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PACT rollout was incomplete and didn’t include clinical pharmacy specialists.

The pilot project also supports PACT components related to nursing services and patient’s concerns about nontraditional care models, according to information presented at the August VA conference.

Another gold status project described during the conference focuses exclusively on pharmacists’ services within the PACT initiative. The project originated at the William S. Middleton Memorial Veterans Hospital in Madison, Wisconsin, and was pilot tested in Texas at the El Paso VA Health Care System.

According to data presented by El Paso VA Health Care System Clinical Pharmacy Specialist Larry Salvatti during the August conference, the integration of clinical pharmacy specialists into PACT programs has trimmed 15 minutes of overall PACT care provider time from each new patient appointment.

Salvatti’s data indicated that 76% of patients who saw a pharmacist before their scheduled appointment with another PACT clinician went on to cancel that appointment. During the first four weeks of the pilot project, the time savings associated with the pharmacists’ services created openings for 13 new primary care appointments for veterans.

According to Salvatti’s presentation, the medical center plans to expand the pilot initiative next year and anticipates that the project will result in 1833 newly available primary care appointments for veterans annually. To support the rollout, the medical center has approved the hiring of four additional clinical pharmacy specialists.

A third gold status project, developed by Certified Pharmacy Technician Kristine Gherardi of VA Boston Healthcare System’s Jamaica Plain campus, focused on “code tray redesign” for improved safety and efficiency during emergency code responses. The project was pilot tested at the VA Loma Linda Healthcare System in California and is scheduled for deployment at three more VA medical centers, according to information presented at the conference.

VA launched the Diffusion of Excellence initiative this year to engage frontline employees and solicit their ideas for improving care for veterans. According to VA, more than 250 projects were submitted for evaluation as gold status best practices.

—Kate Traynor

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CDC chief praises pharmacists’ work on hypertension

At the time they contributed to the Million Hearts achievement, Reliant’s pharmacists were operating out of pharmacies housed in the same buildings as the clinics.

“We were retail pharmacists and we were doing clinical work,” explained Folasade Foose, a clinical pharmacist for the health system.

“Most [of] the interactions with the patients were done over the phone,” she said. “We did have the opportunity in some cases, if the patients were already filling their prescriptions at our retail sites, . . . to talk with them face to face.”

But now, Foose is one of four full-time clinical pharmacists at Reliant who are fully integrated into patient care teams, working face to face to improve their patients’ health.

“We’re there for any medication-related questions or concerns of the patients and also as support for the doctors,” Foose said.

Foose said Reliant’s entire staff pitched in for the Million Hearts Initiative during the 2015 campaign. She said the pharmacists whose work Frieden cited had focused on about 400 patients with diabetes and hypertension who weren’t taking an angiotensin-converting enzyme (ACE) inhibitor or angiotensin receptor blocker (ARB).
“We did a thorough medication review and we looked over their charts, and then we made recommendations to their primary care physician if they should be on an ACE inhibitor or an ARB. At that point, if the physician agreed with the recommendation—and in most circumstances they did—we reached out to patients,” she said.

That outreach included calling patients to explain the benefits of the therapy, describe potential adverse effects, ensure that patients could afford the medications, and provide counseling on lifestyle modifications.

Under the current team-based model of care, Reliant’s pharmacists continue to focus mainly on patients with diabetes, hypertension, or both.

“But if a doctor feels that a patient would benefit from our services, we’re always open to these ad hoc consultations,” Foose said.

For the approximately 550 patients with hypertension, she said, “We are getting them in, taking that blood pressure. We are following them long term.”

That means checking whether patients are having their prescriptions refilled, recommending dosage changes, and reviewing laboratory test results.

When appropriate, Foose said, a pharmacist adjusts the patient’s drug regimen to help achieve hypertension control targets. Other interventions may include referring patients to a dietitian or nutritionist.

All of this is done in consultation with the patient’s primary care provider (PCP), she said.

“We are enforcing the messages the PCP has given them already,” Foose explained.

She said Reliant is capturing but hasn’t yet reported outcomes data under the team-based model. And pharmacists aren’t directly billing for patient encounters, though she said that could change if the profession is granted healthcare provider status under Medicare.

“But right now it’s not something that we have the ability to do,” she said.

Foose said she’s excited to have had the opportunity to use her skills to do more than just dispense medications. But she said it’s also important for pharmacists to recognize their ability to help patients solve problems related to affording their medications and getting prescriptions filled.

“Oftentimes when patients go to their primary care physician, they might be a little bit hesitant to admit that they’re having issues paying for their medications or they’re having other issues,” she said. “We should focus on the health of the patient—the whole patient—as best we can. And sometimes that involves looking at copays and looking at affordability. . . . And if affording medications affects compliance, then it is something that we should be involved in.”

—Kate Traynor

Hospital pharmacists take time out for antimicrobial stewardship

Hospitals large and small are exploring pharmacy-managed antimicrobial therapy “time-outs” as part of antimicrobial stewardship strategies.

In Illinois, four Northwestern Medicine hospitals—333-bed Central DuPage Hospital in Winfield, 159-bed Delnor in Geneva, 98-bed Kishwaukee in DeKalb, and 24-bed Valley West in Sandwich—recently presented findings from a study of pharmacist-led antimicrobial therapy time-outs, as did 650-bed University of Nebraska Medical Center in Omaha. The results of the two studies were presented at the October 2016 IDWeek conference in New Orleans.

An antimicrobial therapy time-out, according to the Centers for Disease Control and Prevention’s (CDC’s) core elements for hospital antimicrobial stewardship programs, is a systemic evaluation, at a set time point, of the need to continue antimicrobial treatment.

Although CDC recommends that hospitals adopt a policy of routinely requiring a time-out 48 hours after the initiation of antimicrobial therapy, that timing isn’t always practical.

“It takes about 72 hours to turn around our cultures,” said Radhika Polisetty, clinical and infectious diseases pharmacist at Central DuPage Hospital. Thus, for their study, the pharmacists at the four Northwestern Medicine hospitals performed time-outs 72 hours after initiating therapy so that their recommendations were backed by microbiology test results.

Overall, the six-month study found that the time-outs did not alter the overall use of antimicrobials at the hospitals, as measured in days of therapy per 1000 patient-days.

But the project successfully highlighted the interventions recommended by pharmacists—443 in all, for 1674 patients—and the 96.8% acceptance rate for those recommendations among physicians.

“We have the data to support that the recommendations that are being made are valid,” said Elizabeth Jochum, pharmacy clinical coordinator for the Kishwaukee and Valley West hospitals.