Transitions in Care
Best Practices Models:
Case Studies in Pharmacy Practice

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- The content of this presentation was created by the presenters and does not necessarily reflect the views of Baxter Healthcare Corporation.
- Our speakers have accepted an honorarium from Baxter for this presentation.
About Our Speaker

Desi Kotis, PharmD

- Desi Kotis, PharmD, is the Director of Pharmacy at Northwestern Memorial Hospital in Chicago. She is responsible for clinical leadership development, teaching post-graduate pharmacy students in administration advanced clerkship with a clinical focus on Prentice women’s hospital and gynecologic oncology patients and training new clinical pharmacists and pharmacy technicians.
- Desi assisted in integrating CPOE, automated MAR, BCMA for the pharmacy department with a primary responsibility for the integration of the automated dispensing machines in the critical care, medicine, oncology, and the medical/surgical units. She serves as Co-head of implementation of the HIV ambulatory care clinic, ICU, transplant, and medicine pharmacists. Desi serves as a member of the Board of Directors for the Illinois Council of Health-System Pharmacists. She currently serves as Vice-Chair of the UHC (University Health Care Consortium) Pharmacy Strategic Initiative. Desi holds faculty appointments at Schools of Pharmacy in the state Illinois as well as colleges of pharmacy at Purdue University and Drake University.

About Our Speaker

Michelle Thoma, RPh, PharmD

- Michelle Thoma, RPh, PharmD is Pharmacy Manager, Ambulatory and Transitional Patient Care Services, Compliance and Quality Improvement Officer at the University of Wisconsin Hospital and Clinics, and Clinical Instructor with the UW School of Pharmacy. Michelle received her Bachelors and Doctor of Pharmacy degrees from the University of Wisconsin at Madison.
- She is responsible for managing patient care pharmacy services throughout ambulatory care, including primary care and specialty clinic sites and infusion center services, as well as serving as the administrative pharmacy director over the transplant and neurosciences service line. Michelle coordinates department and organization wide regulatory compliance and quality improvement initiatives. Michelle is an active member of the Pharmacy Society of Wisconsin, American Society of Health-System Pharmacists, the Wisconsin Department of Health Services Mental Health Drug Advisory Board and the University Health System Consortium’s Pharmacy Performance Improvement & Compliance Committee.
Objectives

- Define the current barriers to successful transitions of care.
- Describe the role of the pharmacist in various transitions of care models.
- Discuss the impact of transitions of care programs on medication safety and hospital readmission rates.
- Identify best practices for transitions of care that could be implemented at your institution.

Agenda

- Increased Scrutiny on Readmissions
- Understanding Key Drivers of Readmissions
- Implementing a Targeted Set of Interventions
- Pharmacist Involvement in Program
- Examples of Pharmacist Interventions
- Program Results
Why?

- Health care costs rising faster than Consumer Price Index\(^1\)
- United States has highest per capita spending\(^2\)
- Public disclosure of readmission rates in future
- Lower case payments for readmissions\(^3\)

3. Centers for Medicare and Medicaid Services:. Readmission Reduction Program. www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/
How Much Is “At Risk”?  

- Annual revenue forfeited with 30-day readmission rates greater than benchmark  
- Organizations with a large Medicare volume  
  - 3% reduction: $3.1M-$4.7M  
- Organizations with typical Medicare volume  
  - 3% reduction: $1.0M-$2.1M  


Readmissions/Transitions in Care  

- Failed transitions lead to substantial costs, morbidity, mortality, and reputational risk.  
- Nearly 1 in 5 patients experience an adverse event during transition from the hospital to home.  
- In one analysis, almost half of patients discharged from hospitals had lab results still pending and 12.6% required urgent action.  

Hospital Discharge Needs Redesign

- 49% of hospitalized patients experience at least one medical error in medication continuity, diagnostic work-up, or test follow-up.8
- Patients surveyed at discharge: 9
  - 27.9% were able to list all their medications
  - 37.2% were able to state the purpose of their medications
  - 14% were able to state common side effects of their medications

Learning by Doing

I hear and I forget;
I see and I remember;
I do and I understand.

-Chinese Proverb
Learning by Doing

- Teach Back
  - An active form of learning
  - Provides a highly effective introduction to a subject
  - Repetition and reinforcement
    - To master new information, adult learners must have the opportunity to practice multiple times over an extended period of time.

Master New Information

- Assume new self care responsibilities
- Monitor and respond to new or evolving symptoms
- Understand the disease process

Effective Outpatient Care

- Timely follow-up with PCP
  - National guidelines for heart failure—no timeframe
  - High risk patients may benefit from follow-up within 24 hours
  - All patients have follow-up within 7 days

Effective Outpatient Care

- Medication Reconciliation
- Over 1/3 of patients have errors on admission
  - Half required increased monitoring
  - 10% harmful
  - 49% omission error, 30% wrong dose, 11% wrong frequency
- Elderly and those on large numbers of medications are at increased risk
- Medication list may avoid error
Problem for a Long Time


- Continuity of patient care between different health care settings has been advocated for nearly 20 years, but little has been done to affect it.\(^\text{11}\)
- This study emphasized the current lack of effort by health care providers in hospitals and nursing homes to find a workable solution.\(^\text{11}\)


National Intiatives\(^\text{12}\)

- BOOST (Better Outcomes for Older Adults Through Safer Transitions)
- RED (Re-engineered Hospital Discharge)
- STAAR (State Action on Avoidable Rehospitalizations)
- Care Transitions
- Evercare
- TCM (Transitional Care Model)

National Initiatives

- Interdisciplinary Team
- Tools and Training for Discharge
- 7-day Post-Discharge Plan

Northwestern Memorial Hospital

- Strategic Plan: Provide the highest quality, most effective and safest care.
- Problem Statement: During Q2 FY10, 18 med/surg/heme-onc patients per day were readmitted within 30 days of discharge as unscheduled inpatients.
  - Readmission rate of 15%
Northwestern Memorial Hospital

- 30-day Medicare readmission rates, 2006-2009:
  - AMI  21.6%
  - HF   27.4%
  - PN   23.1%

Northwestern Memorial Hospital

- Goal:
  - By Q4 2011 reduce 30-day unscheduled NMH readmission rate below 21.4% for Medicare patients with AMI, HF, PN.
  - Improve patient satisfaction with the discharge process.
System Deliverables

- Restructure hospital discharge transition process
- Reorganize responsibilities
- Utilize revised electronic record forms and notes
- Improve hospital to outpatient physician communication
- Enhance patient and caregiver education
- Perform outreach follow-up phone calls to patients after discharge

Team-Based Care

- Physician
- Nurse
- Pharmacist
- Social Worker
## Increased Scrutiny of Readmissions

### CMS High Readmission Hospital List

<table>
<thead>
<tr>
<th>Provider Number</th>
<th>Hospital Name</th>
<th>City</th>
<th>State</th>
<th>ZIP Code</th>
<th>County Name</th>
<th>30-Day Readmission Rate</th>
<th>Discharges</th>
</tr>
</thead>
<tbody>
<tr>
<td>12345</td>
<td>ABC Hospital</td>
<td>Chicago</td>
<td>IL</td>
<td>60606</td>
<td>Illinois</td>
<td>10%</td>
<td>1000</td>
</tr>
<tr>
<td>67890</td>
<td>XYZ Hospital</td>
<td>New York</td>
<td>NY</td>
<td>10001</td>
<td>New York</td>
<td>12%</td>
<td>1200</td>
</tr>
</tbody>
</table>

### Projected Medicare Payment Penalty Based on Baseline Readmissions Performance

<table>
<thead>
<tr>
<th>Year</th>
<th>Penalty</th>
</tr>
</thead>
<tbody>
<tr>
<td>2010</td>
<td>1%</td>
</tr>
<tr>
<td>2013</td>
<td>2%</td>
</tr>
<tr>
<td>2015</td>
<td>3%</td>
</tr>
<tr>
<td>2020</td>
<td>4%</td>
</tr>
</tbody>
</table>

- CMS authorized to start penalizing for excess heart failure, pneumonia, and AMI readmissions
- CMS plans to withhold payments for excess COPD, CABG, and PCI readmissions

## Understanding Key Drivers of Readmissions

### Patient Fills Rx at Pharmacy

- Access to medications not a problem, but compliance with regimen concerning

### Patient Takes Medication

- Concerning rate

### Patient Attends Outpatient Appointment

- Patients unable to attend appointments as they readmit prior to the scheduled date

### Patient Monitors Signs/Symptoms

- 15% visited the MD in person; 85% called the office

### Raw Readmission Survey Results

<table>
<thead>
<tr>
<th>Interview Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Did you have a caregiver at home?</td>
<td>65.4%</td>
<td>34.6%</td>
</tr>
<tr>
<td>Did you have difficulties with ADLs?</td>
<td>34.6%</td>
<td>65.4%</td>
</tr>
<tr>
<td>Did you receive Rx?</td>
<td>87.0%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Were you able to pick up your Rx?</td>
<td>100.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>Did you understand the reason(s) for the Rx?</td>
<td>95.2%</td>
<td>4.8%</td>
</tr>
<tr>
<td>Did you take the Rx?</td>
<td>90.0%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Did your MD recommend OP follow-up?</td>
<td>75.0%</td>
<td>25.0%</td>
</tr>
<tr>
<td>Did your MD schedule the appointment for you?</td>
<td>45.0%</td>
<td>55.0%</td>
</tr>
<tr>
<td>Did you attend your appointments?</td>
<td>36.8%</td>
<td>63.2%</td>
</tr>
<tr>
<td>Were you educated on warning signs?</td>
<td>79.2%</td>
<td>20.8%</td>
</tr>
<tr>
<td>Prior to your admission did you visit or call your MD?</td>
<td>60.0%</td>
<td>40.0%</td>
</tr>
</tbody>
</table>
Pilot Program: Implementing a Targeted Set of Interventions

1. Assess Discharge Planning Needs & Coordinate Care
   - SW completes psychosocial assessment and identifies discharge barriers within 24h of admission and confirms prior to discharge (placement, caregiver, home care, etc.)
   - CF initiates discharge ‘checklist’ upon admission.

2. Conduct Patient Education Promoting Self-Management
   - 1:1 pharmacy education for identified patients (high risk, X-ray meds, etc.)
   - 1:1 nursing education using teach-back

3. Securing Follow-up Appointment/Placement
   - CF ensures that follow-up appt is scheduled for within 72 hours of discharge
   - Hospitalist provides succinct discharge summary to PCP, supported by verbal communication prior to discharge

4. Perform Revised* Discharge Follow-up Phone Calls
   - CF calls patient 48 hours post-discharge to confirm follow-up appt attendance, discuss other clinical/social issues or follow-up care (continued care coordination post-discharge)

Inpatient Transition Bundle

Primary Ownership: Care Facilitator / Social Worker
- SW completes psychosocial assessment and identifies discharge barriers within 24h of admission and confirms prior to discharge (placement, caregiver, home care, etc.)
- CF initiates discharge ‘checklist’ upon admission.

Primary Ownership: Hospital MD / Care Facilitator
- CF ensures that follow-up appt is scheduled for within 72 hours of discharge
- Hospitalist provides succinct discharge summary to PCP, supported by verbal communication prior to discharge

Primary Ownership: Bedside RN / Inpatient Pharmacist
- SW completes psychosocial assessment and identifies discharge barriers within 24h of admission and confirms prior to discharge (placement, caregiver, home care, etc.)
- CF initiates discharge ‘checklist’ upon admission.

Primary Ownership: Care Facilitator / Inpatient Pharmacist
- SW completes psychosocial assessment and identifies discharge barriers within 24h of admission and confirms prior to discharge (placement, caregiver, home care, etc.)
- CF initiates discharge ‘checklist’ upon admission.

Pharmacist Involvement in Pilot Program

Patients admitted to Telemetry Unit (15E/15W) during May – August 2011

Physician to assess patient and contact pharmacist if medication issue is identified

Care Facilitator to assess patient and contact pharmacist if medication issue is identified

Pharmacist is contacted – performs medication history, medication education, and disease state education

Upon discharge, pharmacist gives patient medication chart and provides a second discharge counseling session

Pharmacist performs 48-hour post-discharge telephone call to patient’s home and reviews discharge instructions, outpatient primary care physician appointments, and medication knowledge and compliance

Outpatient dispensing pharmacy is contacted if access to medication is a problem
Examples of Pharmacist Interventions

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Intervention Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication Reconciliation</td>
<td>Physician ordered Flecainide 100 mg Daily per patient medication history list. Pharmacist noticed this unusual order since flecainide is usually not a daily medication. Pharmacist spoke to physician who asked the pharmacist to see patient for medication education. Pharmacist asked patient about his flecainide dose. Pt stated he takes flecainide 100 mg twice a day. Pharmacist notified MD and order was changed to the correct home dose. Pharmacist proceed with medication education for all of the patient’s home medications.</td>
</tr>
<tr>
<td>Post-Discharge Callback</td>
<td>Upon post-discharge callback, patient stated he did not receive his fenofibrate (Tricor®) prescription (Triglycerides &gt;500) from his local Walgreens. Pharmacist called the patient’s Walgreens to verify that the prescription was not written. Walgreens looked at the scanned prescription and realized that they forgot to type in the prescription (there were 3 prescriptions on 1 prescription paper). They will process the prescription now. Pharmacist then called pt back and he agreed to go back to Walgreens later that day to pick up his fenofibrate prescription.</td>
</tr>
<tr>
<td>Prevention of Adverse Event</td>
<td>Pharmacist was contacted for medication education. Upon speaking to the patient, the pharmacist discovered that the patient’s levetiracetam (Keppra®) was not ordered. Per patient, he last had seizures 3/2011 due to medication non-compliance. Patient was counseled on the importance of taking his medication twice a day and the deleterious effects of seizures. The pharmacist called patient’s Walgreens and the patient’s wife to verify dose of levetiracetam. Physician was contacted for medication order. Medication counseling was also provided to patient’s wife.</td>
</tr>
</tbody>
</table>

Pilot Program Results

<table>
<thead>
<tr>
<th>Outcome Metric: Capacity</th>
<th>Metric</th>
<th>Baseline (Q4 FY10)</th>
<th>Goal (FY11)</th>
<th>15E / 15W Pilot</th>
<th>Variance from Goal</th>
</tr>
</thead>
<tbody>
<tr>
<td>Readmission Rate 30-day Acute Myocardial Infarction (AMI), Medicare only</td>
<td>19% ([n = 3/16])</td>
<td>19%</td>
<td>14%* ([n = 3/22])</td>
<td>-5 pp</td>
<td></td>
</tr>
<tr>
<td>Readmission Rate 30-day Heart Failure (HF), Medicare only</td>
<td>27% ([n = 21/79])</td>
<td>24%</td>
<td>24%* ([n = 25/104])</td>
<td>0 pp</td>
<td></td>
</tr>
<tr>
<td>Readmission Rate 30-day Pneumonia (PN), Medicare only</td>
<td>18% ([n = 2/11])</td>
<td>17%</td>
<td>4%* ([n = 1/23])</td>
<td>-13 pp</td>
<td></td>
</tr>
<tr>
<td>Avoidable Days Number of Avoidable Days Attributed to Patient, Care Team, Hospital</td>
<td>31.67 days (66% of total)</td>
<td>30 days</td>
<td>25 days*** (50% of total)</td>
<td>-5 days</td>
<td></td>
</tr>
<tr>
<td>Average Length of Stay (inpatient ALOS (Days))</td>
<td>4.6 &lt; Baseline</td>
<td>4.4*</td>
<td>N/A</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Outcome Metrics: Patient Satisfaction

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline (Jan-May 11)</th>
<th>UHC Top Decile</th>
<th>15E / 15W Pilot</th>
<th>Variance from Baseline</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient Satisfaction (Press Ganey)</td>
<td>% VG Extent felt included in decisions about treatment</td>
<td>59%</td>
<td>62%</td>
<td>63%**</td>
</tr>
<tr>
<td></td>
<td>% VG Extent felt staff worked together to care for you</td>
<td>71%</td>
<td>62%</td>
<td>78%**</td>
</tr>
<tr>
<td></td>
<td>% VG Discharge overall</td>
<td>64%</td>
<td>62%</td>
<td>69%**</td>
</tr>
<tr>
<td></td>
<td>% VG Extent felt ready for discharge</td>
<td>69%</td>
<td>62%</td>
<td>72%**</td>
</tr>
<tr>
<td></td>
<td>% VG Instructions care at home</td>
<td>66%</td>
<td>66%</td>
<td>73%**</td>
</tr>
<tr>
<td>Patient Satisfaction (HCAHPS)</td>
<td>Discharge Information Domain</td>
<td>52%</td>
<td>66%</td>
<td>82%**</td>
</tr>
<tr>
<td></td>
<td>Communication about Medicines Domain</td>
<td>52%</td>
<td>66%</td>
<td>76%**</td>
</tr>
</tbody>
</table>

*Data from 5/2 through 9/14 (reporting period) | **Data from 5/2 through 7/27 (n = 70 surveys from patients discharged between 5/2 and 8/31) | ***Data from 5/2 through 6/30 (per Case Management documentation) | Outcome metrics have been calculated in the aggregate for all patients discharged from both 15E and 10W. | Baseline and Pilot Patient Satisfaction performance based on discharge date of patients (not survey received date).
Transitions of Care: The First 30 Days

- Period of time following discharge from the hospital is a vulnerable time for patients
- About half of adults experience a medical error after discharge
- 19-23% suffer an adverse event, most commonly an adverse drug event
- Transition of care helps to decrease the disconnect from the hospital to the post-acute settings
  - Better communication between providers
  - Effective medication reconciliation
  - Adequate patient education about medication use
  - Closer medical follow-up

Pharmacists and Successful Transitions

- Pharmacist services are needed more than ever!!
- It is well established that pharmacists are critical members of the healthcare team and this will become even more apparent in the future for hospitals and/or health-systems
- Pharmacists bring value by being the medication expert
- Pharmacists are well trained on evidence-based literature, which is necessary for sustainable changes
- Pharmacists are cost-conscious
  - Being very creative in times of unsurpassed drug shortages
- Pharmacists understand and embrace the patient-centered approach

Lit. #111768    07/12

Barriers to a Successful Transition

- Fragmented health care systems, difficult to obtain documentation standards throughout the continuum of care
- Few “plug-and-play” models for medication reconciliation, organizations design and implement custom procedures for their institution (making it difficult to “transfer” information between organizations)
- Lack of trained and competent individuals available to complete medication histories and reconciliation
- Organization and patient financial resources lacking which impacts reconciliation, adherence strategies

Lit. #111768    07/12
Overcoming Barriers: UWHC Strategies

- Effective Medication Reconciliation
  - Perpetual; Performed by trained and competent individuals (including technicians!)
- Post Discharge Medication Adherence Tactics
  - Project RED, UWHC primary and specialty care call back programs
  - First dose teaching/early education
- Transitional Care Specialists
  - A new role for pharmacy technicians

Medication Reconciliation

- Studies have clearly shown the patient safety issue with medication discrepancies
  - In one study, significant discrepancies were found in 25% of patients’ medication histories and admission medication orders
  - A study utilizing 12 years of data determined that patients prescribed chronic medications were at higher risk for unintentional discontinuation following hospital discharge
    - If patient had an ICU stay during the hospitalization, the risk of medication discrepancies increased even more

References:

Medication Reconciliation

- Implementation of a sound medication reconciliation program can reduce medication errors at discharge by approximately 50%\(^\text{15}\)
- Thoughtful and methodical approach leads to improved outcomes
- Pharmacists and technicians do it BEST!


UWHC Medication Reconciliation

- Performed by decentralized, integrated pharmacist teams and pharmacy students/technicians with oversight
- All inpatients have a medication history and full reconciliation completed within 24 hours of admission and is part of daily profile monitoring
- Inpatients have reconciliation performed by the pharmacist at D/C
- Pharmacists staffing in primary care and specialty clinics perform medication reconciliation with each visit
- Sources of Information
  - Electronic Medical Record
  - Patient, family members
  - Outside facility records (hospitals, SNF)
  - Local pharmacy
  - Past discharge summary

Lit. #111768  07/12
A Great Role for Technicians

- Pharmacy technicians attempt to call approximately 50% of planned surgical cases on the day prior to admission
  - 5 hours per day, estimated 0.67 FTE; complete an average of 12 histories per day
- Benefits
  - Enhanced productivity of nurses, pharmacists, physicians
  - Reduced costs to organization
  - Prescreen for non-formulary, multi-dose medication needs prior to admission

Project RED: Re-Engineered Discharge

- Boston University Medical Center and grant supported through Agency for Healthcare Research and Quality and the National Institutes of Health
- Strategies to improve hospital discharge process that promotes patient safety and reduces re-hospitalization rates
- Implemented 11 elements of practice shown to reduce re-hospitalizations

Key Components of RED\textsuperscript{16}

- Educate the patient
  - Diagnosis, treatment options
- Follow up
  - Post discharge appointments/tests
  - Procedures/evaluations
- Reconciliation of discharge plan
  - National guidelines, critical pathways
- Problems?
  - Who to call


Lit. #111768  07/12

Key Components of RED: Meds!\textsuperscript{16}

- “Confirm the medication plan”
  - Discharge medication reconciliation: Actively reconcile prior to admission medications, medications taken during the hospital stay and those prescribed at the time of discharge
  - Patient education
    - Teach the patient about changes
    - What the medication “plan” is
    - Review medication’s indication, the schedule, and what side effects to look out for…and how the patient can monitor for effectiveness
    - Assess the patient’s understanding
      - Teach back!!!
- Communicate the plan to everyone, everywhere


Lit. #111768  07/12
Key Components of RED

- Post Discharge Assessment
  - Patient can name strength, route, frequency
  - Is patient taking?
    - If no, is MD aware?
    - If no, patient error?
    - If no, system error?
  - Does patient/caregiver understand indication of medication?
    - Educate if no
  - Any side effects?
    - Educate on how to manage
  - Check for drug-drug, drug-food, drug-disease interactions
    - Interventions are documented

UWHC Post Discharge Call Back

- Review medication reconciliation, medication adherence plan, patient’s comprehension of medication plan, comprehensive profile review, enrollment in mail order program, medication assistance program(s); referral to medication therapy management services
- Post Abdominal Transplant (0.4 FTE)
  - Part of interdisciplinary clinic, calls made two weeks post transplant OR patient is seen by pharmacist at post-discharge follow up appointment
- Primary Care (0.8 FTE): Implemented Feb, 2012
  - Risk Stratification
    - 4 or more chronic medications and/or discharged on IV antibiotic therapy
    - Reason for hospitalization: 2 or more of the following acute exacerbations and/or chronic disease states (CHF, Pneumonia, COPD, myocardial infarction, diabetes)
Primary Care Call Back Results

<table>
<thead>
<tr>
<th>Clinic Days</th>
<th>Total Number of Patient Profiles Reviewed</th>
</tr>
</thead>
<tbody>
<tr>
<td>83</td>
<td>370</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of UW Health Clinics Served</th>
<th>New Patients Reviewed per Day</th>
</tr>
</thead>
<tbody>
<tr>
<td>24</td>
<td>5.6</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Number of UW Health Primary Care Providers Served</th>
<th>Total Number of Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td>103</td>
<td>947</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Interventions per Patient</th>
<th>Interventions per Patient (exclude Follow-Up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.6</td>
<td>1.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Recommendation Status</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accepted</td>
<td>257</td>
</tr>
<tr>
<td>Rejected</td>
<td>34</td>
</tr>
<tr>
<td>Pending</td>
<td>29</td>
</tr>
</tbody>
</table>

Acceptance Rate: 88%

Primary Care Results

Pharmacist Interventions in Primary Care

<table>
<thead>
<tr>
<th>Type of Intervention</th>
<th>Number of Interventions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[Graph showing the distribution of pharmacist interventions by type]
Medication Adherence

- Approximately $290 billion of healthcare expenditures could be avoided each year with improved medication adherence.
- Strategies to increase medication adherence include:
  - Medication regimen simplification
  - Identifying if medications are cause for symptoms, problems
  - Medication education, tailored for patient and caregiver
  - Hospital pharmacist and community pharmacist hand-offs


Adherence Assessment

- Therapeutic drug levels
  - UWHC pharmacists may order under protocol
- Measurement of physiologic markers
  - Blood pressure, blood glucose, INRs, etc
- Patient self report/diaries
- Pill counts/prescription refill frequencies
  - Reporting capabilities through mail order and medication therapy management programs
Inpatient First Dose Teaching

- More counseling opportunities for students, increased patient interaction early on during the stay
  - Encouraging teach back methods
- Increased awareness for pharmacy and current transitional care pharmacy services (discharge specialist, mail order, primary care MTM services)
- Outcomes measured: Patient Satisfaction and HCAHP surveys results: “Did you receive counseling for all first-doses/new medications while in the hospital?”

First Dose Teaching

- After first dose and teach back training, fourth year pharmacy students complete a minimum of 40 patient counseling interactions focused on “first-dose teaching” under the supervision of an inpatient pharmacist over an 8-week period
- Students assess patient profiles daily for new medications which will be continued at discharge
- Education documented in EMR (all disciplines can see which medications have been counseled on)
Results: First Dose Teaching

- 11 students participated
  - Counseling occurred with 374 unique patients
  - 481 “first dose counseling” episodes documented as completed by the pharmacy technician
  - Most frequently counseled medications
    - antibiotics
    - beta blockers
    - warfarin
- Outcomes assessment in progress

Pharmacy Specialist Transitional Care

- Objectives/Goals of the Position
  - Expansion of the Medication Assistance Program (MAP), Medication Prior Authorization Coordinator (MPAC) positions, and Discharge Medication Specialist position
- Outcomes Measured
  - Multidisciplinary workload/productivity
  - Patient and staff satisfaction
Conclusions

- Employ multiple strategies when striving for successful transitions of care
  - Medication reconciliation a must at all interfaces of care
  - Be creative in the way you utilize students and technicians
  - Learn from the success of others
References


We Welcome Your Questions

- You can submit questions throughout the webinar using the form on your screen
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- The views and opinions expressed during the question and answer session are those of the individual presenters and should not be attributed to Baxter