



## Surviving MI

AN ACC QUALITY INITIATIVE

### Questions-and-Answers from “Building the Case for Pharmacy” Webinar

**Presentations by:**

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**Q: How do pharmacists know which patients to target? How are acute coronary syndrome (ACS) patients identified?**

**A: Tracy-** We use our EMR to flag patients. The in-patient clinical pharmacist flags patients who are post percutaneous coronary intervention (PCI) and will be receiving the KATS-PLEDGE program. There is a column on the patient worksheet that indicates KATS-PLEDGE, which alerts the Meds-to-Beds team to expect a fax with prescriptions and alerts the pharmacist who is caring for the patient on the day of discharge that discharge orders have been placed (the column flashes red) and education is needed. Overall, it's a manual flag that is evident to everyone involved in the process. Our EMR is Allscripts and for in-patient we use Sunrise Clinical Manager (SCM).

**Brett-** Our EMR is PCS. We rely more on case managers, but it's the same type of thing; we look for patients coming back from the cath lab and for key words in admission and progress notes. In addition to case managers, pharmacists, nurses, and other members of the team have a role in identifying patients and making sure no one falls out. Our process is similar to what Tracy described; we fill medications ahead of time in anticipation of discharge. Commonly, patients get really excited when they are being discharged, but they don't realize there could be 5 or 6 hours in between when the doctor completes the discharge process, the paper work is finalized, and follow up appointments are scheduled. Therefore, it's important to get these medications preemptively to avoid delaying discharge any further and to prevent patients from leaving before receiving their prescriptions.

**Q: What are the division of responsibilities between bedside nurses or advanced practice nurses, the prescriber, and the pharmacist? How are various tasks divided and conquered?**

**A: Tracy-** In 2011 we quickly realized that when ownership is shared, no one owns it. As such, we assigned ownership for each phase of the process. For example, a prescriber is required to sign off on the final discharge medication list after the pharmacist has prepared it, acting as a second check. When this occurs, the list is released to go to the patient's discharge summary and education materials. Then the bedside nurse prints the education materials, which include the medication list, discharge instructions, follow up appointments, and any other pieces of information completed by the multi-disciplinary group. The nurse provides these materials to the patient, reviews their medications, and identifies additional issues at that point. If the patient is flagged as KATS-PLEDGE (meaning they had an AMI), the pharmacist will visit that patient, deliver the prescription bottles, review all of the medications, and provide education.

Indications are not included on the medication list because it is generated from our IT resource, which currently does not require anyone to enter in the indications. We're hoping to be able to do this within the next year, but we do have some people who are reluctant to put indications into the medications because so many of them are used for off label indications so it would have to be a manual process.

*Brett-* In general, we try to see each patient and review patient medications. A lot of these patients have other cardiology issues that require Coumadin counseling, which presents a good opportunity to counsel them on their current medications. We round on all of the floors where we have dedicated pharmacists, which gives us another opportunity to anticipate problems and visit patients in their rooms and counsel them on their medications. Our process is similar to what Tracy described, but one difference is that we actually print the medication lists ourselves versus the nurse doing it, and all of the pharmacists have to review it. If there are any errors, we notify the physician and will sometimes even place a hand note on the list if there is something important. The nurse will again review those medications at discharge and make sure that we counsel the patient. If the patient is receiving their medications from us through the concierge service or Meds-to-Beds, then the out-patient pharmacist will counsel the patient.

**Q: Do you track the next refill (out 30 days), especially with branded medicines like Brilinta (ticagrelor)? Do you find that patients use up their 30 day supply and don't refill? If yes, is that a concern?**

*A: Tracy-* Yes, it is a concern and we do track refills. In retail pharmacy, we adjudicate patient prescriptions through their insurance to determine co-payments, even though we are reversing out of their own insurance and putting it through for either the voucher program or through our own insurance/private fund. At the time of discharge, we know what the cost of the prescription will be for the patient and often are able to denote if that is acceptable. One of my biggest concerns was removing the patient from the normal flow of their home pharmacy by providing discharge concierge services. Therefore, we do provide all patients who receive our Beds-to-Meds service (not just AMI) with information on how to refill their prescriptions. Patients are able to continue using our pharmacy services by calling to place a refill, which can then be mail ordered to them. We also provide instructions on how to get the prescriptions transferred by providing the bottles to their preferred pharmacy. We have just started tracking what percentage of our prescriptions are refilled and sent through our pharmacy as well as the percentage of those that go out the door and get transferred. Once the prescription is transferred, we have trouble assessing adherence beyond that point, but we are seeing a fair amount of patients who choose to stay with us. When patients follow up with us, a considerable amount of prescriptions have to be changed due to intolerable side effects or a change in insurance. For patients who do not follow up with us in the clinic, we attempt to contact them at least 3 times by phone.

**Q: How do you utilize pharmacy techs and students?**

*A: Tracy-* Our Pharmacy Techs are hired at a higher pay grade and required to have advanced experience. They are Transitions of Care Technicians trained utilizing the MARQUIS training system to perform the "Best Possible Medication History". Pharmacy students receive similar training, and in addition to medication history participate in reconciliation and discharge education.

*Brett-* The pharmacy department at Ephraim McDowell is very dependent on the contributions of our students and technicians. Students are permitted to immerse themselves in all of the daily activities of our pharmacists. Students are directly engaged in: patient counseling, clinical rounds, kinetics, MUEs, journal clubs, case presentations, topic discussions, and numerous other learning opportunities. While there are minimal expectations for our student involvement, they are each given as much responsibility

and autonomy that each individual can balance within legal and professional boundaries. Technicians play a critical role in our medication preparation, compounding, ordering, and distribution. Ephraim McDowell has high expectations for its pharmacy technicians, but such responsibility provides them with rewarding experiences.

**Q: What is your training and onboarding process for new pharmacists?**

**A: Tracy-** Specifically for the CV pharmacists we have a power point and web-based training to orient them to KATS PLEDGE. Then we provide team-based feedback as notes are reviewed in clinic.

*Brett-* We have a standard six week training program which includes ACLS training. During the six week introduction period, new pharmacists and residents become acclimated with the computer system and our policies. There is a competency check off list for clinical competency, hospital distribution, aseptic technique, and clinical shadowing on all of our floor units.

**Q: Is there a reason Prasugrel is not included as one of the DAPTs?**

**A: Tracy-** Prasugrel is P&T approved and was discussed when we established KATS PLEDGE Rx component. However, the consensus with Pharmacy and Cardiology was that Ticagrelor would be our preferred agent. With clopidogrel as back-up if there are long-term financial issues or intolerance. With no direct comparison between prasugrel and ticagrelor we felt the strongest clinical evidence supported ticagrelor.

*Brett-* Prasugrel is actually on our formulary at Ephraim McDowell and welcomed should an interventionalist prefer it over ticagrelor or clopidogrel. Most of the formulary decisions our institution makes has to be a balance between prescriber preference and cost. In fact, we do see prasugrel loading prior to catheterization in some patient cases at EMRMC. Upon discharge, our cardiologists prefer ticagrelor or clopidogrel, and those preferences are driven by the PLATO trial (ticagrelor) or patient adherence and personal financial profiles (clopidogrel is generic).

**Q: Are the retail pharmacists engaged in taking report from hospital pharmacy and working with the transitions of care?**

**A: Tracy-** The retail pharmacists provide filling of discharge medications. They also offer to counsel on delivery. If the patient requests this is done by phone (as a technician delivers). They also leave a note in the inpatient chart with information about copayment, etc.

*Brett-* Our outpatient pharmacists are very involved in our transition process, however those with other community pharmacies seem to be less engaged. From my experience, chain retail pharmacies progressively demand more from their staff pharmacists with less and less help from overlapping pharmacists or technicians. This really minimizes the ability of PharmDs and skilled outpatient pharmacists to maximize their potential and utilize their knowledge. In an understaffed retail environment, pharmacists too often struggle to maintain the unrealistic expectations promoted by their corporate leaders. With enormous pressure to sustain many responsibilities (dispensing, safety, vaccinations, pseudoephedrine dispensing, counseling, MTMs, etc), the retail pharmacists' priorities often make engaging in the transitions of care very difficult. The professionals that are the absolute best at whatever they do - servers, financial planners, medical personnel - realize that the formula for maintaining high standards and recurring business is having *less* clients but dedicating *more* attention to them rather than overemphasizing volume. Retail pharmacy is in an interesting transition currently. Hopefully the corporate decision makers will realize that the professional culture they are promoting are not the best for patients, their technicians, or their pharmacists. Many hope, as I do, that

retail pharmacists will be given more resources to extend their efforts more consistently into ambulatory care areas such as transitions of care

**Q: Any recommendations for patients without a Meds to Beds Service?**

**A: Tracy-** For health systems unable to provide meds to beds, helping the facility getting the Rx electronically to their preferred community pharmacy, asking pharmacists for cost information, ensuring the pharmacy has prescriptions available to dispense, and counseling the patient on what each medication is for and potential side effects could all be done. Also, follow-up calls (to ensure patient picked up medications) and post-acute care face-to-face visits within 5-7 days could still be performed.

**Brett-** For those hospitals and medical centers without outpatient services, I would suggest trying to work with a local pharmacy to establish a dependable working relationship in order to facilitate patient needs. State laws permitting, such institutions should be open to allowing staff from a local pharmacy fill and dispense medications bedside to patients. For those institutions with outpatient services, I suggest selling the benefits of a concierge service to your administration. With the imminent reimbursements for pharmacists as providers, the financial opportunities for such services will increase during the forthcoming years. We are already seeing pharmacists being recognized as providers in some states, including North Carolina and California.

**Q: How are the 30 day free medications provided to patient paid for?**

**A: Tracy-** Currently the cost of these is covered by UKHealthCare. We are a 340b institution, and unless a change is made, discharge prescriptions can be purchased at 340b prices. For the generics included in this program it makes the costs of the Rx minimal. When ticagrelor is used, if the patient is eligible, we dispense the first 30 day supply using the AstraZeneca voucher program. We knew up front that if this program ends we will have to re-evaluate the impact and direct/indirect cost as well as cost avoidance and revenue to discuss sustainability.

**Brett-** The outpatient pharmacy pays for the 30 day free medications at EMRMC. This is possible since our data shows the costs of the programs offset CMS penalties associated with potential readmissions. The case management and outpatient pharmacy departments share the cost associated with the coaching aspects of our programs (telephone calls, counseling, etc).

**Q: How do you go about recruiting and keeping good pharmacists if you are in a rural area?**

**A: Brett-** The atmosphere and professional nature at Ephraim McDowell create an interesting, yet welcoming environment which recruits and maintains good pharmacists even in our rural area of Danville, KY. Our director, Joan Haltom, is very involved in professional organizations and the interests of our pharmacist staff; she has a progressive outlook on the profession of pharmacy. She is very encouraging and gives us freedom to choose projects and learning opportunities that are interesting to each us and relevant to our department and organization. In addition our staff of pharmacists are very team oriented and flexible towards our scheduling, so generally having important days scheduled away from work or having support on internal projects is not a conflicting issue. We also have two PGY1 residents and most of the clinical staff pharmacists' precept and are very engaged in the residents' interests and endeavors.