic if you are looking at the clinical FTE I have 4.9 clinical FTE that spans the whole health system and recover nine internal medicine clinics in six family medicine sites. Pharmacist time at this PCMH sites vary depending on how big or how small the health centers are. Some of our health centers, pharmacist or their half-day we can some of our larger centers the pharmacist or three days a week. In terms of what we do at the practices we have to service line so one is disease management services focusing on diabetes, hypertension, epidemiology -- second service I whopper is the comprehensive medication review. Basically why those three conditions we recognize that diabetes, hypertension are really the bread and butter of primary care and makes up a bulk of the patients that we see and manage for chronic conditions and also a lot of the quality metrics that is out there whether the private insurances or through ACO, many of the quality metrics is surrounding these disease states and also wanted to be mindful that will pharmacist can provide a wide array of management services wanted to make sure we dig a hole deep enough so that we could really demonstrate the impact that we have in patient care rather than spreading our resources across multiple disease states. -- Are the patient to come to the clinic in the may be taking 15, 20 medications and physicians are already running behind him patients have all these questions as to what they are taking, why they are taking and these are the types of patients are situations where pharmacist can step in and really help physicians to be able to take ownership of that explanation or counseling the patient. We are also helping physicians by reviewing the meds focusing on is a patient on the best expect patient medication, are they on the safest medication and also are they the most cost affordable medications. With those three things in mind we look through the medication, look for opportunities to improve their regimen and then we communicate closely with the physicians to make any changes that are needed. The reason I think this allows us to do this seamlessly is we work in the clinic with the providers side-by-side so we have easy access to our physicians. We have full access to medical records and were able to document in real-time in the medical record in terms of what services we are providing and at the same token we can actually look up the things that have happened to the patient prior to our visit to that we make sure that our services are in sync with the medical providers and make sure we are providing continuity of care as well as coordinated care.

Pharmacists have cleft of practice agreement with our physicians which allows the pharmacist to do certain functions that the physicians delegates. That includes evaluating and optimizing treatment regimen. We provided medication management to achieve treatment goals so for patients not achieving a goal, blood pressure goal, if pharmacist is able to intensify treatment to make sure that we meet the treatment goal. Assess and address barriers to medication adherence. This is another area that the pharmacist folks are -- focus their efforts on. As you know there is medications prescribed may be about 30 to 50% of the patients actually do not take the medication as prescribed so if you are thinking about -- is unused or used incorrectly that poses a lot of issues in overall care of the patient. We addressing the barriers to taking the medication as well as what we can do to help streamline that process.

We also focus on providing education not only on medications but also on chronic condition so helping them understand that why they take drug ask for what condition and why that is important for them to continue to take the medication even though there glucose might be under better control over their blood pressure might be better under control so we spent a lot of our time explaining and counseling patients on their chronic conditions as well as medication. We perform a limited physical assessment for the patient. We can order labs and facilitate ordering the medical equipment. Also patients once they have diabetes and have not been to an ophthalmology we are able to facilitate that referral on patients that we have. We also spend a lot of our efforts in helping patients with self-management goals and utilizing motivational strategies. We find that empowering the patient not only with the knowledge that they need that helping and coaching them to take more ownership up their healthcare has been a very important part of the success that we were able to see inpatients.

I want to go back to the service line that we provide and do a little deeper dive into the services in terms of how we deliver the care. As I mentioned earlier, for disease management services, we focus primarily on diabetes, hypertension, Hyperlipidemia. We also are proactively identifying patients using our disease registries or are looking to clinic schedules. We find that in a busy clinic day, it is often times physicians, is difficult for physicians to remember to refer the patient to the pharmacist. Given that they are taking care of head to toe and they are already facilitating many referrals, even though they recognize the value the pharmacist to bring to the table, it may not trigger their memory to refer the patient to the pharmacist so rather than waiting with a referral to come our way we actually proactively ma'am the registry and identify patients that we think would benefit and then we coordinate with physicians to ensure the patient would indeed be someone we should be reaching out to. We do a lot of proactive outreach to the patients. Patients are scheduled for an initial half-hour appointment, face to face and that is something we put her to do but if the patient is unable to come in and person we can also meet that need by conducting it through the

phone. Patients are scheduled for anywhere from 15 to 30 minute follow-up to improve the control or medication management. We really foster more of the frequent touches rather than long visits with the patient. We find that chunking our appointments to more frequent appointments with the patient really help to engage the patient and have that connection and build that relationship with patient so we really looked at the way we conduct our visits and streamlined our I is so we are more efficient with our visit to where touching patients more frequently.

The conference of medication review services. Our initial appointment for the CMR services is focusing on patients medication concerns, confirming that patients actually have an indication for the medication, associate patients understanding of disease status and treatment plan and identifying potential barriers to treatment including drug costs. This is something that hits home for our seniors especially those who have Medicare. Are vulnerable to following -- falling into don't holes in the calendar year and when that happens, often times the patient liability and drug cost increase it if not doubled, tripled the normal co-pay so that puts a huge burden on Medicare patients who have a fixed income so we really work with patients to proactively anticipated and help patients manage the situation rather than waiting for that time to hit.

In two weeks we schedule a follow-up with our patients and during that time, it's what we really discuss the new treatment plan to improve efficacy, safety and look for opportunities to lower drug costs. What we do in between the two weeks is to discuss any issues that we might have discovered with the provider and we might have some further dialogue, what would be the best go forward plan for the patient. During the follow-up it allows us to implement that plan and also to do any additional counseling and reinforcement.

Both initial and follow-up appointments can be done over the phone or at the clinic and if you combine those two appointments, it leads anywhere from 75 to 90 minutes of CMR experience.

All those efforts led to come and we looked at our glycemic control inpatients and stratified based on their baseline A1 C so patients with ALC A1 C greater than seven, -- greater than nine and then each category that patients receive significant difference in decrease in A1 C control and all three cohort of patients.

I also want to do a snapshot view of the therapeutic activities by pharmacist. In year three we have actually made over 2674 interventions. If you look at our intervention spread is about 50% of our therapeutic interventions were really dosage intensification so increasing the dose because patients not meeting their treatment goals. The other half is split between adding new meds or stopping that's. We might have decreased a

dozer stopped meds for safety reasons either the patient has [Indiscernible] indications are that might have an adverse event over might have done that for cost reasons so there are different reasons why we have made these type of medication adjustments to improve their overall therapy.

We also looked at some of the process measures for diabetes so on the bottom we track all of the QI metrics that we follow for patients with diabetes and the yellow bar indicates patients that are not managed by pharmacist in the blue bar represents patients that are co-managed by pharmacist and with a primary care provider and every one of those measures the group that has pharmacist involved in their care had a higher goal attainment in terms of reaching some of the quality metrics. If you spend the same data a little different way of looking at whether we actually met the threshold and when we meet the threshold then we also get performance-based payment for meeting these measures. The group that did not have a pharmacist involvement where they met the goal three out of seven thereby being paid on those measures but the group that pharmacist engage with actually met six out of seven goals so if it were to translate the data to a larger population that would have been the impact that we would have had in terms of getting paid on the performance measure.

Will all of this data is pointing to improving outcome for patients, what is really important is to make sure that we have this trusting relationship with the physicians because none of this is possible unless the physician instruct the pharmacist to act on their behalf and work with the patient so I have done a survey with our medical directors to see how satisfied are they with pharmacist being embedded in the clinic and some of the questions that I have asked them was, does the clinical pharmacist positively impact the health status of your patient? I have massive the effect the positive practice whether they find that to be of value. I asked about whether the pharmacist provided useful communication in regards to the health status of their patients. I also wanted to see what their thoughts were about are the pharmacist making appropriate clinical decisions for their patience and overall what their satisfaction is with pharmacist being in their clinic. As you can see, four point it was our our fridge out of five in terms of physician and all of those 15 health centers -- actually go and meet with the medical director and health center managers to get that direct feedback to see what are we doing well what duty to do better and it is so rewarding every year when I meet with them to get such a positive and warm feedback and how value added the pharmacist are and how they have become part of their core team in Michigan now in a new building goes up for health centers, actually get notified two years in advance when actually having I haven't started the building because they want to make sure that they will have a pharmacist in the team when the building is act Julie operation -- actually in operation. It has now become a part of our

norm, not something that is extra or is something that is a luxury but it is an expectation and necessity as part of our care team.

What did the practice model provide us with? It really give us a building block we needed for future innovations. When the special the specialty physician or pharmacist are doing and the patient centered medical home they started asking, we want pharmacist in our clinic so we started expanding the model into specialty clinics and I now have pharmacist in cardiology, [Indiscernible], psychiatry, and we're continuously building more clinics where we're embedding the pharmacist into their clinics. SPECweb also focused on building a true medical neighborhood by collaborating with patients in a medical home and also community pharmacies. We recognize that we have so much bandwidth within our academic institution to care for our growing population and we thought if we could share collaboration with those practitioners in the community who are already touching our patients, who are already engaging with our patients and if we could rates to our [Indiscernible] to come together think we could definitely be able to provide much more comprehensive and coordinated care versus fragmented care that we live today. We're fostering that relationship and having a solid medical home model allowed us to build this partnership with community pharmacies and we're going to a pilot project right now. SPECweb also created a telehealth partnership with home care services leveraging the technology to be able to Skype in the patients with the pharmacist because many of these patients who go through home care services are homebound. As much as we would like them to come in to see the pharmacist, transportation, special issues make it very difficult for these patients to come in and receive their care so we are able to using video technology able to bring the patient to the pharmacist care. We have a pilot study that is unfolding as we speak.

We have implemented an employer-based comprehensive review program two years ago so these are our own employees and retirees that are offering the comprehensive medical review with and we have been able to touch many of our own employees and retirees that have led to positive impact are going to some analysis right now to look at some of those outcomes.

Also working with payers to improve HEDIS and start measures is something that there's a been interested in as we started to work. It is really having the pharmacist embedded in the clinic working together with physicians . It is addressing a lot of these star measures in organically grown because it is embedded in our practice model so the payers have been very interested in partnering with us to explore that opportunity.

I'm going to take a little bit of a turn at talk a little bit about what we are doing in the accountable care organization space. We are applying the principles of patients of a medical home and have really engaged and have specialty engagement in our practices and we have also added the element of inpatient care and transitions of care into the fold because under the East ELM umbrella we are responsible for the whole spectrum of the patient care not just the primary care or the ambulatory side. Some of the ACL goals are to avoid unnecessary duplication of services and medical errors. I linking provider reimbursements to quality metrics and reducing the total cost of care for an assigned population. We know that when Inacio succeeds in saving healthcare dollars, CMS shares the savings and we are participating in the Medicare savings program.

Some of our target outcomes is to align our pay for performance indicators with an associate financial benefit. Align with avoidance of penalties of financial impact especially when it comes to readmission. Costa savings to employers as well as new revenues from direct billing opportunity so we are actually participating in a national demonstration project where pharmacist our billing for our services through care management role and we have third-party payers that pays directly the four service for the services.

Groups in Michigan have formed larger ACL network, a physician organization of Mystic -- Michigan. Our ACO partners are spread across our state. We have the 11 positional organizations that are currently part of our Medicare share savings program so they are part of our network and we collaborate together to improve the care of our patients across to our health systems.

Last year the POM ACO board has officially approved my role for the ACO where I was tasked to replicate University of Michigan health systems, patients on medical home program crossed our ACO network so my promise to the ACO board was that I will be able to focus on for physician organizations to kick off the year with that and really hoping them to develop the infrastructure and in that pharmacist and in the primary care clinics. My act with them was to invest in hiring a pharmacist to provide services across 223 practice sites so that they can learn within their organization how to develop and facilitate these type of services. It was interesting experience for me and a very eye-opening experience. I think I have experienced what it is like to build clinical programs in my own backyards. I have done that for the past 20 years but have never really build programs that is in somebody else's background and that makes it very challenging especially if the other backyard looks very different than yours. I am very used to more of the integrated health system look versus a lot of the physicians organizations that I have been working with under the ACO model actually do not have an innovative system . It is made up of hundreds of individual

practitioners so how do I put my arms around an organization where there structured very differently and they have different EMR accesses that are very different, their leadership structure is different. It created a new way of thinking and how do we provide support for those physician practices and maybe you cannot embed a pharmacist in the one physician offices. How do we go about strategically providing support for those small practices is where we're at right now trying to create those solutions for the smaller practices. Our focus area still is the same and now we're focusing on a comprehensive medication review and focusing on a cord disease state services.

My pitch to the ACO was that we could certainly plant trees separately and they could build their own pharmacy program however if we could do together and really bundle our resources we could actually create a forest together. What that means for us as an ACO is then we can now create a standard of practice really the best standard of practice and then we have the ability to scale it and reproduce the results of be able to collect data in a meaningful way so that we could reflect on our journey to see how we could continuously improve our process. My involvement with ACO has really brought in our in terms of how we go about population management especially when it involves pharmacist.

Creating a new opportunity for future pharmacist, pharmacist are being recognized as an integral member of the new care delivery model. The advisory Board Company, it is probably one of the most reputable healthcare consulting firms and they've actually produced a white paper this year in February in response to their customers asking, requesting about embedding or integrating committees -- integrating pharmacist into the primary care. University of Michigan was found is one of the best practices within the white paper and they've also listed for other great programs that are doing similar types of things but in a different setting. I would encourage those of you in the audience who is interested in this type of work to get the white paper read about what others are doing in different parts of the country.

We also need to develop a sustainable financial model for pharmacist. Notice I stated financial model not a reimbursement model. As our healthcare is moving away from volume 2 value in as we start to talk more about performance-based payment and bundle payment rather than the four service I think it is really important for us to put our arms around what that model looks like and not so much on our the pharmacist bring the revenue to meet their cost budget neutral.

The impact on patient care and healthcare cost is going to be really important to continue to foster this type of innovation and providing leadership training for future

pharmacist to build the new healthcare landscape is going to be critical to the success of the pharmacist being an important member of the health care team.

With that, that concludes my presentation. I would really like to open up the line to take questions and I would like to hear what others are doing at their organization, the challenges they are facing's I think would be great if we could utilize the remaining time to have that dialogue and also to clarify and answer any questions that the audience might have. I will kick it back to you.

Thank you Dr. Hae Mi Choe. That was extremely motivating, encouraging and informative . At this time I ask the operator first of all if you would open up the evaluation for those to complete the short devaluation of today's webinar and then continue on to open up our lines for questions and answers please.

Will now begin the question-and-answer session. If you have a question please press*one on your touchtone phone. If you wish to be removed from the queue please press the #or the hash key. If you are using a speakerphone you may need to pick up the handset first before pressing a number. If you have a question please press*one on your touchtone phone. We're standing by for questions.

Dr. Choe I do have one question that came in on the chat that I will have you address. We had one participant ask, how many patients and providers are at each of the practice sites that you are speaking of?

That is a common question that I get for many organizations that are trying to treat a practice model like it's. I think it really depends. There are multiple factors that go into the determining panel size or number of FTEs dedicated to some of these health centers. Things that I look at have a magic formula to plug-in to estimate the number of efforts needed for a particular tent -- panel size but really you are looking at how engaged is the practice in terms of team care, the willingness of the physicians to delegate some of these care coordinations and the work the pharmacist due to the pharmacist. Most of our practices have smaller sites were pharmacist our half-day week, I have at least two full-time physicians practicing in an internal medicine or family medicine. Then it varies and the site that I have pharmacist three days a week I have 8.5 FTE for the physicians practicing in that health center. Rather than really looking at the number of patients that health centers have or the FTE, I really look at the different elements that have I mentioned to determine how much effort to dedicate to the health centers and I like to start small because no matter how interested, how invested the practice site might be, the logistical aspect of integrating a new care provider is different. It takes time. The last thing I want to do is put a valuable pharmacist in the clinic is not being very productive so we always start low, typically

half-day to one day week and we built from there. As the practice evolves, as the physicians become more familiar with the pharmacist role, as the pharmacist become more comfortable being embedded in the setting that was her to gradually increase their efforts.

Julie please go ahead.

I actually have a couple of questions. One of them is when you're pharmacist sees a patient did they clinic and they come back for these visits or even their initial visit do you feel that to the insurance company? Is that a fee for service payment you receiver do consider that part of your global fee that you are billing for the physician? My second question is to also employ health coaches in any of your clinics or is it only pharmacist?

I will address the first question. We are participating in the national demonstration project, multi-payer initiative so we have three commercial payers that pay fee for service and then we have Medicare and Medicaid that gives of its capitated payments. That initial capitated payment that we get actually cover some of the cost of the pharmacist because we are part of the care team that they are paying us for and then we also bill directly for our services to the private payers in the reimburses for those visits, both telephonically as well as space to face visit. The second question was about health coaches. We do not have health coaches in our health system. I know there are other organizations that have included health coaches into their, I have heard great things about them. We just haven't really latched on to that role quite yet but I am very interested in understanding and learning more about their role.

Once again for any questions online it is*, one. Julie please go ahead.

When you bill to the commercial companies for the physician or for the pharmacist you build those that incident to to a physician visit or are they credentialed as their own care provider and paid as such?

It is form of his incident to billing so to speak because we do bill under the referring provider but we do not have, we don't follow the bylaws of the incident to billing. I guess you could look at it is it is a form of incident because we do not bill under Tran 12 or pharmacist we bill under the provider.

We have another question in chat. What CPT codes are being built and are they built by the pharmacist, the clinic or the physician?

The CPT codes we call them G codes and that is specific to our project that we are working on, that is the code that we bill under for the three of our major payers in the state of Michigan.

There is a lot of other billing opportunities that are not part of the demonstration. I'm actually working with physician organizations that are not part of the demonstration project. It is a little bit more challenging because they have Medicare incident to billing route that they could use. Just this year Medicare has released care management codes that pharmacist could also utilize. There is transitional care codes that pharmacist also could be part of but remember the transition care code is not paying for that pharmacist time but a pharmacist could be the first call that you make within 48 hours and for the provider to Billy higher reimbursement than just a regular clinic visit to. There is other type of billing that could be done if you have practices that are not part of the demonstration project but keep in mind that each state has their own scope, practice scope law that could be more prescriptive or not. Each state has their own law about what pharmacist can and cannot do so there is a lot of variability that goes into play. That could be a whole another discussion about to billing for pharmacist. We have been very fortunate in the state of Michigan to be part of the demonstration project that allowed us to build this way. Even for those of us who are not part of the practice, two of our large commercial plans have recognized pharmacist providing this type of care and they're reversing as for those services in a different format. It is not a traditional CPT code.

We have another question from the chat. They want to know how many, what is the average patient load at each center? While I am at it, Jennifer could you please pull up the evaluation so that our participants can complete the evaluation at this time while we are still in chat then I'm taking questions?

I have a minimum expectation for the pharmacist in a half-day clinic. We expect our half-day clinic, our minimum goal is 5 to 6 patients in a half-day. Our half-day clinic is not four hours it is 3.2 hours because I put in an 80/20 rule for administrative versus direct patient contact so given for hours, 3.2 hours is actually delivering the care to the patients and .8 hours is dedicated to documentation and any care coordination they have to do outside of that direct services. It depends on if your clinic, if you are only their half-day a week then your impact encounters would be 5 to 6 in the half-day but if you are there six sessions and you multiply that by six. In terms of unique number of patients that we check it could very because some practices have a lot more elderly patients, we're doing much more frequent follow-up over the phone which then increases the number of encounters but not necessarily number of unique patients. I have some sites where they are really actively working on blood pressure so all of the patients with elevated blood pressure will come back and do a follow-up with the

patient if their blood pressure is elevated. In those clinics I have hired unique number of patients but the number of average follow-up per patient would be much lower. While we have, we have created a system and a process to support that system, we give you a lot of flexibility within each practice to really focus and channel their energy in utilizing the pharmacist as the needs arise. What that does is really empowers each clinic to really owned that process while we are maintaining so we have some consistency a crossed health centers.

-- Across health centers.

Have a couple of questions that come from the chat. One is can are you measuring patient status -- satisfaction? In the demonstration project. The second question is, how can we stay up-to-date with the development of this program, one of our participants is working in a community health center doing the same functions but is experiencing difficulty in expanding this program.

In terms of come I'm sorry could you repeat the first question?

The first question was, are you measuring patient satisfaction in the demonstration project?

Not for the demonstration project but we're measuring for our comprehensive review for our retirees. We're measuring that and we're sending out surveys to the patients and the feedback we have received from the patients has been amazing. Not only in terms of numerical numbers our ratings are very high out of five-hour averages anywhere from 4.7 4.72 4.724 point a. What is impressive and what makes me smile is what I read the comments of patients have stated. Usually when you ask for a survey patients are quick about filling out the bubbles but people do not take the time to write things in the comments section unless you are really happy or really unhappy. That we did a data dump of all the comments that people have been thinking that some will be bad, some will be happy and so every single one of them has been extremely positive. This is what drives me to continue to advocate for pharmacy services and continue to do that on behalf of the patients. We collect satisfaction for the subset of patients but we do not do that across our 15 centers for our demonstration project. In terms in keeping up with -- in the struggles that you might be facing, it is not uncommon to run into barriers when you are implementing a program like this. We have launched this back in 2009 with the onset of patients in a medical home certification within our health system. I am very grateful to our leadership within the University of Michigan health system that allowed us, allowed me to really build this infrastructure and have the vision to create this with me. Sometimes it is not always easy to find visionary leaders who are willing to invest in

building this type of model because you do not see the parent all are for dollar transaction when you are hiring a pharmacist and having them do this type of work. I do believe as we were heading toward a whole different payment reimbursement model I think it is really important for us to look at how we impact quality in the value pharmacist add in that arena rather than at looking at do they bring in the dollar that they spent on paying for pharmacist time. I think those are going to be important. In the state of Michigan as we have expanded the UNH model to our ACO network so now our ACL are working through building in their -- ACO are working in building to the model. Our Blue Cross Blue Shield is our biggest pair in Michigan. I got behind us and have supported a collective quality initiative where we are going to be focusing on embedding pharmacist in the practices across the state and we are launching the coordinating center as we speak. Tomorrow I'll be presenting at our quarterly meeting addressing with all the physician organizations in the state of Michigan. Vast majority of them will be there and I will be launching coordinating center to move this model across our state and that is to really create this model across different -- within Michigan in finding solutions to the smaller practices where we can't afford to put a pharmacist they're not even at a half-day but figuring out then how do we then service those positions that they have the access to patient care.

Operator are there any questions in the Q?

Again for any questions that is*one. At this Thomas you have no questions into.

We happen in the chat box. How do pharmacist work with the entire care team is the first question and is the physician consult the pharmacist or do you use a risk assessment to identify patients?

The first question I'm just jotting a downside to not lose sight of the question. How to interface with our other disciplines? I think one of the important things that we stress with our pharmacist is really become integrated with an interact with other healthcare providers because last thing we want to do is to complicate the picture even more by trying to compete for patients are trying to overlap our services. We haven't some of our clinics we have weekly huddles with all of our caregivers so we have physician, pharmacist, nurse, medical assistant, one representative from each discipline which get together once a week as part of our quality huddle to think about how would we address some of the metrics that we are not reaching our goal, who could do what and when? Having the whole team there to have the open dialogue has been extremely helpful, helping us understand what each of our strengths are in leveraging our strengths rather than trying to compete for patients has really helped us to develop and foster the teamwork. We refer patients to each other all the time. I may be seeing a patient who has had me for a social worker may be sending a message to the so-called

worker and thank you see Mrs. Joan she is struggling with some of the issues in whatever that might be. The social worker might help. We referred patients to dietitians who really have inspired to learn more about how to do heart counting and is looking for more in depth education in that arena and we would send patients to the dietitian who could really take the ball and run with it. We do this across all disciplines so we are really working as a team rather than in our own silos and that has really fostered that home teamwork within the patient centered medical home. In terms of how do we identify patients? We take patients based on referrals obviously as the physician identify patients that they think the pharmacist would be helpful we get those patients but we also rely on the registry to identify patients not meeting treatment goal. For example I could pull down, look for a clinic and I could say, pull me a list of all the patients whose A1 C is greater than nine. With a click of a button I could pull the list. Then either the pharmacist or we work with panel managers and say, out of this list, 50 of these patients are probably the best fit to see a pharmacist and they might be calling the patient, introducing our services in making an appointment with the pharmacist in the clinic. We do a lot of proactive outreach looking at specific registries. We have not developed any risk stratification tools specific to pharmacist. That is something we have in our queue to work on in the future development to figure out who would best benefit from having pharmacist do a comprehensive med review on. That is something that we are looking over to building within our system. As of right now, we rely on our disease Registry to help us with that.

Are there any questions in the Q? Spec at this time we have no further questions.

Dr. Choe have a couple more questions. Are you using the chronic care management option for your Medicare patients that you started since January? That is the first question. The second question is, how do you initially sell the concept to your physicians, are they resistant?

The first question about care management codes, we actually within our system we do not use the care management code because we are participating in the national demonstration project. Since CMS already pays is for care management that would be double dipping so we are not allowed to bill that code. However some of the other physicians that I am working with have tried to utilize this care management code and they have rented to subscribe -- struggles in doing that in some of that is a logistical issue. Only one person that the patient signs off on could be billing the codes. There are co-pays, does the coinsurance with the monthly charges I go to the patient and sometimes patients do not want to pay for that especially when the patients are living under a fixed income. There are some challenges that came with utilizing this code that has not been widely adopted but I still think that is an opportunity where we could

capture some of the revenue that exist today. The second question was how to promote this to physicians who are resistant to pharmacist role? This topic could be another our topic of discussion because there are different reasons why physicians are resistant. It is hard to generalize one strategy to fit that barrier. In a nutshell since will have three minutes left it is hard to me to go deeper into this discussion but I think understanding physicians pinpoint is really important when we go to the physicians and helping the physician. That pinpoint is different for each position. For example when you go into a new practice where physicians are themselves new in terms of building their practices the last going to tell him is pharmacist could help you improve your access because that is not the pinpoint. The fact that perceived as negative because now they're taking patients away from the patients they should be saying and vice versa. There are other things. Again in two minutes to go it is hard for me to go into each detail. The collaborative practice could be another example. Some physicians may say this is great seeming I can delegate this, you do not have to come and ask me every time you need to make med changes? On the flipside some physicians might this some physicians may say what you mean it going to be changing meds? Have a full gamut. Even physician perception of the same practice agreement. Understanding patient/physician perspective and what is important to them and what is helpful to them and begin to chip away at that is the best approach in developing that relationship with the physician and not go with one approach for all physicians because it is going to be different depending on who you talk to. That is a great question and it is a question that I think warrants a longer discussion.

Tran 12 we're at the top of the hour. That was an amazing presentation and even more so the answers to the questions that come out of our audience. At this time I want to thank you for all some presentation and Thank you to our audience for joining us today. On the webinar for -- and accountable care organizations. I want to remind you decides will be available on our Lake superior you to pages in the next few weeks. At this time we're going to end our webinar and thank you all again. Have a great day.

Thank you.

[Event Concluded]