UPMC PALLIATIVE AND SUPPORTIVE INSTITUTE

THE TABLET: PALLIATIVE CARE PHARMACY TIPS

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If you have a topic you would like the pharmacy team to answer, please send your suggestions to: lowrymf@upmc.edu

TODAY'S TOPIC:

UPMC Quality Improvement: Description of Palliative Care Pharmacist Interventions surrounding Medication Prescribing Across Care Transitions (IMPACT) Program
Results presented at AAHPM Annual Assembly and State of the Science 2022, Manuscript under review

Background:

- Pharmacist-led transitions of care programs reduce medication errors, and improve medication reconciliation and patients' understanding of appropriate use of medications in high-risk, medically complex patients
- Evidence for the role of the palliative care pharmacist in transitions of care is limited
- The Palliative Care Pharmacist Interventions surrounding Medication Prescribing Across Care Transitions (IMPACT) Program was started in April 2021. IMPACT program is a pharmacist-led telephonic transitions of care program that sought to improve medication outcomes in high-risk seriously ill, non-hospice, patients seen by palliative care at UPMC Shadyside Hospital planning to follow with palliative care at Hillman Cancer Center
- The goals of this program were to ensure access to discharge medications, provide comprehensive medication review and reconciliation, explore medication adherence, reduce medication-related problems and symptom burden for a medically complex patient population with high readmission risk

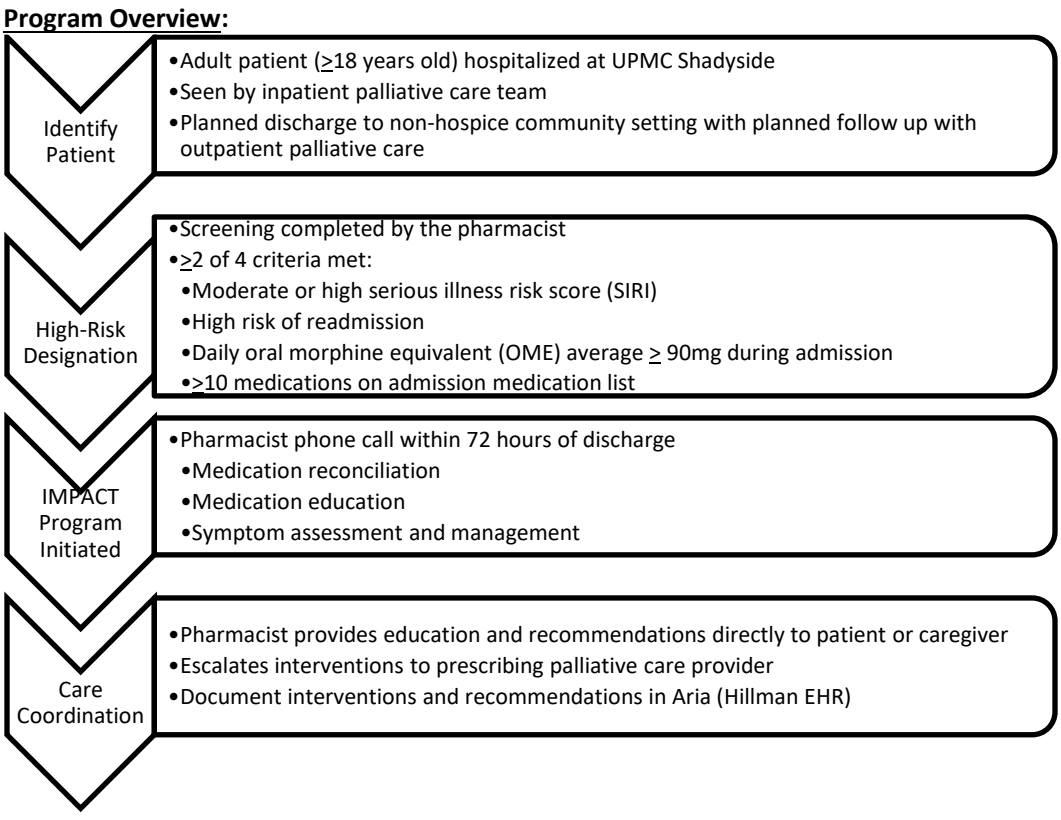
Importance:

It is important to internally examine innovative patient care models to promote highest quality of care for our patients.

The Research:

Objective: To describe 1) the program and 2) pilot data surrounding its feasibility and effectiveness

Program Overview:



Feasibility Data:

- 77 patients eligible for pharmacist intervention, 44 patients reached by pharmacist (57%)
- Average time spent by pharmacist per patient encounter was 65 minutes (range: 35-105 minutes)
- Average time to pharmacist speaking with the patient was 2.75 days (range: 0.79-6.07 days)

Average Medication Reconciliation Discrepancies Identified and Resolved by Pharmacist Per Patient

Category	Average Per Patient
Medications missing from medication list	7.8
Medications inappropriately listed on medication list	2.8
Medications with wrong doses	2.4
Medications with wrong formulation	0.7
Medications with wrong frequency	1.4
Total number of medication discrepancies	14.9[a]

[a]Independent categories of discrepancies do not add up to total average per patient due to rounding to nearest tenth

Pilot Study:

- Retrospective chart review of eligible patients between April 2021- July 2021; compared patients who were reached by pharmacist (n=44) with those who were eligible for the program but not reached by pharmacist (n=33)
- Exclusion Criteria: patients with planned readmission (eg. Surgeries, treatment, or procedures)

Results:

Hospital Readmissions and Emergency Department Visits

	IMPACT Group	Usual Care	OR (95% CI)
Any admission within 30 days	20 (45.5%)	19 (57.6%)	0.61 (0.22 – 1.67) p = 0.36
Any admission within 7 days	2 (4.5%)	9 (27.3%)	0.13 (0.01 – 0.70) p = 0.007*
Any ED visit within 30 days	2 (4.5%)	3 (9.1%)	0.48 (0.04 - 4.47) p = 0.65
Any ED visit within 7 days	0	1 (3.1%)	0 (0 – 29.25) p = 0.43

- Average time to readmission following discharge was 16.7 days in the PharmD group compared to 6.5 in usual care group

Discussion:

- Pharmacist identified and resolved a large number of discrepancies and drug therapy problems through medication reconciliation and patient assessment during transitions of care
- Short-term readmissions were lower in the group who connected with the pharmacist
- Limitations exist with the pilot data analysis: findings are descriptive, causality cannot be determined. "Usual care group" may have less access to or fewer healthcare resources as a true control group was not utilized. Did not investigate reasons for readmission.

CLINICAL PEARL: Pharmacist involvement within transitions of care is valuable