Improving Continuity of Care with Clinical Pharmacist Discharge Counseling

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Objective

Utilize clinical pharmacists to improve medication safety when transitioning care of patients from hospital to home

Background

- Transitions of care or "the movement of patients between health care practitioners, settings, and homes as their condition and care needs change" are a focus of Joint Commission
- Ineffective transition of care practices lead to an increase in hospital readmissions and costs
- Miscommunication between medical providers can be a cause of medical errors
- Clinical pharmacists can improve transitions of care by assisting with medication reconciliation, education, and cost concerns
- Clinical pharmacists could improve HCAHPS scores at Orange City Area Health System (OCAHS)

Clinical Pharmacists Discharge Education Timeline

2016	2017	2018	2018	2018	2018
September	**September**	**January**	**August**	**October**	**December**
Clinical pharmacist hired • *Available by consult 3 days per week*	*Second clinical pharmacist hired* • *Available by consult Monday-Friday*	*Team Meeting* • *Discussed patients that would benefit from pharmacy intervention* • *Decision to meet with patients who were on ≥ 8 chronic medications*	*Team Meeting* • *Discussed ways to improve process* • *Decision to meet with patients starting on a new chronic medication* • *Tried having clinical pharmacists go to inpatient care conference*	*Team Meeting* • *Discussed ways to reach more patients, improve process* • *Decision to contact and/or review all patients discharged home from OCAHS* • *Decision to have clinical pharmacist on inpatient floors Monday and Thursday mornings*	*Presented process to hospital staff* • *Started "rounding" with providers on Monday and Thursday morning and upon request*

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Planning and Implementation

- **Plan:**
  - Hire clinical pharmacists to provide coverage Monday through Friday.
  - Develop process for identifying patients that would benefit from clinical pharmacists intervention
  - Identify opportunistic time and location to meet with providers and/or patients regarding medication-related concerns
- **Implementation:**
  - Hired initial clinical pharmacist in September 2016 and second clinical pharmacist in September 2017
  - Team established: Leadership, quality, clinic manager, director of patient care, clinical pharmacists
  - Plan for identifying patients that would benefit from clinical pharmacy interventions developed; Plan adjusted when barriers identified
  - Physicians notified of process; Physicians consult pharmacy when medication concern identified
- **Safety Goals:**
  - NPSG 3: Improve the safety of using medications
    - NPSG.03.06.01: Maintain and communicate accurate patient medication information
  - Improve medication understanding when patients transition from hospital to home

Data Collection

- Percentage of patients contacted or reviewed regarding discharge medications.
- Number of interventions made
- HCAHPS scores

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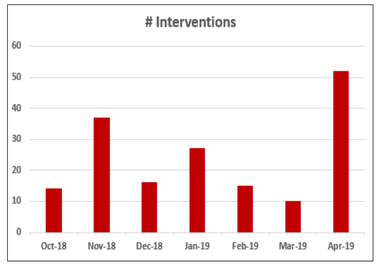
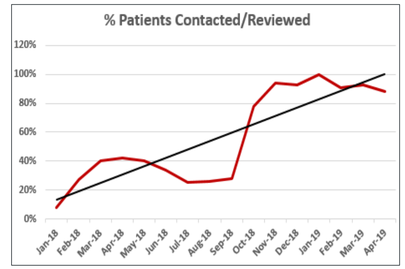
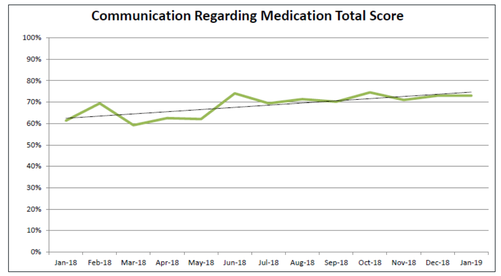
Analysis

- 91% of patient's medications reviewed on average since October 2018
- 171 total interventions performed since October 2018
- HCAHPS score improving since implementation







Clinical Impact

Medications added:
- Aspirin for patient with significant PVD (stopped for surgery, forgot to restart)
- Admitted for NSTEMI, discussed benefit of statin with patient and ultimately he agreed to start statin

Assist with medication set up:
- Non-Adherent patient: Recurrent seizures not taking medications
- Dementia patient: Taking 2-3x potassium dosage
- Arranged administration of injection in infusion center to reduce length of stay

Assist with medication reconciliation / transition of care:
- Admitted for hypertensive emergency, anti-hypertensive medication sent to mail order pharmacy; assisted with getting locally for first month
- Admitted for hyperkalemia; potassium dose on discharge was incorrect; corrected order
- Extensive cardiac history; antiplatelet therapy not reordered after surgery; discussed with cardiologist and had restarted
- Admitted for respiratory infection and ordered nebulization; patient did not have nebulizer so assisted with getting one

Labs/Tests ordered:
- EKG for patient on citalopram 40 mg daily
- DEXA for patient with fracture, need for osteoporosis treatment

Next Steps

- Additional availability for providers (i.e. Monday-Friday)
- Face-to-face transition of care follow-up visits for patients with chronic conditions or multiple medications leading to chronic care management (CCM)