Pharmacist-Led Transitions of Care in an Indigent Population

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Conflicts of Interest

I have no conflicts of interest or financial affiliations to disclose.
Objective

Define the pharmacist’s potential role in indigent care transitions.
Need in Alabama

- As of 2016, 27.6 million uninsured nonelderly individuals
- 1 in 10 nonelderly Alabama residents have no insurance
- 47 out of 50 states (America’s Health Rankings)
- No access to primary care
Self-pay patient identified by Care Coordinator

Contact MMC PharmD via phone call to set up follow-up appointment

Care coordinator and MMC PharmD will determine an appointment time

Appointment time will be shared with the patient and documented in Cerner

Occurring while the patient is hospitalized
Mercy will call the patient to remind them of the appointment prior to the visit.

Visit: Medication access problem solving, medication reconciliation, symptom assessment, f/u visit scheduling.

Visit with physician, NP, PA.

Phone call with pharmacist: medication access, symptom assessment, hospital admission status.
Enrollment

First 6 months:
- 126 patients referred
- 70 attended
  - 55.5%
30 Day Readmissions

70 attended
- 11 of 70 had hospital admission or emergency department (ED) visit within 30 days of discharge (15.7%)
  - 3 admission (27.3%)
  - 8 ED only (72.7%)

56 did not attend
- 11 of 56 had a hospital admission or ED visit within 30 days of discharge (19.6%)
  - 9 admissions (82%)
  - 2 ED only (18%)
60 Day Readmissions

72 attended
- 16 had hospital admission or ED visit within 60 days of discharge (22.8%)
  - 6 admissions (37.5%)
  - 10 ED only (62.5%)

56 did not attend
- 14 had a hospital admission or ED visit within 60 days of hospital discharge (25%)
  - 10 admissions (71.4%)
  - 4 ED only (28.6%)
Readmission rates remained high in patients who were referred. Those who followed up with PharmD and MMC had lower rates of hospital encounters overall at 30 and 60 days post-discharge. Those who followed up with MMC were less likely to be admitted to the hospital than those who did not follow up with MMC.

<table>
<thead>
<tr>
<th></th>
<th>30 Days (n, %)</th>
<th>60 Days (n, %)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Readmitted</td>
<td>Not Readmitted</td>
</tr>
<tr>
<td>Attended</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td>Readmitted</td>
<td>Not Readmitted</td>
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<tr>
<td></td>
<td>11 (15.7)</td>
<td>59 (84.3)</td>
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<tr>
<td></td>
<td>Admission</td>
<td>ED Only</td>
</tr>
<tr>
<td></td>
<td>3 (27.3)</td>
<td>8 (72.7)</td>
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<tr>
<td>Did not attend</td>
<td></td>
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<tr>
<td></td>
<td>Readmitted</td>
<td>Not Readmitted</td>
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<tr>
<td></td>
<td>11 (19.6)</td>
<td>45 (80.4)</td>
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<tr>
<td></td>
<td>Admission</td>
<td>ED Only</td>
</tr>
<tr>
<td></td>
<td>9 (81.2)</td>
<td>2 (18.2)</td>
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</tbody>
</table>
Future Plans

NACDS funding

<table>
<thead>
<tr>
<th>Usual Care</th>
<th>Translational Care</th>
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<tbody>
<tr>
<td>• Initial visit at 7-14 days post discharge</td>
<td><strong>Usual Care +</strong></td>
</tr>
<tr>
<td>• Follow-up visit with provider 30 days post-discharge</td>
<td>• At home testing supplies (BG monitor, BP monitor, scale)</td>
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<tr>
<td>• Phone call from pharmacist 90 days post-discharge</td>
<td>• Financial transportation assistance</td>
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<tr>
<td></td>
<td>• Incentive for completing the program</td>
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</table>
# LACE Index

<table>
<thead>
<tr>
<th>Feature</th>
<th>Description</th>
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<tbody>
<tr>
<td>Length of stay</td>
<td>+1 through +6</td>
</tr>
<tr>
<td>Acuity of admission</td>
<td>Hospital via ED=3; Other=0</td>
</tr>
<tr>
<td>Comorbidities</td>
<td>+1 through +6</td>
</tr>
<tr>
<td>ED visits</td>
<td>Number of ED visits within the last 6 months</td>
</tr>
</tbody>
</table>
Assessment Question

Which of the following puts a patient at high risk for hospital readmission?

a. Frequent emergency department visits in the previous 6 months
b. Hospital admission for observation
c. More than 2 chronic medications
d. Lack of access to transportation
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Questions?
References


