Riverside County Regional Medical Center

Department of Pharmacy Services

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Pharmacy Management Project Director

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Vice Chair – Specialty Acute Care
Objectives

- Understand concepts in creating a pharmacist-driven Core Measures compliance models.
- Utilize available resources to develop your own core-measures program.
- Identify target outcome measures to assess effectiveness of the programs.
- Learn key lessons in implementing your core-measures program successfully.
Background

- Riverside County
  - 7,200 square miles
  - shares borders with Orange, San Bernardino, San Diego, and Imperial counties
  - extends from within 14 miles of the Pacific Ocean all the way to Arizona
  - topographically, mostly desert

http://www.rctlma.org/rcd/default.aspx
### People QuickFacts

<table>
<thead>
<tr>
<th>Category</th>
<th>Riverside County</th>
<th>California</th>
</tr>
</thead>
<tbody>
<tr>
<td>Population, 2010</td>
<td>2,189,641</td>
<td>37,253,956</td>
</tr>
<tr>
<td>Population, percent change, 2000 to 2010</td>
<td>41.7%</td>
<td>10.0%</td>
</tr>
<tr>
<td>Population, 2000</td>
<td>1,545,374</td>
<td>33,871,648</td>
</tr>
<tr>
<td>Persons under 5 years old, percent, 2009</td>
<td>7.9%</td>
<td>7.5%</td>
</tr>
<tr>
<td>Persons under 18 years old, percent, 2009</td>
<td>29.0%</td>
<td>25.5%</td>
</tr>
<tr>
<td>Persons 65 years old and over, percent, 2009</td>
<td>11.5%</td>
<td>11.2%</td>
</tr>
<tr>
<td>Female persons, percent, 2009</td>
<td>50.0%</td>
<td>49.9%</td>
</tr>
<tr>
<td>White persons, percent, 2010 (a)</td>
<td>61.0%</td>
<td>57.6%</td>
</tr>
<tr>
<td>Black persons, percent, 2010 (a)</td>
<td>6.4%</td>
<td>6.2%</td>
</tr>
<tr>
<td>American Indian and Alaska Native persons, percent, 2010 (a)</td>
<td>1.1%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Asian persons, percent, 2010 (a)</td>
<td>6.0%</td>
<td>13.0%</td>
</tr>
<tr>
<td>Native Hawaiian and Other Pacific Islander, percent, 2010 (a)</td>
<td>0.3%</td>
<td>0.4%</td>
</tr>
<tr>
<td>Persons reporting two or more races, percent, 2010</td>
<td>4.8%</td>
<td>4.9%</td>
</tr>
<tr>
<td>Persons of Hispanic or Latino origin, percent, 2010 (b)</td>
<td>45.5%</td>
<td>37.6%</td>
</tr>
<tr>
<td>White persons not Hispanic, persons, 2010</td>
<td>39.7%</td>
<td>40.1%</td>
</tr>
</tbody>
</table>

### Households, 2005-2009

<table>
<thead>
<tr>
<th>Category</th>
<th>645,185</th>
<th>12,187,191</th>
</tr>
</thead>
<tbody>
<tr>
<td>Persons per household, 2005-2009</td>
<td>3.11</td>
<td>2.91</td>
</tr>
<tr>
<td>Per capita money income in past 12 months (2009 dollars) 2005-2009</td>
<td>$24,642</td>
<td>$29,020</td>
</tr>
<tr>
<td>Median household income, 2009</td>
<td>$55,151</td>
<td>$58,925</td>
</tr>
<tr>
<td>Persons below poverty level, percent, 2009</td>
<td>13.9%</td>
<td>14.2%</td>
</tr>
</tbody>
</table>
Level II Adult & Pediatric Trauma Center
362 Single Patient Rooms (Hospital)
77 Licensed Beds (Psychiatric Treatment Facility)
12 Operating Rooms
Intensive Care Units (Adult, Pediatric and Neonatal)
Pharmacy with Clinical Pharmacist on Site
Complete Radiology Services including MRI & CT Scans
Occupational & Physical Therapy Services
Complete Clinical Laboratory Services
Complete Pulmonary Services including Hyperbaric Oxygen Treatments
Complete Diagnostic Services including EEG, EKG and Echo

Full Pediatric Services
Birthing Rooms
Emergency Room and Trauma Center
24 Hour Physician Staffing
Adjacent Helipad
Immediate OR Access
Abuse Services
Child Assessment Team (CAN Team)
Elder Abuse
Drug Endangered Children
SART (Sexual Assault Response Team)
Childhood Injury Prevention Center
A successful man is one who can lay a firm foundation with the bricks others have thrown at him.
System Change

- Transactional Change
  - Individual tasks, skills, abilities

- Transformational Change
  - Altered paradigm
  - Shift in values
  - Reform in beliefs
Cost Control is **Transactional**
Quality Improvement is **Transformational**
“Transformed means that when times are tough, we invest more in quality”

Charles Buck
– retired GE executive
Hospital Quality

- CMS Core Measures
- NCQA HEDIS Measures
- HITECH Act – meaningful use
- Value-Based Purchasing
- HAI payment adjustment
- HCAHPS
Roles of the RCRMC Pharmacists

- Inpatient Pharmacists
- Admission Pharmacists
- ED Pharmacists
- Kinetics Pharmacists
- ID Pharmacists
- Unit Based Pharmacists
- Specialty Service Pharmacists
- Core Measures Pharmacists
- Discharge Pharmacists

- Outpatient Pharmacists
- Managed Care Pharmacists
- Medication Safety Pharmacists
- IT Pharmacists

- Ambulatory Care Pharmacists
- Community / School Based Clinic Pharmacists
- Telephonic Disease Management Pharmacists
- Mail Order Pharmacists
Continuity of Care

Traditional = Snap Shot
Continuity of Care

Continuity of Care = Whole Picture
ACHIEVEMENT

You can do anything you set your mind to when you have vision, determination, and an endless supply of expendable labor.

www.despair.com
Strategic Quality Initiatives

- Improve quality of care
  - Continuity of care
  - Coordination of services

- Integrate multidisciplinary teams
  - Vertical & Horizontal integration

- Efficient use of resources
  - Cost savings
Pharmacist-Driven Core Measures Program
Core Measures and Pharmacist-Driven Programs

- **AMI**
- **CAC**
- **ED**
- **HF**
- **PN**
- **VTE**
- **STK**

**Heart Failure – A Comprehensive Pharmacist-Driven Care Model**

**Pharmacist-Driven Comprehensive Antimicrobial Stewardship Program**

**SCIP VTE Prophylaxis Protocol**

**SCIP Antibiotics Prophylaxis Protocol**

**Pharmacist-Driven Stroke Care Model**

**Inpatient Pharmacy Anticoagulation Service – Warfarin Therapy**

**Pharmacist-Driven VTE Prophylaxis Protocol**
VTE prophylaxis
### Background

- Between 200,000 and 300,000 US patients die of VTE each year (surgery-related and non-surgery-related)—more deaths than from AIDS, breast cancer, and traffic accidents combined*.

- VTE causes an approximate 10% hospital readmission rate by day 90 post surgery and results in substantial resource utilization and excess charges.
  - Each hospital-acquired DVT represents an incremental inpatient cost of $10,000, while each PE represents $20,000.


**RCRMC Goals for VTE Prophylaxis Program**

1. Standardized VTE risk assessment
2. Ensure safe and effective use of pharmacologic VTE prophylaxis
3. Improve patient outcome/Avoid preventable VTE/PE
4. Avoid unnecessary cost associated with preventable VTE/PE
RCRMC VTE Prophylaxis Program

- Pharmacist evaluates patient’s risk for VTE within 24 hours of admission or surgery using standardized risk assessment form
- Pharmacist consults physician when changes in VTE prophylaxis regimen is recommended
- Pharmacist monitors relevant lab values daily for possible Heparin-Induced Thrombocytopenia (HIT)
- All patients who are on pharmacological VTE prophylaxis have CBC drawn at least every 3 days per Pharmacy Protocol
Quality Improvement

- Review of any incidence of potentially preventable VTE
- Quarterly review of core measure fall outs

Identified:

- Many times due to lack of documentation of administration of prophylactic agents (Mechanical/Pharmacological) → Now included in pharmacy assessment/documentation
- Falling out of time window → Twice daily reviewing of surgical cases. Working with nursing to ensure proper administration time
### VTE Prophylaxis Per Pharmacy Protocol -- Progress Note

**Date/Time** | **Discipline** | **Pharmacy**
--- | --- | ---

#### S/O

**Past Medical History:**

<table>
<thead>
<tr>
<th>Ht:</th>
<th>Wt:</th>
<th>Allergy</th>
</tr>
</thead>
</table>

**Labs:**

<table>
<thead>
<tr>
<th>BUN/Scr.</th>
</tr>
</thead>
</table>

**PE:**

- □ Patient is ambulating
- □ SCD On
- □ TED hose On

**A/P:**

**VTE risk factors include:**

- □ Patient is at low risk for VTE
- □ Contraindication to pharmacological anticoagulants
  - □ Yes →
  - □ No

**Patient currently has VTE prophylaxis orders for:**

- □ TED hose
- □ Heparin 5000 units subcut q8h
- □ SCD
- □ Lovenox 40mg subcut q24h
- □ None
- □ Lovenox 30mg subcut q24h (Renal Dose)
- □ Other:
- □ Patient does not require pharmacological or mechanical VTE prophylaxis
- □ Patient has received pharmacological VTE prophylaxis on the day or day after admission. Date received: ___________

Pharmacist will monitor daily and discuss with the physician if there is any change.

VTE prophylaxis performance measure completed the day of or the day after hospital admission.

Pharmacist: Pharm.D Ext.
## Table 1: DVT Prophylaxis (Adult) Risk Screen

### 1. Assign risk score using criteria below

<table>
<thead>
<tr>
<th>A. Risk Factors (RFs) with value of 1 point</th>
<th>B. RFs with value of 2 points</th>
<th>C. RFs with value of 3 points</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age &gt;40 – 60 years</td>
<td>Age 61 - 70 years</td>
<td>Age over 70 years</td>
</tr>
<tr>
<td>Family history of DVT or PE</td>
<td>Major surgery</td>
<td>Prior history of DVT/ PE</td>
</tr>
<tr>
<td>Leg swelling, ulcers, stasis, varicose veins</td>
<td>Malignancy</td>
<td>Acute MI/CHF</td>
</tr>
<tr>
<td>Inflammatory bowel disease</td>
<td>Multiple trauma</td>
<td>Severe sepsis (Sepsis w &gt; 1 organ failure)</td>
</tr>
<tr>
<td>Central line</td>
<td>Spinal cord injury with paralysis</td>
<td>Stroke with paralysis</td>
</tr>
<tr>
<td>Bed confinement /immobilization &gt; 24 hours</td>
<td>COPD/asthma exacerbation</td>
<td>Hyperviscosity syndromes</td>
</tr>
<tr>
<td>Pregnancy, or postpartum &lt; 1 month</td>
<td></td>
<td>Hip and Knee replacement</td>
</tr>
<tr>
<td>Minor Surgery</td>
<td></td>
<td>Inherited thrombophilia</td>
</tr>
<tr>
<td>Estrogen therapy/ SERM</td>
<td></td>
<td>Acquired thrombophilia</td>
</tr>
<tr>
<td>Erythropoiesis-stimulating agents</td>
<td></td>
<td>Paroxysmal nocturnal hemoglobinuria</td>
</tr>
<tr>
<td>Nephrotic syndrome</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

# RFs point= ______  
# RFs point= ______  
# RFs point= ______

### 2. Total Risk Score (A+B+C)*

- Low Risk = 1 point
- Moderate Risk = 2 points
- High Risk = 3 – 4 points
- Very High Risk > 4 points

### 3. Early ambulation for all patients when possible, with assistance if necessary.

### 4. □ Patient is on therapeutic anticoagulation. Additional pharmacologic thromboprophylaxis is not required

### 5. □ Patient has contraindication to pharmacologic therapy: __________

#### Order for thromboprophylaxis:

<table>
<thead>
<tr>
<th>Low Risk (1 pt)</th>
<th>Moderate Risk (2 pts)</th>
<th>High Risk/Very High Risk (≥3 pts)</th>
</tr>
</thead>
<tbody>
<tr>
<td>[ ] Sequential compression device (SCD)</td>
<td>[ ] Sequential compression device (SCD)</td>
<td>[ ] Sequential compression device (SCD) AND</td>
</tr>
<tr>
<td>[ ] Early Ambulation</td>
<td>[ ] Enoxaparin 40mg SubQ q 24 hr</td>
<td>[ ] Enoxaparin 40mg SubQ q 24 hr</td>
</tr>
<tr>
<td></td>
<td>[ ] Enoxaparin 30mg SubQ q 24 hr (Dosing for CrCl &lt; 30 ml/min)</td>
<td>[ ] Enoxaparin 30mg SubQ q 24 hr</td>
</tr>
<tr>
<td></td>
<td>[ ] Heparin 5000 units SubQ q 8hr</td>
<td>[ ] Heparin 5000 units SubQ q 8hr</td>
</tr>
</tbody>
</table>

### Other Orders:

#### Contraindication to Pharmacological Prophylaxis

**Relative**
- History of cerebral hemorrhage
- Craniotomy within 2 weeks
- GI, GU hemorrhage within the last 6 months
- Thrombocytopenia (Platelet < 100 k/uL)
- Coagulopathy (INR > 1.5)
- Active intracranial lesions/neoplasm/monitoring devices
- Diabetic Retinopathy
- Vascular access/biopsy sites inaccessible to hemostatic control

**Absolute**
- Active hemorrhage
- Heparin, enoxaparin, or warfarin use in patient with heparin-induced thrombocytopenia
- Warfarin use in the first trimester of pregnancy
- Severe trauma to head, spinal cord or extremities with hemorrhage within last 4 weeks
- Indwelling epidural/spinal catheter placement or removal

**Pharmacist signature/ Print**

**Phone #**

**Date/Time**
VTE Core-Measures

- VTE-1: VTE Prophylaxis
- VTE-2: Intensive Care Unit VTE Prophylaxis
- VTE-3: VTE patients with anticoagulation overlap therapy
- VTE-4: VTE patients receiving unfractionated heparin with dosages/platelet count monitoring by protocol
- VTE-5: VTE discharge instructions
- VTE-6: Incidence of potentially-preventable VTE
# of Patients Assessed by Pharmacist for VTE Prophylaxis

12-Month Data

*Medical Patients*
Interventions by Pharmacist

<table>
<thead>
<tr>
<th>Month</th>
<th>Apr 10</th>
<th>May 10</th>
<th>Jun 10</th>
<th>Jul 10</th>
<th>Aug 10</th>
<th>Sep 10</th>
<th>Oct 10</th>
<th>Nov 10</th>
<th>Dec 01</th>
<th>Jan 11</th>
<th>Feb 11</th>
<th>Mar 11</th>
</tr>
</thead>
<tbody>
<tr>
<td>D: intervention</td>
<td>93 92</td>
<td>95 93</td>
<td>66 65</td>
<td>48 47</td>
<td>72 70</td>
<td>138 135</td>
<td>190 179</td>
<td>137 131</td>
<td>143 39</td>
<td>156 53</td>
<td>173 70</td>
<td>186 84</td>
</tr>
<tr>
<td>N: # accepted intervention</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>
Surgical Care Improvement Projects (SCIP)
Pharmacist Driven SCIP Program

- VTE Prophylaxis (VTE 1 & 2)
- Prophylactic Antibiotics Discontinued Within 24 Hours After Surgery End Time
- Surgery Patients on Beta-Blocker Therapy Prior to Arrival Who Received a Beta-Blocker During the Perioperative Period: pharmacist review prior medication history and ensure BB is continued during perioperative period
Core Measures - SCIP

% compliance

1st Qt 10
2nd Qt 10
3rd Qt 10
4th Qt 10

SCIP Care-2  SCIP-2a  SCIP-3a  SCIP-OP-7  VTE-1  VTE-2

1st Qt 10  2nd Qt 10  3rd Qt 10  4th Qt 10
<table>
<thead>
<tr>
<th>Date/Time</th>
<th>Discipline</th>
<th>Pharmacy</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>SCIP Performance Measure Reviewed by the Pharmacist</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Post-Surgical VTE Prophylaxis Per Pharmacy Protocol</td>
</tr>
<tr>
<td></td>
<td></td>
<td>S/O</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Past Medical History:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Past Surgical History:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Labs: PE:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>A/P VTE risk factors include:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Patient is at low risk for VTE</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Contraindication to pharmacological anticoagulants</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Yes →</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Patient currently has VTE prophylaxis orders for:</td>
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<td></td>
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<td>□ TED/SCD □ Heparin 5000 units subcut q8h</td>
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<tr>
<td></td>
<td></td>
<td>□ None □ Lovenox 40 mg subcut q24h</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Lovenox 30 mg subcut q24h (Renal Dose)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Patient does not require pharmacological or mechanical VTE prophylaxis</td>
</tr>
</tbody>
</table>

|           |            | Prophylactic Antibiotics Discontinuation Per Pharmacy Protocol |
|           |            | □ Patient received prophylactic antibiotics perioperatively. |
|           |            | □ Prophylactic antibiotics is discontinued 24 hours post anesthesia end time |
|           |            | Pharmacist will monitor and discuss with the physician if there is any change. |
|           |            | SCIP performance measure completed 24 hours post anesthesia end time. |

|           |            | Pharmacist: PharmD. Ext 30248 |

DISCIPLINE LEGEND:
- MD/DO: Physician
- RN: Nursing
- RPH: Pharmacist
- PT: Physical Therapy
- OT: Occupational Therapy
- RT: Respiratory Therapy
- S.W.: Social Service
- SP: Speech Pathology
Heart Failure
Heart Failure Program

- Patients admitted with diagnosis or history of HF are automatically enrolled in Pharmacist-Driven HF program
- Clinical Pharmacist provides initial consultation within 24-48 hours of admission: medications, diet, exercise, smoking cessation, symptoms of worsening heart failure…
- Pharmacist conducts medication reconciliation and reviews current medications: Review for optimized therapy
Heart Failure Program

- Upon discharge, Pharmacist conducts discharge medication reconciliation and provides discharge consultation regarding any changes, discontinuation or addition of medications.
- Pharmacist ensures patient will obtain 30 day supply of medications.
- Pharmacist ensures all core-measures are met before discharge.
- Upon discharge, Clinical Pharmacist will refer patient to outpatient pharmacy services (Medication Management Telephonic Model, ambulatory clinics) as appropriate in collaboration with case management. Currently in process of expanding pharmacist service.
Heart Failure Core-Measures

- HF-1: Discharge Instruction
- HF-2: Evaluation of LVS function
- HF-3: ACEI or ARB for LVSD
- HF-4: Adult smoking cessation advice/counseling
- Best practice: Beta blocker
Pharmacist-Driven Heart Failure Program

- Medication Reconciliation
- Medication Review and Optimize Therapy
- Patient Education
- Empower Patients for Self Management
- Referral to HF Clinic
- Referral to DSM – Telephonic Model
PMH:

- If patient is diagnosed with HF or admitted for HF exacerbation or has a history of HF with LVEF (<40%), recommend patient be discharged with the following:
  - ACEI/ARB
    - Benazepril (Lotensin)
    - Losartan (Cozaar)
  - Beta-Blocker
    - Carvedilol (Coreg)
    - Metoprolol XL (Toprol XL)

NOTE: If patient cannot be discharged with these medications MUST document the reason (ie. contraindication, allergy, etc)

Patient Consultation:

- Discussed low-salt diet, fluid restriction, healthy lifestyle, activity level, smoking cessation, avoidance of EtOH & illicit drugs, daily weight monitoring.
- Educated patient on sx of worsening HF and what to do if symptoms worsen.
- Educated patient on HF medications, proper use, expected effects, significant ADRs, and potential drug interactions.
- Spanish translation provided if Spanish-speaking.

Intervention:

- Recommend considering alternate agent for NSAID. NSAID can cause sodium retention and peripheral vasoconstriction and can attenuate the efficacy and enhance the toxicity of diuretics and ACE inhibitors.
- Recommend considering alternate agent for antiarrhythmic agent. Antiarrhythmic agent can exert important cardiodepressant and proarrhythmic effects. Only amiodarone and dofetilide have been shown not to adversely affect survival.
- Recommend considering alternate agent for Calcium Channel Blocker. Calcium channel blockers can lead to worsening HF and have been associated with an increased risk of cardiovascular events. Only the vaso-selective ones have been shown not to adversely affect survival.

Other recommendation:

Please feel free to contact with any questions.

Pharmacist: PharmD. Ext 30222.
### Core Measures Discharge Note

**Pharmacy**  

1. **ACUTE MYOCARDIAL INFARCTION**
   - Patient is being discharged with the following: If not, reason stated:
     - Aspirin
     - Beta-Blocker
     - ACEI or ARB for LVSD
     - Statin

2. **HEART FAILURE**
   - EF: _____%
   - Patient is being discharged with the following: If not, reason stated:
     - ACEI/ARB
     - Beta-Blocker
     - HF written and verbal education provided to patient addressing the following: 1. Activity level, 2. Diet, 3. Discharge medications, 4. Follow-up appointment, 5. Daily weight monitoring, 6. What to do if symptoms worsen

3. **STROKE**
   - Patient is being discharged with the following: If not, reason stated:
     - Antithrombotic therapy
     - Statin
     - Anticoagulation therapy for Afib/flutter
     - N/A

4. **ALL PATIENTS**
   - Smoking cessation advice/Counseling
   - Spanish translation provided if Spanish-speaking.
30-days Hospital Re-admission Rate

*Data collected based on patients followed by pharmacists*
Vaccination
Pharmacist-Driven Hospital-wide Immunization

- **Employee Flu Drive**
  - 89% (vs. 50%)

- **Admitted Patients**
  - **Influenza**
    - 96% Screened and Immunized
  - **Pneumonia**
    - 99% Screened and 89% Immunized

- **Core Measures**
  - PNA-2, PNA-7, Prev-Imm-1, Prev-Imm-2
  - Improve quality of vaccination screening and overall patient care
Financial Impact of Pharmacist-Driven Core Measures Program
## Risk of Deep Vein Thrombosis in Hospitalized Patients

No prophylaxis + routine objective screening for DVT

<table>
<thead>
<tr>
<th>Patient Group</th>
<th>DVT incidence (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical Patients</td>
<td>10-26</td>
</tr>
<tr>
<td>Major gynecological, urological, or general surgery</td>
<td>15-40</td>
</tr>
<tr>
<td>Neurosurgery</td>
<td>15-40</td>
</tr>
<tr>
<td>Stroke</td>
<td>11-75</td>
</tr>
<tr>
<td>Hip or knee surgery</td>
<td>40-60</td>
</tr>
<tr>
<td>Major trauma</td>
<td>40-80</td>
</tr>
<tr>
<td>Spinal cord injury</td>
<td>60-80</td>
</tr>
<tr>
<td>Critical care patients</td>
<td>15-80</td>
</tr>
</tbody>
</table>

Reference: [www.ahrq.gov](http://www.ahrq.gov)

Each hospital-acquired DVT represents an incremental inpatient cost of $10,000, while each PE represents $20,000.
DVT/VTE Prophylaxis Interventions - Financial Impact

Assumption: 15% prevalence rate, $10,000 / incident

Total savings/cost avoided to date = $1.8 million
• Total savings/cost avoided to date = $1.8 million

Return on Investment (ROI) = 10.6
Heart Failure Program

30-days Hospital Re-admission Rate

*Data collected based on patients followed by pharmacists
Financial Impact

8 x $15,293* = $122,344 / month

= $1.46M / year

* based on article by Peacock, 2003

Prior to HF Program
May - Dec 2010 Average

~8 re-admissions prevented per month
Managed Care
Medically Indigent Service Program (MISP)

- Sept 2009
- Formulary management
- Disease management

- Pharmacist coordinated care
- Vertical & horizontal integration
- Improve quality
  - Reduction of poly-pharmacy, poly-prescribers,
  - Standardization of care
Pharmacist-Managed Medically Indigent Service Program

~ $450,000 / month
= ~$5.4 M / year
Pharmacist-Managed Patient Assistance Program

$170,000 / month = $2 million / year

- Increased access to medications
- Increased compliance and adherence
Pharmacist-Driven Strategic Quality Initiatives

- Improve overall QUALITY and outcomes
- Enhance safe use of medications
- Efficient use of resources
Take home message
1) Research

- Data collection
- Hospital statistics
- Current practice and quality measures
- Expected outcomes/impacts
2) Institution support
  ◦ Administrators
  ◦ Physicians
  ◦ Nurses
  ◦ Pharmacists
3) Develop collaborative practice protocol
   ◦ Evidence based practice
   ◦ Best practice standards (tailored to your institution)
4) Implementation
   ◦ Staffing requirement
   ◦ Workflow
   ◦ Staff training – getting out of the comfort zone
5) Quality assurance
   ◦ Monitoring mechanism
   ◦ Data collection and reporting
   ◦ Re-evaluate program and modify