Transition of Care Initiatives for Inpatient Pharmacists

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Internal Medicine Clinical Specialist

Objectives

• Identify transition of care opportunities for inpatient pharmacists
• Discuss Lancaster General Health’s (LGH) experience
• Review initial LGH transition of care initiative outcomes

“Approximately half of all hospital-related medication errors and 20% of all adverse drug events have been attributed to poor communication at the transitions of care”

“With millions of Americans taking multiple medications for chronic conditions, the costs of poor medication management surrounding hospital admission and discharge run into the billions of dollars”

Transition of Care Opportunities for Pharmacy

• Medication History
• Medication Non-Adherence Screening
• Medication Reconciliation – Admission and Discharge
• Patient Education
• Ensuring Medications Filled/Delivered to Patient at Discharge
• Discharge Communication to PCP Offices
• Connection of Patient to Outpatient Services to Improve Compliance / Follow-up
• Post Discharge Phone Calls

Opportunities

Goal: Improve patient outcomes by involving pharmacists/pharmacy extenders in medication-related transitions of care across healthcare settings

Does anyone else feel like this?

Where can we have the most impact?

What needs are present in my health system?
Lancaster General Health

- 630 licensed bed not-for-profit community health system

Current Pharmacy Transition of Care (TOC) Initiatives
- Medication History
- High Risk for Readmission Medication Reconciliation and Patient Counseling
- High Risk Medication Patient Counseling and Discharge Communication

Pilot Phase TOC Initiatives
- Red, Yellow, Green Chronic Pain Patients for Surgery
- Pharmacist Discharge Medication Reconciliation and Patient Discharge Counseling
- Meds to Beds

General Workflow for High Risk Medication TOC Patient

First Step: Pharmacy Extender Identification
Screening for criteria and triaging to Pharmacist

Second Step: Pharmacist Assessment
Reason for high risk medication issue
Adverse Drug Reactions (ADR)

Third Step: Pharmacist/Patient Assessment
Assess baseline knowledge
Targeted questioning reason for medication issue / ADR
Patient-specific counseling

Fourth Step: Discharge Communication
Specific discharge communication sent to the managing provider

TOC: Coumadin Assessment

Warfarin Admission Assessment for INR <1.7 or >3.5:
The patient's chart has been reviewed to determine why the patient was {therapeutic/subtherapeutic/supratherapeutic} on this admission. The patient was admitted for *** and had an INR on admission of ***.
Warfarin Indication: *** Target INR: ***
Today is hospital day #: ***
The cause of the out of range INR was found to be related to ***.
A pharmacist will follow up with the patient during this admission for provide targeted warfarin re-education/counseling.

- Adverse Drug Event Review:
  - Was the out of range INR directly involved or contribute to this admission? (Yes / No)
  - If Yes: Please complete Adverse Drug Event I-vent

TOC: Coumadin Counseling

Transition of Care – Warfarin High Risk (Admission with INR <1.7 or >3.5) – Pharmacist/Patient Education

Warfarin Indication: *** Target INR: ***
Outpatient Warfarin Managing Provider: ***
The patient was interviewed for possible contributing reasons for out of range INR, their baseline warfarin knowledge was assessed, and warfarin education was provided with teach back. The following was determined:
Potential reasons for subtherapeutic/supratherapeutic INR on admission: ***
Patient’s baseline warfarin knowledge assessment noted the following: ***
Patient’s education and teach back summary (reviewed warfarin indication, target INR, INR monitoring, medication/diet/alcohol interactions, importance of compliance and when to notify their managing provider): ***
Identified Warfarin Education Areas for Reinforcement: ***

TOC: Coumadin Discharge Communication

Attn: Anticoagulation Management Provider

Subject: Warfarin Discharge Alert - Sub/Supratherapeutic INR on Admission

Your patient *** was admitted to the hospital on *** with a reason for admission of ***.
The patient had a sub/supratherapeutic INR admission of ***. The cause of the out of range INR was found to likely be related to ***. The doses of warfarin your patient received during this admission can be reviewed in the after visit summary or Epic Synopsis activity. The patient received counseling related to their warfarin management and they were advised to contact your office directly for any questions post-discharge.

Opportunities for re-education include: ***
The patient was instructed to recheck their INR on: ***

If you have any questions, please contact the inpatient pharmacy at 717-544-4056.
TOC: Coumadin
Pharmacy Resident Project: Erin Freeman, PharmD

10/23/14-1/21/15

Outpatient Provider Survey [scale of 1 (unsatisfied) - 5 (satisfied)]:
1. Length of time to read
2. Time until receipt
3. Amount of information included
4. How much information was used in the alert
5. How much alert affected warfarin education/management

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<td>Intervention</td>
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TOC: Coumadin
Pharmacy Resident Project: Erin Freeman, PharmD

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<td>Reported</td>
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<td>Bleeding, n (%)</td>
<td>1 (100)</td>
<td>34 (75.6)</td>
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<td>Thrombosis, n (%)</td>
<td>11 (24.4)</td>
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*Control ADRs were identified solely by retrospective chart review

TOC: Diabetes
April-May 2015

• Counseling Targets
  • Diabetes medications
  • Management of hypo/hyperglycemia
  • Sick management
  • Non-adherence barriers

• Discharge Communication Targets
  • ADA goal optimization recommendations
  • Outpatient DM education
  • Glucometer requests
  • Sick management development

TOC: Diabetes
Pharmacy Resident Project: Erin Freeman, PharmD

30 Day Readmission

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TOC: Medication Adherence

ASHP-APhA Medication Management in Care Transitions Best Practices

• Common Barriers to Transition of Care Services
  • Financial and Staffing Resources
  • Communication
  • Difficulty Developing Partnerships

• Elements for Success
  • Multidisciplinary Support and Collaboration
  • Effective Integration of the Pharmacy Team
  • Data Available to Justify Resources
  • Electronic Transfer of Patient Information
  • Strong Partnership Network


Assessment Question

Pharmacists can be involved in transitions of care by:

a) completing a medication history or medication reconciliation
b) counseling on a new medication or medication adherence
c) communicating to PCP/outpatient practice or post discharge follow-up call
d) all of the above

Questions?

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