

Medication Management in Ambulatory Care



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Objectives



- Introduce the pharmacist roles being highlighted to improve transitions in care
- Define the objectives and preliminary outcomes of the Creekside pilot project
- Discuss innovative strategies being used to connect pharmacy services throughout healthcare
- Evaluate lessons learned and discuss how to remove obstacles in order to expand MTM

Why pharmacists?



- 10-25% of hospital and nursing home admissions are caused by the inability of patients to take their medications as prescribed¹
- Nearly 20% of Medicare patients are readmitted within 30 days after discharge²
- 63% of medication related errors resulting in death or major injury were caused by breakdowns in communication³



Current Pharmacist Roles



- **Inpatient**
 - Dispensing and Clinical Pharmacist
 - *Discharge planning/consults?*
- **Ambulatory**
 - Retail pharmacist
 - *Medication Management Pharmacist*
- **Skilled Nursing Care Units**
 - Pharmacist chart consults
 - *Pharmacist transition consults?*

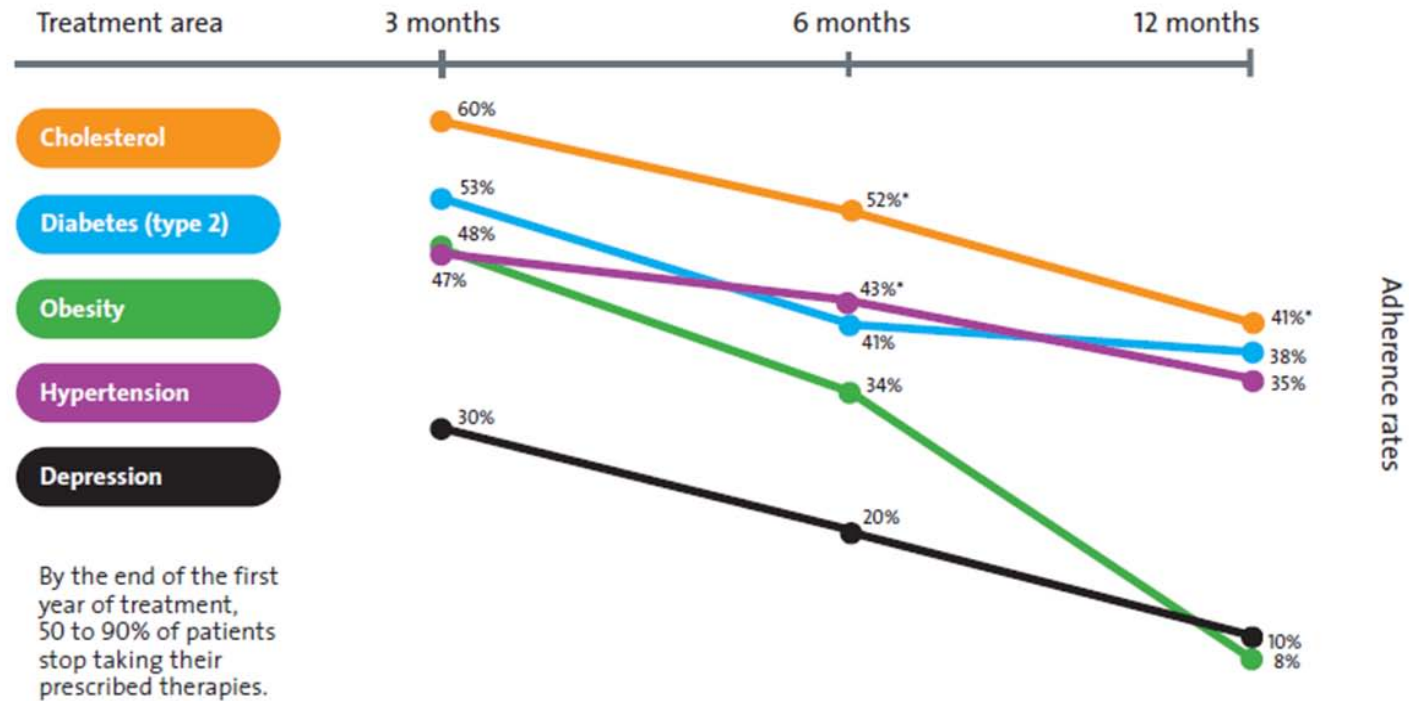


**“Drugs don't work in
patients who don't take
them”**

C. Everett Koop, MD

Many patients stop taking their medications

Adherence rates plummet in just a few months



* Adherence rate ranges were averaged. Source: Various sources; A.T. Kearney analysis

The Case for Smarter Medicine | 11

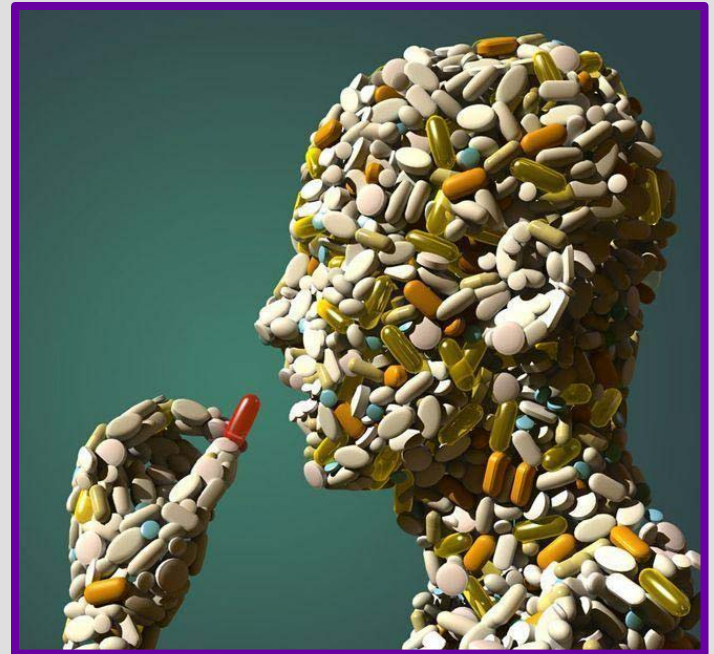
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24% of e-prescriptions sent were never filled within 6 months of the written date⁷

Medication Management?



- Evaluation and management of medications, focusing on areas for potential medication intervention
 - Indication
 - Effectiveness
 - Safety
 - Convenience/Compliance—
Adherence!



Opportunities at Park Nicollet



- 7 pharmacist providers in 8 primary care clinics (family medicine and internal medicine)
- Involve Pharmacy in Ambulatory Care Reforms
- Strengthen connections within pharmacy at Park
 - Retail
 - Hospital
- Build partnerships with medical team to optimize patient experiences and health outcomes

How can we strengthen these connections?

Creekside Pilot



- **Goal:** Improve medication use and safety through transitions in care to decrease hospital readmission
- Patients seen for an inpatient pharmacist discharge consult 24-28 hours prior to leaving the hospital
 - **Eligibility:** High-risk patients based on chronic medical conditions, 5 or more medications at admit, 3 or more new medications at discharge, non-elective admission in the past 30 days
- **Follow-up with Medication Management pharmacist**
 - Within one week of discharge
 - Encouraged to bring in all home medications for reconciliation

Creekside Pilot



- **Preliminary Outcomes**

- Patients tracked on service: 213
- Patients eligible for a pharmacy consult: 170
- Pharmacy consults: 34
- Total patients to TCU = $42/213 = 19.7\%$
- Eligible patients to TCU = $41/170 = 24.1\%$
- Consult patients to TCU = $6/34 = 17.6\%$

Creekside Pilot- Survey Results



- **The most valuable aspect of the Consult to the physician**
 - Medication interactions
 - Med reconciliation
 - Patient education for reduction of med errors
 - Simplifying regimen
- **The most valuable aspect of Consult for your patients**
 - Simplifying med list
 - Teaching patients about medications
- **100% of residents involved in the study:**
 - would like to see the consult service continued at Methodist Hospital
 - feel the consult process enabled them to work collaboratively with the pharmacy counterparts and fostered a “team care” approach

Patient Case



- **49 year old female**
- **Hospitalized 3/27**
 - Atypical chest pain
 - Dyspnea on exertion
 - Heart failure
- **Elevated troponin level (3/28/2012)**
- **Significant past medical history:**
 - Congestive Heart Failure, EF 48%
 - DM Type2, uncontrolled
 - Fibromyalgia
 - Anxiety and Major Depressive Disorder (severe)
 - Hyperlipidemia
 - Hypertension
 - Hypothyroidism
 - GERD
 - Fatty Liver - Nonalcoholic
 - Hodgkin's Lymphoma (1991)

Patient Case



- Per discharge: physician added furosemide, pharmacist recommended an increased dose of simvastatin
- Discharged 3/29
 - Follow-up with primary care physician 4/2
 - Follow-up with medication management pharmacist 4/3
- CC: Drugs interacting with current dose schedule

Diabetes

- Accu-Check Blood Glucose Monitoring
- Aspirin 81mg 1 tab daily
- Humalog insulin 9 units/carb with food
- Lantus 67 units in the AM, 77 units PM
- Victoza 0.6mg daily

Asthma

- Albuterol-ipratropium nebs BID or q4h prn
- Advair 250/50mcg 1 puff BID
- Proair HFA 2 puffs q6h PRN

CAD

- Simvastatin 40mg 1 tab at bedtime
- Fish oil (Omega-3) 1 tablet daily

RLS

- Ropinirole 2mg, 2 tabs at bedtime

Hypothyroid

- Levothyroxine 112mcg 2 tabs daily

Fibromyalgia /Pain

- Gabapentin 300mg 3 tabs 3 times daily
- Ibuprofen 600mg 1 tab 3 times daily
- Lidoderm 5% patches, apply up to 3 patches as needed
- Hydrocodone-acetaminophen 5-500mg 1 tab q 6hrs PRN

GERD

- Nexium 40mg 1 cap daily

Depression/ Anxiety

- Cymbalta 30mg 3 caps daily
- Lorazepam 1mg, 1 tab 3 times daily as needed

Hypertension

- Hydrochlorothiazide 25mg 1 tab daily
- Metoprolol succinate 200mg 1 tablet daily
- Furosemide 40mg 1 tab daily
- Lisinopril 5mg 1 tab daily

Medication Interventions



- **Indication**
 - No indication for ipratropium
- **Effectiveness**
 - Neuropathic pain is severe despite gabapentin
- **Safety**
 - Ibuprofen with CHF
 - Cymbalta is causing some anxiety
- **Adherence**
 - Only checking fasting blood glucose (no postprandial)

Medication Recommendations



1. Taper off of gabapentin for discontinuation
2. Start Lyrica 75mg twice daily
3. Decrease dose of Cymbalta to 60mg daily
4. Change albuterol/ipratropium nebs to albuterol nebs
5. Begin checking blood sugars 2 hours after a meal at least once daily
6. Discontinue ibuprofen



Providers

Health Care
System

Patients

Potential Benefits

- Time allocation
- Maximum ability used

- Cost savings
- Appropriate allocation of resources

- Improved understanding, satisfaction
- Decreased use of the healthcare system

Lessons Learned



- **Planning for the ‘unexpected’**
 - Communication Barrier
 - Difficult to implement changes at discharge
 - TCU Patients
- **Gaining buy in**
 - Physicians
 - Nursing/support staff
- **Educating patients**
 - What and why?

Looking forward



- **Working with ED Pharmacists**
 - Referral form within the EMR
- **Improving relationships with TCU providers**
 - Where are most of our patients going?
- **Increasing visibility in the system**
 - Expanding to new sites, participating in new quality initiatives

Questions or comments:
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References



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Beyond Consulting

PHARMACIST OPPORTUNITIES IN THE SNF-TCU

Joe Litsey Pharm. D. C.G.P.

Objectives



- Describe the traditional role of the consultant pharmacist in a skilled nursing facility
- Identify the limitations of electronic medical record systems in the care transition process
- Identify how the roles of consultant pharmacist and provider pharmacist can be expanded in the TCU of a skilled nursing facility and how use of technology can assist in transitions of care

Consultant pharmacist-101



- SNF contracts with pharmacist
- Provides consultation on “all aspects of pharmaceutical services”
 - Policy and procedures
 - Coordinate pharmaceutical services
 - Emergency medication contents
 - Interdisciplinary team member
 - **Medication Regimen review**

Medication regimen review (MRR)



- **Intent**

- Assist facility maintain resident's highest practicable level of functioning by preventing or minimizing adverse consequences related to medication therapy

- **Goal**

- Preventing, identifying, reporting and resolving medication-related problems, or other irregularities through collaboration with interdisciplinary team

- **Minimum requirements**

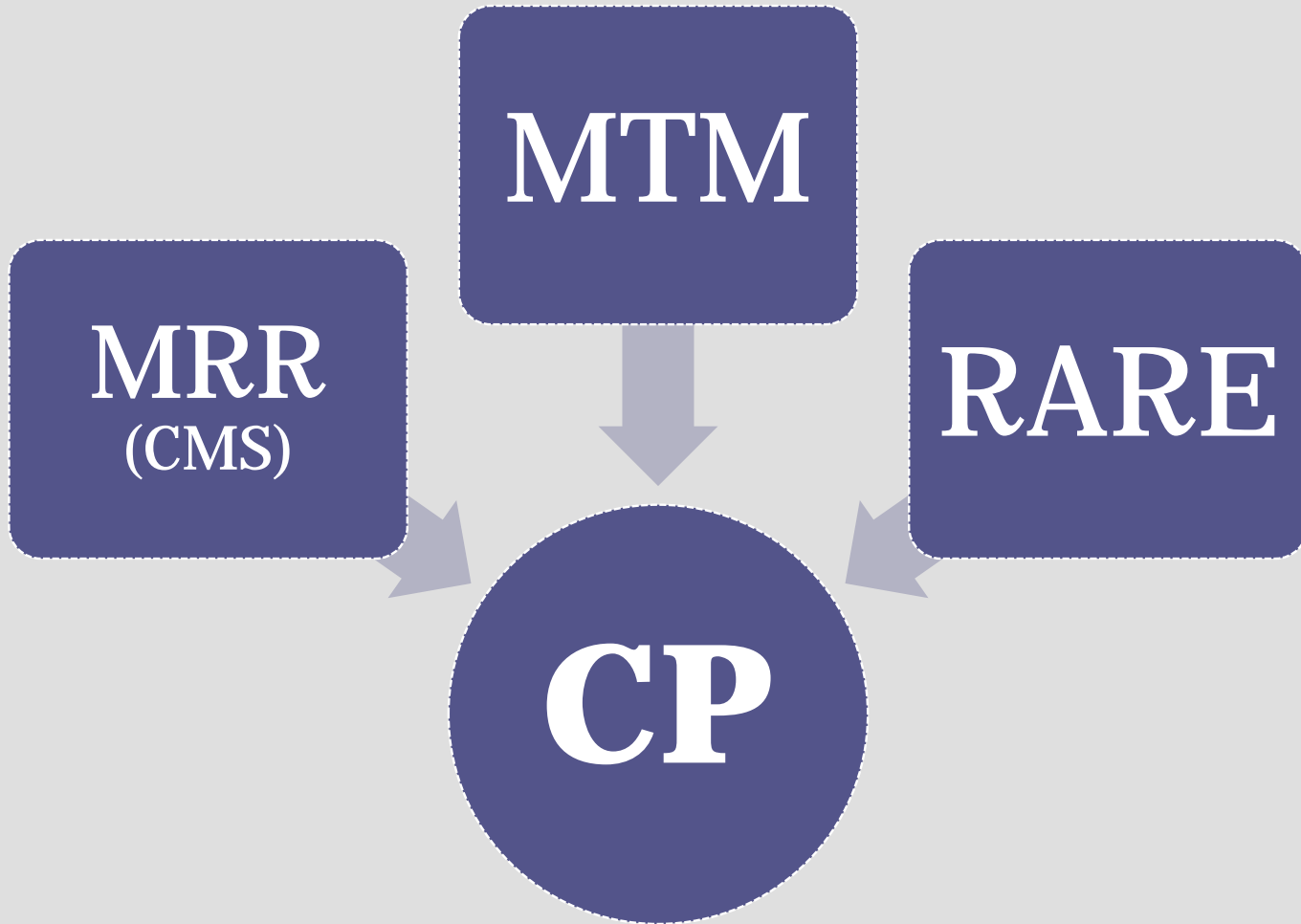
- Monthly review of each resident
- Establish procedures addressing MRR for:
 - ✦ ≤ 30 day admit
 - ✦ Acute change of condition (ACC)

≤ 30 day admission (SNF-TCU)



- Address in policy and procedures
- Increased frequency of consultant visits
- Information technology
 - EMR
 - Email
 - Fax
- Fee structure

Expanding opportunities



RARE – consultant pharmacist



- RARE recommendations for med management:
 - Ensure patient understands the “why”; “how”; “when” of medication use
 - Medication reconciliation
- Apply \leq 30 day admission/ACC policies
- Limitations
 - Medication counseling at TCU discharge
 - Limited availability for direct patient interaction
- **INVOLVE PROVIDER PHARMACY IN PATIENT’S MEDICATION MANAGEMENT UPON DISCHARGE FROM THE SNF-TCU**

requirements



PHARMACY AND TCU

INCENTIVE

WILLINGNESS

TIME

VIDEO CAPABILITY

HIPAA COMPLIANCE

PHARMACY

DC MED LIST

MED LIST B/4
HOSPITALIZATION?

CASE LOAD
EXPECTATIONS

PERFORMANCE
METRICS

TCU

POINT PERSON

SELECTION
CRITERIA

PERFORMANCE
METRICS

Selection criteria



Medication Hassles

- Polypharmacy
- Potentially inappropriate medications
- Medication regimen complexity



Poor Med Management

- Non-adherence
- Non-compliance



Hospital readmission



Medication regimen complexity



- Metered dose/dry powder inhalers
- Nebulizers
- Injectable medications
 - insulin
- Oral anticoagulant
 - Warfarin
 - Dabigatran (Pradaxa)
 - Rivaroxaban (Xarelto)
- Multiple daily dosing ($\geq 4x/day$)
- ≥ 10 routine medications

Next Webinar



Topic:

The Aging Network - Helping Older Adults Live Well at Home Today

Date: Tuesday, July 24, 2012

Time: 12 Noon – 1p.m. CDT

Future Topics:

To suggest future topics for this series, Reducing Avoidable Readmissions Effectively “RARE” Networking Webinars, contact Kathy Cummings, kcummings@icsi.org