PHARMACIST ENGAGEMENT AND QUALITY OF AMI CARE

Evidence Brief

BROAD ENGAGEMENT OF PHARMACISTS in care of hospitalized patients is associated with better patient outcomes including mortality rates.[1-5] Greater use of pharmacists has been shown to improve adherence to guidelines for medication prescribing for patients with acute myocardial infarction (AMI) through reminders, audit and feedback,[6-7] as well as to reduce adverse drug events.[8] Evidence-based core clinical pharmacy services include: drug protocol management, participation in medical rounds, participation in cardiopulmonary resuscitation teams, patient drug histories and in-service education.[2,9] Pharmacist services provide both direct cost savings and estimated cost avoidance through prevention of adverse drug events and reduction in lengths of stay.[1, 10-12]

PHARMACISTS ROUNDING ON PATIENTS WITH AMI is one concrete approach to integrate pharmacists into care for patients with AMI. Interdisciplinary rounds have been associated with improved core measures performance and decreased length of stay for patients with AMI.[13] Recent evidence indicates that having pharmacists round on all patients with AMI is associated with lower 30-day mortality rates in hospitals without cardiologists on staff 24/7.[14] Hospitals with top performance in care of patients with AMI report a broad staff presence and expertise in AMI care that includes close integration of pharmacists who actively inform and influence clinical decisions.[15]

Illustrations from the field in the Curry et al study:[15]

"It's a really multi-disciplinary effort here. We have pharmacists involved. They come by and check charts to see this person with an ejection fraction less than 40%. If they're not on an ACE inhibitor, they page the doctor or they put a note in the chart: is there a contraindication for this patient on the ACE inhibitor? From a pharmacist."

"We weren't meeting certain targets…on our aspirin and beta blockers. Our pharmacy director was able to convince the administration, 'Give us six months. We'll devote a FTE to it and see if we can turn the numbers around.' [Now] we identify the patients with non-STEMIs and STEMIs right off the bat, anyone with chest pain, shortness of breath…We look in their charts. 'Is it an MI or not? Okay. Did they get their aspirin, their beta blocker? And if [not], let's contact the physician.'"

"Once the physicians found the success they were having and the trust they had, they said, 'just go ahead and document that and write in the chart per us.' All of the cardiologists were on board and said, 'What you're doing is the right thing; go ahead and take care of it.'"

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