

# Integrating Pharmacists into Primary Care and Prevention Efforts

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## Background:

Piscataquis County and Dexter, Maine: An under-served county with a population with low health scores, higher incidence of opioid overdose mortality.

Also, high treatment costs threaten long term institutionalization, costing USD 1,600/month more to CMS (2012), thus Fall Prevention is also a priority area for improvement. (1)

## Problem:

Medication misadventures are a lead contributor to US medical malpractice entailing approximately 1,000 deaths daily. (2) Upwards to \$300 billion annually are attributed to medication mismanagement in US ambulatory care patients. (3) “Practices such as **pharmacist-led medication reconciliation** and **review of high-risk medication use** are two evidence-based solutions that have a **persistent implementation gap** ... worthy of further study” – AHRQ Technical Brief, 10/19/16. (4)

The Community Pharmacy Foundation awarded a grant to Dragatsi & Co. for a demonstration project aimed at serving patients who suffer from two or more chronic disease conditions, who wish to remain home based and who live in an underserved area with low health scores. This followed another medication-review project through which the author was consulted by providers who served complex, chronically ill patients and showed an ROI of 1:24.

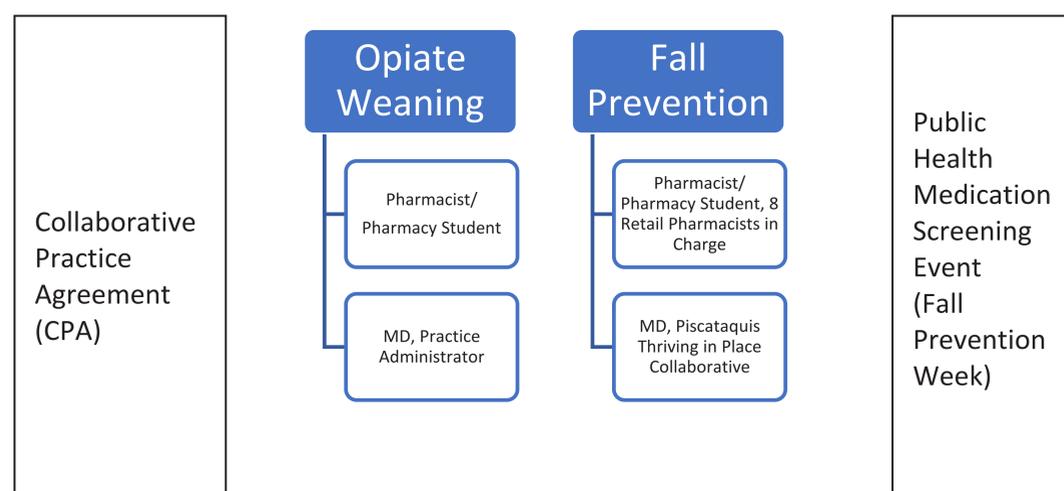
## Results:

**Primary Care Opiate Weaning: 43% reduction in Morphine Sulfate Equivalent (MSE) load in 30 patients over 6 months;** no pain related ER/hospital visits, maintained or improved customer satisfaction scores.

**Fall Prevention Week: \$279,103 worth of preventable adverse drug events identified in 25 patients.**

**Overall (Grant) Outcome: institutionalization did not occur** for any eligible patients receiving pharmacist intervention over 11 months.

## Strategy



The grant project had a two-pronged approach based on new statewide legislative opiate limit requirements applicable to primary care practices, and Piscataquis Thriving in Place Collaborative area needs assessment for fall prevention.

**Collaborative Practice Agreement:** 30 patients were seen one on one by the pharmacist and physician to determine optimal over-the-counter medicine/supplement/herbal adjunctive therapy during weaning, then mandatory group teaching (3 sessions over 3 months), then as a physician-pharmacist team with the patient and caregiver. Patients expressed feedback to physician, completed satisfaction surveys and completed group teaching post-test evaluations. Area pharmacists were integrated into clinical follow-up for continuity of care and coaching.

**Fall Prevention Week Medication Screening:** Community and pharmacy screening events were scheduled. All eight pharmacies in the project catchment area participated. An AHRQ medication fall risk assessment tool was circulated with one session of training and the event was publicized. A form letter was prepared identifying medications requiring discussion, and appropriate collaboration was set up between the retail pharmacist and the provider to follow up medical reconciliation and clinical issues.

**Ongoing Challenge:** integration of new role of collaborative provider into existing reimbursement structure.

## Take Home Message

**Pharmacists, when strategically positioned as collaborating care providers can help restore an interrupted medication safety net, encourage consumer engagement and demonstrate significant gains towards improved healthcare quality and reduced costs.**

## References:

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- 3) NEHI Research Brief, “Thinking Outside the Pillbox & System-wide Approach to Improving Patient Medication Adherence for Chronic Disease, NEHI, 2009.
- 4) Shekelle, P et al, Patient Safety in Ambulatory Settings, AHRQ Technical Brief #27, October 19, 2016

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