Trinity Health
Alliance of Michigan

POPULATION HEALTH PHARMACY & PHYSICIAN ORGANIZATIONS

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AGENDA


Population Health & Pharmacy
Initiative Selection and Design
Current Program Examples
Presentation emphasis: medication adherence, utilization and health equity

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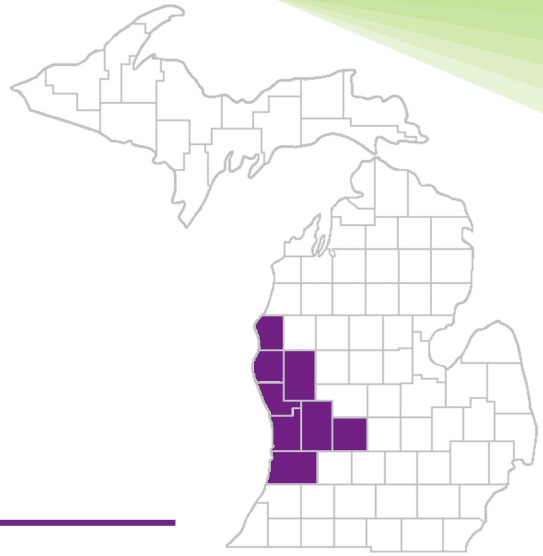


1943 Clinicians in Eight Counties

238 Primary Care Physicians

844 Specialists

771 Advance Practice Providers

279k Total Attributed Lives

253k APM Attributed Lives

$1.1B APM Attributed Lives

Trinity Health Michigan

$4.7B
In Revenue

$177.4M
Community Benefit Ministry

9
Hospitals

13
Medical Centers

23
Urgent Care Locations

25
Continuing Care Locations

20,453
Employees

3,755
Physicians and APPs

2,286
Affiliated Physicians

6.6M
Patient Encounters

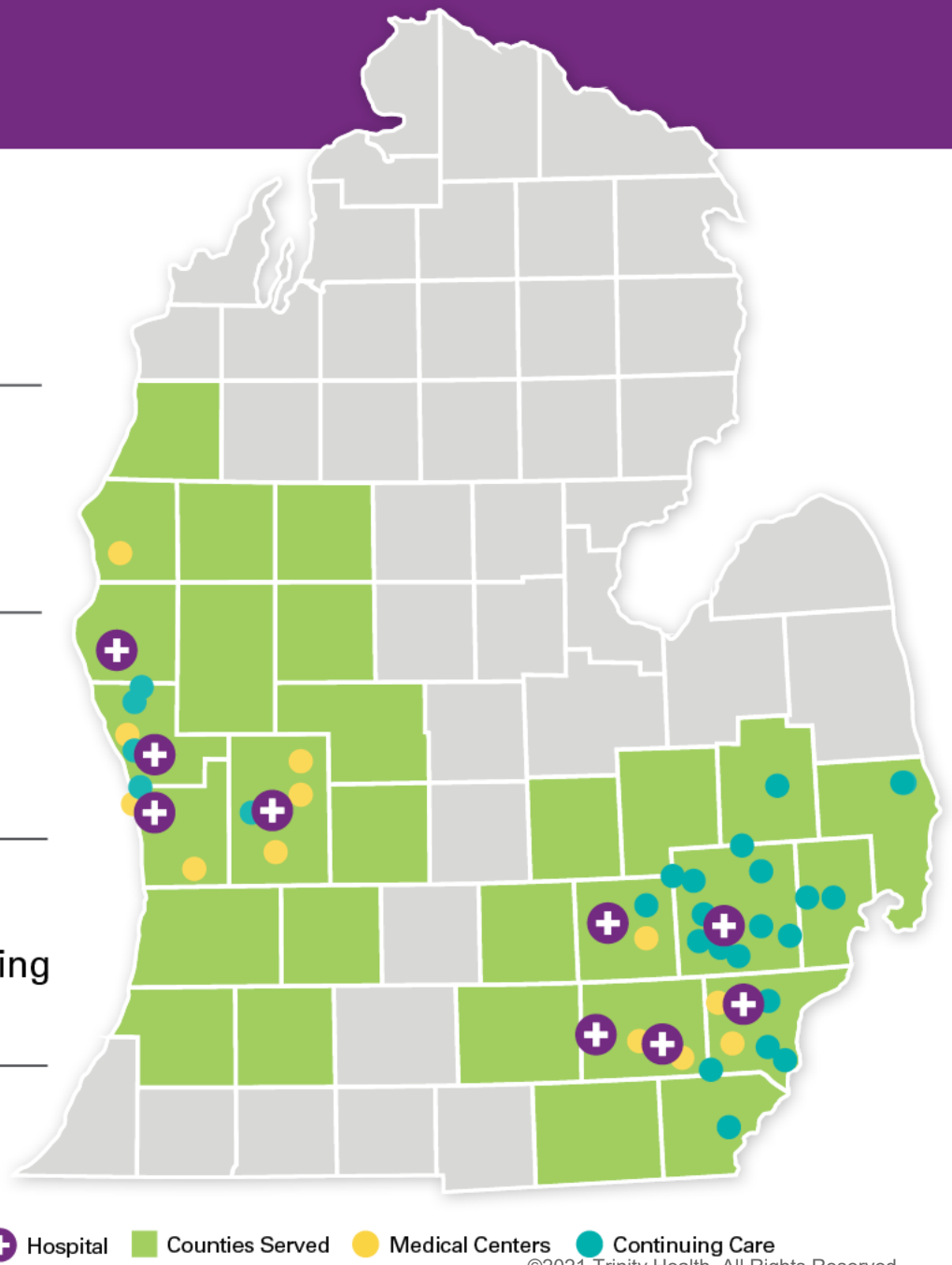
89,773
Surgeries (IP/OP)

9,960
Births

251K
Home Care/ Hospice Visits

1,420
Senior Living Residents

Trinity Health



One Culture: Who We Strive to Be

Trinity Health

Our **Mission**

We, Trinity Health, serve together in the spirit of the Gospel, as a compassionate and transforming healing presence within our communities.

Our **Core Values**

- Reverence
- Commitment to Those Who are Poor
- Safety
- Justice
- Stewardship
- Integrity

Our **Vision**

We will be the most trusted health partner for life.

Our **Actions**

As a Trinity Health colleague, I will:

- Listen to understand.
- Learn continuously.
- Keep it simple.
- Create Solutions.
- Deliver outstanding service.
- Own and speak up for safety.
- Expect, embrace and initiate change.
- Demonstrate exceptional teamwork.
- Trust and assume goodness of intentions.
- Hold myself and others accountable for results.
- Communicate directly with respect and honesty.
- Serve every person with empathy, dignity and compassion.
- Champion diversity, equity and inclusion.

Our **Promise**

We Listen.

We Partner.

We Make it Easy.

TRINITY WEST MICHIGAN PHARMACY SUPPORT MODEL

- Ambulatory & population health pharmacy
  - Location: embedded in physician practice, centralized on-site and remote
  - Resources: pharmacists, residents, students, technicians
  - Coordinate with other pharmacy teams: retail, specialty, acute, infusion

- Employed medical group and affiliate office support
  - EMR access: scheduling, documentation, communication
  - Collaborative agreements: ambulatory, population health, retail

OPPORTUNITY IDENTIFICATION

1. Gap Analysis
Evaluate available data and performance trend over time.

2. Resource Review
What evidence, tools or best practices already exist?

3. Impact Analysis
Summarize potential performance improvement and assess priority of work effort.

4. Design
Develop (or update) workflows, educate teams, gain buy-in.

5. Coordination
Facilitate the work and support care teams.

6. Monitoring
Did we achieve the expected outcome?

CURRENT PROGRAM EXAMPLES

- Primary Care Emphasis
  - *Comprehensive Medication Management*
  - *Diabetes Initiative*
  - *Medication Adherence Monitoring*
  - *Weight Management*
  - Transitions of Care (heart failure)
  - COPD Management
  - Statin Use Assessments

- Specialty Care Emphasis
  - Anti-VEGF: Age-Related Wet Macular Degeneration
  - Narcolepsy Management
  - Outpatient Infusion

SELECTED PROGRAM OVERVIEW

Diabetes Medication Management Initiative

Statewide, multidisciplinary team focused on evidence-based diabetes management to improve quality of care, reduce inappropriate (or inefficient) use of pharmaceuticals and lower cost of care.

Medication Adherence Monitoring

Pharmacy technician led strategy to engage patients, providers & care teams in appropriate medication use and improve 5 STAR HEDIS performance

Obesity Medication Management

Emphasis on evidence-based utilization of chronic weight management medications including Saxenda® and Wegovy® to lower cost of care.

Comprehensive Medication Management

Pharmacist evaluation of medication regimen safety & efficacy with resolution of medication therapy problems supported by collaborative practice agreement and provider/care team collaboration.

STATEWIDE DIABETES MEDICATION MANAGEMENT INITIATIVE

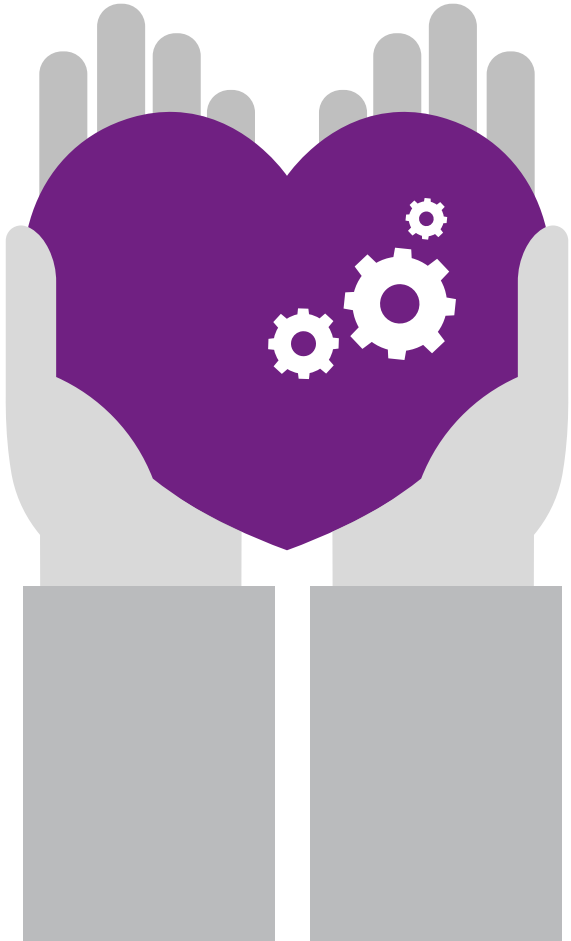
Team Development

Statewide, multidisciplinary team with representation from endocrinology, primary care, pharmacy and care management created in May 2020 with an emphasis on colleague health plan.

Intervention Creation

Four interventions in total:

1. Initiate metformin in T2DM who are using insulin
2. Eliminate co-prescribing of GLP-1 & DPP-IV
3. Initiate SGLT-2 in T2DM & HF
4. Convert DPP-IV to SGLT-2 in T2DM & HF



Care Team Intervention Delivery

Care team members created workflows, rationale and supplemental information to support intervention delivery. Interventions began Summer 2021.

Performance

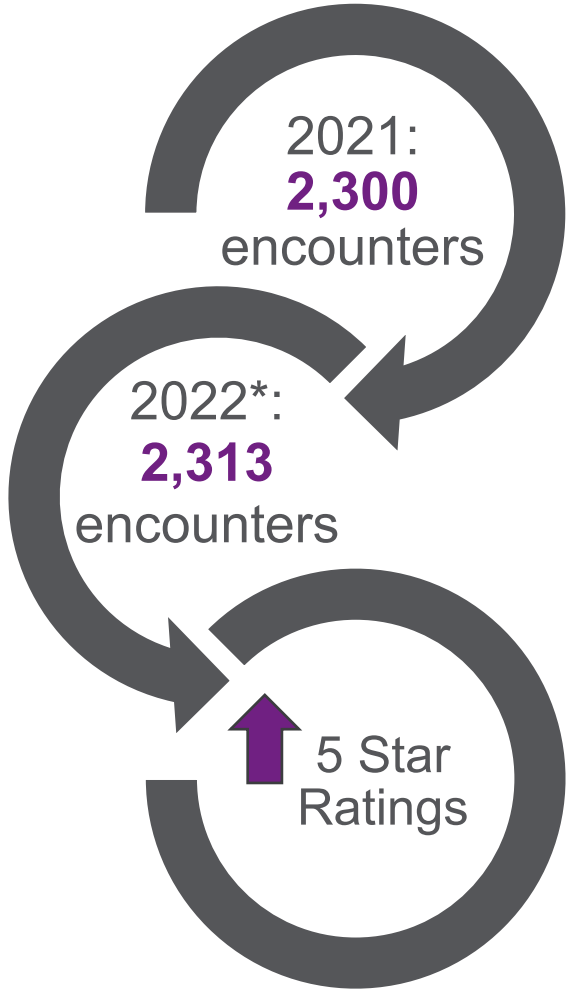
Since initiation of the program, interventions have led to nearly $340,000 in annualized savings for the colleague health plan

T2DM: type 2 diabetes mellitus, GLP-1: glucagon like peptide 1 agonist, DDP-IV: dipeptidyl peptidase-4 inhibitor, SGLT-2: sodium-glucose cotransporter-2 inhibitor, HF: heart failure

MEDICATION ADHERENCE MONITORING

- Primary focus: triple-weighted HEDIS 5 Star measures
  - Cholesterol (statins)
  - Hypertension (renin-angiotensin system agents)
  - Diabetes

- Pharmacy technician and student led program
  - Complete initial evaluation: motivational interview, standardized documentation
  - Identify and resolve patient-specific barriers
  - Refer to pharmacist, care management, provider as appropriate

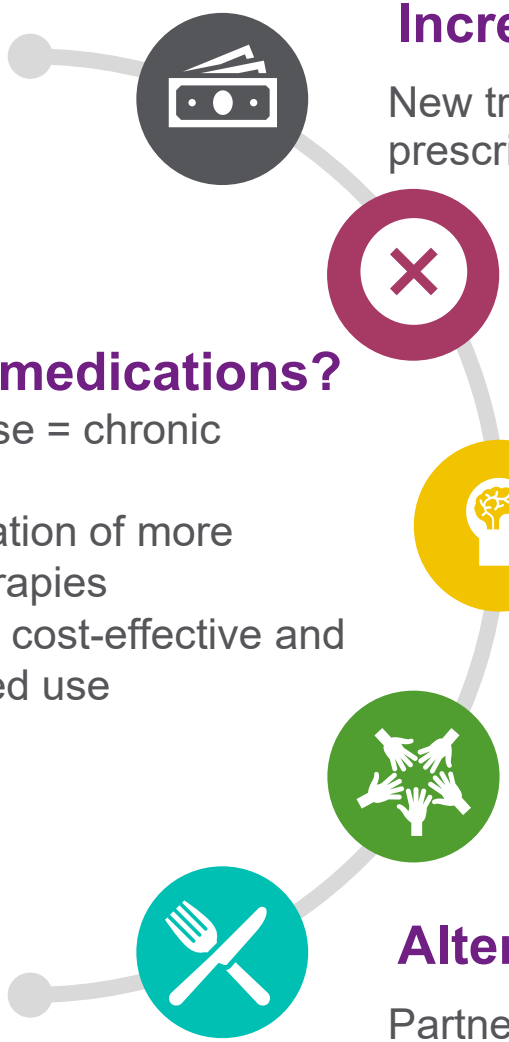


*2022 data current thru 10/19/22

OBESITY MEDICATION MANAGEMENT

Why obesity medications?

- Chronic disease = chronic medications
- Growing utilization of more expensive therapies
- Goal: promote cost-effective and evidence-based use



Increasing Cost

New treatment options to market, increasing utilization over time (top 5-10 prescribed drugs by cost), cost/pound lost over 1 year: $1,579

Inappropriate Utilization

45% “failed” therapy, but 38% remained on therapy despite failure.

Knowledge Gaps

Identified need for obesity management education for providers and care teams

Care Team Approach

Pharmacist-led assessment, education and intervention designed to engage with patient and connect to resources

Alternative Options

Partnership with lifestyle medicine programming & alterations to utilization management criteria with payer

COMPREHENSIVE MEDICATION MANAGEMENT

Best Practices

Well defined & established workflows differed by region. Limited support staff to assist with administrative tasks.

Pre-2019

Pilot Program

Workflow consolidation, leveraged pharmacy techs for outreach. Streamlined approach with Epic go-live in early 2020.

2019 & 2020

Targeted Populations

Early program evaluation showed cost savings. Began plans for expansion & developed patient identification process.

2021

All Contracts

Enrolled all value-based contracts into program. Program evaluation shows cost savings and clinical improvements.

2022 and Beyond

Calendar year 2021: **11%** reduction in admissions, **9%** reduction in ED visits, **5%** savings in prescription drug costs and **4%** savings in total cost of care. Equivalent to **$100 savings per intervention member per month**.

QUESTIONS / DISCUSSION