Impact of Internal Medicine-Transitions of Care Program

In A Community Hospital

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Objectives

- Describe the Internal Medicine (IM) pilot Transitions of Care service
- Describe the program’s target patient population
- Share preliminary findings of the pilot program
Identification of barriers to compliance

Education

Risk Stratification

30 Day Readmission

Our Purpose
Services Provided

Patient Centered Services

- Medication history
- Identification of barriers to compliance or adherence
- Discharge counseling
- Follow-up phone calls

Clinical Services

- Therapeutic Drug Monitoring
- IV to PO conversion per protocol
- Renal dose adjustment
- Adverse drug reaction evaluations and report
- Allergy assessment and update
- Antibiotic Stewardship
- Warfarin dosing per protocol
- DOAC dosing and Monitoring
- Resolve rejected orders

Pilot Period: May 1, 2019 to July 31, 2019
Target Population

Legend:
T2DM: type 2 diabetes
LAI: Long acting insulin
AC: Anticoagulation
COPD: Chronic obstructive pulmonary disease
CHF: Congestive heart failure

Highest Population at Risk for Readmission
Patient Selection

Inclusion Criteria
- Admitted from home
- New or existing diagnosis of COPD and or CHF
- Currently taking or new initiation of DOAC
- Currently taking or new initiation of warfarin therapy
- Discharged home from hospital

Exclusion Criteria
- Admitted from Facility
- Cognitive impairment or mental defect
- Discharged to facility
Methods

- Identify patients at admission
- Obtain accurate home medication list
- Resume home medications appropriately
- Complete discharge med rec & education
- Complete Follow-up phone call
Results

Percent Patients per Month

- May
  - 47%
- June
  - 53%

Total n = 121
- May n = 64
- June n = 57
## Results

<table>
<thead>
<tr>
<th>Endpoint</th>
<th>Result</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age</td>
<td>• 74.75 years old (35 - 99)</td>
</tr>
<tr>
<td>Number of Home Medications</td>
<td>• 12 (3-26)</td>
</tr>
<tr>
<td>Medication History Discrepancy</td>
<td>• 2 (0-6)</td>
</tr>
<tr>
<td>Most Common Barriers Identified</td>
<td>• Financial</td>
</tr>
<tr>
<td></td>
<td>• Poor understanding of Medications</td>
</tr>
<tr>
<td></td>
<td>• Side Effects</td>
</tr>
<tr>
<td></td>
<td>• Physical impairment</td>
</tr>
<tr>
<td>Most Common Risk Factor</td>
<td>• CHF</td>
</tr>
<tr>
<td>More than one risk factor</td>
<td>• 44.1%</td>
</tr>
<tr>
<td>30 Day Readmission</td>
<td>• May: 14%</td>
</tr>
<tr>
<td></td>
<td>• June : 12.2%</td>
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</tbody>
</table>
Medication To-Bed *Plus

- Partnership with outpatient pharmacy
  - Deliver all new medications at the bedside prior to discharge
  - *Plus complete education on all new medications and changes to medication regimen
  - Added benefit of medication delivery to home
  - Referral to Medication Management program for post discharge follow-up
- Launched in July
IM-TOC PLUS MEDS TO BED PROGRAM RESULTS

- 318 patients admitted to 5S
  - 15.09% Readmission Rate
- 56 patients enrolled in IM-TOC & Meds to Bed
  - 8.93% Readmission Rate
Resolve Barriers to Compliance

30 Day Readmission by 6.9%

IM Pilot Service Launched

Enhanced Patient Services

Discharge Education and Follow-up
THANK-YOU!