Practice Spotlight

Dignity Health- Northridge Hospital Medical Center
Chronic Disease and Transitional Care
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IN YOUR VIEW, HOW WOULD YOU DEFINE THE IDEAL PRACTICE ADVANCEMENT INITIATIVE?

To understand the unique needs of each patient, the ideal practice model involves a transitional care program where chronic disease patients are followed from the time of their admission though their discharge and as they transition back home. The ideal model involves a team of physicians, nurse practitioners, nurses, social workers, and pharmacists who work collaboratively with patients, care partners, and other medical personnel, as well as skilled nursing facilities and home health agencies to focus on the patients’ health, satisfaction, and reduced readmission rates. Our Chronic Disease and Transitional Care Program launched in January 2015 and saw more than 3,800 patient encounters in the first year of operation. The program has grown extensively and patient encounters now average 7,300 annually.

HOW DO PHARMACISTS IN YOUR RE-DESIGNED PHARMACY PRACTICE ADVANCEMENT INITIATIVE PROVIDE CARE TO PATIENTS AND ENSURE SAFE AND EFFECTIVE MEDICATION THERAPY?

The pharmacists in our Chronic Disease and Transitional Care Program are directly involved in our patients care in various ways. Once we have identified our patients, our pharmacists prepare them with discharge counseling before they leave.

Our pharmacists perform medication therapy management, in conjunction with the nurse practitioners, to provide recommendations for changes in patient medication regimens in correlation with patient diagnosis. Our pharmacists also perform discharge medication reconciliations for patients going home or patients who transfer to one of our collaborating skilled nursing facilities. Medication reconciliation is the process of comparing a patient’s medication orders to all of the medications that the patient has been taking. This is done at the time of discharge, where new medications are ordered and existing orders are rewritten. Most of the discrepancies or medication errors are caught during the medication reconciliation process. Any mitigations are then discussed between the pharmacists and physicians, who together find resolutions and communicate back to the patient. Mitigations may include, but are not limited to: incorrect doses, duplicate medications, omissions, drug interactions, insurance issues, medication history conflicts, and gaps in care.

Pharmacists make home visits to assist patients with understanding their medications, empowering them with autonomy over their medications and an opportunity to take an active role in their own care. We also ensure that patients have access to their medications and account for any missing medications. Patients are taught how to store and when to administer their medications, their indications, any side effects they may experience and warnings to be aware of.

Pain management and diabetes management education has become another area of pharmacy focus. Pharmacists are involved in selecting appropriate medication therapy for the pain management team, as well as, identifying appropriate candidates for pain management consults. Our pharmacists are also involved in newly diagnosed diabetes patient education,
which involves blood glucose monitoring, medication management services, and disease state education.

**WHAT SERVICES HAVE YOU DETERMINED TO BE ESSENTIAL TO SUPPORT YOUR PHARMACY PRACTICE ADVANCEMENT INITIATIVE?**

Pharmacist-led medication reconciliation seven days per week is essential in supporting our pharmacy practice advancement initiative. Collaboration with nurse practitioners in our program has also been essential to expand the pharmacists’ role in medication therapy management, dosage adjustments, recommendations and lab monitoring. After the nurse practitioners perform their physical assessments, the pharmacists are consulted for medication changes. Our medical director also provided essential guidance and support with clinical decision making.

Including pharmacists in home visits is also crucial to ensuring medication compliance by our patients. Patient education and consultations have played a large role in patient medication compliance.

Collaborating with skilled nursing facilities (SNFs) has also assisted in providing better patient care to those who use one of ten collaborating SNFs. This has allowed for ease of access to our patients. Additionally, we conduct weekly conference calls to share key learnings, patient outcomes and best practices.

We have also developed relationships with local pharmacies that deliver bedside medications to the patients prior to discharge from the hospital, so that patients have their prescriptions in hand while receiving a consultation.

**WHAT TECHNOLOGIES HAVE YOU IMPLEMENTED WITHIN YOUR PRACTICE SITE TO FACILITATE YOUR PRACTICE ADVANCEMENT INITIATIVE?**

We have implemented the use of OnePass, a more effective and secure HIPAA compliant text messaging application platform for communication between our physicians, pharmacists, nurse practitioners (NPs), collaborating SNFs and home health agencies.

We have also implemented EMMI, our electronic automated phone call system that phones patients who are enrolled in our services on a daily basis, and asks them a series of disease related questions. EMMI alerts our pharmacists and NPs daily of any critical changes in health status that need follow up.

We have developed remote access to the Medication Administration Record (MAR) for our patients at our collaborating SNFs. These portals allow us to access all of our patients’ medications and ensure that all the medications prescribed for our patients are accurately transitioned over to the SNFs.
Lastly, we have implemented the use of EDDIE, an internal electronic data system used by the pharmacist to determine how many different emergency departments patients have visited. This is used along with CURES, the California controlled substance database, which identifies patients’ current controlled substance prescription usage. These tools are used in combination in an effort to prevent unnecessary hospital admissions.

**HOW WOULD YOU SHARE THE SUCCESSES OF YOUR PRACTICE ADVANCEMENT INITIATIVE WITH OTHER PHARMACY DIRECTORS AND ADMINISTRATORS?**

We share the success of our program by collecting data and demonstrating our results. Overall, we have seen a yearly decrease in readmission rates from patients who went to SNFs and patients that went home. We have also seen a decrease in pharmacist medication reconciliation mitigations and medication errors as prescribers are being made aware of the mitigations that are found. The estimated number of dollars saved from reduced readmissions and shorter hospital length of stay between June of 2016 and July of 2018 at our facility is over $20 million. We share our advancement and success both internally and externally. We provide service line presentations to senior leadership, the community board and foundation board, as well as present data at monthly operative meetings. We share information externally with Health Service Advisory Group (HSAG) for Medicare data, as well as medical groups we collaborate with, such as Health Care Partners.

**WHAT ARE SOME KEY CONSIDERATIONS TO GAIN EMPLOYEE ACCEPTANCE AND BUY-IN TO IMPLEMENT A NEW PRACTICE ADVANCEMENT INITIATIVE?**

Collaboration with other healthcare providers is crucial. Setting goals, establishing new initiatives and accomplishing them builds trust between staff and encourages a team effort. Understanding the unique clinical skills of a pharmacist is important in distinguishing them from other health care providers. Pharmacists are distinguished based on their vast knowledge of medication management. It is also important to understand the priorities of the organization’s leadership and ensure that the new practice advancement initiative goals are properly aligned with the goals of the organization.

**HOW DID YOU GAIN SUPPORT OF ADMINISTRATORS, PHYSICIANS, AND NURSING TO IMPLEMENT YOUR NEW PRACTICE ADVANCEMENT INITIATIVE?**

Physician, nursing, ancillary, leadership, and the foundation staffs were all part of the program design in the initial phases of our Chronic Disease and Transitional Care Program. The framework for our program was Project BOOST, which we use as our patient assessment tool. The Coleman and Naylor transitional care model was the inspiration for our post discharge care delivery. Communication with the medical staff and pharmacy’s response to consults helped us gain support of administrators. Additionally, we also received support in the form of grant funding from Cardinal and UniHealth that has enabled us to have the manpower for all of our services for the following three years.
WHAT ARE SOME LESSONS LEARNED WHILE IMPLEMENTING YOUR PRACTICE ADVANCEMENT INITIATIVE THAT YOU WOULD LIKE TO SHARE WITH OTHER PHARMACISTS?

Efficiently collecting data from different departments, as well as our own, was one of the biggest challenges we faced in the development of our Chronic Disease and Transitional Care Program. Data Coordinators assisted in portraying the readmission data by collecting information from our hospital database and logs that track patient encounters, such as home visits, bedside education, phone calls, and medication reconciliations with our Chronic Disease and Transitional Care Team. Implementing a program of this scope is not limited to the pharmacy team. It is imperative to have an interprofessional team working together to provide each patient their individual care plan.

References:
