# Best Practice Pearls

Michelle Fine
Anne Misher
Jennifer Splawski

Speakers have no conflicts of interest to disclose

# Implementation of a Comprehensive Transition of Care Model for Patients with Heart Failure

Michelle Fine, PharmD, BCACP, BCPS
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## Objective

Pharmacist
- Describe three potential roles for pharmacy involvement in transitioning heart failure patients between inpatient and outpatient.

Pharmacy Technician
- Describe three potential roles for pharmacy involvement in transitioning heart failure patients between inpatient and outpatient.

## The Ugly Truth about Heart Failure Readmissions

- One of the most common reasons patients over the age of 65 are admitted to the hospital
- 30-day readmission rate exceeds 24% for Medicare
- Three out of four of the early readmissions may be preventable
  - Incomplete treatment in hospital
  - Poor coordination of services or communication of plans at discharge
  - Inadequate access to care in early follow-up

Desai AS and Stevenson LW. Rehospitalization for heart failure. Circulation 2012; 501-506.

## Bridge and Transition Team-"BAT"

- NMH HF readmission rate: 35%
- BAT Team Created
  - Goal to reduce readmission rates
  - Multidisciplinary
    - Inpatient and outpatient pharmacist

## Outpatient Pharmacist Role

- Transitional care phone call
- Seven-day follow up visit with Nurse Practitioner
  - Medication Reconciliation
  - Compliance Assessment
  - Education
  - Refills
  - Clinical Recommendations
- Pill box and med chart teaching

## Transitional Care Call Pilot Data

Of the patients called and reached, 57% had at least one medication error after hospital discharge

## Comprehensive Transition of Care Pharmacist Program

- Three pharmacist model
  - Inpatient heart failure pharmacist
  - Outpatient heart failure pharmacist
  - Meds to bed program
- Goal of the program
  - Reduce hospital readmission rates
  - Decrease medication discrepancies at the 2 day follow up phone call
  - Improve patient satisfaction scores

## Inpatient Pharmacist Role

- Admission
  - Medication reconciliation
- Discharge
  - Review of discharge instructions to correct errors
  - Creation of a personalized medication chart
  - In-person education about medications
  - Pill box

## Personalized Discharge Medication Chart

| Medication (Generic/Brand) | Dose | Used For | Morning | Noon | Dinner | Bedtime | Special Notes |
|---|---|---|---|---|---|---|---|
| Aspirin | 81 mg | Protect heart, help keep stents open | 1 tablet | | | | |
| Atorvastatin (Lipitor) | 80 mg | Protect heart, lower cholesterol | | | | 1 tablet | **New medication** Switched from simvastatin |
| Clopidogrel (Plavix) | 75 mg | Protect heart, help keep stents open | 1 tablet | | | | |
| Furosemide (Lasix) | 20 mg | Fluid pill or diuretic | 1 tablet | | 1 tablet | | |
| Lisinopril | 20 mg | Protect heart, open blood vessels to help heart pump stronger | 1 tablet | | | | **Dose increased!** |
| Metoprolol succinate (Toprol XL) | 50 mg | Protect heart, slow heart rate, helps heart relax | 1 tablet | | | | |
| Spironolactone (Aldactone) | 25 mg | Helps your body get rid of salt and water, keeps potassium levels stable | 1 tablet | | | | **New medication** |
| Tamsulosin (Flomax) | 0.4 mg | Prostate medication | | | | 1 capsule | |

| STOP TAKING THE FOLLOWING MEDICATIONS | |
|---|---|
| Medication Name (Brand/Generic) | Reason for Discontinuation |
| Simvastatin (Zocor) | Switched to atorvastatin (Lipitor) |
| Ibuprofen (Motrin, Advil) | Causes fluid to build up and can hurt your kidneys |

## Meds to Bed Pilot

- On-site prescription verification and fulfillment through Specialty Pharmacy
- Medication delivery to bedside
- Support with financial obstacles
  - Prior authorizations
  - Patient co-pay assistance

## Comprehensive Transition of Care Pharmacist Program

| | |
|---|---|
| Patient understanding | • Discharge Counseling<br>• Medication Charts |
| Prescription | • Meds to Bed Program |
| Adherence | • Pill Box |
| Cost of medications | • Meds to Bed Program |

## Impact of Comprehensive Transition of Care Pharmacist Program

- Single-center, retrospective cohort study of BAT patients on our inpatient cardiac telemetry floor
  - Control (n=376): Multidisciplinary support from the BAT team
  - Intervention group (n=100): Additionally received the inpatient pharmacist intervention

## Impact of Comprehensive Transition of Care Pharmacist Program: *30- Day Readmissions*

## Impact of Comprehensive Transition of Care Pharmacist Program: *Patient Satisfaction Survey (HCAHPs)*

## Expansion of Pharmacy Transition of Care

- BAT patients admitted to general medicine floors
- 539 of 944 patients targeted by the BAT team were counseled by an inpatient pharmacist
- Intervention was associated with (*as compared to patients not seen by a pharmacist*)
  - Increased patient adherence to their cardiac medications: 66% v. *44%*, p=0.01
  - Decreased readmission rate at 30 days: 13.7% v. *19.5%*, p=0.017

## Challenges Overcome

- Outpatient
  - Resolving medication errors
- Inpatient
  - Communication about the discharge plan
  - Education for weekend and evening discharges

## Applying to YOUR Transition of Care Program

- Assess where your system break downs are occurring
  - Target those areas for interventions
- Interventions can improve your work flow and patient care
- Start with a pilot group
- Team work
  - Communication
  - Do not duplicate work

## Assessment Question

Jeremy is a transition of care pharmacist for an internal medicine department. He sees patients on admission to perform a medication reconciliation, counsels patients at discharge, and sees patients with providers in a 7 day office visit. Unfortunately in clinic Jeremy has noticed his patients forgot to pick up medications from the local pharmacy at discharge. Select the most impactful intervention pharmacy could make to improve medication adherence.

A. Pharmacists e-prescribe the medications to the pharmacy
B. Partner with a local pharmacy to initiate a Meds to Bed Program- including technician support to deliver medications and complete prior authorizations
C. Send email reminders to physicians to prescribe discharge medications
D. Post a sign in the break room reminding prescribers and nurses to counsel patients on picking up medications at discharge

# Incorporating Pharmacists into Annual Wellness Visits to Meet Institutional Goals

Anne Misher, PharmD, BCACP, BC-ADM, CDE
Clinical Assistant Professor
University of Georgia - Southeast Georgia Campus

## Objective for Pharmacists and Technicians

- Describe how Medicare Annual Wellness Visits can expand the role of pharmacy services in the healthcare setting

## Medicare Annual Wellness Visit (AWV)

- Introduced in January 2011 by Patient Protection and Affordable Care Act
- Yearly appointment to discuss a patient's plan for preventative care
  - Emphasis on wellness and disease prevention
- Similar to the Welcome to Medicare visit with some important differences
  - Not a head-to-toe physical exam
  - Cannot have an AWV in the same year as the Welcome to Medicare exam

## AWV: Required Components

| Required Components | Initial AWV | Subsequent AWV |
|---|---|---|
| Medical history | Obtain medical/family histories | Update medical/family histories |
| Vitals | Measure height, weight, body mass index, blood pressure, and other values deemed appropriate based on medical history | Repeat measurements |
| List of medical providers | Obtain and document during this visit | Update and record changes |
| Cognitive impairment screening | Required | Required |
| Depression screening | Required | Not required |
| Functional status | Observe directly and document functional ability and safety level | Not required |

## AWV: Qualified Providers

## AWV: Patient Eligibility

- Medicare Part B beneficiary for at least 12 months
- Eligible for a one time initial AWV and then a repeat AWV every 12 months
- Physical examination is not a required component as part of the AWV

## AWV - What is needed to bill?

**Required components**
- Initial vs subsequent AWV

**Health risk assessment**
- Helps to gather required information
- Guidelines available in CDC consensus document

**Personal prevention plan**
- Provided to patient upon completion of AWV

## AWV: Coding and Diagnosis

- Coding
  - G0438; annual wellness visit (initial visit) [estimated reimbursement: $169]
  - G0439; annual wellness visit (subsequent visit) [estimated reimbursement: $112]
- Diagnosis
  - Must report diagnosis, but nothing specific required
  - May choose any diagnosis code consistent with the patient's examination

## AWV: Personal Prevention Plan

**Initial**
- Written screening schedule for next 5–10 years
- List of risk factors and conditions for which interventions are recommended or underway
- Appropriate personalized health advice and referral to health education, preventive counseling services, or community-based interventions aimed at reducing identified risk factors

**Subsequent**
- Similar to initial visit, but the screening schedule and list of risk factors/conditions is updated.

## Pharmacist-Run AWVs

Primary care provider completes AWV to meet financial targets
- Many providers fall short of anticipated completion rate

A total of 2068 patients were eligible for AWVs in 2015

The clinic's goal completion rate is 85%
- Would generate a total revenue of ~$180,000
- Allow for additional physician appointments

## AWV Workflow at Advocate Medical Group

**Prior to Visit**
- Pharmacist reviews patient profile
- Vaccine history
- Medication assessment
- Preventative care

**Upon Arrival to Clinic**
- Patient completes HRA in waiting room

**During Patient Visit**
- Vitals taken
- Providers, PMH, FH and HRA reviewed
- Medication review
- Depression screen
- Functional ability
- Vaccines administered
- Advanced directives

**After Visit**
- Documentation completed
- Recs sent to provider
- Follow-up completed as needed

## AWV at Advocate Medical Group – Results

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- April – December 2015

## AWV at Advocate Medical Group – Results

Images:
http://multivictim.org/
http://4teena10.blogspot.com/
http://kristinaallen1000.wikispaces.com/

## AWV – Pearls and barriers

| Time consuming | Lack of understanding | Disruptive to workflow | Considerations |
|---|---|---|---|
| • Several components<br>• Elderly patient population | • Uninterested in preventative care<br>• Awareness of clinical pharmacist role | • Previously performed by physician and/or other healthcare professional | • Use modifier-25 if E/M services are provided on the same day<br>• Discussing advance directives |

## Which of the following components of AWV can be completed by a pharmacist?

a) Collecting and/or updating medical history and medical providers
b) Taking vitals including height, weight, body mass index and blood pressure
c) Screening for cognitive impairment, depression and functional status
d) All of the above

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# Life Saving Naloxone Kits

Jennifer Splawski PharmD, BCPS
Clinical Pharmacy Specialist - Emergency Medicine
MacNeal Hospital

## Objective for Pharmacists and Technicians

- Discuss which patients are most at risk for opioid overdose and should receive a life-saving naloxone kit.

## Chicagoland Opioid Crisis

- The Chicago metropolitan area ranks first nationwide in emergency department mentions of heroin use
- Cook County has seen a 53.46% increase in opioid/heroin deaths from 2010 to 2015
  - 68.27% increase in ED usage due to opioid overdose
- Illinois ranks 35th in drug overdose deaths

## Hospital Location

- Our hospital is located near the "heroin highway" near the West Side of Chicago

## Audience Poll

How many opioid + heroin overdose deaths were reported in the State of Illinois in 2016?

A. 2,410
B. 1,266
C. 2,306
D. 1,040

* As last reported by Illinois Department of Public Health

## House Bill 1

- Heroin Crisis Act aka "Lali's Law"
- Improves reporting on overdose statistics
- Increased drug overdose prevention programs
- Offers protection for healthcare providers who prescribe or administer opioid antagonists in good faith
  - Specifically labeled pharmacists as "healthcare professionals"

## House Bill 1

- Delineates what opioid overdose education should contain
  - For patient, educator, and in schools
- Allows pharmacists to dispense opioid antagonists without prescriptions in community pharmacies
- Increases insurance coverage for opioid antagonists
- Education of public on proper disposal of unused medications
- Much Much more!

## Goal of Our Program

- The goal of our program is to reduce opioid overdose deaths through naloxone distribution and overdose education in keeping with our hospital mission of helping people live happier and healthier lives.

## Naloxone Mechanism of Action

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## Team

- **Leaders:** Emergency Medicine Pharmacist and Psychiatrist
- Behavioral Health Nursing Staff
- Psychiatrists
- Onsite outpatient pharmacy
- Inpatient pharmacy
- Much support from leadership team, specifically CMO

## Program Coverage

- Focused on behavioral health units of the hospital

## Staff Education

- 90 min multidisciplinary sessions were hosted by ER PharmD and Psychiatrist
  - CE was available
- Reviewed epidemiology of overdose, rationale and scope of overdose prevention and naloxone kit distribution
- Hands on training with kit and goals of patient education
- Goal to reduce staff stigma with addiction and increase overdose prevention

## Process

RN identifies pt in need of a kit

## Identifying those in need of a kit

- Patients currently registered in a detoxification program
- Known opioid abusers
- Known heroin abusers
- Patients consuming high doses of opioids
  - > 80 mg of oral morphine equivalents
- Patients using opioids concurrently with benzodiazepines
- Patients with a history of mental health condition and concurrently use opioids

## Process

RN identifies pt in need of a kit → MD writes prescription → RN faxes script to onsite pharmacy (OP) → OP reviews insurance coverage → OP dispenses Narcan® or refers to inpatient pharmacy to dispense naloxone

Inpatient Pharmacy Kit

Outpatient Pharmacy Kit

## Process

RN identifies pt in need of a kit → MD writes prescription → RN faxes script to onsite pharmacy (OP) → OP reviews insurance coverage → OP dispenses Narcan® or refers to inpatient pharmacy to dispense naloxone → OP delivers and counsels on Narcan → RN counsels on naloxone

## Patient education

- Easy to read pamphlets reviewed with patient and included in kit
  - How to identify an overdose
  - How to respond to an overdose
  - How to avoid an accidental overdose
  - Color pictures educating how to put naloxone kit together
  - Important phone numbers
- Videos available reviewing kit and overdose prevention
- Dummy kits available for patients to practice with

## Results

- 278 kits dispensed from 11/11/2016 to 2/2/2018
  - 72 inpatient pharmacy
  - 206 outpatient pharmacy
- Direct Costs
  - Cost per kit
  - Cost per RN to educate
  - Cost per pharmacist to profile and technician to fill
- 5 lives saved
  - Several additional lives saved per patient recall

## Conclusion

- Dispensing these kits into the community and providing overdose education aligns with our hospital mission to help people live happier, healthier lives.

## Self-Assessment Question

- Which of these patient's should receive a naloxone kit upon discharge from a behavioral health services.
  A. A 55 year old male with a history of heroin abuse who just completed a detox program
  B. A 24 year old female with a pmhx of schizophrenia who uses hydrocodone/acetaminophen for chronic back pain due to a previous car accident.
  C. A 35 year old male with a history of oxycodone/acetaminophen addition and talking clonazapam as needed for anxiety
  D. All of the above

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