Mission and Vision

- **Mission**: The WPIC Pharmacy Department is committed to excellence in psychiatric pharmacy services, care of patients, education, and research.

- **Vision**: To achieve excellence in patient-centered care that is founded on the principles of safe, evidence-based, effective, and cost-effective use of medicines.
Outline

- Using the Toyota Way and PPC Principles
- Pharmacist Role in Patient Care at WPIC
- JHF Pharmacy Agents for Change Fellowships
- Future Directions
The Toyota Way and PPC

- Standardizing Pharmacy Processes
- Improving Operational Efficiency
- Ongoing Quality and Safety Initiatives
- Collecting and Monitoring Data
- Communicating Outcomes
JHF Pharmacy Agents for Change

- **Project 1:** Pharmacist Management of Polypharmacy: Reducing Fall Risk in Psychiatric Inpatients

- **Project 2:** Bridging the Transition from Hospital to Home: Implementation of a medication discharge program
Fall Risk Assessment in Elderly Psychiatric Patients

Karen Fielding, PharmD
Western Psychiatric Institute and Clinic
July 1, 2010
Original Process for Fall Risk Assessment

- Fall assessment tool does not account for polypharmacy
- No pharmacist involvement in fall risk assessment
- No pharmacist intervention related to medication fall risk
Countermeasures

- Pharmacist-modified fall risk assessment created
  - Included additional drug classes
  - Accounted for polypharmacy

- Standardized recommendations developed

- Template created to communicate recommendations
Countermeasures

- Assessment of medications completed upon admission to the 41-bed geriatric unit
- Drug therapy and monitoring recommendations made for patients who scored above the assessment threshold
- Actions were documented in the clinical documentation system
## Assessment Tools

<table>
<thead>
<tr>
<th>Before</th>
<th>After</th>
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<tr>
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<tr>
<td><strong>Pharmacist-Modified Fall Risk Assessment</strong></td>
<td></td>
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<tr>
<td>____ Anticonvulsants (2pts/med)</td>
<td>____ Non-benzodiazepine hypnotics (2pts/med)</td>
</tr>
<tr>
<td>____ Lithium (2pts)</td>
<td>____ Histamine Blockers (2pts/med)</td>
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<tr>
<td>____ Anticoagulants due to risk of injury (2pts/med)</td>
<td>____ Proton Pump Inhibitors (2pts/med)</td>
</tr>
<tr>
<td>____ Cathartics, laxatives, stool softeners (2pts/med)</td>
<td>____ Antipsychotics (2pts/med)</td>
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<tr>
<td>____ Diuretics (2pts/med)</td>
<td>____ Antidepressants (2pts/med)</td>
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<tr>
<td>____ Anti-hypertensives/cardiac (2pts/med)</td>
<td>____ Hypoglycemics (2pts/med)</td>
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<tr>
<td>____ Narcotics/NSAIDs (2pts/med)</td>
<td>____ BPH and Incontinence Medications (2pts/med)</td>
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<tr>
<td>____ Benzodiazepines (2pts/med)</td>
<td>____ Antiparkinsonian medications (2 pts/med)</td>
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<tr>
<td>____ Muscle Relaxants (2pts/med)</td>
<td>____ Antipsychotics (2pts/med)</td>
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</tbody>
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New Process

- Admission to 12th floor
  - Pharmacist Modified Fall Risk Assessment
    - Pharmacist Modified fall risk score < 14
      - Documentation in TheraDoc
    - Pharmacist Modified fall risk score > 14
      - Progress note created
      - Clinical Team notified
      - Documentation in TheraDoc
October 2008 – May 2009

- 344 patient medication profiles were assessed by a pharmacist
- Of 167 total therapy recommendations made, 61 were measurable
- Of the 61 measurable recommendations made, 46 were accepted (75.4%) 
- The pharmacist-modified assessment accounted for polypharmacy thus resulting in a higher Fall Risk score than the original assessment
Results

Average Fall Risk Score on Admission

Original Assessment: 6.23
Pharmacist-Modified Assessment: 12.99
Conclusion

- A reduction in falls was not observed during this pilot project.
- Awareness of the role medications play in fall risk increased.
  - Prescribers have begun to make therapy changes prior to the pharmacist intervening.
- Integrate a staff pharmacist into the multidisciplinary treatment team and increase pharmacy involvement in direct patient care.
Bridging the Transition from Hospital to Home: Implementation of a Medication Discharge Program

Jamie L. Montgomery, RPh
Western Psychiatric Institute and Clinic
July 1, 2010
Background

- Hospital discharge can be a vulnerable time for any patient
- Health care system presents many barriers to medication access
- Medication and treatment adherence may be affected
- A successful inpatient stay can be quickly reversed if patients are unable to continue their medication regimen after discharge
Background

Gaps identified in discharge planning/aftercare:

- Communication between levels of care
- Shared medical record
- Patient education
- Medication procurement
- Outpatient follow-up
Current Hospital Discharge Process

Admission to WPIC

Inpatient Treatment

Inpatient Discharge

Treatment Compliance

First Outpatient Appointment

Treatment Non-compliance

Relapse/Re-hospitalization
Improved Hospital Discharge Process

Variation from current process included pharmacist counseling during inpatient stay and prescriptions filled prior to discharge.

- Admission to WPIC
- Inpatient Treatment
  - Pharmacist counseling/education provided
- Inpatient Discharge
  - Discharge prescriptions filled and given to patient
- Treatment Non-compliance
  - Relapse/Re-hospitalization
- Treatment Compliance
  - First Outpatient Appointment
New Discharge Process

1. Patient identified for discharge

2. Prescriptions filled at Forbes Pharmacy

3. Medications couriered to inpatient unit

4. Pharmacist provides medication counseling and educational materials

Patient discharged with medication and knowledge
Before

Patients given discharge packet with multiple prescriptions. Requires patient to navigate the complex system to obtain medications.

After

Discharge prescriptions processed prior to discharge. Pharmacist resolves barriers to medication access through interaction with physicians and third-party insurers.
Pilot Data Results

- A total of 93 patients were eligible for the pilot medication discharge program between January 2008 and December 2008.
- Of these, 74 patients were discharged with medications in hand versus written prescriptions.
- A total of 464 prescriptions were dispensed and required 142 pharmacist interventions.
- Of the patients who received aftercare within the WPIC system, program participants were:
  - More likely to attend their first scheduled outpatient appointment (31%)
  - Less likely to be readmitted to WPIC within 60 days of discharge (12%)
Discharge meds provided: 464

142 interventions were required to process these prescriptions
Lessons Learned

- Discharge is a complex process involving multiple disciplines
- Understanding individual roles and increasing communication between disciplines are key to successful coordination of care
- Integrating pharmacy services into the discharge planning process improved patient care and enhanced communication between inpatient and outpatient settings.
Future Directions

- Electronic Prescribing
  - Prescriptions electronically sent Forbes Pharmacy
  - Outpatient Pharmacist has access to medication records
  - Medication reconciliation

- Program was implemented primarily as a patient care initiative

- Unexpected benefit - revenue generating
Program Expansion

- Business Plan
- Transitional Care Pharmacist
- Program expansion
  - 2008: 73 Patients, 304 Prescriptions
  - 2009: 238 Patients, 1,373 Prescriptions
  - 2010*: > 500 Patients, >3,000 Prescriptions
  *projected
Patient-Centered Philosophy

Develop a Pharmacy Practice Model to:

- Provide direct patient-centered care
- Promote the safe and effective use of medications
- Develop customer-driven programs and services
- Remain committed to education, training and research

Expanding Pharmacy Services

- Pharmacist participation in medical rounds, treatment team meetings, and patient medication education groups
- Decentralized practice model on geriatric and pediatric units
- Transitions in Care Program
- Metabolic Monitoring Clinic
- Smoking Cessation Program
- Medication therapy management (MTM) Services
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JHF Project Teams

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