



# The Art & Science of Formulary Management – Acute to Ambulatory Strategy

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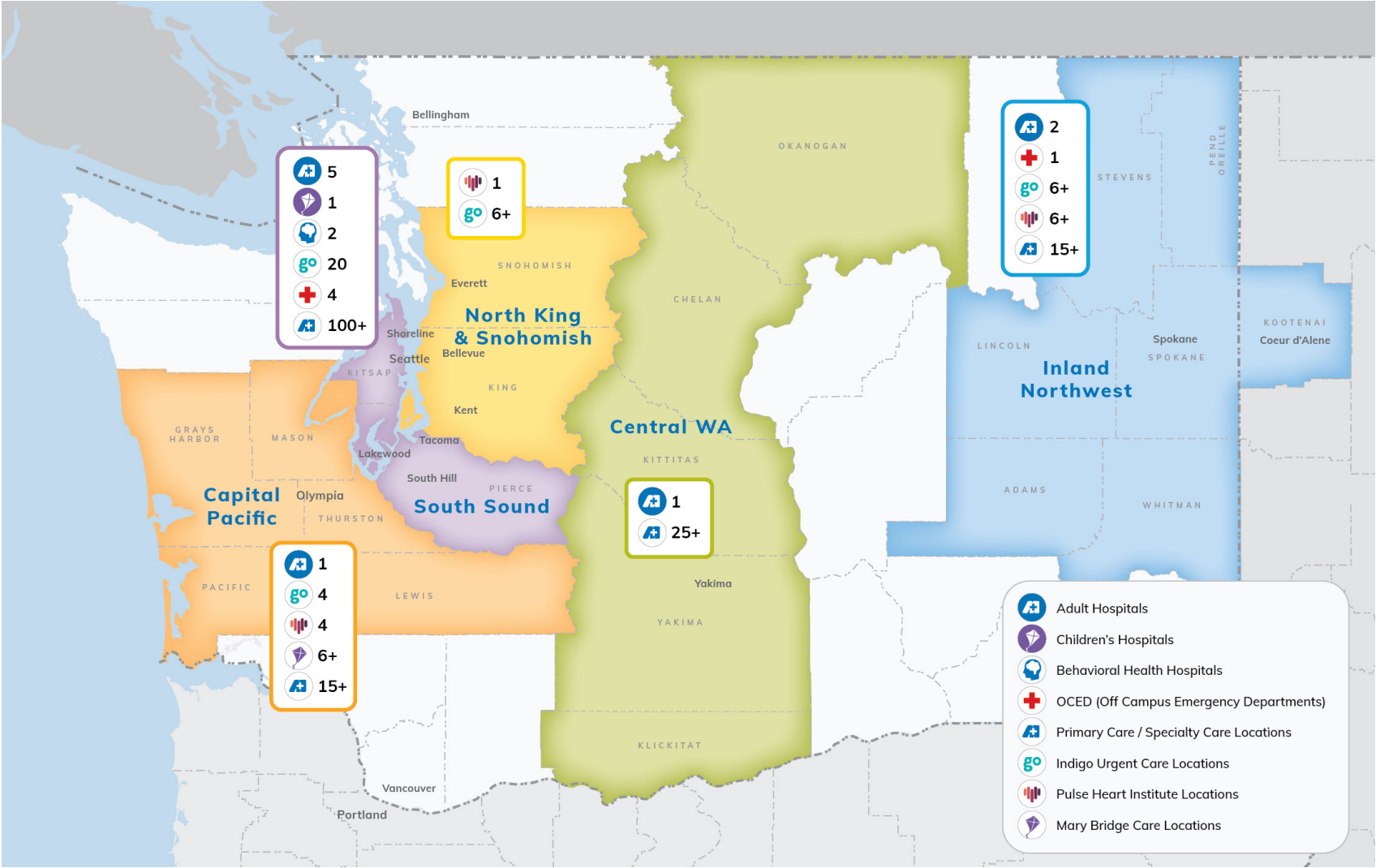
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# MultiCare Health System's Footprint in the PNW



# Objective: Explain how leveraging the inpatient clinical practice model can impact population health outcomes

- A clinical pharmacy leadership team that includes representation across multiple sites of care provides a broad perspective that facilitates coordination of care positively impacting population health overall.
  - Establish standards of care for both inpatient and ambulatory services
  - Determine best treatment options considering all settings
  - Use all patient contact points to convert to preferred therapy
  - Improve efficiency by establishing long-term treatment options consistent with those preferred by payors
  - Align with organizational strategic priorities around quality and patient outcome measures

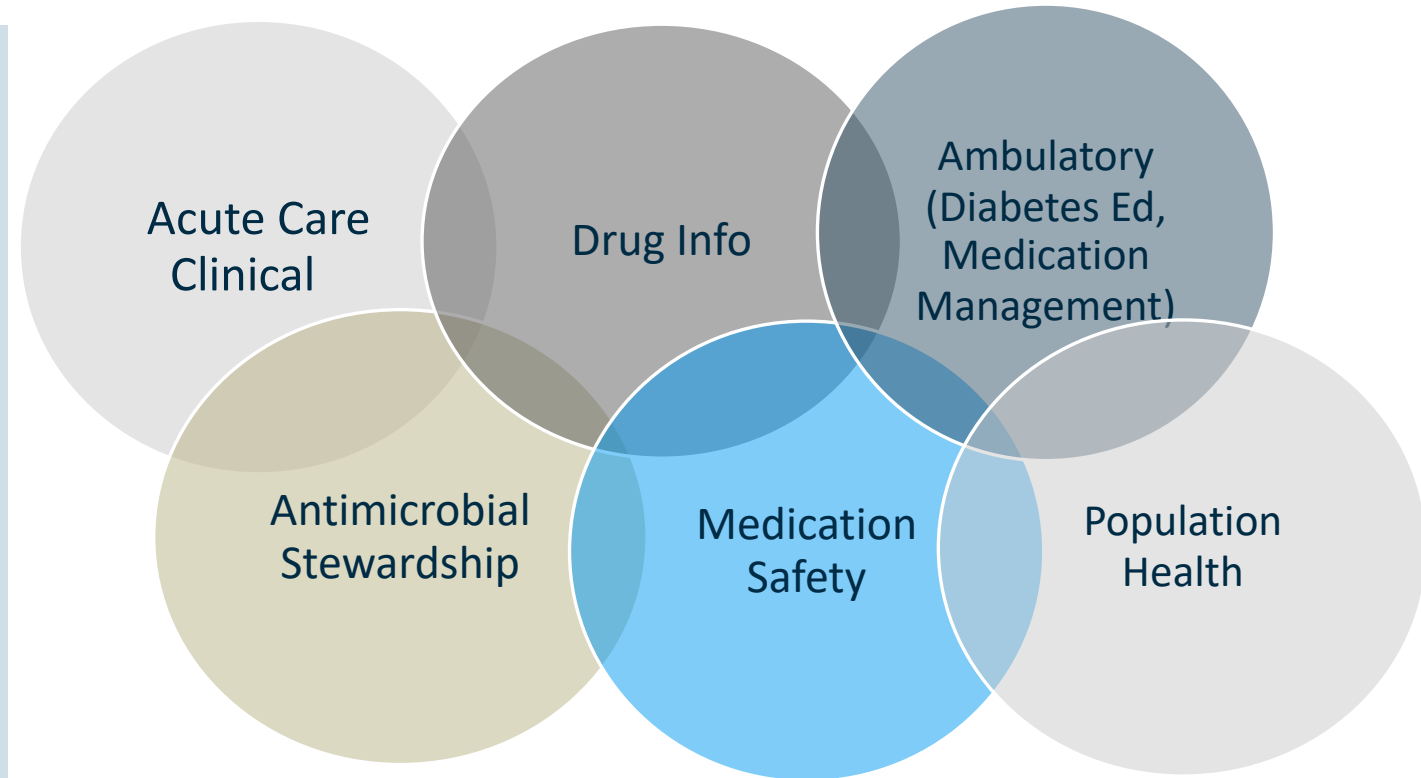


Coordination of medication management efforts by clinical pharmacy leadership team representing multiple areas of practice

# MultiCare Pharmacy Clinical Services

## Team:

- Diabetes Services/Medication Management Clinic, Pam Kramer
- Acute Care Clinical Services, Bryan Rowe (INW), Tara Kamprath (Yakima), Hope Barnes, (PSRN), Alesya Dragan (PSRS), Becky Carpenter (Pediatrics)
- Drug Information, Catherine Brown
- Medication Safety & QI, Brent Dammeier, Nicole Lloyd
- Managed Care Pharmacy, JT Lew, Michael Lee



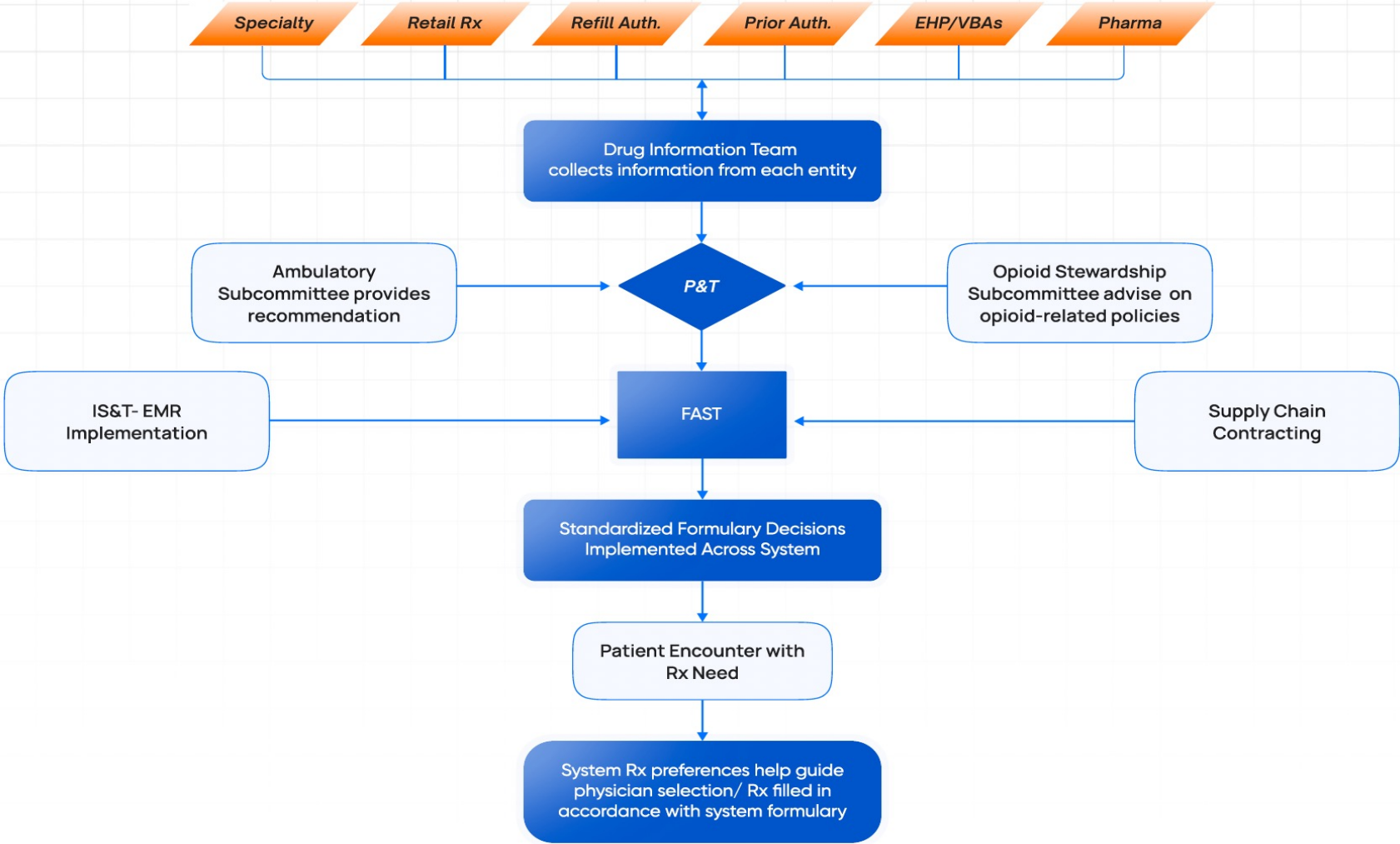
# Formulary Alignment Project

- Expansion of formulary management into ambulatory practice.
- Ambulatory P&T Subcommittee:
  - Hospital based infusion centers
  - Primary Care and Specialty clinics
  - Employee Health Plan
  - Value Based Care/Shared Risk Programs

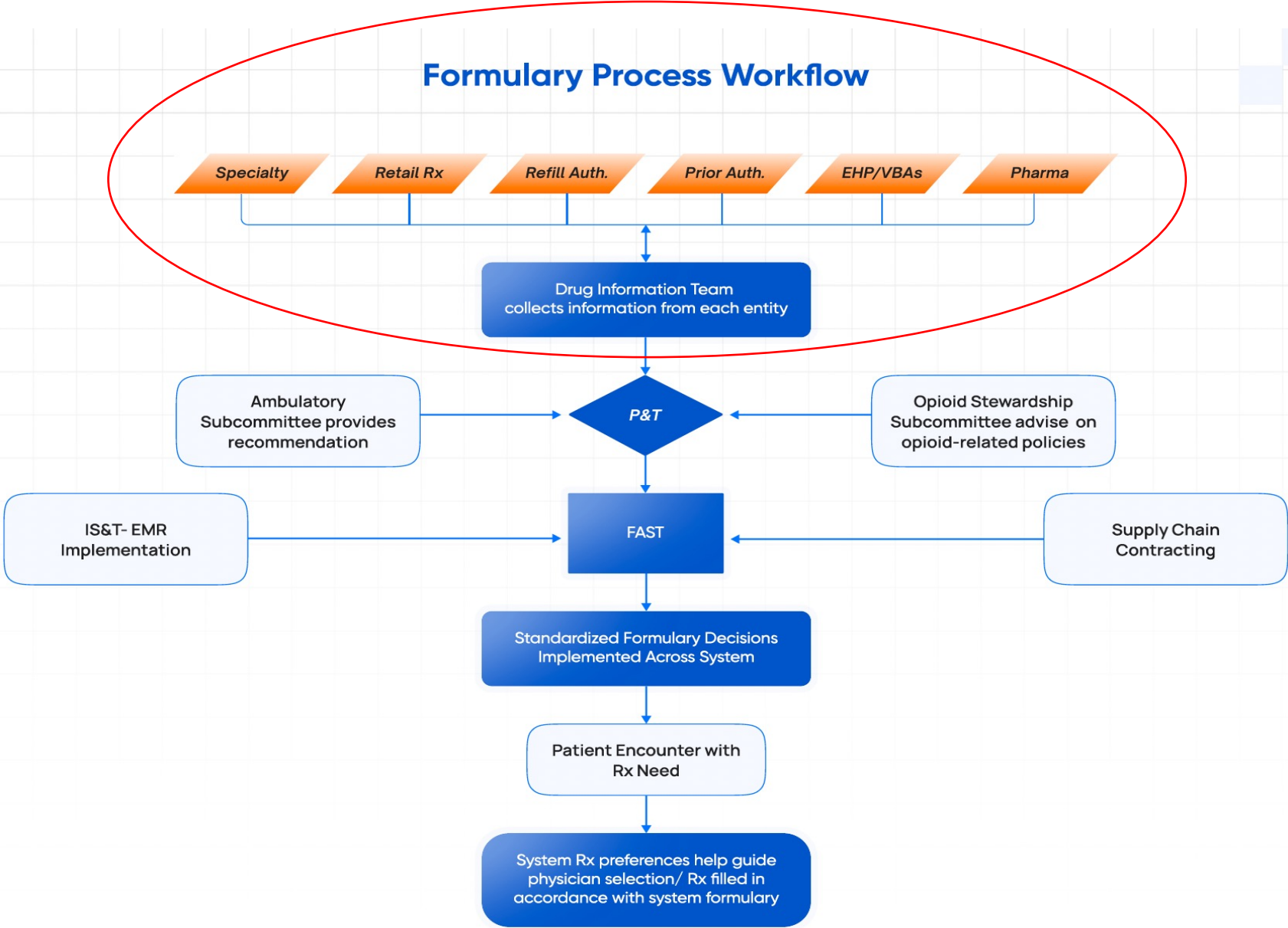
# Formulary Process



## Formulary Process Workflow



# Formulary Process

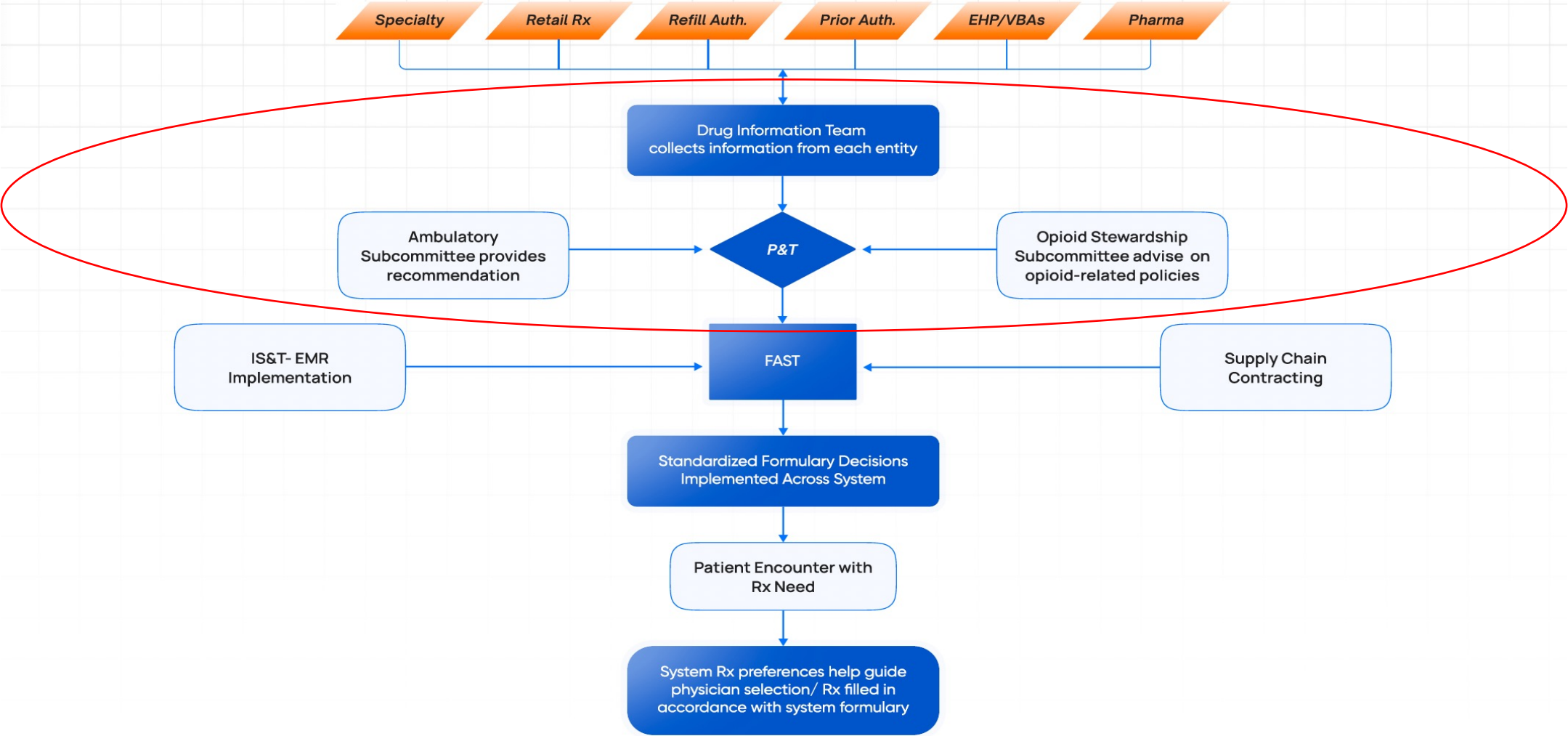




# Formulary Process



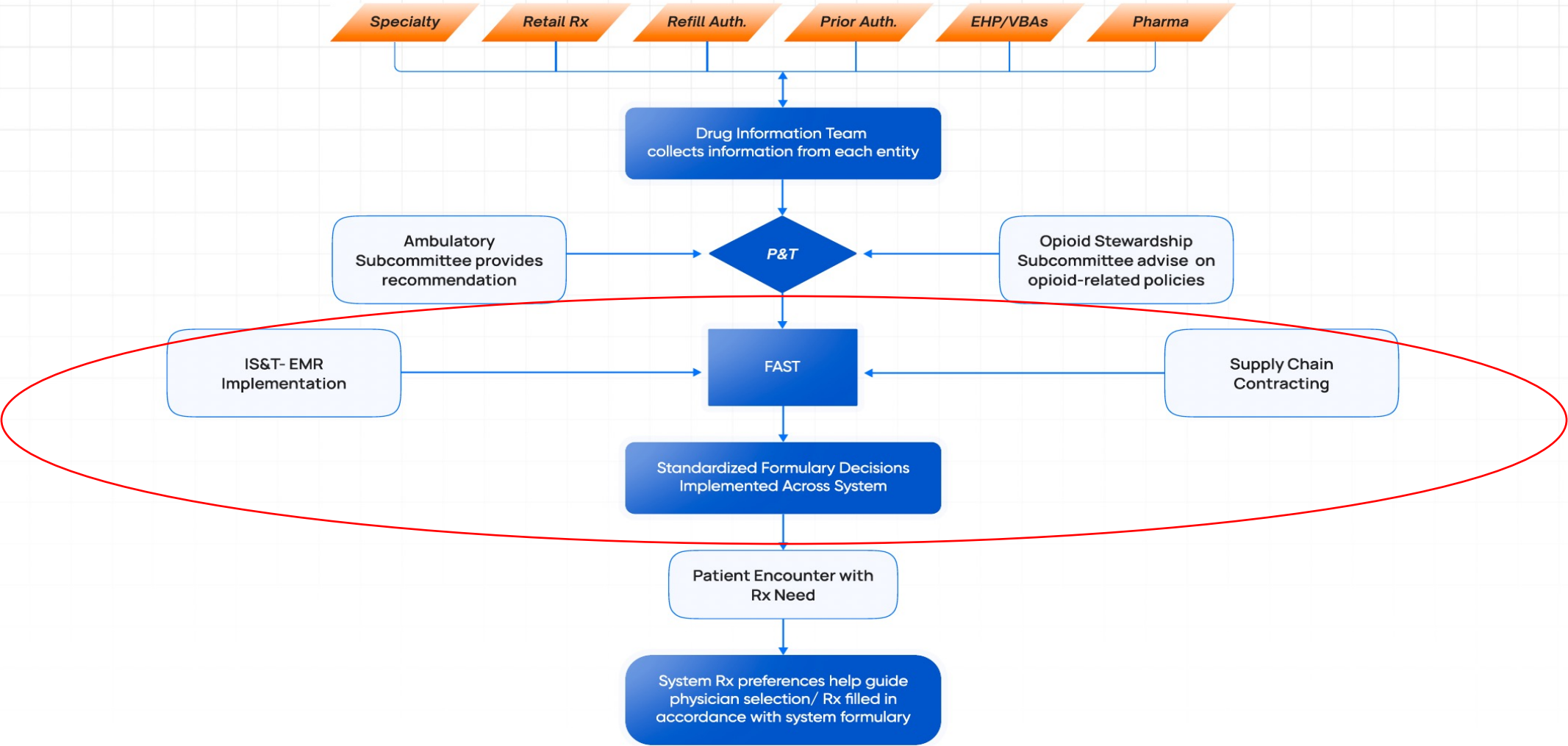
## Formulary Process Workflow



# Formulary Process



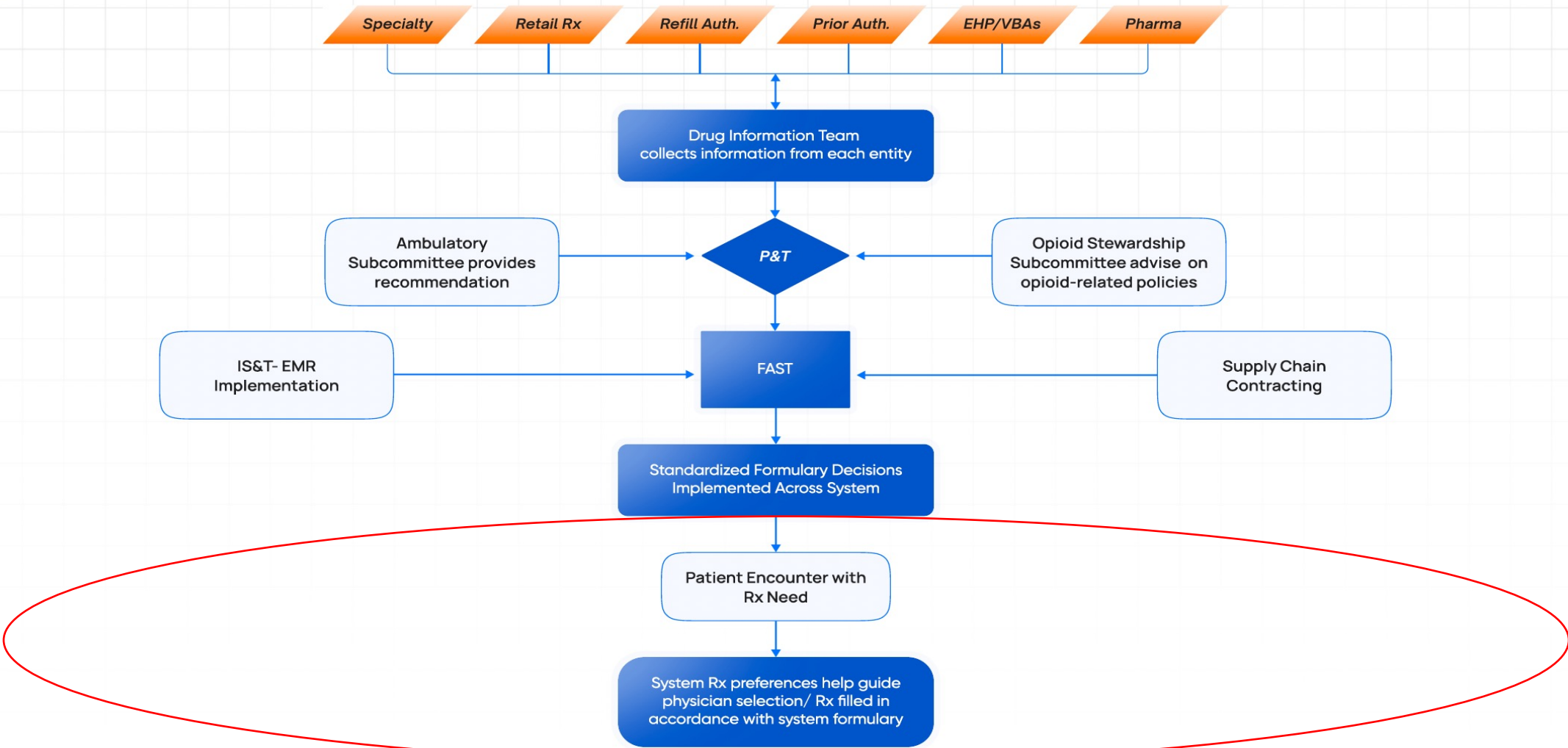
## Formulary Process Workflow



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## Formulary Process Workflow



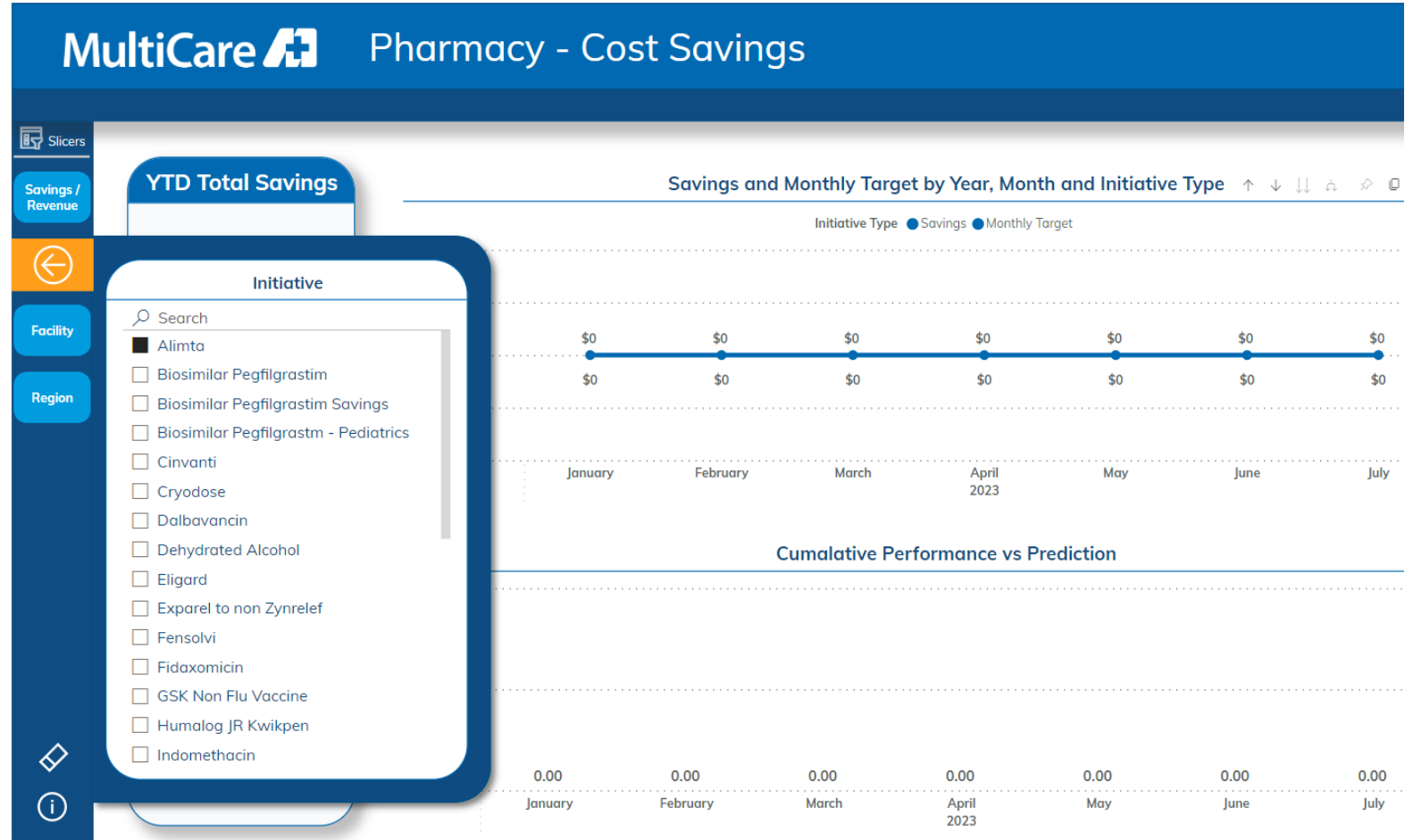
# High-Cost, Low-Value Drug Project

Targeted guidance in clinic EHR directing therapy away from “dumb” drugs that are not preferred regardless of insurance or clinical situation, yet are prescribed because providers are unaware of the high cost/low value

- Present information and alternatives upon prescribing but allow for continuing with original choice
- Track response to alerts and adjust accordingly
- Example: esomeprazole

# Dashboards: Financial Savings

Financial initiatives tracked monthly. Report by overall savings, region, site, initiative, revenue, savings, cost- avoidance



# Medication Safety: DOAC Referral Initiative

“Anticoagulants have been consistently identified as the most common causes of adverse drug events across health care settings” – Office of Disease Prevention and Health Promotion<sup>1</sup>

- ORBIT-AF II: 1 in 8 patients (n = 5,738) in the community were on an inappropriate DOAC dose<sup>2</sup>
- SAGE-AF: 23% (n = 460) of atrial fibrillation patients  $\geq$  65 years old were prescribed an inappropriate DOAC dose<sup>3</sup>
- Mayo Clinic: 14.8% (n = 8,576) of atrial fibrillation patients were prescribed an inappropriate DOAC dose<sup>4</sup>

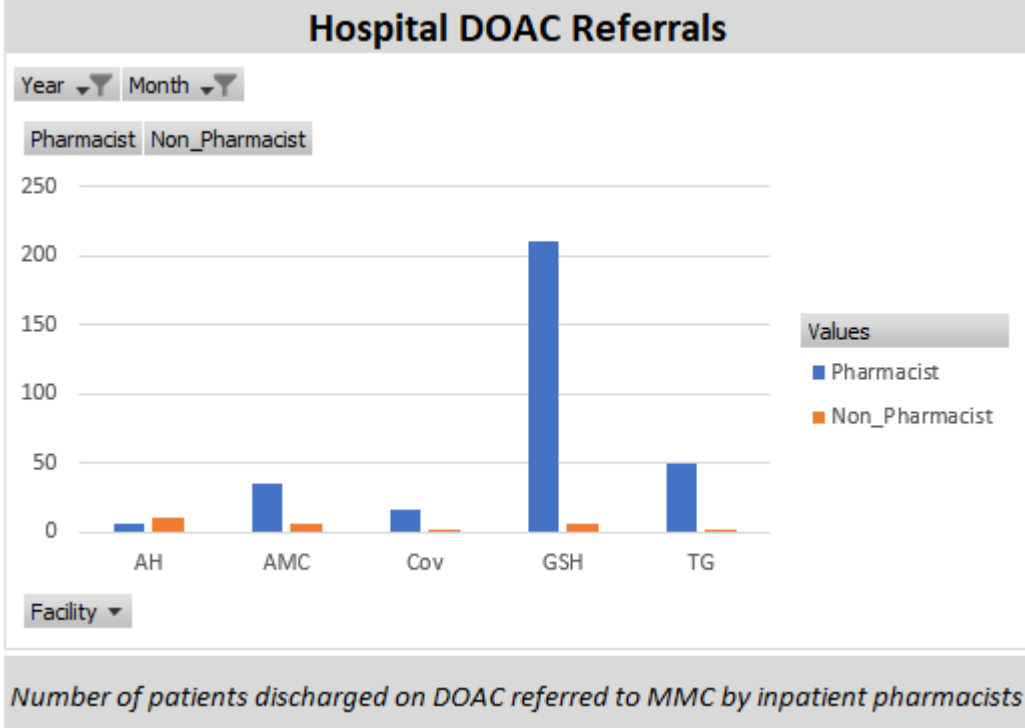
1. National Action Plan for ADE Prevention, U.S. Department of Health and Human Services, ODPHP (2014)
2. Steinberg B, et al, Off-Label Dosing and Adverse Outcomes, J. Am. Coll. Cardiol. (2016)
3. Sanghai S, et al, Rates of Potentially Inappropriate Dosing of DOACs, J. Am. Heart Assoc. (2020)
4. Sugrue A, et al, Inappropriate Dosing of DOACs, Am. J. Cardiol. (2021)

# Medication Safety: DOAC Referral Process

Inpatient pharmacists identify patients who may benefit from being referred for outpatient DOAC management:

Engagement variable between acute care sites.

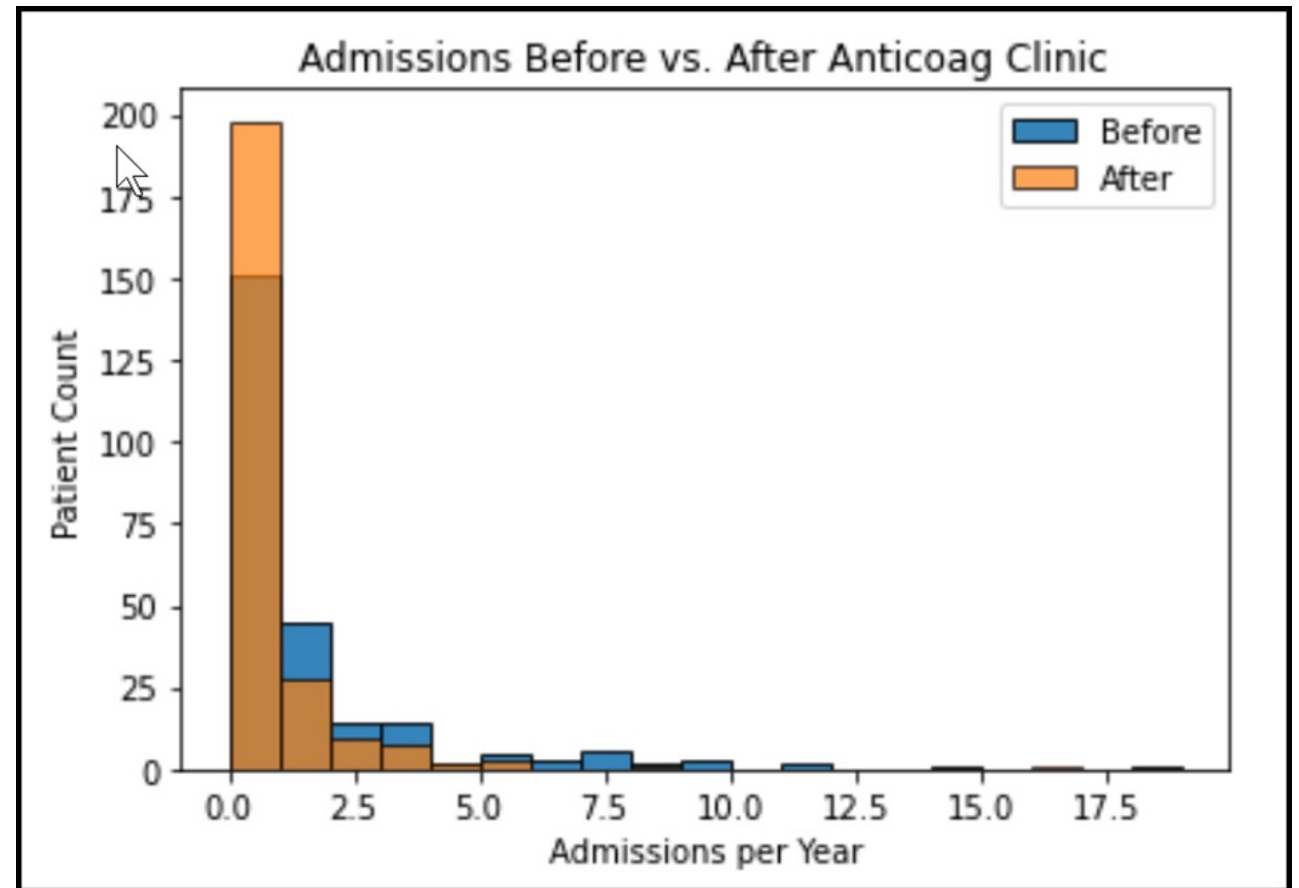
New starts	Non-adherence	Polypharmacy
Renal dysfunction	Incorrect drug or dose	Extreme weight (BMI > 40 or < 18.5; > 120 kg or < 60 kg)
History of a bleed or clot	Financial barriers	Drug-drug interactions



# Dashboards: DOAC Initiative Outcomes

**The average number of admissions per year was 1.48 before being seen in the clinic compared to 0.60 admissions per year after being seen\* ( $p=0.0000006$ )**

**Although there may be other variables, it is possible this intervention has saved 219 admissions per year**



- \*Data includes only patients who had at least 90 days of data on anticoagulants before being seen and more than 90 days as patients.
- Data provided is from the internal database of the presenting organization.



# Questions or Case Discussion