The Role of the Clinical Pharmacy Specialist in Transitions of Care

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CPE Information and Disclosures

Kyleigh Gould declares no conflicts of interest, real or apparent, and no financial interests in any company, product, or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

The American Pharmacist Association is accredited by the Accreditation Council for Pharmacy Education as a provider of continuing pharmacy education.
CPE Information

- Target Audience: Pharmacists and Pharmacist Technicians
- ACPE#: 0202-0000-18-212-L04-P/T
- Activity Type: Knowledge-based
Learning Objectives

1. Explain the role of the CPS in transitions of care
2. Explain the role of the pharmacist in suicide prevention
3. Identify best practices related to transitions of care and suicide prevention
Question 1. Hospitalizations for which conditions are considered largely preventable if ambulatory care is provided in a timely and effective manner?

a) COPD  
b) CHF  
c) Pneumonia  
d) Hypertension  
e) All of the above
Question 2. Utilizing Clinical Pharmacy Specialist Providers at the top of their scope have shown to:

a) Improve cost
b) Improve Healthcare Effectiveness Data and Information Set (HEDIS) measures
c) Improve Strategic Analytics for Improvement and Learning (SAIL) measures
d) Improve access
e) All of the above
Question 3. Improving Veteran transitions of care is the responsibility of:

a) Primary Care Provider
b) Clinical Pharmacy Specialist Provider
c) Nursing
d) All team members
The Role of a Clinical Pharmacy Specialist (CPS)

CPS=PHARMACIST PROVIDER

- Independent Prescriptive Authority
- Practice-Area (Global) Scope of Practice to manage multiple chronic disease states of Patient Aligned Care Team (PACT) patients
- Panel and Population Management

IMPROVING ACCESS

- Comprehensive Medication Management (CMM) services to allow the provider to focus on other Veterans with care related issues
- Bridging the gap to specialty care
- Same Day Medication management services
CPS Providers Improve Access

Evolution of Roles

Previously Focused Disease State Management

Comprehensive Medication Management

PACT
- Diabetes
- Hypertension
- Hyperlipidemia
- CV Disease
- Thyroid Disease
- Heart Failure
- COPD & Asthma
- Smoking Cessation
- Pain
- Mental Health
- Hepatitis C
- Obesity
- Anemia

PACT
- Provide comprehensive medication management visits in between PACT provider visits to achieve quality outcomes
- Reduce revisit rates, next 3rd available appointments, and new patient wait time
- Decrease shifts to Specialty Care
VA CPS Providers

- In 2017, **3,910 CPS providers** conducted over **5.6 million visits** for Veterans with both chronic and acute diseases

- VA trains over 600 PGY1 and PGY2 Pharmacy Practice Residents annually
  - Ability to employ VA trained CPS providers system-wide to bridge existing gaps, supports the academic mission of the VA

- Implementation of the Gold Status Diffusion of Excellence Project "Improving Access to Primary Care Utilizing CPS", demonstrated **27% of PCP return appointments** can be averted with CPS provider integration, opening **850 new appointment slots** per quarter
  - Applying the increase in access VA-wide would result in more than a quarter of a million newly opened primary care appointments annually
  - Improve transitions of care for new Veterans and Veterans transitioning from the Department of Defense
Access to primary care services across the country continues to be in high demand with a significant shortage expected by 2025.¹

The VHA, within its Open Access Roadmap, has set a goal reduction in PCP revisit rates of 10-20% per year being reasonable, and reductions of more than 20% per year being highly commendable.

PACT CPS providers have a clear-cut benefit on quality and safety metrics, including Healthcare Effectiveness Data and Information Set (HEDIS) measures and Strategic Analytics for Improvement and Learning (SAIL).

Currently over 1,900 CPS providers in the VA have a global SOP and prescriptive authority in PACT.
How are CPS providers at your site currently functioning?

Do they practice consistently at the top of their scope?

What are your facility goals for improvement in Veteran care and/or outcome measures?

Have CPS providers been involved with addressing any of the above goals?
Creation of a Uniform Standard for Clinical Pharmacy Practice

**VHA Handbook 1108.11 Clinical Pharmacy Services**

- Provides procedures and direction for decision making and program development related to clinical pharmacy practice.
- Provides guidance related to pharmacy professional practice, staffing models, clinical pharmacy workload, and Pharmacy Benefits Management (PBM) Services support.
- Standardizes policy requirements for clinical pharmacist scope of practice and oversight by the Executive Committee of the Medical Staff and processes aligned with facility bylaws.
- Ensures the Chief of Pharmacy Services has oversight for professional practice for all clinical pharmacists within the facility.
CPPO PACT Strong Practices: Ambulatory Care Sensitive Conditions
Hospitalizations for ambulatory care sensitive conditions (ACSC) such as heart failure, pneumonia, hypertension, and COPD are considered largely preventable if ambulatory care is provided in a timely and effective manner.

Transitions of care can be difficult and complicated for Veterans following a hospitalization.

Multiple clinical trials have demonstrated the value of clinical pharmacist’s interventions at discharge (inpatient) and in chronic disease management (outpatient).
Clinical Pharmacy Practice Office
PACT Strong Practices

Strong Practices

Congestive Heart Failure (CHF) within PACT South Texas VA

Utilizing Clinical Pharmacy Specialists (CPS) to Improve Access to Patient Care Tennessee Valley VA

Inter-Professional Transitions of Care Service for COPD Management Madison VA
Pharmacist to Pharmacist Transitions of Care Program: Tennessee Valley Healthcare System (TVHS)

- Clinical Pharmacist (CP) rounding with inpatient medicine teams at both facilities focusing on pharmacotherapy and medication reconciliation at discharge
- Clinical Pharmacy Specialist (CPS) specializing in comprehensive medication management available in all PACT clinics (CVT or face to face)
- Transitions of Care Initiative sought to leverage clinical pharmacy presence ACROSS practice settings
Tennessee Valley Healthcare System:
Pharmacist to Pharmacist Post Transitions of Care
Tennessee Valley Healthcare System: Pharm to Pharm

Veteran admitted with COPD, DM, HTN, HF related diagnosis

- Inpatient medical team, with Clinical Pharmacist, assesses whether Veteran is appropriate for PACT Clinical Pharmacy Specialist
  - If team agrees, consult placed

- Inpatient Clinical Pharmacist provides standardized discharge education regarding disease state and medications
  - Completes standardized documentation in CPRS to hand-off to PACT Clinical Pharmacy Specialist

- PACT Clinical Pharmacy Specialist receives consult and schedules veteran to clinic within 7-10 days of discharge

- Patient’s pharmacotherapy is evaluated by PACT Clinical Pharmacy Specialist and modified as necessary
  - Education provided

- Patient is followed up in PACT Clinical Pharmacy Specialist until disease-specific goals of care are achieved in conjunction with Primary Care Physician
TVHS Methods: Implementing the Initiative Phases

- Education
- Inpatient Clinical Pharmacists’ Role
- Outpatient Clinical Pharmacy Specialists’ Role
# TVHS Results

<table>
<thead>
<tr>
<th></th>
<th>Heart Failure</th>
<th>COPD</th>
<th>HTN</th>
<th>Diabetes</th>
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<tbody>
<tr>
<td><strong>All-Cause</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>30 day all-cause readmission</td>
<td>17.3% (19/110)</td>
<td>17.5% (7/40)</td>
<td>25.0% (1/4)</td>
<td>0.0% (0/17)</td>
</tr>
<tr>
<td>30 day all cause ED visit</td>
<td>12% (13/108)</td>
<td>10.0% (4/40)</td>
<td>25.0% (1/4)</td>
<td>11.8% (2/17)</td>
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<tr>
<td>90 day all-cause readmission</td>
<td>25.9% (22/85)</td>
<td>40.0% (16/40)</td>
<td>50.0% (2/4)</td>
<td>11.8% (2/17)</td>
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<tr>
<td>90 day all-cause ED visit</td>
<td>19.3% (16/83)</td>
<td>25.0% (10/40)</td>
<td>25.0% (1/4)</td>
<td>23.5% (4/17)</td>
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<tr>
<td><strong>Index</strong></td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>30 day index readmission</td>
<td>1.8% (2/109)</td>
<td>10.0% (4/40)</td>
<td>0.0% (0/4)</td>
<td>0.0% (0/17)</td>
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<tr>
<td>30 day index ED visit</td>
<td>0.9% (1/108)</td>
<td>2.5% (1/40)</td>
<td>0.0% (0/4)</td>
<td>5.9% (1/17)</td>
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<td>90 day index readmission</td>
<td>9.9% (8/81)</td>
<td>20.0% (8/40)</td>
<td>0.0% (0/4)</td>
<td>5.9% (1/17)</td>
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<tr>
<td>90 day index ED visit</td>
<td>2.5% (2/81)</td>
<td>5.0% (2/40)</td>
<td>0.0% (0/4)</td>
<td>5.9% (1/17)</td>
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### TVHS Preliminary Results

<table>
<thead>
<tr>
<th>Description</th>
<th>Value</th>
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<tbody>
<tr>
<td>Average time to follow-up (days)</td>
<td>5.39</td>
</tr>
<tr>
<td>Follow-up within 10 days after discharge</td>
<td>92.9%</td>
</tr>
<tr>
<td>Follow-up within 14 days after discharge</td>
<td>98.7%</td>
</tr>
<tr>
<td>No shows or cancellations (number, %)</td>
<td>13, 25.5%</td>
</tr>
</tbody>
</table>
South Texas VA Healthcare System:
Utilization of PACT CPS in Heart Failure
Utilization of the PACT CPS to reduce CHF Readmission Rates for South Texas Veterans Health Care System (STVHCS)

- Access
- Coding
- Education
Access – Intervention One

➤ CHF Huddle

➤ QM identifies patients admitted who are potential for primary CHF

➤ Since December 2012, reviewed weekdays

➤ Track primary diagnosis, ECHO results, whether readmission within 30 days, Red Folder education during hospitalization, Home Telehealth referral, Palliative Care consult if appropriate, follow-up post discharge
Access – Intervention One

► Intensive Follow-up Post-discharge

► Month 1
  ► Weekly follow-up with either PCP, PACT Clinical Pharmacy Specialist, or Cardiology

► Month 2
  ► Biweekly follow-up with either PCP, PACT Clinical Pharmacy Specialist, or Cardiology

► PACT RNs, PACT CPS, Cardiology CNS coordinating
Intervention One – Data Evaluation

- Six months following implementation:
  - 138 patients seen with readmission within 30 days: 21.7% (Baseline was 29.67%)
    - Of the patients who saw a PACT CPS post-discharge, 3% had a readmission in 30 days
    - Of the patients who did NOT see a PACT CPS post-discharge, 27% had a readmission in 30 days
  - Within 7 days of discharge, 40% of patients had a discharge follow-up scheduled of which 33% attended
1. Development of the CHF Discharge Follow-up Order Set

2. PACT CPS visit to replace PCP visit given intervention one data
Improving Transition of Care and Coordination of Intensive Follow-up

- June 2015- implemented CHF Discharge Follow-up order set

![Reminder Dialog Template: PMG TEST](image)
High Risk:
- > 2 Hospitalizations for ADHF within 1 year
- LVEF < 25%
- All patients with NYHA Class IV on admission
- CHF patients who develop AKI (30% increase from baseline SCr) toward the time of discharge

1st Appointment within 7 days - Cardiology
2nd-4th weeks, PACT CPS

Not High Risk:
- Patients who do not meet the criteria for “high risk”

1st Appointment within 7 days - PACT CPS
2nd-4th weeks, PACT CPS and at least one visit with Cardiology
Access

- Patients with 30-day readmissions were less likely to be seen by a PACT CPS at baseline, and both interventions
Access

- Readmission rates decreased by 5% from baseline
- Mortality rates also decreased with each intervention
  - Baseline: 10%, Intervention one: 8.06%, Intervention two: 7.16%
William S. Middleton VA Hospital, Madison, WI:
Inter-Professional Transitions of Care Service for COPD Management
Inter-Professional Transitions of Care Service for COPD Management: William S. Middleton VA Hospital, Madison, WI

- **Purpose**: To develop a post-acute care service for COPD patients within the clinic setting

- **Target population**: Patients who recently presented to the Emergency Department or Hospital with a COPD exacerbation

![Diagram showing interdisciplinary care model]

Innovative Population health service
Hospitalizations and Emergency Department Visits Prevented

Access to care

Pharmacist Interventions
Inter-Professional Transitions of Care Service for COPD Management

- PCP visit for other disease states
- PharmD/RN Visit 3 weeks (45 minute visit)
- Telephone Appt. 2 months (15 minute visit)
- Spirometry 3 months (30 minute visit)

Primary Care Provider Visit:
- Two CAT scores
- Updated spirometry
- Adherence information
- Medication adjustments
- Referrals placed

PCP as care coordinator now has more information available to coordinate COPD CARE and manage multiple disease states
Inter-Professional Transitions of Care Service for COPD Management: Visit 1

- Post acute-care
  - 1. Medication adherence and self-assessment
    - Medication reconciliation
    - Inhaler technique
    - Rescue inhaler frequency
    - Use of spacer
  - 2. Disease state management
    - COPD Assessment Test (CAT) Score
    - Exacerbation history
    - Combined Assessment of COPD
  - 3. Referral/Tools
PharmD or RN Telephone Appt.
- Review medication adherence
- Assess COPD symptoms (CAT score)
- Address patient concerns
- Assess use of COPD Action Plan
Inter-Professional Transitions of Care Service for COPD Management: Results

October 1, 2015

COPD Service

- Hospital
  - N = 6 Patients

- ED
  - N = 13 Patients

Total N = 19 Patients

March 1, 2016

Control Group

- N = 38 Patients
Inter-Professional Transitions of Care Service for COPD Management: Results

30-day Readmission Rates

- **P=0.047 for number of admissions**
  - **Total= 0% of patients**
    - **0.0% (n=0)**
  - **Total n=19**

- **Hospital + ED= 57.1%**
- **ED = 42.9%**

**Total n=37**

**COPD Service**
**Control**
Inter-Professional Transitions of Care Service for COPD Management: Results

% Patients seen 30 days post discharge

Saved PCP appointment 68% of the time

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<td>35.10%</td>
<td>73.70%</td>
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Diffusion of PACT Strong Practices for ACSC

- Increase Veteran access to CPS services resulting in improved access to care, satisfaction levels with care received, and health outcomes
- Optimize the role of the CPS provider in caring for Veterans with ACSC
- Optimize the provision of medication management and disease management services to Veterans with ACSC
Diffusion of PACT Strong Practices for ACSC

- Improved operational efficiency of processes within the PACT model allowing for the provision of timely care, improved clinical care and PACT team (provider and staff) increase in satisfaction

- Decreasing reliance on current PACT providers for medication management services allowing these providers to reduce their panel revisit rate for movement into an open access model with appointment availability today and in the future
Things To Consider

► Who is your Pharmacy lead for ACSC?
► Start with your Chief of Pharmacy
► Identify a PACT CPS who has an interest and include them in facility discussions
► Evaluate CPPO PACT Strong Practices for implementation
► Coordinate opportunities to ensure each discipline is working together
Breakout

- What do we do with this information?
- How would you operationalize this at the facility level?
- How would you implement or advance CPS providers to have an active role in transitions of care?
Implementation/Training

- Ensure CPS provider competency
  - CPPO competency documents
- Develop training plans as appropriate
  - Shadowing/Mentoring
  - PACT Bootcamps
  - Guideline reviews
  - Workgroups to create templates
Implementation/Training

- Utilize all team members
  - Role clarification
- Outline implementation process
  - Create standard work
- Track outcomes!
PBM Guidance and Field Specific Tools

- CPPO Monthly PACT Teleconferences
  - Focus on Standardization of the PACT CPS Role and Dissemination of Strong Practices within the field with teleconference presentations
- PACT CPS National Collaborative Care Agreement
  - Standardized template for site utilization
- PBM Guidance on PACT CPS Referral and Handoff
PBM Guidance and Field Specific Tools

- **PBM Tool Kit CPS and Missed Opportunities**
  - Strategies for evaluation and overcoming MO
- **PBM Tool PACT CPS and Ancillary Support**
  - Guidance on use of ancillary support for PACT CPS
- **PACT Strong Practice Competition**
  - Dissemination plan to the field for tracking of implementation developed
- **PBM Guidance on Patient-Self Referral Direct Scheduling**
  - Guidance on implementation of PSDS in PACT
CPS providers have global scopes of practice and provide comprehensive medication management services.

Utilizing CPS providers at the top of their scope and expertise have shown to improve transitions of Veteran Care.

All team members, working together, can improve Veteran care!
Question 1. Hospitalizations for which conditions are considered largely preventable if ambulatory care is provided in a timely and effective manner?

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b) CHF
c) Pneumonia
d) Hypertension
e) All of the above
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Answer: d) All team members
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PACT Strong Practice Competition
Thank you for your participation!

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