Emerging Trends in Value-Based Care and the Pharmacist’s Role

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Mount Sinai Health Partners
Polling Question 1

Which health-system care setting do you focus most of your work?

1. Inpatient
2. Transitions of care
3. Outpatient clinic
4. Infusion center
5. Plan
6. Other
Polling Question 2

Does your organization participate in a population health management accountability initiative (e.g. ACO or commercial)

1. Yes
2. No
3. Not sure
4. Not applicable
Polling Question 3

If yes, does your organization employ a pharmacist in population health or ACO?

1. Yes
2. No
3. Not applicable
Objectives

1. Define Value Based Care

2. Describe the role of pharmacists and technicians in a value-based care environment

3. Identify emerging trends in value-based care that are geared towards provider organizations
What is Value?

Value Based (Health)Care is a healthcare delivery model in which providers, including hospitals and physicians, are paid based on patient health outcomes.
CMS Value Based Programs

CMS’s move towards paying providers based on the quality, rather than the quantity of care they give patients versus total billable services.

<table>
<thead>
<tr>
<th>LEGISLATION PASSED</th>
<th>PROGRAM IMPLEMENTED</th>
</tr>
</thead>
<tbody>
<tr>
<td>MIPPA</td>
<td>ESRD-QIP</td>
</tr>
<tr>
<td>ACA</td>
<td>HVBP</td>
</tr>
<tr>
<td>PAMA</td>
<td>HAC</td>
</tr>
<tr>
<td>MACRA</td>
<td>VM</td>
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</tbody>
</table>

**LEGISLATION**
- ACA: Affordable Care Act
- MIPPA: Medicare Improvements for Patients & Providers Act
- PAMA: Protecting Access to Medicare Act

**PROGRAM**
- ESRD-QIP: End-Stage Renal Disease Quality Incentive Program
- HVBP: Hospital Value-Based Purchasing Program
- HAC: Hospital Acquired Condition Reduction Program
- VM: Value Modifier or Physician Value-Based Modifier (PVBM)
- SNF-VBP: Skilled Nursing Facility Value-Based Purchasing Program

APMs: Alternative Payment Models
Value Based Payments

Value-based care differs from a fee-for-service or capitated approach, in which providers are paid based on the amount of healthcare services they deliver. The “value” in value-based healthcare is derived from measuring health outcomes against the cost of delivering the outcomes.

Value-Based Health Care Benefits

<table>
<thead>
<tr>
<th>PATIENTS</th>
<th>PROVIDERS</th>
<th>Payers</th>
<th>SUPPLIERS</th>
<th>SOCIETY</th>
</tr>
</thead>
<tbody>
<tr>
<td>Lower Costs &amp; better outcomes</td>
<td>Higher Patient Satisfaction Rates &amp; Better Care Efficiencies</td>
<td>Stronger Cost Controls &amp; Reduced Risks</td>
<td>Alignment of Prices with Patient Outcomes</td>
<td>Reduced Healthcare Spending &amp; Better Overall Health</td>
</tr>
</tbody>
</table>

Allows payers to increase efficiency by bundling payments that cover the patient’s full care cycle, or for chronic conditions.
What Is The Impact of Risk On Delivery Models?

Changes in the Health Ecosystem 2020

THE US DIGITAL HEALTH ECOSYSTEM 2020

PRIVATE INSURERS
- United Healthcare
- Anthem
- Aetna
- Cigna
- Clover
- Oscar
- Devoted Health
- Humana
- Centene
- Molina Healthcare
- Bright Health
- Zipari
- Alignment Healthcare

INSURANCE STARTUPS

PAYERS
- Comcast
- Kroger
- Haven
- Collective Health
- Accolade
- Grand Rounds
- Walmart
- Apple
- Amazon
- Confluent
- Sharecare

EMPLOYERS
- Health Systems and Hospitals
- Retail Clinics
- Telemedicine Providers
- Provider Startups
- Consumer Devices
- Medical Devices and Software
- Regulators

Note: This graphic is illustrative, not exhaustive.
Emerging Trends in Value Based Care - Macro

- Patient Centered Medical Homes (PCMH) place the primary care physician at the driver and coordinator of medical services with specialists.
- Personalized, customized healthcare and hyper-convenience is better than incentives to create a stickiness for patient’s self management and investment in their health.
- Mixed FFS and VBC models emerge in decisions. Health systems are interested in turning to telehealth, however are on hold until they are paid for services, but are trialing models with employees. Heavily dependent on state rules.
- Employers are including digital tools into their benefits package to improve health and decrease costs.
- Employers are contracting directly with providers for pricing and quality arrangements.
- Medicaid risk arrangements are emerging in markets, NY included.
- Niche digital and AI will continue to enter to provide solutions for target disease state livongo, wellcare
- Startup alternative provider delivery models are contracting directly with insurers – Cityblock, OneMedical, ChenMed
Emerging Tends in Value Based Care - Micro

- Payers-providers launched patient visits at homes with care team members for home-bound, high risk patients, post-discharge visits and more!
- Virtual high utilization rounds with payer-providers, including pharmacy
- Shared services for technician outreach for adherence
- Medicare AWVs with pharmacists
- Pharmacists provided telehealth visits, centralized care (including behavioral health trained)
- Dose titration, management AI assisted algorithms for non-pharmacist!

→ The main goal is: modifying patient behaviors, medication management, HEDIS Star Successes

→ Where pharmacists are lacking: cost savings, proactively managing out of pocket maximums, site of service optimization and utilization management of medical benefit
Pharmacy Related Start-Ups

**PHARMACY RELATED START-UPS**

What are they disrupting, and who are they going against?

- **Current large market players**
  - CVS Health
  - Walgreens
  - Walmart

- **What about Amazon?**

- **Current large market players**
  - CVS Health
  - Walgreens
  - Walmart

- **What about Amazon?**

- **On-line Teleservices**
  - Now offering competition for traditional
  - Brick & mortar clinics

- **What about Amazon?**

- **New area where companies are aiming to help**
  - Pharmacies and patients keep their medications safe.

- **What else can be disrupted?**

- **Traditional drug references available to the public have been limited**
  - New companies are seeking to expand that knowledge to the general public.

- **Where there was once the $4 Dollar List, now we have multiple companies creating drug coupons to reduce drug prices.**

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Mount Sinai Health Partners, Population Health
Mount Sinai Health System: Positioned for Value

With breadth and depth of assets, Mount Sinai is well positioned as one of the highest value providers in New York City

Health System Assets

- Icahn School of Medicine at Mount Sinai
- Flagship academic hospital + 6 community hospitals
- >300 community care locations throughout NYC Metro
- >6,600 physicians on medical staff (~2,500 employed)
- Clinical affiliations that further our geographic reach

Best Value in NYC

- **Quality**: ranked in the top 10 nationally in CareChex ratings for patient safety in medical & hospital care
- **Reputation**: our flagship hospital & medical school are in top 20 nationally; the most “best doctors” in NYC
- **Cost**: the “lower-priced” alternative compared with our academic medical center peers in NYC

![Map of New York City with hospital locations]

*Source: New York State Health Foundation. Why are Hospital Prices Different? An Examination of New York Hospital Reimbursement. December 2016.*
Mount Sinai Health System: Investing in Value

With a focus on value, Mount Sinai has heavily invested in population health solutions, supported by a new business model engaging directly with purchasers of healthcare.

**New Business Model**

Key goals include:
- To become the purchaser’s partner of choice
- Align financial incentives around outcomes
- Earn trust with our patients so that Mount Sinai is their provider of choice
- Manage outcomes, patient experience and costs

**Strategic Initiatives**

- **New Leadership** – hired new leaders to launch a 400+ FTE team dedicated to population health & value
- **Network Development** – launched clinically-integrated network of hospitals & ~3,200 physicians
- **Changing Compensation** – shifting physician compensation to an outcomes-based model
- **Investment in Enablement** – $100M in IT & services to enable care teams for managing populations
- **Quality Management** – standardizing & improving care processes for chronic illness & specialty care
- Value-based contracts with all commercial health plans
- Full risk-based contracts for Medicare/Medicaid lives
Overall Goals for MSHP Population Health

- Higher Quality/Lower Cost of Care
- Effective management of high cost high need patients
- Focus on Prevention/Annual Wellness Visits/Coding Specificity
- Broaden Care Teams and Delivery Models
- Promote efficiency through outlier identification and variance reduction
- Provide information at point of care
- Alignment of various quality programs (MIPS, CIN, ACO, VBP, PCI)
- Engagement of Specialists to promote success
Challenges Faced to Achieve Goals

▶ 50% of patient attribution in VBCs lies with voluntary physicians
  – >70 different EMRs
  – Geographic distribution
  – Lack of hospital and specialty assets across network

▶ Varying levels of ancillary support
  – Union-related limitations
  – Variable staffing models

▶ Balancing RVU compensation models with Value Based Care

▶ Large patient population requiring risk stratification for optimal efficiency and impact of care management

▶ Unique Manhattan Market competition
  – Payor Benefit Design
2019 MSSP ACO Measure Domains

**Patient/ Caregiver Experience**
- Getting Timely Care, Appointments, and Information
- How Well Your Providers Communicate
- Patients’ Rate of Provider Access to Specialists
- Health Promotion and Education
- Shared Decision Making
- Health Status/ Functional Status
- Stewardship of Patient Resources
- Courteous and Helpful Office Staff
- Care Coordination

**Care Coordination/ Patient Safety**
- Risk Standardized, All-Cause Readmission
- All-Cause Unplanned Admission with Multiple CC
- Ambulatory Sensitive Condition Acute Composite (PQI #91)
- Falls Risk Screening

**Preventive Health**
- Influenza Immunization
- Tobacco Screening + Cessation
- Depression Screening + Follow Up
- Colorectal Cancer Screening
- Breast Cancer Screening
- Statin Therapy for Prevention of Cardiovascular Disease

**At Risk Population**
- Depression Remission at 12 Months
- Diabetes: Hemoglobin A1c Poor Control
- Controlling High Blood Pressure

Measures used to determine MIPS Quality Score
The determination of overall performance and Funds Flow allocation is based on the Mount Sinai Health Partners Clinical Integration Index, which is calculated as follows:

\[
\text{Clinical Integration Participation (CIP) Score} \times 0.3 \times 100 \] + \[
\text{Quality Performance Metric (QPM) Score} \times 0.5 \times 100 \] + \[
\text{Efficiency Performance Metric (EPM) Score} \times 0.2 \times 100 = \text{CI Index}
\]
<table>
<thead>
<tr>
<th>Supporting Clinical Performance</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Improving quality at the point of care</strong></td>
</tr>
<tr>
<td>• Optimize clinical decision support (EMR) or pop health tool for non-EMR practices</td>
</tr>
<tr>
<td>• Claims ingestion to provide Patient 360s with coding, care and pharmacy gaps</td>
</tr>
<tr>
<td>• Annual Wellness Visits address quality measures proactively</td>
</tr>
<tr>
<td><strong>Reaching out to patients who have fallen through the cracks</strong></td>
</tr>
<tr>
<td>• Centralized communication technology: Interactive Voice Response (IVR), Text Message Alerts</td>
</tr>
<tr>
<td>• Medication Adherence tools for clinical pharmacists overseeing coordination staff</td>
</tr>
<tr>
<td>• Mychart and Bulk Orders</td>
</tr>
<tr>
<td>• Outreach to those with no PCP visit in past 12 months prioritized by CDQI and quality opportunity</td>
</tr>
<tr>
<td><strong>Incentivizing performance</strong></td>
</tr>
<tr>
<td>• Alignment of primary care measures for CIN QPM and PCI program</td>
</tr>
<tr>
<td>• ~ $2.5 million distributed in incentive dollars</td>
</tr>
<tr>
<td>• Leverage CIN quality reporting for MIPS</td>
</tr>
<tr>
<td><strong>Getting credit for the quality of care delivered</strong></td>
</tr>
<tr>
<td>• Scaled supplemental EHR payor submissions</td>
</tr>
<tr>
<td>• Automatic CPTII codes in EMRs</td>
</tr>
<tr>
<td>• Prospective clinical data collection from voluntary providers</td>
</tr>
</tbody>
</table>
It takes a village

Centralized

Patient-Facing

Patient Engagement Coordinator/Navigator
Pharmacy Technicians
Care Management (CCC, NCC)

Provider Facing

Office-Based

Pharmacists
CDEs

Pod Meetings
Communications
Town Halls

PEMs/PHMs
Provider Engagement
Practice Transformation
Population Health Pharmacy Services Vision

- Leading population health managers deploy pharmacists across primary care, geriatrics, pediatric, and specialty care practices

- At MSHP we positioned pharmacists as expertise in medication management in primary care to manage patient’s chronic diseases and lower total cost of care

- Investment in practice-embedded pharmacists will accelerate our ability to improve care delivery

- Pharmacist should be added to practices that have 1) large concentration of patients with uncontrolled chronic disease and associated complications, 2) PCP access constraints, and 3) a large Medicare/Medicaid patient mix

- Future investments should expand to specialty service-lines and centralized support for practices with lower volumes of high-risk populations
Responsibility of Pharmacists in Ambulatory Care

Pharmacists support team based care by managing the drug-disease related goals for patients. With the support of analytics and population insights, pharmacists are able to hotspot and optimize therapeutic goals and related issues.
Value-Based Care: Leveraging Pharmacy

**Priorities**

**Ambulatory Clinical Pharmacists Delivered Support**

- Medicare Annual Wellness Visits*
- Medication and Disease Mgmt
- Medication Reconciliation
- Medication Adherence

**Clinical Quality**

+ Partnerships / Community Based Orgs
+ Care Management Collaboration
+ Patient Engagement
+ Specialist coordination

**Satisfaction & Operational Efficiency**

+ Preventable PQI
+ Post discharge COPD/Asthma patients
+ Readmissions
+ Lower Cost Therapeutic Alternative

**Cost / Utilization**

*AWV = Annual Wellness Visit
Domain of Impact

- Patient & caregiver experience
- Tele convenience
- Provider satisfaction

- Team collaboration
- Specialist coordination
- Provider access
- Care management referrals

- Time to goal
- Adherence to treatment plan
- Barrier resolution
- Group medical visits
- Referral support

- Screening
- Referrals
- Community connectivity
- Access & affordability
- Social isolation
2019 MSSP ACO Measure Domains

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**At Risk Population**
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- Controlling High Blood Pressure

**Co-managed by Pharmacist**
Measures used to determine MIPS Quality Score
Develop Pharmacist Referrals “Clinic Within a Clinic”

- Referrals to pharmacists:
  - Uncontrolled chronic diseases
    - HTN, DM, HF, Asthma, COPD, Depression, Behavioral Health
    - Post Discharge
    - High utilizers
  - Polypharmacy
  - Med Reconciliation
  - Medication Adherence
  - Navigation support for Rx
  - Medicare Annual Wellness Visits

- Total cost of care (PMPM) impact on populations managed:
  - Lower cost medication, site of service optimization
  - ED and inpatient visits (preventable and non-preventable)
  - Readmissions rates
  - Medication adherence metrics (challenging with ACO consent)
Medication Adherence

% Patients Meeting Measure

- Medication Adherence for Cholesterol: 77.89% (2017), 80.04% (2018)
- Medication Adherence for Diabetes Medications: 80.62% (2017), 82.31% (2018)
- Medication Adherence for Hypertension: 83.37% (2017), 84.21% (2018)

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## Text Messaging Results

### Missed Fills

<table>
<thead>
<tr>
<th>Category</th>
<th>Count**</th>
<th>% Total Sent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Missed Fill</td>
<td>449</td>
<td></td>
</tr>
<tr>
<td>Removed by ClientTell</td>
<td>74</td>
<td></td>
</tr>
<tr>
<td>Sent</td>
<td>375</td>
<td></td>
</tr>
<tr>
<td>Increase in PDC</td>
<td>221</td>
<td>58.9%</td>
</tr>
<tr>
<td>Picked Up A Subsequent Fill</td>
<td>226</td>
<td>60.3%</td>
</tr>
<tr>
<td>Transitioned PDC Decreasing to Increasing</td>
<td>66</td>
<td>17.6%</td>
</tr>
<tr>
<td>Number of Responses for Outreach</td>
<td>3</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

*Counts represent unique patient/medication combinations
+Patients were only sent one text message if multiple medications required same day pickup from the same pharmacy

### Upcoming Fills

<table>
<thead>
<tr>
<th>Category</th>
<th>Count**</th>
<th>% Total Sent</th>
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</thead>
<tbody>
<tr>
<td>Total Upcoming Fill</td>
<td>980</td>
<td></td>
</tr>
<tr>
<td>Removed by ClientTell</td>
<td>258</td>
<td></td>
</tr>
<tr>
<td>Sent</td>
<td>722</td>
<td></td>
</tr>
<tr>
<td>Increase in PDC</td>
<td>374**</td>
<td>51.8%</td>
</tr>
<tr>
<td>Picked Up A Subsequent Fill</td>
<td>238</td>
<td>33.0%</td>
</tr>
<tr>
<td>Transitioned PDC Decreasing to Increasing</td>
<td>9</td>
<td>1.2%</td>
</tr>
<tr>
<td>Number of Responses for Outreach</td>
<td>8</td>
<td>1.1%</td>
</tr>
</tbody>
</table>

*Counts represent unique patient/medication combinations
+Patients were only sent one text message if multiple medications required same day pickup from the same pharmacy
** Of the 348 that did not see an increase in PDC, 266 ended the year with a PDC > 95
Cost of campaign=$110
Lower Cost Alternative Initiative launched ‘Go to Green’

Proportion of Red PMPM % decrease across the classes:

- Combination NSAIDs: 34% to 11%
- Insulins: 82% to 22%
- PPIs: 93% to 45%
- Topical NSAIDs 83% to 24%
Summary

- Infrastructure for success requires thoughtful build out and mass customization
- While the PCP is at the center, specialist engagement is critical will be critical
- Pharmacists need to be nimble and consider changes to our delivery systems and reimbursement models for providers
- Data Analytics/Clinical Informatics/Decision Support foundational to success
- Data is never perfect but must be leveraged to drive change
- Variance Reduction to drive quality and efficiency
- Strategic Partnerships to Build Value
- Pharmacists as integral part of the Care Team brings significant value
Learning Objectives

1. Define Value Based Care
2. Describe the role of pharmacists and technicians in a value-based care environment
3. Identify emerging trends in value-based care that are geared towards provider organizations
Any Questions?
Appendix
J-Curve

Performance

Investment

Decline

Time

Improvement

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Developing Primary Care Pharmacy Services

**Expansion of services**
- **Personnel**: Pharmacy Technicians, PGY2 Pharmacy Residents
- **Scope**: behavioral health, heart failure, Anticoagulation, Smoking Cessation, pharmaceutical cost reduction

**Collaboration**
- Inpatient Transitions of Care Team
- Care Management
- Community Partners – pharmacies and CBOs

**Billing**
- Annual Wellness Visit (AWV)
- Diabetes Self-Management Training (DSMT)
- Incident to physician
- Medication Therapy Management (MTM)
- Chronic Care Management (CCM)

**Initiation of Collaborative Drug Therapy Management Practices**
- Asthma
- Diabetes / CKD
- HTN
- Cholesterol
- COPD

**Credentialing and privileging**
- Practice Onboarding
- Scope of Pharmacists
- Workflow Dev

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Sustainability with Value: Medicare Annual Wellness Visits

- **Goal:** preventative visit to assess patient’s health and risk factors (not a physical exam)

- **Components:**
  - *Collection of Patient Information*
  - *Patient Health Risk Assessment:*
    - Functionality: ADLs, IADLs, falls, memory decline, pain score, mini-mental exam
    - Behavioral/social risk factors: Smoking, alcohol/drug use, depression assessment
    - Preventative services: Screening tests and immunizations
  - *Counseling and Shared Goal-Setting:*
    - Address identified risks
    - Personalized health advice, with written action plan for 5-10 years
    - Link to community resources, as needed

- 8+ quality metrics can be addressed in 1 AWV
  - Colorectal cancer screening, breast cancer screening, BMI, blood pressure, med adherence, diabetes A1c/nephropathy/eye exam, etc

- **Benefits:**
  - Sustains Pharmacist Resource Investment in Primary Care
  - Provider Satisfaction
  - Patient Satisfaction, engagement & team-based care
  - AWVs attributed to PCPs (RVUs)
Value Add of Pharmacist Conducted AWV

- 77 y.o. male presents for Annual Wellness Visit with 3+ severe past hypoglycemic episodes
- Significant PMH: CAD, CKD Stage 2, edema, HTN, T2DM, PVD, PAD
- Preventative Risk Factors and Conditions identified; plan of care developed

AWV Findings for PCP Follow-up:
- Abnormal Three Item Recall – f/u with PCP to conduct MMS
- Aortic Aneurysm Screening - PCP placed order for screening
- counsel on HCP and options to discuss future planning goals with PCP at f/u

Due now:
- Shingles Vaccine
- Lipid Panel
- Diabetes Eye Exam

Updated 5-10 year Preventative Schedule:
- Flu vaccination due 9/2019
- Diabetes foot exam due 9/2019

- Diabetes microalbumin due 10/2019
- Pneumococcal due 1/2020
- Colonoscopy due 2020
- Td vaccine 8/2028

Medication Related Problems Addressed:
- Clopidogrel 75 mg once daily – reconciled with cardiologist and removed from med list
- Diabetes medication regimen optimization, patient had many severe hypoglycemic episodes. Initiated plan to titrate down mealtime insulin and titrate up trulicity
- F/U with PharmD for diabetes management (telehealth/clinic)