Utilizing Inpatient and Outpatient Pharmacists during Hospital to Home Transitions in Care: A Critical Collaboration to Improve Medication Safety

Event ID: 2314792
Event Started: 2/18/2014 3:18:52 PM ET

What are those hospitals doing? These two bullet points are part of those. Anyone is welcome to contact me. In the justification documents only 50% of patients could state the name or purpose of their meds at the time of discharge and readmission rates more than double when the med discrepancies found after transition process. All that I don't think are too surprising that are important when you're doing the justification documents. And our appointment with the vision initiative is to improve the medication safety across the transition and we wanted pharmacists collaborating with inpatient and out should sit for so I do love the emoticons because they think they're very silly and funny. Next is the reconciliation of medication safety and what the pharmacist do anyway which is a fair question by the way. And whatever I sit in the room a few in a room so for me in the strictest stance and the word that means of the drug list is quote unquote correct meaning that came as an example so if Kim is taking two beta blockers then I will write that down and that is accurate and that is which is taking. I don't think that pharmacists ever do the reconciliation Mike it because the pharmacist would never walk away from a scenario or see somebody on a lot of acting medication three times a day and say nothing. So I think that whenever you have a pharmacists doing medevac that you also have someone providing education safety for you. The next piece the whole concept that the pharmacist is always drug-related and hours tell this to my students that will come back with what you think is going on with this patient and they come back with all these answers for what's going on then we can check to Doug fix it or give you drug and fix it and that's what we think will bring to the table. So when I talk about our pharmacist approval presentation be they inpatient, outpatient or what have you, them but there doing is the competence of medication review which is a lot of syllables to say for tenants. Every medication that we see we are checking is that medication indicated? Is it effective as a working for wanted to. Visit stay for the patient given the other disease states can actually get the axis call so that we can give of the guideline recommended stuff but if they're not interesting dedication we are not doing any good. So really pharmacists is about those poor things.

This gives you little bit of history about how we approached it and the title is long and huge and it was a big job and a large process and we did not just get there overnight. This is kind of a third step in three things that we did at Methodist. The first phase was just information gathering. We identified what could be the benefits. We looked at patients -- and this is a chart review -- but we looked at patients were older than 65 years and we found that they had an increase in the readmission for anybody you on more than eight chronic medications at discharge. When we had
pharmacists review these lists, these discharge medalists, the phone six things per patient that had flagged for them some kind of problem albeit the indication or the efficacy or the safety or access. And you can see that about 60% of the recommendations were qualified as being of the severity where it could have potentially caused adverse drug event. So not all of them but some of them. And the ones that were subacute if you will, things like adding calcium to patient hops or adding a multivitamin or things like that, changing to a generic drug would be good example of something that would not be considered ADE.

The second phase from the chart review that we did is that we looked at 35 patients I think all of this that we actually did a 35 patient prospective review the goal was to look at how with the pharmacist and the hospitals interact with each other. One, where the recommendations of the pharmacist could make out be of value? And two, if we have a pharmacist nicking these recommendations will that be accepted by the physician? Because you can talk all day but if the physicians don't see the value for our to receptive to that, then what have you done. And you can see here by the data from our little 35 patient pilot that we found that 75% of the patients that we side did have a change after pharmacist that assisted with them. And that 70% of the pharmacists recommendations were accepted by her positions. Most importantly maybe is that all of those physicians that we survey which were only seven but still we did want the service to continue.

So I think that what we discovered here is that that collaboration with the physician pharmacist collaboration prior to discharge was useful.

Now we're onto phase 3. How did we get into this big project where we are actually standing the transition. Here, we wanted to not only have the pharmacist collaborate with doctors at the time of discharge, but to also try and do a quasi-warm handoff the flow with our outpatient empty and colleagues. Of course the goal was to enable the discharge team sees that pharmacist and offer the handouts. When we communicated with all of the different specialties that we needed to talk to get this going to were really three tenants of this entire transition project. One was medevac that we wanted an accurate list across the transition was both safe and effective with admin directions and indications, and that becomes huge we are looking at patients were discharged to a skilled nursing facility. In Minnesota at any rate, if the medication has allotted 2 to 4 mg every 4 to 6 hours, that is not considered a direction that skilled nursing facility can use. It means to say that it is allotted to milligrams every four hours for pain in the range of 7 to 8 or something of that nature. Also sliding scale insulin, the patient will not be able to get their insulin at the transit at the skilled nursing facility until they get a really specific direction for that. So that something we wanted to work out. Patient education of preferences was another tenant of this project. And this goes back to that concept, and we all know this, that we are going to nod and smile at whomever we need to, the social worker from sister Dr. whomever, -- or the pharmacist or doctor or whomever. So we said let's have the pharmacist talk to the doctor but what do they need to try to build the medication list around not work

Lastly the last tenant was just access. We wanted to make sure that that the patient could actually get the medications like and when we started collaborate with the retail and we found something very interesting with ethics of wonderful and medical chart and electronic chart amusing. In EPIC will consider prescription to the retail pharmacy that is right down the hospital. We can send it to Walgreens, two blocks away or we can send it to CBS 20 miles away, why we cannot print out the prescription at all the maybe now you're going to be the same thing any don't need the new prescription. That's wonderful. The problem was from our retail and that was exactly what was happening. Ms. Jones antibiotic was here at the retail site in the hospital, but her letter pressure medication was in Walgreens and by the way we did not even feel her other
prescription. So it was a big mess and that was one thing so we try to do as well. That's a very strategic about these medication to make sure they're getting where they need to go. Lastly we focused our intervention on patients with MI or no more Aniya and just to try to whittle down our population a little bit tech I know that these slides and Candace did send me a note about this thing that this slide has been amended and it has an American to read it to the goodness. I wanted to show you guys the slide for two reasons. One, it looks at how did we do the planning. So had this first bullet point that the pharmacist transition planning and I did have the great and the bullet point beneath it that shows all of the columns that I had. There was a column the needs assessment of the workflow process and a column for each one of these below that it shows you the special entities that populated those columns. So we sat down a concluded via the table that would need the assessment and who needs to be the table for the outcome measures. If you read through these, some of the marker dystonic no-brainers like bedside nursing our system of inpatient pharmacy but some of them may surprise little bit and they certainly surprised me potentially with some more of what was at the bottom in terms of communication I wanted to to see the discipline huddle meetings everyday talk to a lot or many of these disciplines about the highlight and get there by in and get their feedback because they were 10 written documents total that we gave out the different disciplines and they all had that of what was going to go on. But that they also had their very own step-by-step pictorial at the constructions with how the rules and EPIC would change because we are adding a pharmacist to the discharge process and for the handoff.

And in italics at the top it is Italian state and I'm Italian and you would know it if you look at me because I'm gesturing wildly is a big so presentation. It means in the mouth of the Wolf which I guess and it really is a good luck thing but if a very appropriate manner put it on almost everything that almost I could see because that way I can constantly remember the Wolf. So it works for me.

So this is a process flow chart and data painful some marker to read it to you. Because the idea of utter process flow chart looks like and basically if you were to read to this whole thing is that what it would tell you is that the pharmacist we consult could have anybody consult us. So in addition to could be social workers or pair enter beside nursing or anybody at all the put in the consult for this pharmacist in the pharmacist what about it the patient and go see the patient and then they would team up the medications and EPIC for the Dr. So rather than the traditional pharmacy retrospective thing for Kim writes the prescription and I look at it and said there is a problem. And then I go back to Kim and I am wasting her time changing it. But we have the pharmacist do this say that you come up with what you think makes sense for the discharge plan to put it in EPIC then assign it and hold it so the doctor still have complete control over everything. They can modify the prescription the pharmacist put in and they can delete it or they could add or do whatever. But it was all set up for them and that we could ensure things like the indications are on their of the directions are on there. It's going to be sent to the right location once it leaves the hospital. So talk to the patient and we tip the mental would talk to the doctor. We did discharge education counseling for our patients and then we would talk to the patient about these magical clinical MTM pharmacist out in the outpatient setting and say, you could continue to get the intensive medication help from a pharmacist that you could meet out there. We have brochures with the smiling faces on them so that we could say look, you're going to meet with Allison when you get out and this is what Allison looks like in this is her phone number. Ideally we wanted as many patients to say yes to this as possible.

Here are our outcome measures. I'm not going to read them to you because we are going to go to the one by one here is you look at what the data is. You can see that they're focused on the AAA
them, cost quality and experience. Here are the pilot study results. We sell 192 patients. We had to pharmacists working two days a week and one pharmacist working five days a week. And about 45 patients per shift. The system was a bit of a disappointment when we started the pilot was not the web of aviator nine patients a day. At that really didn't work out for couple of reasons. A this another pharmacist on the floor this it what you come help me with this or value it Ms. Jones liver function or the quality of these drugs I think something is interacting. The point is bigger called for other important patient care duties and the other thing that we found is that the hospitals really prefer pharmacist involvement as soon as possible and then ongoing.

The next bullet looks at our refers. Those that actually solve the pharmacist in these are orders of with the did the most frequently. So was first the hospital in the center care integration team and the social workers and nurses that helped with the discharge of almost all of our patients. In the emergency room pharmacists. We do have some pharmacists and our ED as well and bedside nursing after that. We did have 40 patients the ticket consulted for the purpose but could not be seen. I think that is kind of the nature of the beast a little bit is that everybody wants to discharge patients at the same time and it's complicated.

For average length of stay for patient population was five days for the Rangers won to 12. It could take 30% of our patients that discharge and I think we were little bit surprised by that we didn't know that that would be the case that we started.

Here is a population demographics and I should mention that the readmission tools that I wonder if this was maybe three years old not started developing the readmission risk stratification totally did it initially. Then how they would be be admitted and how can we identify the patient and give them

Just services. Then now linking to the years go on. These components have come up to be very important as possible in the hospital in terms of the patient's readmission risks. Then there less than 50%. Marital status and then the Medicare and Medicaid. These are a little bit of a surprise as well very much dominated the population. Then the slides particularly apologize for the busyness. The point out that the pharmacist word my opinion seeing the patients they should have been seeing. The patients at an average of 9.3 chronic conditions then you can see the range there behind it. 44% of our patients have documented mental health diagnosis, alcohol abuse or some cognitive impairment. And you can see the boxes across the reason for the consult. Then we were out originally hoping to catch the heart failure and acute MI patient and will actually dead also that if you're not getting the right person on board with the pharmacist to help you then it's a great thing for me to see as well. So the patients had an average of 9.2 conditions had an average of 13 medications. Again to me we are hitting the right population. I don't want to see Mr. Jones was happy and onto meds and 60 results are rather see these patients addicted to the range there. When one should Suzanne 26 chronic medications I should mention that that did not include the PRN. We did not include the chronic or the antibiotic that would only be on for six or seven days or what have you. In this last bullet points I won't read two. But you can check out this article if you wish. The article looks at what are the high readmission risks that patients can be on and there is a lot of literature out there on this. I find that a lot of it is soft, particularly the analytics of the data are not so hot. But that that this was pretty good news for the medications that it showed to be high risk for readmission of the anticoagulant antidepressant or opiate or hypoglycemic. And no surprises there to pick. We did to the chart review of Methodist Hospital for this from the exact same drugs for us as well.
So getting out for outcomes, cost, this is another slide they came pointed out in city have a lot of funky stuff by just that he debuted mission they do and I said that wasn't intentional because it reminds me to talk about how it difficult to retention is. There are just so many kinds on the issues. Couple a, are you really comparing apples to apples then with the readmission rate for patients for the CAP. As you recall the most of the Medicaid patients is appropriate. We are missing the COPD population. It is very hard to compare. They that thing is that we have or care integration team an excellent bedside nurses. We cannot throw pharmacist in and say look at what we did. You don't really know who is making the benefit. But you can see the proboscis boxes are readmission rate for each quarter and 2013 for each quarter the that's the readmission rate for 2012. The patient stories I won't belabor them because I don't want to be here all day but I completed a lot of them. The first one that didn't have insurance where they were trying to get in Georgia the social worker was talking to the daughter in Georgia that if you could get them here that they could live with me and I think that this was a good example of what our pharmacist dead which that the boxes in the field them for the gentleman and they did that and that was a help.

The next patient looks at a lot of conditions and a lot of meds and she has got a lot of physicians. That are kind of adds up as we all know the pharmacist that her patient was also very charming kind of guy. This last patient was in eighth is patient and came in on the following medications that got switched in-house then of course is a combination pill. Use fascinating and was very smart. Hinted that they were both beta blockers that he was just going to change his dose said these are the beta blockers in here so now will still have these in a get home is forward to stick 100 mg. Also he felt that that he would take the step when he got home just because the names with the same. We were able to hedge that off work so here are the medication safety outcomes. First of all you can see that what we are calling the test going to the usability are exactly those ones that we talked about before. If you compare this dose to discuss every 46 hours that you may get the ax absolutely zero for the patient.

Then the pharmacist was able to find about five drugs with the patient that prefers the two men was in the range one thing that we did that I thought was chemical was who did this found a particular recommendation. The last column there looks at the ratings. The rating of two which he was sees with the data is. At the data (that had the severity of three. Severity rating of two means that has this recommendation not what it had gone through the then what are professional may have had to have is the potential mortality could occur. And I would say that we did have an independent panel look at those and give the ratings. Here is the empty I'm so sometimes and some of us of the issues if you will or the recommendations of the found that would things that this patient is an attentive opiates or 300 but does that need to be fixed right now they're also having a heart that because there's good I'm no longer taking the discharge that I think this is one of the limitations work that we had enough effort in outcomes to look into what the MTM impact was. Things like what are the baseline what of the medication recommendations that they're looking at. But variables led to some of those handoff failures that could we evaluate how long it did take them to take the call?

And last film of the most interesting is maybe somebody was there with the continued relationship with the pharmacist. They discharge the hospital outpatient pharmacist then they may say what is going on or what are you taking the time to figure out what they're really doing what the meds. Does this patient need to be seen by me or some pharmacist on a regular basis.

Here is her patient experience data. 67% of our patients were responding in the boxes. Those are the reasons why we did not get all of our patients. And during the MTM call, that heart of it is
that they asked the patient the three questions. So we can see that 97% of our patients when asked felt that the inpatient pharmacist had hoped of that the inpatient promises top and 90% would like to see pharmacist again before leaving hospital.

These are fun and I will not read them too but our pharmacist had. One of our pharmacist is going into patient-- So these are some of the things that we're doing. And that is all that I had for you guys to the standard conversation. Alexander Radmanovic these two questions.

Thank you Felix ask a question please press star one on your phone. Please press the pound and has to. If you have a question please press star one on your touchtone phone. And we have a question.

I'm wondering if they had developed some modules. Or participants within EPIC system because we have had some problems in the MTM having some of the EPIC problems build.

Yes was a part of who first and just to clarify was it specifically about EPIC and our MTM program?

Yes.

Unfortunately I'm not the best advocate answer that question but we will ask Molly Barnett she is the leader of our MTM group. But I know that initially what was challenging, because I was around when we first got our clinical MTM from assist and it was very difficult with EPIC for them to decide, are you a doctor? No I am not. Are you a nurse? No I'm not work so was hard for them I think what to classify as and we were trying to say that well we are not a doctor but we can write prescriptions and its under collaborative agreement is with the meat stuff by Dr. and some of them don't. I know that that was definitely challenging in the beginning. And as the correct type of provider. So we solve those problems and from there we have built a form for the MTM group have really been able to because you saw how many locations are MTM folks are in. And personally I know little bit about this and I'm personally working the ambassador sent to that's attached to the hospital so work of the MTM pharmacist there one day a week. Not 100% sure the answer to question.

Do you provide contact information?

Yes I would do that and I think that Molly would be so happy to talk to.

So looks like we have a question in the chat box. It says, do you have a formal referral process from the inpatient pharmacist to the outpatient MTM pharmacist? Also what to do the MTM is not covered for patients in outpatient setting?

That's wonderful question. So we do have a formal process for the referral for the inpatient to the outpatient pharmacists. The only thing that I would caution everyone on is that when we started doing this and again for some reason the EPIC people kind of wanted it to be different for everyone so they wanted a different process for the ED pharmacists versus the physician this is the pharmacist making the referral to or outpatient. But, what we end up talking them into is that we have the discharge navigator in EPIC and the referral process is just in the discharge navigator. So anyone can do it. Part of that was getting out hospital team to agree to signing off on it. So they decided what disappearance and they were very liberal about it, bless their hearts, they could refer a patient to our MTM program. And the way that we got the hospitals as a group
to agree to this, and it's not duplicitous anything, but we just explain to them that personally as a MTM pharmacist that I would never get a referral and then go off and do either one with the patient. What I do is that I have a referral from the inpatient center and I looked at the price they should then evaluate them a little bit and I noticed that Kim is there Dr., their provider on the outpatient side and so I would contact her and say I know that your patient Mr. Jones just got out of the hospital. I have got a referral from the hospital, are you okay with me collaborating with you on the stair Joneses care? Does that answer that part of it anyway?

And in the second part was what are we doing for revisions were not converts. That's a challenging question I think. Right now, we are only providing the MTM for patients were either health partners as you probably know we have recently become part of health partners and so we only see patients have health partners insurance or insurance. Our MTM pharmacist out of the goodness of their heart were doing the call for everyone so that we did a follow-up call within 2 to 4 days, even if you are not at Park Nicolet insurance so it's a good question and that's difficult. But we are not dealing 41 us that questions at least not yet. Digerati ask that? This the last question is the billing.

In the chat with anything about all patient management with those of the MTM management bill for services?

We are not currently billing for our services. We are however, since we became part of the health partners family conversations have one doubt quite a bit more about that and as I'm sure you all know, it could be billing, but the billing system is so cumbersome and really does not allow for good billing. So I think that something that we are hoping for.

So we do have one more question here in the chat box. Alexander Mabel check with you first to see if we have any other calls?

I'm sure no questions at this time.

Okay. So next question here is how many referrals did you receive from your criteria versus how many you were able to complete.

So there was that sly and then we just go back up to it again. About the referrals. There we go. So the box across the center here this looks at why we got the referrals and where kind of the referrals came to pick out for like to answer that well.

Amanda if you are on do maybe want to press star one?

Yes, hello Amanda.

This just that in our process and other we end up having a lot more people that kind of qualify for the consult. But then those that were actually able to see them to be less, so I was just curious for you guys, were you able to see everybody being able to give dedicated resources? Over the people that you still missed that technically qualified according to your criteria?

Amanda do you mean on the inpatient side or on the MTM group?

I mean on the inpatient side.
On inpatient side we saw 193 patients but we did have 40 in the two-month span that we were not able to see just because we were understaffed and did not have enough time. Our outpatient group as you saw just did a phenomenal job of making these calls and seeing these patients. And they're relatively new. I'm not sure if that kind of helped. But another anecdote really our MTM pharmacist loved it. They felt like these were high need patience, high-impact patients that they were able to do. And actually that was part of what they had at the hospital and it was the -- testing but it was focused on emotional needs both if we are going to do a short round on one of the stages that may have the hospitals there or the inpatient pharmacists or the MTM pharmacist and the primary care doctor all their to talk about whatever more challenging patients. So was really great.

We have two more questions in the chat box. The first one is are you using pharmacy students or pharmacy technicians in the inpatient medication history process?

So to me this may be gets back to that led requirement issue that if what you are looking for is that if you look at the data is what you're looking for the correct met list but you don't really needed evaluative any way shape or form, which of course may answer that is that of course we wanted evaluated. But if you don't necessarily need the pharmacist, and we do have pharmacy students in our ED. Would make sure that their present at the end of the second year that they're doing the med rec services under a pharmacists.

Okay. Next question is with the final discharge process it EPIC are the pharmacist able to go back and fix what was already done if it is incorrect?

That's a good question and answer to that is that you won't believe that we are. I think with EPIC it is even more complicated than with that the physician did when they have to fix it. Like if there to process the medication, then the pharmacist would not be able to go back in and change it. If the doctor -- because our doctors can also append the medication so for Dr. signed up in the answer is no. Or if the doctor only printed thing that I'm going to go talk to and the answer is yes and maybe I had bit and what do think you should take a nice about the 200 so it's a biblical back and fix it for them if the drug is pending.

The next question is what if it is documented by the inpatient Prime Minister -- pharmacist if it is completed but it communicate medication issues that need follow-up or for the MTM team that will be talking with the patient after discharge?

That's a good question I we did greatest artform and epic for documentation turned to keep it consistent. Initially is a pharmacist I was have this need to say that I want to write a met list that the has got to be a list in our note. But we decided is that there are too many medalists floating around that may or may not be accurate so in our section that says the discharge medalists and it asks them to go and see the after visit summary because it is a click away and that is the true met list which I love I think it is wise of us. Then we categorized our next piece into two chunks. One of them was here things that we did with the patient today so I canceled this patient today on the LASIK so we decided to change this other medication. What did we do. And then we had a separate box that was just designated for MTM. So we did have an area where we chest documenting that okay, in a very respectful way, because all of our colleagues to do have this. But is also kind of by the way that I noticed that they're not in any supplement for calcium the bone marrow the bone indexes this or what have you. So we did have separate sections for here's what I did in-house and here's what I sent to our colleagues.
· Billing how you justify productivity for the patient?

Right now and I do wish that Jeff Schaffer was here because he's very passionate it wonderful. He is our utilization director of the pharmacy a Park Nichols and he just loves to talk about shared savings. And trying to show her readmission rates and trying to look at because he does a lot of data looking at patients with the drug and he would document all of our readmission stuff with the drug reactions in figure out the money for them. Is really excellent that talking with our payers talking with art ministry it is about that shared status especially in terms of the Amgen program -- the MTM program where actively and aggressive -- aggressively seeking ways to get reimbursed.

Last question in the checkboxes for substantially disabled patient is moving from hospital to home, their consulting pharmacist to follow-up after discharge. To the call directly or work with homecare personnel for outpatient primary care providers?

For patients that one from hospital to home, our consulting pharmacist, one of the big things that we realized that we needed to consult was that of your systems were doing this to, but our system is providing a nurse provided follow-up call after patient is discharged. So one to two days after patient leaves with the policy then we can give the patient the call. When we looked at those and the questions that were being asked, to be honest to be very matter-of-fact, the goal of those patient satisfaction, then they did ask questions like to have questions about your medicine to which my response to be that way you are not taking the right medicine how do know they're not taking the right medicine. So don't know if we were seeing the drug issues that we wanted with those calls. But we did have to coordinate with them. So that her patients knew what was going on. The last thing we wanted was for the patients to say Artie got a call it now you are calling me and it all feels very disjointed. So we had that

Is potentially the question about your consult pharmacists follow-up after discharge? The inpatient pharmacist did not. The last thing that we did was to consult our MTM pharmacists and the MTM pharmacist took it over from there. They were calling patients directly at home and they were dealing with the primary care provider. Again because the -- one of our MTM pharmacists would never not talk to the primary care provider before providing patient care. If possible if Kim is the physician a Gina have a very close relationship and work together all the time, maybe get a consult from Kim's patient and I don't mention it to her this, what have you. But our policies for MTM pharmacist to contact the primary and to say just touching base and I'm going to start seeing your patient.

Question how long did the MTM pharmacist follow the patient outpatient setting? I think this is one of the things that we don't know but we are going to find out and were working on the date of right now. We are so excited about it. I want to know the answer to that question. Were we able to build a relationship? I love the MTM call is a triage call. Who knows how better the how often the patient needs to be seen then the outpatient pharmacist. I just love that I think that they were able to evaluate patients and maybe all that they need is a call or maybe they can say how would you like to come see me in a week or two weeks or even a month depending on the acuity of care.

So I don't know the answer to this it Christopher but we well.

Alexandra do we have any other questions on the phone?
I'm showing of the questions on the phone.

Okay. Will I have 20 7 PM. So we are just about out of time. So the evaluation questions should be on his screen now if you could fill those out for us that would be fantastic. I want to thank Anne Schullo-Feulner for being here and for the presentation and all the great information. The looks like maybe some folks were having trouble accessing the slide, the handouts. Will make sure that those get out to all of you. And we will also follow-up with folks who wanted specific information. And otherwise we are done. So have a good afternoon and we will see you next time.

Thank you so much. Goodbye.

Thank you ladies and gentlemen. This concludes today's conference. Think you for participating.