A New Spin on Transitions of Care: Bridging the Gap between Inpatient and Outpatient Settings

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Objective

1. Describe the process of establishing the pharmacists' role in transitional care by linking the inpatient and outpatient settings.

Background

- High risk of **negative outcomes** during care transitions
- Multidisciplinary healthcare teams are **complex and can contribute to confusion**
  - Important to have a "point person" (i.e. RN transitional care manager)
- **Benefits of adding a pharmacist** to the transitional care team are well-established in the literature
  - Decreased readmission rates / increased time to readmission
  - Improvement in chronic disease states
  - Identification and resolution of medication-related problems
- Currently there are **no standard workflow processes or defined roles** for pharmacists within the transitional care team

Key Steps

Why

- What is the goal of the service?

Where

- Inpatient, outpatient, or both?

Who

- Which patients will receive pharmacist services?

How

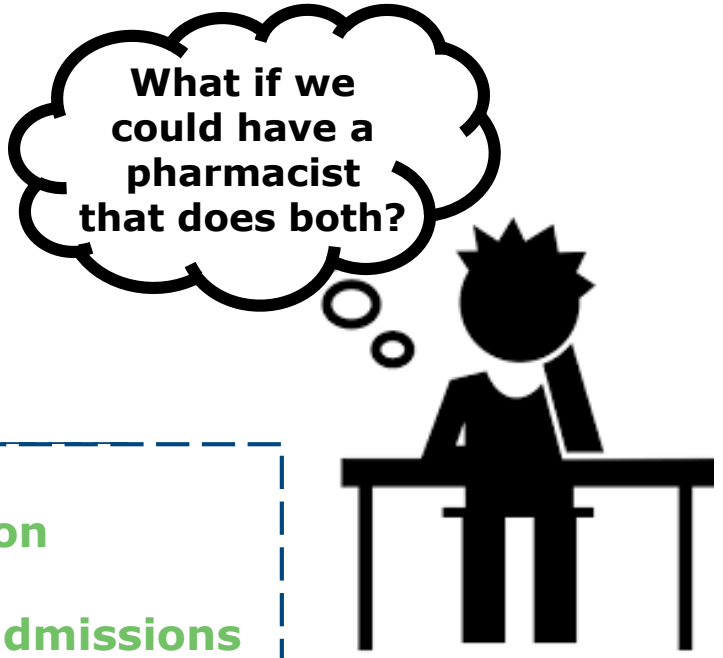
- What does the day-to-day workflow look like?

Step 1: "WHY are we doing this?"

1. Return on investment
   - Decrease readmissions
   - Increase contact with PCP
   - Improvement in disease-specific outcomes
2. Goals of leadership at your institution
3. Provider-identified needs
4. Financial incentives
5. Patient-centered, high-quality, care

Step 2: "WHERE does the Pharmacist fit in?"

Inpatient:
- ~~Medication reconciliation~~
- ~~Discharge counseling~~
- **Assist with patient access to medications**



~~OR~~ **AND**

Outpatient:
- **Follow-up on items deferred during admission**
- **Provide additional counseling/education**
- **Optimize medication regimen to prevent readmissions**

Hawes EM, et al. Journal of Primary Care & Community Health. 2013;5(1):14–8.
Hawes EM, et al. North Carolina Medical Journal. 2018;79(1):4–13.
Arnold ME, et al. American Journal of Health-System Pharmacy. 2015;72(11_Supplement_1).

Step 3: "WHO receives Pharmacist services?"

Considerations:

- Available, validated, risk-assessment tools:
  - HOSPITAL score
  - LACE score
  - MEDCOINS score
- Medicare high-cost readmission diagnoses
- Feasibility:
  - Number of patients pharmacist can intervene on consistently
  - Tools already built into your electronic medical record (EMR)

vs.

3. Complex medication regimen:

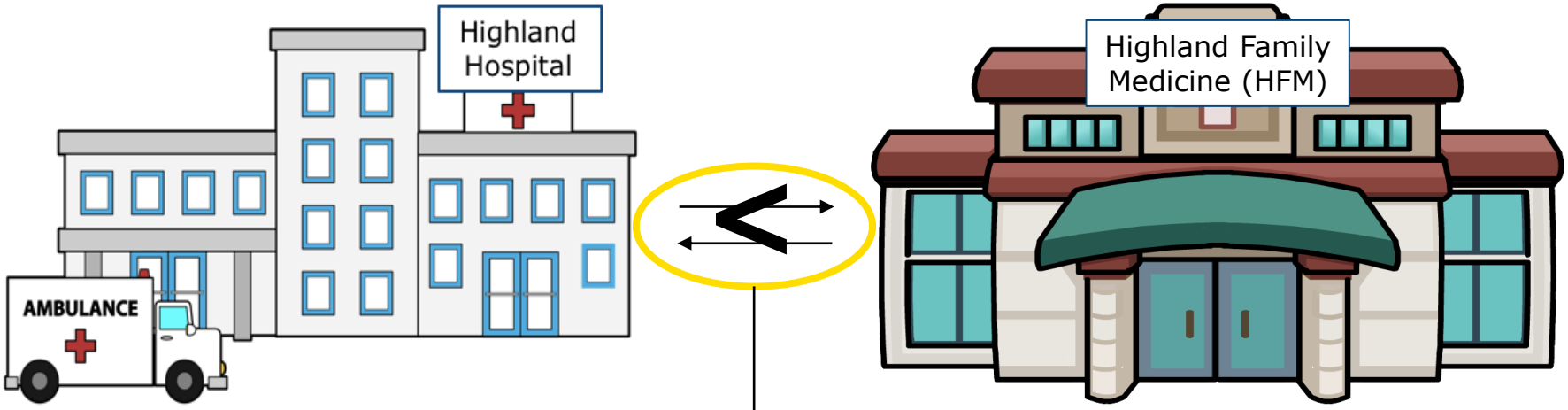
Individualized factors:

- Who are:
  - Your most at risk populations?
  - Your highest-utilizers?
  - The patients that fit within your overall goal?

Step 4: "HOW is this model going to look?"

Pharmacist's role on our TCM team:

- Approximately 50% of time is dedicated to TCM services

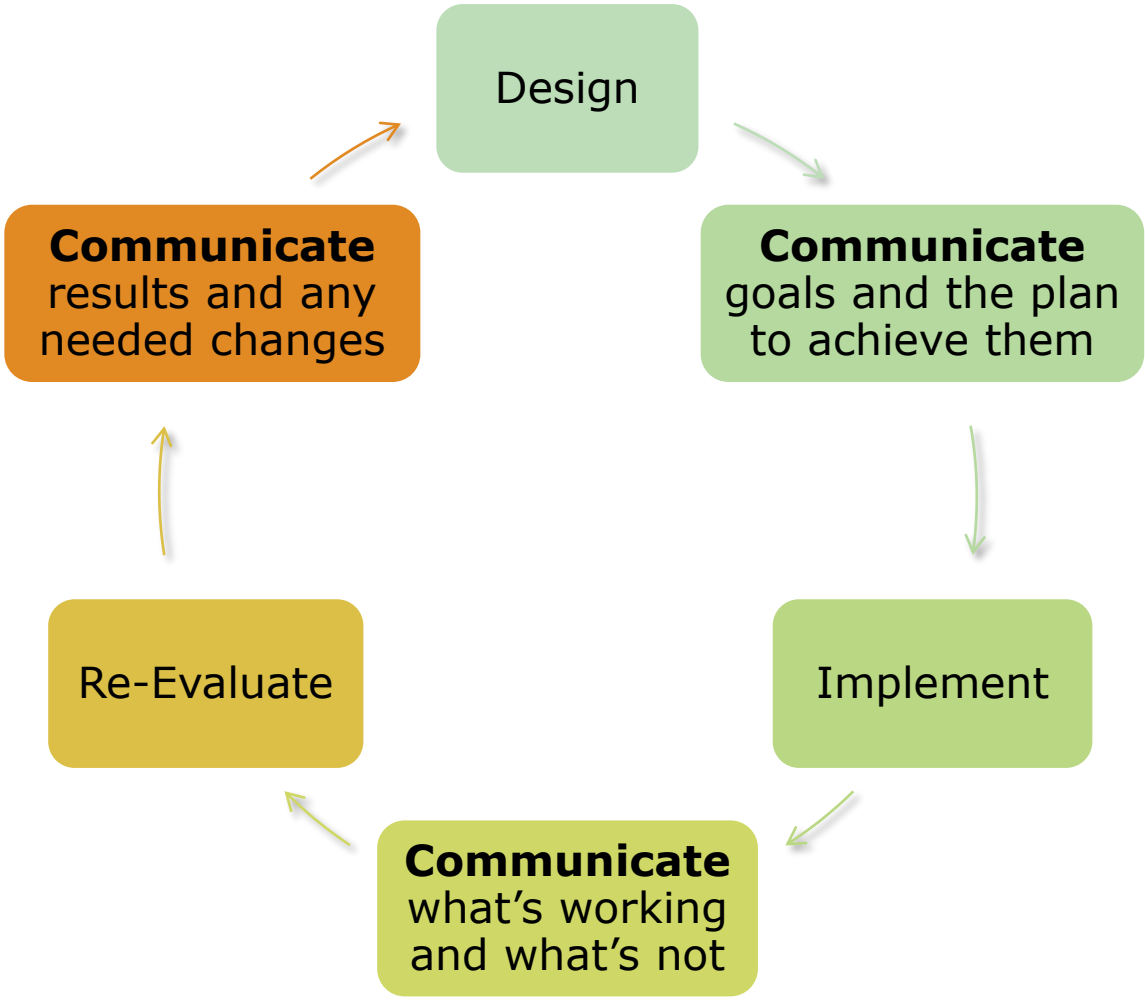


- Interdisciplinary rounds 2x/week
- Initial contact with patients
- Identify/resolve access barriers

RN TCM and Pharmacist provide continuity and consistency for patients by serving as "links" between the inpatient and outpatient settings

- Discharge co-visits with providers:
- Follow-up on "loose-ends" from admission
- Provide counseling/education
- Optimize medication regimen

Process of Continuous Improvement



Conclusions

- Incorporating a pharmacist onto the transitional care team improves overall health outcomes and increases quality of care.

- Following a stepwise process helps with successful integration of a pharmacist into the transitional care setting.
  - Allows for tailoring of individual components based on site-specific needs

- Frequent communication and re-evaluation of processes are key

- Positive outcomes seen after short period of time / small # of patients
  - Improvement in disease-specific outcomes
  - Increased continuity of care
  - Decreased readmissions