Pharmacists in Transitions of Care: We Can All Make a Difference

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Disclosure
The speakers of this panel have no actual or potential conflict of interest in relation to this program to disclose.

Objectives
By the end of this presentation, audience members should be able to . . .

• Assess barriers to obtaining an accurate medication history and identify resources to overcome these barriers
• Examine the specific role and identify the contributions of pharmacists in multi-disciplinary Transitions-of-Care Rounds
• Describe the key components of a pharmacy-led discharge counseling service
• Explain the role of a medication expert performing transitional care services in an outpatient, interprofessional setting

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Objective: Assess barriers to obtaining an accurate medication history and identify resources to overcome these barriers

Current State Analysis

<table>
<thead>
<tr>
<th>Admission</th>
<th>Discharge</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Patients confused or do not bring medications or list (or bring outdated information)</td>
<td>• Primary physician completes discharge medication reconciliation and consultants orders may not be carried out</td>
</tr>
<tr>
<td>• Nursing staff busy with other competing priorities</td>
<td>• Medications get continued patient does not need</td>
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<tr>
<td>• Physicians perform medication reconciliation prior to medication history completed</td>
<td>• Patients can not afford medications</td>
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<tr>
<td>• Medication information entered incorrectly</td>
<td>• Discharge education by nursing can be inconsistent when busy and rushed</td>
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<tr>
<td>• And more...</td>
<td>And more...</td>
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Let’s start at the very beginning: admission medication history

• Medications are a leading cause of adverse events among hospitalized patients1,2
• Studies show:
  • Up to 60% of inpatients will have at least one medication discrepancy in their admission medication history2,3
  • More than 40% of medication errors are believed to result from inadequate reconciliation at transitions of care4,5
  • Of these errors, about 20% are believed to result in harm
  • The Match study found that over one-third of patients had a medication error at admission, and of those 85% had errors that originated in the admission medication history6
• These errors are of particular concern since they are unlikely to be detected by CPOE systems
Let’s start at the very beginning: admission medication history

• Medication histories are a vital part of the admission assessment in order to:
  • Identify potential drug-related pathologies as the cause for hospital admission
  • Detect drug interactions with new medications initiated inpatient
  • Identify poly-pharmacy
  • Prevent interrupted or inappropriate drug therapy during hospitalization
  • Avoid confusion at discharge
    • Errors on admission histories are often perpetuated at hospital discharge

Let’s start at the very beginning: admission medication history

• Barriers to obtaining an accurate medication history
  • Patient unable to report a complete and/or accurate history
    • Altered mental status, dementia, poor historian
    • Unconscious or sedated
    • Intubated
    • Didn’t bring medication bottles or a list
  • Inability to communicate effectively
    • Poor health literacy
    • Language or cultural barriers
  • Time constraints and competing priorities
  • Hours of operation of pharmacies and PCP offices may limit ability to confirm medication lists

Let’s start at the very beginning: admission medication history

• Resources to help with obtaining medication histories
  • Outpatient pharmacy
  • Family members and friends
  • MAR if patient presents from a facility
  • Prescription Drug Monitoring Program (PDMP)
  • Insurance billing or claims data (if supported by your EMR)
  • Previous discharge medication lists
  • Primary Care Provider
  • Pharmacists are medication experts, prioritize accurate medication information, and have the expertise to utilize these resources well making them ideal for involvement in medication history taking

Let’s start at the very beginning: admission medication history

• Pharmacy involvement in medication history collection
  • Pharmacists obtained medication histories
    • Patients admitted through Emergency Department Monday through Friday 10 am to 6 pm
    • Patients in an intensive care unit or on a rounding service covered by a clinical pharmacy specialist
    • Pharmacy students on rotation
  • Education provided by pharmacists to medical residents at Noon Conference
  • Readmissions Committee
    • Multidisciplinary team looking at every readmission for targeted disease states to identify solutions to prevent future readmissions
    • “Meds to Beds” program
      • Initial emphasis on cardiology floor for heart failure patients
      • Now rolling out to additional areas

Pharmacy involvement in medication history collection

• Process:
  • Emergency department: One staff pharmacist and one clinical pharmacy specialist will collect medication histories on patients prior to admission
  • Inpatient floors and intensive care units: Patients covered by pharmacy rounding service or in an ICU will have admission medications reviewed and medication history will be performed if needed or by physician consult
  • Education:
    • Pharmacy students perform medication histories for all patients being prospectively monitored
    • Noon conference on medication history taking and medication reconciliation provided to medical residents by a clinical pharmacy specialist

Pharmacy involvement in medication history collection

• Issues with service establishment:
  • No additional personnel or funding provided to establish services
  • Establishing a work space in a busy and already crowded Emergency Department
  • Limited coverage hours:
    • Emergency Department pharmacists (Monday through Friday 10 am to 6 pm)
    • Clinical Pharmacy Specialists (Monday through Friday day shift – hours vary by service line)
  • Inconsistent student volumes on rotation
  • Barriers to obtaining medication histories consistent with common barriers previously discussed
Readmissions Committee

- **Process:**
  - Multidisciplinary team reviews all readmissions for targeted disease states
  - Cases evaluated for avoidable contributing factors and trends
- **Common Issues:**
  - Readmission for unrelated problem driving up readmission rates for targeted disease states
  - Unavoidable contributing factors identified
    - Nonadherence to medications despite education/counseling
    - Lack of follow-up despite appointments made prior to discharge
    - Financial barriers
  - Little physician engagement at meetings

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Objective: Examine the specific role and identify the contributions of pharmacists in multi-disciplinary Transitions-of-Care Rounds

Background

- UAB Hospital is an 1150-bed major academic medical center located in Birmingham, AL
- The institution has recently refocused efforts on reducing length of stay, preventing readmissions, and improving transitions of care

Transitions of Care Rounds

- Service-based, multidisciplinary, sit-down rounds
- Primary interaction is between **bedside nurse** and **provider**
- Other disciplines include
  - Social Work
  - Case Management
  - Pharmacy
  - PT/OT
- Focus on “Estimated Date of Discharge” and potential barriers
- Scripted-approach
- Goal = Talk about every patient on the unit (~28-30 patients) in less than 30 minutes

Transitions of Care Rounds – Roll Out

- First implemented in the hospitalist units
  - Best correlation between “unit” and “service”
- Slowly expanded to other units
- About 8-10 months between initial roll-out and implementation on teaching services

Pharmacist’s Role in TOC Rounds

- Focus on discharge and potential barrier
- Pharmacists as a resource
- Two main points of input
  - Anticoagulation Plans
  - IV Antibiotics Plan
Objective: Describe the key components of a pharmacy-led discharge counseling service

Transitional Care Services at Baptist Medical Center South
- Pharmacy driven medication history collection
  - Utilizes pharmacists and pharmacy-LPNs
- Anticoagulant specific “Meds to Beds” program
  - Attempting to provide a free 30-day supply of anticoagulants/antiplatelets to patients prior to discharge
- Discharge medication counseling provided by pharmacists
  - Utilize pharmacists to counsel patients who are determined to be at a high risk for readmission

Pharmacy Driven Medication History Collection
- Goal:
  - Collect an accurate medication history in a timely fashion on every patient being admitted into the hospital. This should include all medications (OTC, Rx, etc.) a patient is prescribed or currently taking.
- Process:
  - Emergency room: LPN’s will collect medication histories on patients prior to admission
  - Inpatient floors: Pharmacists and LPNs will collect medication histories on patients not seen by LPNs in the ER
  - Interview the patient/family/caregivers, review pill bottles, review insurance billing information as available, and call patient pharmacies/SNF/physicians as needed to clarify any medications or their directions

Medication History Collection
- Common Issues:
  - Patients/family members/caregivers not knowing the patient’s medications
  - Inability for staff to contact pharmacy (weekends, nights, VA, etc.)
  - Physicians not updating active orders once an accurate medication history has been obtained

“Meds to Beds” Program
- Goal:
  - Provide all patients being prescribed an anticoagulant or antiplatelet medication a 30 day supply for free prior to discharge.
- Process:
  - Daily report provided to case managers that identifies which patients have been prescribed a targeted medication
  - Rx obtained for the medication and given to onsite retail pharmacy
  - Utilize assistance programs or 30-day free discount cards from drug companies to cover cost of the medication
  - Deliver medication to the patient prior to discharge or have patient/family member go by retail pharmacy on the way out of the hospital

“Meds to Beds” Program
- Common Issues:
  - Getting Rx early enough in the discharge process to get filled by retail pharmacy prior to patient leaving hospital
  - Patients being discharged and not getting medication from onsite retail pharmacy (i.e. discharged after retail pharmacy has closed, staff not following protocol to get Rx filled or delivered to patient)
  - Ensuring process is being followed through for all patients
Pharmacist Discharge Counseling

• Goal:
  • Review discharge orders and provide discharge counseling to patients at high risk for readmissions

• Process:
  • Identify patients at high risk for readmission or who have been diagnosed with targeted disease states
  • Review discharge orders
    • Appropriateness, renal adjustments, drug interactions, etc.
  • Clarify any discrepancies with physicians
  • Provide written and verbal education to patients as able

• Common Issues:
  • Time constraints
    • Patients are anxious to leave the hospital
    • Hospital tries to be very efficient moving patients out once they have discharge orders to free up the bed
  • Patient education/engagement levels
  • Physician compliance
    • Physicians may not correct orders per pharmacy recommendation prior to discharge
    • Physicians may not adjust orders in a timely fashion and the patient is discharged before corrections are made

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Objective: Explain the role of a medication expert performing transitional care services in an outpatient, interprofessional setting

Requirements for billing

• TCM codes:
  • 99495: Moderate Complexity, 14 days of discharge
  • 99496: High Complexity, 7 days of discharge
  • Communication (direct contact, telephone, electronic) with the patient and/or caregiver within 2 business days of discharge
  • Face-to-face visit within 14 days
  • Must furnish medication reconciliation by face-to-face visit

Outpatient Transitional Care Services – Past Experience

• Family Medicine Clinic with East Tennessee State University
  • Rural-based primary care residency program
  • Underserved and indigent patient population
  • 18 residents, 4 full-time faculty physicians
  • Clinical staff and learners from multiple fields

• Interprofessional visits
  • 1 full day a week, 12 patients, 40 minute visits
  • Social worker did discharge phone-call
  • Dedicated room for Transitions of Care (TOC) team

Reimbursement in Alabama

<table>
<thead>
<tr>
<th>HCPCS Code</th>
<th>Fee for Non-Facility</th>
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<tbody>
<tr>
<td>99213</td>
<td>$68.71</td>
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<tr>
<td>99214</td>
<td>$101.39</td>
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<tr>
<td>99215</td>
<td>$136.70</td>
</tr>
<tr>
<td>99495 (within 14 days)</td>
<td>$153.83</td>
</tr>
<tr>
<td>99496 (within 7 days)</td>
<td>$217.76</td>
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Outpatient Transitional Care Services – Past Experience

• Pharmacist role before TOC visit
  • Review discharge paper work prior to visit
  • Reconcile medications (minimum of 3 sources)
    • Discharge list
    • Clinic records
    • Pharmacy
    • Patient (bottles etc.)

• Pharmacist role during visit:
  • Face-to-face interview of pt with behavioral health
  • Assist in medication changes and recommendations

Barriers to Starting TOC services

• 4 hospital systems in Mobile and we are not notified of patient being hospitalized unless they are on our service at USA Medical Center
  • Need to collaborate with hospitals in the area to improve transitional care at discharge
• Little physician buy-in, with high Medicaid population, hard to justify cost savings
• Hospital follow-up visits are treated like any other visit (follow-up, acute care, etc.)
• Relies on APPE students to have full coverage

Questions?

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References