

the quality metric requiring diabetic patients to have an HbA1c less than 9.0. These guidelines include flow charts and other materials that can be used to educate physicians, staff, and patients, in overall care of patients with diabetes. After guidelines are developed, educational presentations are provided to implement these practices in the physician office settings.

With population health, data analysis is critical to determine the areas to target interventions to improve care—whether this analysis is by disease, resource utilization, or at the individual patient level. Weekly, I review medical claims and other patient risk stratification reports to determine which patients might benefit from one-on-one care by our nurse care managers, social workers, and health coaches. Resource utilization analysis helps the ACO to determine where programs to improve care are most needed, for example, overuse of the emergency department.

A Typical Day

In my daily work, I utilize clinical skills in understanding disease treatment and use my management skills to develop processes to address quality standards. My experiences as a drug representative are invaluable in presenting and “selling” the ideas and processes required by providing quality care to sometimes skeptical physicians and more frequently office staff (“We can’t do that! We’re too busy!”). I utilize my previous team-based hospital experience to move the team concept of care into the ambulatory setting as we teach physicians and their office staff to work as a PCMH, including the patient as a team member. I utilize my training in pharmacoeconomics to conduct cost-benefit (cost of providing the service versus the income provided by the service) and cost-effectiveness analysis (cost of the intervention versus the clinical outcome) that help make correct treatment choices for the population.

Daily activities include review of claims data and other clinical outcome data to determine where improvement is needed (e.g., previous month’s increased use of the emergency department in patients with diabetes). With this information, I will determine which quality improvement strategy is needed. For example, I may assign the specific patients to our nurse care managers, who will follow the diabetes guideline that I developed to work with the patient’s physician and patients to determine if the patient’s care plan has gotten off track or if further patient education on disease treatment is needed. I also work on updating current treatment guidelines as well as developing new ones for other diseases that frequently occur in our population. I am involved in meetings with information technology personnel, weekly nurse care manager meetings, and the PCMH home team meetings. In addition, I work with our system’s Center for Senior Health to understand the utilization patterns of our patients who are admitted or are residents of nursing homes so that they can address the needs of this segment of the population.

My Career Path

My initial career goal was to be the assistant director of pharmacy at a large hospital in a Midwestern town. When I graduated from the University of Michigan in 1977, the route to such a goal was usually “working your way up”—no graduate degree required. My faculty advisor, Dr. Rosemary Berardi, encouraged me to think about a residency, but my family financial situation made it necessary to start a full-time job. So Dr. Berardi advised, “Go to a large hospital and learn as much as you can.” Her words have stuck with me, and I give her credit for inspiring me to continue to learn. Those guiding words and experience with that first speed bump in my career path readied me for the travels that have taken me to places that I never would have expected to land, including my current position.

Thus, I began my career in the intravenous (IV) admixture and unit dose dispensing in the main pharmacy at the Ohio State University Medical Center under hospital pharmacy visionary, Dr. Clifton Latiolais, where

innovation was the cornerstone. I volunteered for every opportunity to be trained to cover various areas throughout the pharmacy department. I learned to run the day-to-day operation of the nuclear pharmacy in addition to my regular practice site in the unit-dose and IV dispensing areas. It was the offer to be trained to cover the pharmacy in the rehabilitation hospital, Dodd Hall, that changed my ideas on patient care.

In the discipline of physical medicine and rehabilitation (PM&R), the focus is on the patient's life after discharge—not just what happens during their admission. Further, PM&R specialists routinely rely on other providers such as physical and occupational therapists, speech therapists, and social workers to aid the patient to reach treatment goals. Thus, the addition of the pharmacist to the team was welcomed, and my participation was expected. It was here that I practiced caring directly for patients—from understanding their needs (visual impairment, communication difficulties, and health literacy) to tailoring their medication education. Every population is made of individual patients with varying needs and barriers to treatment that they must overcome to be successful, and we must ensure that their care in the hospital is continued throughout the transition of care to the patient's home setting.

While working at Dodd Hall, it became apparent that to continue toward my career goal, I would need a master's degree in business or administration to move into management. Toward that end, I took a series of positions that would allow me to work a Monday–Friday schedule so I could take classes at night to earn my degree. Several of these positions—a sales representative with a major pharmaceutical manufacturer and a management position with a physician group office—provided me with a broader view of the healthcare process outside the four walls of a hospital and beyond the pharmacy department. Working with the physician group provided me with a background in the Medicare billing and payment system that is essential in my work with the MSSP population in the ACO.

The master's degree in healthcare administration from Central Michigan University program provided me with the understanding of business and corporate structure, planning, and human resource planning in the healthcare environment. I studied with middle managers from the auto industry in my general classes and with physicians, nurses, therapists, and other healthcare providers in my healthcare-specific classes. This program gave me an understanding of how business concepts work in healthcare—across the continuum of care—not just in a hospital's pharmacy department.

As I completed my degree in 1991, a new discipline was developing in pharmacoeconomics, and I had an opportunity to complete a residency in this new area. As healthcare had begun to change and seriously focus on the cost of care, this training allowed me to learn the new language of healthcare (i.e., translating clinical outcomes into economic outcomes) that the chief financial officers of health systems understood. I also realized that one reason that clinical pharmacy had hit such road blocks in its growth was due to problems in demonstrating the worth of our services.

After completing my residency, I was fortunate enough to be hired by Dr. J. V. Anandan in the Drug Information Department at Henry Ford Health System. In my work there with the new concept of an outpatient formulary, I conducted research to show that routine use of statin drugs, regardless of drug chosen, provided limited effect in controlling LDL cholesterol due to poor follow-up and patient nonadherence. I took advantage of this great opportunity to demonstrate the positive effects of a clinical pharmacist's intervention and implemented a successful pilot program. However, it was the demonstration that a pharmacist's intervention resulted in cost-savings for the healthcare system that allowed the program to continue and grow. Utilizing knowledge of pharmacoeconomics analysis, I demonstrated projected savings for the health system from the pharmacist's intervention of over \$2 million over 5 years, which would cover the cost of the pharmacist. The pilot was expanded over the following 2 years to cover all the high-risk patients with cardiovascular disease.²