Targeting transitions of care-Role of the pharmacist in a federally qualified health center

Bridget Bradley, PharmD, BCPP[1]
Sarah Deines, PharmD, BCACP[2]

[1]Assistant Professor, Pacific University School of Pharmacy, Hillsboro, OR
[2]Clinical Pharmacist, Virginia Garcia Memorial Health Center, Hillsboro, OR

ABSTRACT

Transitions of care in services within and between organizations are a potential source of medication-related problems. These include errors in medication reconciliation, which can lead to patient misunderstanding regarding their medication regimen. Health systems have increasingly focused on improving transitions of care to enhance patient outcomes and decrease the risk of adverse events and/or hospital readmissions. The clinical pharmacy team of the Virginia Garcia Memorial Health Center (VGMHC) collaborated with the pharmacy department and discharge planners of a local community hospital. The goal of this collaboration was to streamline the transition of care between the two organizations for new referrals of uninsured, complex patients that were recently hospitalized and needing to establish care with a primary care provider at a federally qualified health center. This article will further describe the process of collaboration between a local community hospital and a federally qualified health center targeting a specific population for transitions of care.

KEYWORDS

pharmacist, patient discharge, medically uninsured

DESCRIPTION OF PRACTICE SITE

Virginia Garcia Memorial Health Center (VGMHC) is a federally qualified health center (FQHC) located in Washington and Yamhill Counties, west of Portland, Oregon. Over the last 37 years, VGMHC has grown from a small, community-run clinic to a full-service community health center that serves more than 35,000 patients per year. VGMHC provides care through a medical home model with patient care teams comprised of providers (i.e., physicians, physician assistants, and/or nurse practitioners), medical assistants, nurses, team assistants (referrals) and patient care coordinators. The medical home model is based on delivering primary care in a comprehensive, coordinated, accessible, and patient centered manner with a focus on quality and safety.[1] VGMHC has four primary care clinics of which two currently offer clinical pharmacy services (CPS) with plans to expand pharmacy services to all four clinics. Each of the four primary care clinics also provides community pharmacy services. The clinical pharmacy team is located in the primary care clinic and includes one full-time clinical pharmacist, one clinical faculty from the local school of pharmacy, a clinical pharmacy technician and pharmacy students and/or residents. Clinical pharmacists provide disease state management through collaborative drug therapy management (CDTM) protocols for depression, anxiety, diabetes, hypertension, and hyperlipidemia. The CPS team also completes comprehensive medication reviews (CMR), medication reconciliation, and answers drug information questions as requested by providers. Over the last year, the CPS team has also begun focusing on improving transitions of care.

The health center has developed partnerships throughout the local area, including relationships with Pacific University's health sciences program and Tuality Healthcare. Pacific University School of Pharmacy has partnered with VGMHC for student advanced pharmacy practice experiences (APPEs) in the VGMHC community pharmacy and the VGMHC clinic, and through faculty practice sites in the primary care clinics. Tuality Healthcare operates a community hospital, which is located adjacent to the Hillsboro VGMHC clinic, and provides a majority of the emergency department and hospital care to patients of the clinic.

WHY WAS THIS CREATED?

It is well established that care transitions can be a source of adverse patient outcomes. This can include medication errors, adverse drug events, readmission to the hospital, and use of emergency room services.[2] VGMHC primary care providers identified this as an opportunity for our clinical pharmacy team to assist with medication

reconciliation, education on medication use, and to assist in identifying barriers to therapy and medication related problems. VGMHC serves patients that have been identified to be at risk of an adverse drug event during a care transition. Patients at risk of experiencing adverse drug events include those with the following characteristics: 1. limited health literacy, 2. prescribed five or more medications, 3. lower income status, and/or 4. those who frequently move or are homeless.[2]

The CPS team recognized that providers were seeing two types of hospital discharge visits: existing patients of VGMHC or those with community health resource (CHR) appointments for new referrals from the hospital for high needs patients. Existing VGMHC patients are either scheduled for hospital follow-up by the patient or by a number of different hospital personnel including unit secretaries, nurses, or providers. CHR appointments are for uninsured individuals with chronic conditions and no access to primary care, and these patients are identified and scheduled at VGMHC by Tuality's discharge planners. As there is limited availability of CHR referrals, only the highest needs patients (e.g., chronic diseases without insurance or primary care provider) are selected for referral.

VGMHC and Tuality Hospital decided to target CHR referrals as a first step in addressing transitions of care. This was decided due to the complexity and needs of new referral patients as well as the ease of training discharge planners on the proposed change in process. After identifying patients, Tuality discharge planners call VGMHC to schedule an appointment with a clinical pharmacist one hour prior to an appointment with a primary care provider (PCP) to establish care.

HOW WAS IT CREATED?

The CPS team began discussions with the pharmacy director at Tuality hospital about a process that would work to schedule CHR patients with a clinical pharmacy appointment prior to the PCP appointment. The CPS team and Tuality pharmacy director then met with the case management supervisor to discuss the program and training needs for the staff of both organizations. These discussions identified that the best way to ensure that appropriate scheduling was completed was to train the discharge planners regarding this new process. The CPS team also worked with the VGMHC clinic manager to educate front staff personnel regarding this new scheduling process. The clinic manager adjusted the provider and pharmacist CHR appointment slots to ensure that a clinical pharmacist would be available prior to the PCP appointment to establish care. Targeting a small and unique population within VGMHC decreased the number of personnel requiring training and allowed for quick adjustments to be made when the program was not working optimally.

WHAT IS THE EVIDENCE SUPPORTING THIS TYPE OF TRANSITIONS IN CARE PROGRAM (OR SIMILAR PROGRAMS)?

The pharmacist in care transitions is documented to be an underused member of the healthcare team.[2] This has been a focus as the post-discharge period increases the risk of adverse drug events (ADEs) and most of these ADEs could have been prevented through improved communication and coordination of care.[3] It is estimated that 12% to 19% of patients experience an ADE after hospital discharge and a large percentage of these ADEs may have been preventable or severity could have been decreased. The role of the pharmacists in the ability to manage such ADEs has previously been supported in the literature.[4,5] The ADEs experienced at care transitions can result in emergency department visits and hospital readmissions.[4] The inpatient setting has been a focus of transitions of care. Specifically, medication reconciliation related to the Joint Commission National Patient Safety Goal that states: the health-system should maintain and communicate accurate patient medication information.[5] The Pharmacist Intervention for Low Literacy in Cardiovascular Disease (PILL-CVD) study focused on pharmacists working in an inpatient setting providing medication reconciliation upon admission and discharge, counseling early in hospitalization, and discharge counseling to improve care transitions.[3] Pharmacists that participated in this study were interviewed and reported that the most important component of the intervention was the medication reconciliation but felt that all the interventions were valuable.[3] The patient perspective is also important during care transitions and the study by Cawthon et al. found that patients perceive a pharmacist-led intervention to be very helpful.[6] Patients specifically noted that discharge counseling provided by the pharmacists that addressed proper medication administration as well as potential side effects and their management was found to be the most beneficial information provided to the patient. Expanding the focus to ambulatory care settings is a natural step as many patients after discharge are scheduled with their primary care provider or specialists for follow up.

WHAT OCCURS AT THE CLINICAL PHARMACY APPOINTMENT?

The day prior to the visit, the clinical pharmacy technician contacts the patient and prints the previous discharge

summary. (See Figure 1). During the clinical pharmacy appointment, the patient is triaged and meets with the clinical pharmacist who provides a comprehensive medication review modeled after published resources (see Figure 2).[7]

WHAT BARRIERS (OR OTHER PHARMACOTHERAPY ISSUES) ARE FOCUSED ON AT THE CLINICAL PHARMACY APPOINTMENT?

The focus of these appointments is to address any potential adherence issues as the patient may have been discharged with a number of medications. A common potential barrier is cost for this patient population and the visit allows time to assist the patient with completing prescription assistance program paperwork, if applicable. The visit also focuses on the CPS team entering medications into the patient's electronic medical record for the provider to sign and order for the patient. At the appointment with the CPS, it is important that the discussion regarding the preferred pharmacy is identified to assist with a smooth transition for filling medications.

CONCLUSION

The transitions of care program has been successful in orienting patients to clinical pharmacy services at VGMHC and for identifying barriers to medication adherence. This program has also resulted in CDTM referrals to CPS for these high-risk patients without previous primary care services. Based on the success of this targeted transitions of care program for CHR patients, the VGMHC providers have requested expansion of the dual pharmacist/provider visit for all hospital discharge patients. The PGY1 Community Pharmacy resident is focusing on this workflow as part of a residency project this year.

Figure 1. Clinical Pharmacy Services Workflow Prior to Patient Visit

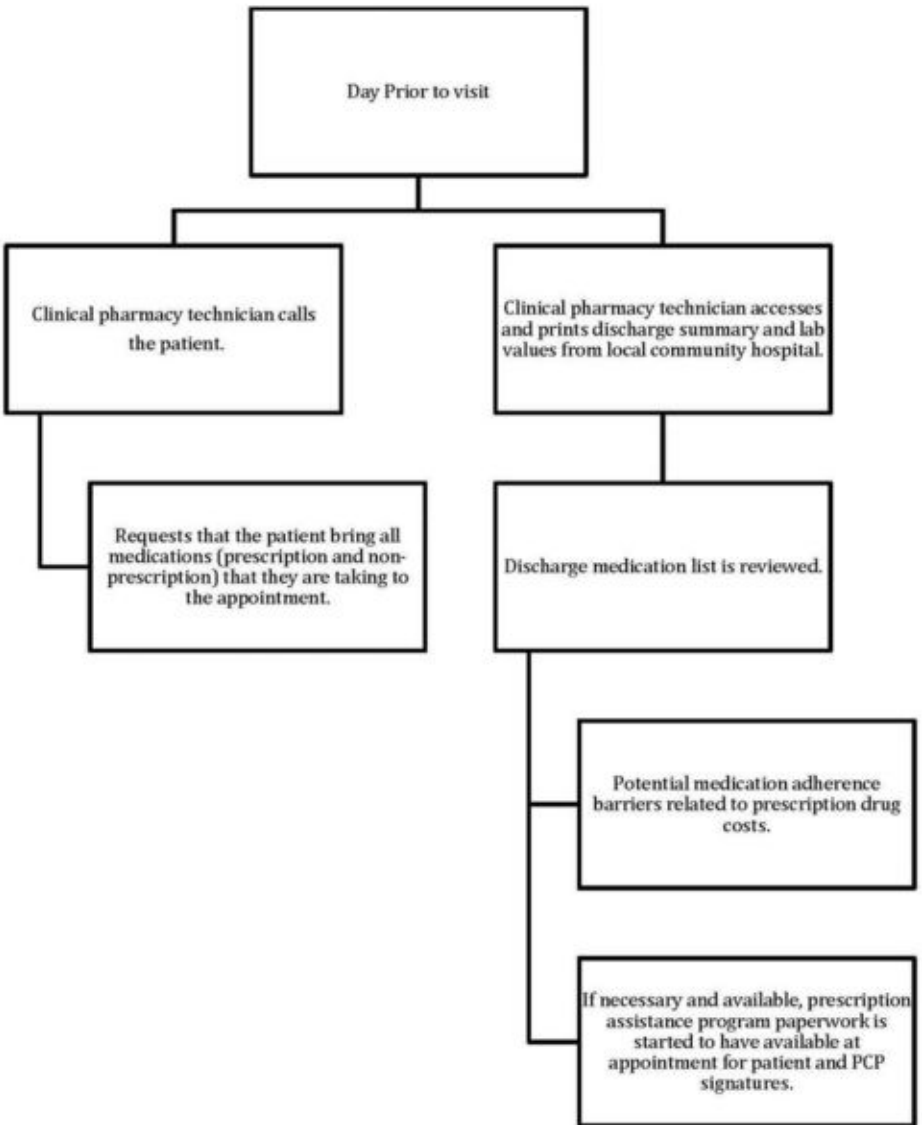
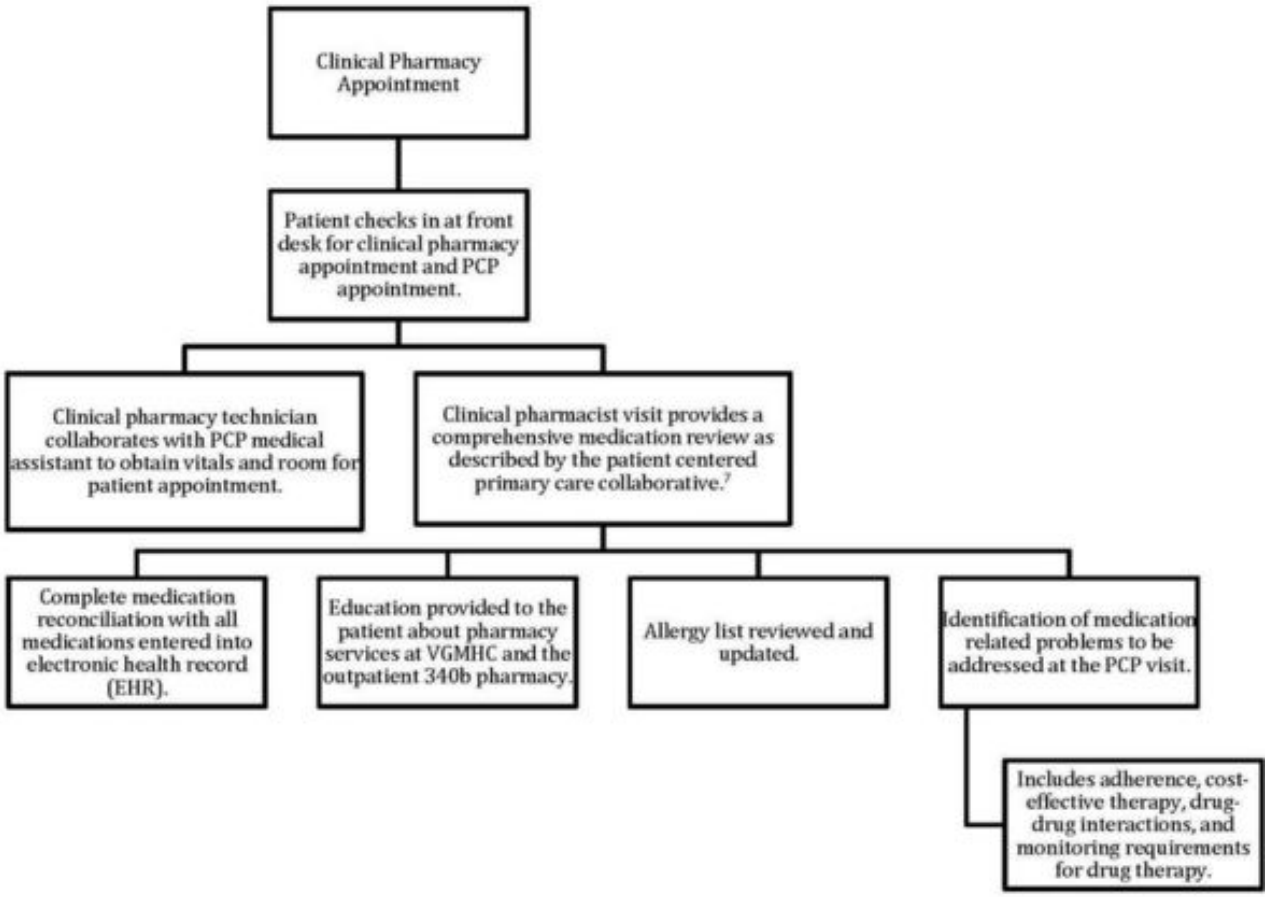


Figure 2. Clinical Pharmacy Services Appointment Workflow



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