A Starting Point

• In 2015 the local hospital was hit with a 1.48% reimbursement penalty
  • Heart Failure 25.5% (19.6%)
  • COPD 20% (20.76%)
  • Total Hip Replacement/Total Knee Replacement 7.4% (5.193%)
• Pilot study: 8 patients, 142 medications
  • 59 discrepancies
    • 17 medication omissions
    • 29 gaps in therapy
• Grant funding provided the necessary seed to get started
• Medications filled at discharge & delivered to patient*
• Disease state and medication education
• Medication reconciliation sent to primary care provider
• Reinforce adherence & education at Days 3, 7 and 25 post discharge

*For patients who also elect Realo as their pharmacy. All patients who elect service receive education, medication reconciliation and follow-up calls.

Establishing the Service

• Champions
  • Hospital Vice-President
  • Medical Director
  • Quality Innovation Network – Quality Improvement Organization (Alliant Quality)

• Business Associate Agreement
  • Granted electronic health record (EHR) access

• Multiple meetings to work out a protocol
  • In-service trainings for staff
  • IT department and legal
  • “Meet and Greet” with providers
  • Regular attendance at department meetings

• Message was important
  • Teamwork divides the task and multiplies the success
How It Works

• Included in admission query for every patient
  • Response is required to complete check-in
• Daily referral report sent to pharmacy
• Pharmacist has remote access to hospital EHR
• Pharmacy staff onsite every day (M-F) to assess referrals
  • Not all referrals are valid
• Patients are followed throughout stay
• Follow-up at 3, 7 and 25 days post discharge

Our Key Partners

• Hospital Administration
• Hospitalists
• Discharge planners
• Nurses – floor and emergency department
• Local free clinic
• Social workers
• Home health agencies

We all share the same goal!
Payment for Services

• No financial agreement with hospital

• Rx volume and referrals

• Hospital is part of accountable care organization (ACO)

• Providers in ACO are now partners for other services

• Transitional Care Management (TCM) codes have not been of interest to providers (yet!)

How Have We Done?

• What we track:
  • Total number of referrals
  • Known readmissions
  • Fill conversion
  • Retention (refill rates)

• Results:
  • 84 positive referrals in first 14 months
  • 1 known readmission
  • 152 new Rx
  • 56% retention rate *difficult to track across multiple stores; may be higher
FAQ

• No requirement to fill Rxs with our pharmacy
• Postgraduate Year 1 (PGY1) pharmacy resident is primary driver of program
  • Technicians, students also utilized
  • ~1 hr onsite, ~1 hr on follow-up calls
• Not disease-state focused
  • Initially just looked at heart failure, COPD and diabetes (county-wide priority)
  • Hospital staff requested we open to all patients
• We are dependent on hospital for data to validate

Conclusion

• First place a patient stops when leaving the hospital is the pharmacy

• But the community pharmacist is usually the last to know about medication changes

• How can you make a difference in your practice?
Panel Discussion
Mariel Shull, PharmD, BCACP
Diana Quach, PharmD, BCGP
Christina Nunemacher, PharmD, BCGP
Moderator: Addolorata M. Ciccone, PharmD, BCGP