Strategies for Successful Transition of Care Pharmacist Services

Christina Nunemacher, PharmD, BCGP
Clinical Pharmacist
Realo Discount Drug

2018 ASCP Annual Meeting & Exhibition
November 1-4, 2018
#SenioRx18

1

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

Community Pharmacy Foundation

2

TRANSITION TO WELLNESS

- 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.*

3

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

4

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

5

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!

6

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!)

7

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

8

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

9

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?

10

Panel Discussion

Mariel Shull, PharmD, BCACP
Diana Quach, PharmD, BCGP
Christina Nunemacher, PharmD, BCGP
Moderator: Addolorata M. Ciccone, PharmD, BCGP

11