include the need to obtain a written agreement from patients to receive the care. Medicare coinsurance and deductibles apply to TCM and CCM services, which could pose an obstacle to patients’ acceptance of the services.

Shilliday and Leal welcomed the new opportunities for reimbursement of pharmacists’ patient care services. But they emphasized that incident-to billing is not a substitute for the recognition of pharmacists as healthcare providers under the Social Security Act.

Shilliday noted that her MAC’s previous refusal to allow higher-level billing for pharmacists’ incident-to services was based on the fact that CMS didn’t list pharmacists as recognized providers.

Leal explained that incident-to billing “only covers what the provider specifically asks for you to help with.”

If a physician refers a patient to a pharmacist for diabetes management, only those services are billable as incident to the physician’s service. This applies even if the pharmacist discovers during the encounter that the patient has uncontrolled hypertension or other problems and addresses those.

“You will [treat them], because that’s our clinical obligation. But for reimbursement purposes, you’re only able to do what the [physician] asks you to do,” Leal said.

Thus, to allow pharmacists broader opportunities to use their skills and be reimbursed for their work, “it’s very critical to get provider status,” Leal said.

—Kate Traynor
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Pharmacists integrate into geriatric emergency department

When Upstate University Hospital in Syracuse, New York, began looking at adding a geriatric emergency department (ED) to Community Campus, the pharmacy department did not have to ask about participating, said director Beth Szymaniak.

“We were invited to be on the committee, and we were automatically assumed . . . to be a part of it,” Szymaniak said of the eight-bed geriatric ED, which opened in July 2013. “We just had to figure out how many FTEs [full-time equivalents] we wanted.”

The number of pharmacist FTEs in the geriatric ED is now 2, which was the pharmacy department’s original request, said the long-time director.

Pharmacist services should be an ancillary service of all geriatric EDs, according to a set of guidelines developed by nonpharmacy organizations.

Approved in October 2012 by the American College of Emergency Physicians Geriatric Section and the Academy of Geriatric Emergency Medicine, the document “Geriatric Emergency Department Guidelines” supports dual goals for an ED specializing in the care of people 65 years of age or older:

• Recognize the patients who will benefit from inpatient care.
• Efficiently provide outpatient care to those who do not require inpatient resources.

The guidelines recommend completion of a medication list for all patients 65 years of age or older arriving to the ED.

The guidelines do not recommend a specific professional for completing the medication list. But they do recommend a multidisciplinary approach to managing patients who are taking more than five medications, using any “high-risk” medication, or experiencing signs or symptoms of an adverse drug event.

Nikolas Onufrak, one of the two pharmacists in Upstate University Hospital at Community Campus’s geriatric ED, said the multidisciplinary team strives to prevent initial hospitalizations and also repeat visits due to lack of comprehensive care.

So far, said pharmacist Kelly R. Braham, the admission rate for patients from the geriatric ED, which operates 8 a.m. to 10 p.m. daily, has decreased to 35% from an initial 42%.

Braham and Onufrak said their primary responsibility as geriatric emergency medicine pharmacists is to analyze patients’ medication regimens.

However, getting to the point of being able to analyze the regimens, Onufrak noted, requires “a little detective work.” That means a lot of phone calls to pharmacies and physician offices and conversations with patients and family members, he said.

“We do the best we can to figure out what they actually are taking and reconcile that with the reason why they’re presenting to us,” he said. Then attention turns to assessing the appropriateness of all the medication regimens and determining whether any relate to the ED visit.

Braham said she and Onufrak pay particular attention to the overall anticholinergic burden of patients’ medications and use two tools—the STOPP (Screening Tool of Older People’s Prescriptions) and START (Screening Tool to Alert to Right Treatment) criteria—to identify
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“Geriatric Emergency Department Guidelines” is available from www.acep.org/geriEDguidelines.

potentially inappropriate prescribing in older people. The two pharmacists also check for drug interactions before recommending interventions, she said.

And the pharmacists educate the patient as much as possible about every medication on the list and the drug’s purpose.

For a substantial percentage of the patients, said Onufrak, “there are significant [medication-related] interventions to be made at the point of care when they come into the ED.”

Braham recounted one such case from just the previous week.

“He came in and he was taking both apixaban and rivaroxaban,” she said of the patient, who did not speak English. “They were prescribed by two different providers; neither was his primary care doctor. However, he had been on this regimen since May.”

A computed tomography scan of the man’s head showed no sign of bleeding despite his taking the two anticoagulants for six months and recently falling down, Braham said.

“How he got by for that long I don’t know, but that’s something that we definitely rectified,” she said.

More common, Braham said, is the pharmacist’s recommendation to change a patient’s hypertension therapy to avoid a medication that causes orthostatic hypotension, which is a fall risk.

Onufrak said he and Braham typically see 20–30 patients over the course of a 10-hour workday. Not all of these patients are in the geriatric ED, however. As time permits, the two pharmacists also see patients in the transitional care unit and general ED.

Whether geriatric EDs lower costs remains uncertain, however.

An observational study at a community hospital in Ann Arbor, Michigan, found that after its geriatric ED opened in October 2010, patients 65 years of age or older had a lower risk of hospital admission than when that population was seen in the general ED.

But there were no differences in the risks of a repeat ED visit within 30 and 180 days. Neither was there a change in the average length of stay for those patients admitted to the hospital. The researchers reported that the pharmacists evaluated only selected patients in the geriatric ED.

—Cheryl A. Thompson
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News Briefs

• FDA in October approved a drug-eluting peripheral transluminal angioplasty catheter, the Lutonix 035 Drug Coated Balloon PTA Catheter. The agency said the medical device is the first drug-coated balloon for use in reopening thigh and knee arteries that are narrowed or blocked because of peripheral artery disease. According to the device’s labeling, the coating on the balloon contains approximately 3.8 mg of paclitaxel and also polysorbate and sorbitol. Patients should receive dual antiplatelet therapy before the angioplasty procedure in accordance with current medical standards and then for at least four weeks afterward. Inability to receive this dual antiplatelet therapy is a contraindication to use of the device. The labeling states that no formal drug–device interaction studies have been conducted and advises clinicians, when deciding whether to use the device, to consider the potential for systemic and local drug interactions in the artery’s wall. Lutonix Catheter is marketed by Bard Peripheral Vascular, whose parent company bought Lutonix Inc. in 2011.

• Sister Mary Louise Degenhart, ASC, B.S.Pharm., M.B.A., FASHP, and Henri R. Manasse, Jr., Ph.D., Sc.D., FFIP, received two of the three commemorative sesquicentennial medals awarded by St. Louis College of Pharmacy on November 11, 2014—exactly 150 years after the college’s founding—to honor the accomplishments of nationally renowned pharmacy leaders. Degenhart is a lead surveyor for ASHP Accreditation Services and a former member of the Accreditation Services Division. Manasse is a former executive vice president of ASHP.