

# Mercy Medical Group Sacramento, CA

- 280 multispecialty providers
- 7 clinical pharmacists serving 4 regions to support:
  - Utilization management
  - Cost-related non-adherence
  - Uninsured/underinsured
  - Anticoagulation
  - Informatics
    - E-prescribing
    - Pay for Performance
  - Care Team (Transition of Care Model)

# FY'11



## REDUCE AVOIDABLE

1. MEDICAL ADMITS by 10%.
2. READMITS to below national benchmarks.
3. ER VISITS by 10 % .

# Focus on Hot Spots

## (sickest of the sickest)

- Chronic Disease Registry :created using modified Charleston Co Morbidity criteria and prior utilization pattern (Case Index score).  
**3600 patients in registry**
- Referrals from hospital, liaisons, Physicians, SNFs , patient advocates. **70 cases/month.**
- Home Health every discharge reviewed.

# Risk Stratification

Identify those high risk for hospital utilization by using :

- ✓ Modified Naylor score for readmission
- ✓ Comprehensive Clinical Assessments (ReACH) focusing on a patients
  - a) physical ,
  - b) mental and
  - c) social well being

# Care Team Members

- **RN Case Manager** : High touch telephonic case management for m/m of chronic disease and exacerbation of chronic disease and serving as team leader who care coordinates.
- **Licensed Clinic Social Worker**: Home visits addressing social, financial , mental health and using POLST form to address advance directives.
- **Home-visit Providers** : managing high risk patients during transitions of care , acute exacerbation of diseases, ongoing identification and m/m of multiple chronic diseases and providing much needed access for the frail.
- **Pharmacist**: Comprehensive medication review during post discharge phone calls, home visits and in the clinic settings for medication therapy management.
- **Home Health Team** : Identification and risk stratification of high risk patients upon discharge : Multiple resources deployed RN,SW, PT/OT, Speech, Wound care, Dieticians managing high risk patients during transitions of care.
- **SNF Team**

# Care Coordination Conference PCPs



PCP



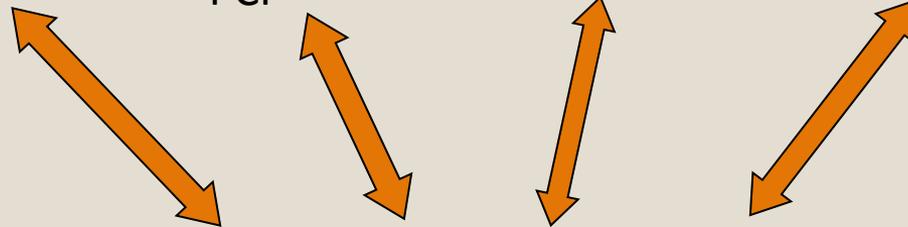
PCP



PCP



PCP



Care Management Team



Once every  
2 weeks  
Case  
conference

Discuss 12-20 High risk patients/session  
Case Managers  
Licensed Social Worker  
Pharm-D, Geriatric House Call Program  
Home Health Nurse



RISK POOL  
@ their doorstep

# Care Team Pharmacist:

- Provides comprehensive medication review
  - Medication reconciliation
  - Determine barriers to adherence
  - Similar duties of consultant pharmacists in long term care
- Discontinue unnecessary medications; add necessary but omitted medications
- Avoid potentially inappropriate medications
- For patients that are homebound or cannot determine medication use, perform home visits
- Document findings, recommendations in patient EHR.
- Work under a collaborative practice agreement

# Medication Reconciliation

- Sources to reconcile
  - Outpatient EHR (Chart)
  - Patient's med list from patient or caregiver
  - Pharmacy
  - Hospital discharge summary
  - SNF discharge summary
  - Home visit when necessary
- Must pick up the phone to get answers!
- Detective work is often necessary

**What Does the Future Hold  
?**