TRANSITIONS OF CARE MSHP SPOTLIGHT

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My interest in transitions of care was initially sparked as a student as I recognized the abundance of opportunities that pharmacists can have improving patients' lives through assisting in seamless medication management during times of care movement. After receiving my Pharm.D. from the University of Minnesota in spring 2014, I focused on implementing pharmacist appointments during care transitions as a PGY-1 Rural Health resident at the Minneapolis VA. Since completion of residency, I have continued to work at the Minneapolis VA as a rotational clinical pharmacist. In this position, I seek to serve as a primary preceptor for student research projects and desire to continue improving medication management in Veterans as they bridge transitions of care. For information regarding our current practice and pilot, I can be reached at Christopher.ploenzke@va.gov.

Transitions of Care Project: Design and Implementation of a Targeted Approach for Pharmacist-mediated Medication Management at Care Transitions

Purpose: To improve patient care through the development of a clinical risk stratification tool to identify high-risk patients and implement pharmacist-mediated medication management after patient care transitions.

Methods: A composite care transition score (CCTS) was developed based upon risk factors obtained from a literature review and combined with a validated stratification tool unique to the Veterans Affairs (VA) population, the Care Assessment Need (CAN) score. High-risk individuals were identified to receive a pharmacist-mediated comprehensive medication therapy management (MTM) encounter within 7 days of a recent transition of care. Pharmacists identified and resolved medication-related problems and drug discrepancies using an independent scope of practice.

Results: A total of 31 patients were seen for MTM encounters over the course of the 4 month pilot. A medication-related problem was identified in 98.7% (n=30) of the patients. A total of 127 medication-related problems were identified resulting in an average of 4.1 ±2.9 (range 0-14) per patient. Additionally, 137 drug discrepancies were found during medication reconciliation, with an average of 4.4 ±2.8 (range 0-13) discrepancies per patient. Encounters occurring by telephone resulted in significantly less time per patient interaction (difference of 15 minutes; p=0.01) and total encounter time (difference of 18.5 minutes; p=0.02) compared to in-person visits without compromising the success of identifying and resolving medication-related problems.

Conclusion: Stratification of patients and utilization of pharmacist-mediated MTM appointments resulted in significant identification and resolution of medication-related problems and drug discrepancies at care transitions.