

Implementation of a Pilot Pharmacist-Led Post-Discharge Transitions of Care Service



Lyndsay Ryan, PharmD (PGY1); Leah Rappsilber, PharmD (PGY2); Faculty Advisors: Crystal David, PharmD, BCPS; Anjly Kunapuli, PharmD, John Bury, PharmD, BCBS, MBA | Oklahoma State University Medical Center, Tulsa, OK; Oklahoma State University Center for Health Sciences, Tulsa, OK

BACKGROUND

- Medication discrepancies during transitions of care can negatively affect patient outcomes making medication assessment an important aspect of patient safety¹
- The Institute of Medicine estimated that medication errors cause 1 of 131 outpatient and 1 of 854 inpatient deaths²
- Prescription errors make up 70% of medication errors that could possibly result in adverse effects³
- The most recent National Patient Safety Goals, effective January 1, 2020, state that maintaining and communicating accurate patient medication information is imperative to improving patient outcomes by decreasing the amount of medication discrepancies⁴
- An increase in the prevalence of chronic disease states and the complexity of the medication regimens often required to manage them has led to a pressing need for improved multidisciplinary collaboration with medication reconciliation in the ambulatory care setting to ensure positive clinical outcomes and patient safety
- To ensure a continuity of care, pharmacists are well equipped with the tools to perform a comprehensive medication assessment that can reduce readmission rates and cost avoidance⁵

OBJECTIVES

The objective of this study was to assess the feasibility and impact of a quality improvement initiative involving recently discharged patients from the Family Medicine Service from OSU Medical Center, utilizing a pilot telephonic pharmacist-led transitions of care program.



METHODS

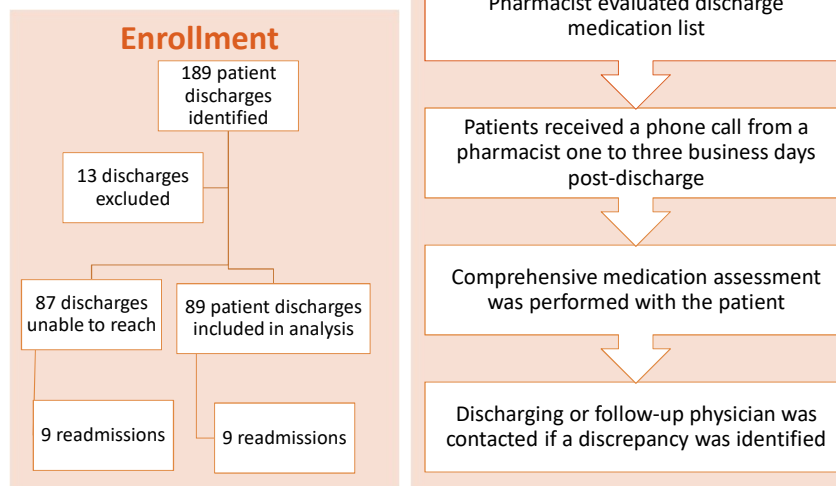
Inclusion Criteria

- ≥ 18 years of age
- English-speaking
- Discharged from inpatient Family Medicine Services
- Scheduled follow up appointment with the Family Medicine Clinic
- Available discharge summary with medication lists

Exclusion Criteria

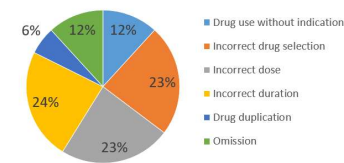
- Pregnancy
- Any patients discharged to a nursing home, psychiatric facility, skilled nursing facility, long-term acute care facility, or prison

Transitions of Care Process

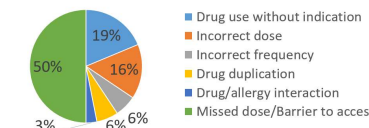


RESULTS

Prescribing Errors Identified Upon Discharge



Errors Identified After Patient Phone Call



30-day Hospital Re-admission Rate

	Received TOC service (n = 9)	Did not receive TOC service (n = 9)
Number of 30-day re-admitted patients – no. (%)	7 (77.8)	6 (66.7)

Through this project, errors were identified and corrected using medication reconciliation, clinical interventions, and patient education. By identifying what kinds of errors are most common, we were able to determine which areas pharmacists are able to intervene to decrease medication errors. Implementing this pharmacist-led transitions of care program allowed for improved healthcare collaboration to ensure patient safety and decrease healthcare costs

DISCLOSURES

No authors of this presentation have anything to disclose concerning possible financial or personal relationships with commercial entities that may have a direct or indirect interest in the subject matter of this presentation.

REFERENCES

- Forster, A. J., Murff, H. J., Peterson, J. F., Gandhi, T. K., & Bates, D. W. (2003). The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital. *Annals of Internal Medicine*, 138(3), 161.
- Witch, C. (2014). Medication errors: an overview for clinicians. *Mayo Clin Proc*, 2014 Aug;89(8):1116-25.
- Velo, G. (2009). Medication errors: prescribing faults and prescription errors. *Br J Clin Pharmacol*, 67(6): 624-628.
- Ambulatory Health Care 2020 National Patient Safety Goals. (n.d.). Retrieved June 24, 2020
- Holt, K., & Thompson, A. (2018). Implementation of a Medication Reconciliation Process in an Internal Medicine Clinic at an Academic Medical Center. *Pharmacy*, 6(2), 26. doi:10.3390/pharmacy602026