Integrating Pharmacist Support for Thriving in Place Home Health Program*

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Objectives

To demonstrate **patient-centered**, **sustainable**, **transferable** and **high quality medication management** services provided by an **independent pharmacist consultant** in **under-served community primary care practices and pharmacies** who cannot otherwise afford experienced clinical pharmacist support, making positive contribution to population health. Patients must have two or more chronic diseases and wish to remain home based.

Methods

1) **Collaborative practice agreement (CPA) with a primary care practice**: opiate weaning, chronic pain, metabolic syndrome, cardiology, evolution into polypharmacy, A1C, BP reduction to comply with MACRA, CQM/meaningful use.
2) **Collaborative public health event(s)** in which increased participation of community pharmacists performing clinical interventions lead to improved outcomes, launched during Fall Prevention Week, Sept. 19 to 25, 2016, follow-up spring 2017.
3) **Hospital based collaborative drug therapy management**: explored pharmacist provision of comprehensive medication management (CMM) to multiple primary care practices for complex patients.

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Results

Primary Care Practice: Pain clinic patients had opioid dosages reduced significantly:

(**43.3% Morphine Sulfate Equivalent (MSE) reduction collectively in 30 patients in first 6 months**) without related ED/hospital admission or falling patient satisfaction scores.

Renewed smoking cessation attempt (8 of 11 smokers in chronic pain group), and

3 long-term institutionalizations prevented (8 months total to date @) $1,600/month to CMS in 2012 dollars) due to clinical turnaround resulting from pharmacist interventions (3).

Sustainability: extend pharmacist efforts as 'clinical staff' for chronic disease management reimbursement codes.

Fall Prevention Week (September 19-25, 2016) fall risk medication screening generated 100% participation of retail pharmacies in target communities using AHRQ Medication Screening Tool (4) for a *complete medication/supplement/herbal list*.

Valuation of interventions preventing probable adverse drug events was $279,109 for 25 patients (2015 US dollars) (1,2).

A similar repeat one day event has been requested by one of the project collaborators in a local hospital for April 3, 2017.

Hospital based CMM: initial interest by target area hospital, not pursued due to inadequate 'incident to' provider support.

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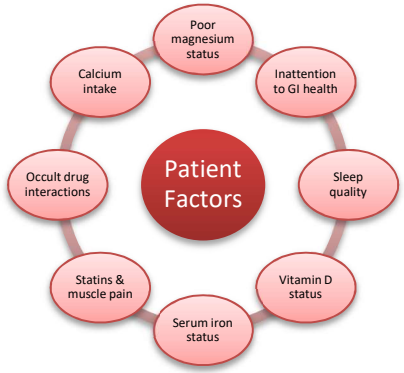
Clinical Issues Identified



Implications/Conclusions

Multi-modal integration of a consultant pharmacist into under-served ambulatory care can extend provider and pharmacist capabilities, improve healthcare delivery and patient outcomes, reduce cost and promote provider status.

References:
1)Burton MM et al, The cost of adverse events in ambulatory care, AMIA Annu Symp Proc, 2007 Oct 11:90-3.
2)CompareMaine, http://www.comparemaine.org/?page=report&procedure=27130, (Hip Replacement), last accessed 3/16/17
3) Marek, KD, Stetzer F, Adams SJ, Popejoy LL, Rantz M. Aging in place versus nursing home care: comparison of costs to Medicare and Medicaid, Res Gerontol Nurs. 2012 Apr;5(2):123-9
4) See https://www.ahrq.gov/professionals/systems/hospital/fallpxtoolkit/fallpxtk-tool3i.html. *Although primarily designed for hospitals, we found this to be ideal for ideal for initial screening in the community in a public health setting.*