Collaborative Care Network

Expert Clinical Recommendation

Megan Jensen, PharmD, BCACP

# Ambulatory Care Pharmacy Services

## Background

In 2015, the Agency for Healthcare Research and Quality (AHRQ) concluded that medication therapy management (MTM) can improve medication adherence, which indirectly has been tied to reduced hospital readmissions. The analysis, published in the *Annals of Pharmacotherapy*, estimated that illness and death in the US from non-optimized medication therapy costs $528.4 billion annually. Additionally, ten to twenty percent of hospital readmissions are due to medication errors and almost sixty percent of medication errors occur during transitions of care (TOC). Information from other organizations, such as Geisinger Health System, demonstrates savings in the millions of dollars for each of their MTM programs. Luminis Health has a team of ambulatory care clinical pharmacists to support providers and patients in the outpatient setting. They are involved in two primary MTM services: ambulatory consults and TOC. Essentially, MTM services are focused on the identification, prevention, and resolution of drug-related problems. MTM is particularly effective for patients with multiple chronic conditions, complex medication therapies, high prescription costs, and multiple prescribers.

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## Send a Referral to a Clinical Pharmacist for an Outpatient Consult

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| **What?** | A referral results in a telephone encounter between pharmacist and patient. It is documented in EPIC and routed (or faxed) to the referring and/or primary provider. The pharmacy note may be a brief communication addressing a specific consult question, or it may be a comprehensive medication review (CMR). |
| **Which problems?** | Medication affordability; polypharmacy; adherence; herbal medication review; medication reconciliation; drug-drug interaction screening; drug information requests; patient education; patient not meeting disease state goals; etc. |
| **Who can refer?** | Physicians, nurse practitioners, physician assistants, inpatient pharmacists, community care managers, social workers, and patient self-referrals accepted |
| **How?** | A consult can be placed in Epic using **Ref 168** (Ambulatory Care Pharmacy Consult) or by calling 443-481-3959. Patients are invited to call. |
| **Response time?** | All referrals will be completed within two weeks. Under special circumstances, a referral for immediate follow-up can be placed. Every effort will be made to complete these within two business days |
| **Unable to contact?** | If the pharmacist is unable to contact the patient after at least 3 attempts (and 10 business days), a letter will be mailed to the patient with a description of the service and invitation to call Ambulatory Pharmacy Services |

## What should providers do with completed pharmacy consult notes?

Review completed notes for MTM recommendations documented in the Assessment/Plan portion of the note. **Recommendations are intended for the provider to review and act on as they deem appropriate**. In the case of an emergent issue, a provider will be contacted immediately via telephone. **The clinical pharmacist is unable to independently prescribe or change any prescription medication in this setting**.

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If a provider makes changes based on the clinical pharmacist's recommendations, they are responsible for communicating these with the patient. The phone number for Ambulatory Care Pharmacy Services will be given to patients, and they are welcome call with questions. The provider may also put in a new referral for patient follow-up and additional medication education if needed.

## Transitions of Care Pharmacy Services

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| **Who?** | **Patients are only provided this service if they meet the following criteria:**<br>-Discharged from certain AAMC patient care units (4MED, HVU, ACE, MSU and ONC)<br>-Readmission risk score ≥10%<br>-Discharged home (not going to rehab, SNF or hospice)<br>-Received inpatient pharmacy services (medication reconciliation and/or patient education) |
| **What?** | Clinical pharmacists perform post-discharge chart reviews and telephone calls for patients at high risk of readmission. These interventions are intended to resolve medication therapy problems between the points of hospital discharge and patient follow-up with their primary provider. |
| **When?** | TOC telephone calls occur within seven days of a patient's discharge. |
| **Which problems?** | During the TOC phone call, the clinical pharmacist completes discharge medication reconciliation, identifies and resolves barriers to obtaining medications, evaluates for adverse drug events, and performs medication education. |
| **How?** | A note that includes medications categorized by disease state and any MTM recommendations is routed via Epic to the provider or faxed to non-Epic offices. If a medication-related problem is identified that requires immediate attention, the PCP is contacted by phone to help resolve the issue quickly. |

## Examples of Medication Errors Resolved by TOC Pharmacists

- Discharge reconciliation problem: A patient is on insulin glargine (Lantus) prior to admission (PTA) and the hospital prescribed insulin detemir (Levemir) on discharge, which is non-preferred product.
- Cost issue: A patient is discharged with a $10 copay card for apixaban (Eliquis), but he is not eligible for the coupon. He cannot afford to pay for it, so the patient does not start taking the medication.
- Missing supplies or medications: A patient is new to insulin and prescribed an insulin pen on discharge but did not receive a prescription for pen needles. The patient doesn't start using insulin.
- Patient doesn't understand instructions: A patient takes amlodipine 5 mg daily PTA. On discharge, the patient is told to take amlodipine 10 mg daily. The patient does not realize she should be taking two amlodipine 5 mg tablets to make 10 mg daily.

## Testimonial by Dr. Hussain

"The Ambulatory Pharmacy Care Referral is a powerful tool that has been invaluable to my practice… [and] the service is particularly valuable for new diabetic patients. I have also found their services useful for dealing with post hospital reconciliation of meds and helping the complex patient with polypharmacy and multiple providers."

"… a team approach using services like the Ambulatory Pharmacy Care Team is next step in our evolution as medical providers."

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