



## COMPLETED GRANT SYNOPSIS

### Creating a Model for Successful Integration of a Community Pharmacist Into the Care Transition Process

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#### Objectives

- Identify care transition needs in a local community that can be met by a community pharmacist.
- Design a care transition program that utilizes the community pharmacist for patients being discharged from hospital to home.
- Establish a formal partnership with a community hospital.
- Obtain access to the hospital’s electronic medical record.
- Create a process for hospital staff to efficiently refer patients for care transition services.
- Evaluate the impact of community pharmacist interventions on 30-day hospital readmission rates.
- Explore payment model options that support sustainability of a community pharmacist-led care transition service.
- Develop guidance on best practices for implementing a community pharmacist-led transition of care service

#### Methods

##### Design

- A prospective pilot study was conducted between October 5, 2016 and February 26, 2017 by a community pharmacy and acute care hospital in eastern North Carolina.
- The community pharmacy was granted remote access to the hospital’s electronic health record (EHR)
- Patients over the age of 18 who were able to independently provide consent or who had a legal representative available to provide consent for them were screened by nursing staff after admission to determine their interest in receiving care transition services from a community pharmacist prior to discharge.
- An automated report of patients admitted in the previous 24 hours and their consent status was sent to the community pharmacy via secure email each morning.
- The community pharmacist accessed the electronic chart for consenting patients to review admitting diagnosis, medication list and pertinent medical history.
- A member of the pharmacy staff went onsite to the hospital, Monday through Friday, to meet with patients who provided consent, assess anticipated follow-up needs and identify potential barriers to medication adherence.
- Patients were monitored remotely by the community pharmacist during their hospital stay using the electronic medical record.
- Filling discharge prescriptions with the community pharmacy providing the service was not a requirement for enrollment in the study; however, patients who elected this option received all maintenance medications in weekly adherence packs delivered to the hospital bedside or to the patient’s home within 24 hours of discharge.
- All enrolled patients received a phone call from the community pharmacist within twenty-four

	<p>hours of discharge to provide disease state and medication education and assess whether all discharge prescriptions were dispensed.</p> <ul style="list-style-type: none"> <li>• The community pharmacist faxed a reconciled medication list to the patient’s primary care provider at discharge, along with a summary of topics discussed with the patient and any drug therapy problems.</li> <li>• Patients received follow-up calls from the community pharmacist at 5, 14 and 25 days after discharge to assess medication adherence, verify follow-up with a primary care provider, reinforce disease state education, address any patient questions or concerns and determine if hospital readmission had occurred since initial discharge date.</li> </ul>
Study endpoints	<ul style="list-style-type: none"> <li>• Establish a formal relationship between the community pharmacy and the hospital.</li> <li>• Gain remote access to the hospital EHR.</li> <li>• Implement a patient referral process between the hospital and community pharmacy.</li> <li>• Evaluate the effect, if any, of community pharmacist intervention on all cause readmissions for the hospital.</li> <li>• Create a payment model to sustain community pharmacist provided transition of care services.</li> </ul>

**Results**

- Between October 5, 2016 and February 26, 2017, a total of 332 patients who met study inclusion criteria were admitted to the hospital.
  - 18 patients were enrolled in the study and received care transition services from the community pharmacist.
  - Patients who declined to enroll in the study (n=235) served as the control group. Other reasons for non-enrollment included: no consent response documented on the daily report (n=63) and transfer to another facility or discharged within 24 hours of admission (n=16).
  - 61% (n=11) of participants had multiple chronic conditions with COPD (56%, n=10), heart failure (50%, n=9) and diabetes (33%, n=6) being the most prevalent.
  - 11% (n=2) of patients enrolled in the study were readmitted to the hospital within 30 days compared with 24% (n=75) from the control group.
  - This study was not powered to show statistical significance between the intervention and control groups.
  - Among study participants, the mean number of active medications on admission was 8. The mean number of active medications at discharge was 11.
  - A total of 42 drug therapy problems were resolved by the community pharmacist during the study period. Duplicate therapy (n=4) and missing therapy (n=32) were the most commonly identified problems at discharge.
- At the conclusion of the pilot study, the hospital requested an indefinite extension of the partnership and added the offer of community pharmacist care transition services as a required step during the admissions process. The automated daily referral reports sent to the pharmacy each day established an efficient and effective means for hospital staff to identify patients with medication-related and/or post-discharge follow-up needs.
- Pharmacy revenue was tracked using prescription filling data from enrolled patients during the initial pilot study period and beyond. From October 5, 2016 through December 6, 2017, a total of 73 patients consented to the care transition service.
  - 59% (n=43) of those were not currently filling any prescriptions with the study pharmacy.
  - 49% (n=21) of those patients elected to fill their discharge prescriptions with the study

pharmacy, for a total of 134 unique, first-fill prescriptions.

- The success of community pharmacist interventions post-discharge was recognized by local physicians and led to the development of additional partnerships between the community pharmacy and outpatient providers for the provision of chronic care management services.
- A consolidated list of best practices based on lessons learned during the development of the service was established to help facilitate the success of future care transition initiatives by other community pharmacists.

### Conclusion

This grant funded study shows that successful integration of a community pharmacist into the care transition process can be accomplished with effective planning and careful development. The idea for this pilot study evolved following an initial assessment of gaps in locally available care transition services. An analysis of the hospital's readmission rates and quality star ratings, along with an understanding of the hospital's staffing structure helped identify areas in the local care transition spectrum in which a community pharmacist could provide helpful intervention, such as medication reconciliation and coordination of prescription delivery to patients at discharge. The end result is the Transition to Wellness program, a unique transition of care partnership between Realo Discount Drugs and Onslow Memorial Hospital in Jacksonville, NC.

Many of the study objectives were not as difficult to achieve as initially anticipated. For example, gaining remote access to the hospital electronic record was easily established once a business associate agreement was signed between the pharmacy and the hospital. Other objectives incurred unanticipated tasks, such as protecting the hospital's need to remain impartial when discussing community pharmacy services. This was accomplished by creating a comparison card, presented to every patient on admission, listing all local pharmacies and the services offered by each. However, there were barriers to program development and success, such as changing stereotyped perceptions about the services provided by a community pharmacist, that were more difficult than originally anticipated. This is reflected in the relatively low numbers of referrals during the initial months of the service.

In-service trainings were offered for clinical staff at the hospital as well as discharge planners, patient care coordinators and others involved in the admission and discharge processes. Having the pharmacist maintain a regular presence at the hospital by going onsite to see patients in the early stages of the study facilitated the success of the paradigm shift. Staffing concerns were addressed by utilizing the community pharmacy's PGY1 resident in addition to a part-time clinical pharmacist during this initial phase. At the end of the grant period, it was determined that the service could be better sustained by utilizing the PGY1 resident or a pharmacy technician experienced with medication reconciliation and documentation to perform the intake visit at the hospital. All patient follow-up continues to be completed by a community pharmacist or PGY1 resident. The number of unique, first-fill prescriptions that resulted from the program suggests that this type of model can be sustainable. A community pharmacy interested in creating a similar partnership should consider the hospital's daily admission rates balanced against pharmacist FTEs that need to be dedicated off-site at the hospital as the program is initiated and relationships with providers are formed.

This study was not structured to look at billing opportunities using Medicare's Transitional Care Management (TCM) service codes; however, community pharmacists should be aware that programs like the one described in this report will satisfy some, but not all, of the requirements for service billing. Therefore, community pharmacies who wish to start a transition of care program that includes these services will need to enter into a structured arrangement with a billing provider who is able to perform the face-to-face visit component of the

TCM codes. Realo continues to evaluate the potential for inclusion of TCM services as part of the Transition to Wellness program.

The relationship between the hospital and the pharmacy has extended well beyond the initial scope of this project. Realo continues to partner with the hospital in support of community health outreach events, which provides an opportunity to work side-by-side with hospital staff, demonstrating the pharmacist's patient care skills as well as knowledge of disease states and treatment regimens. The benefits of including a community pharmacist as part of the patient-centered care team have been highlighted by positive feedback about the Transition to Wellness program from hospital staff and the number of quality interventions communicated with providers. This has led to business partnerships between Realo and providers across the state of NC for the provision of other services, such as chronic care management and remote patient monitoring.