# Utilizing Pharmacy Technicians to Maximize Pharmacist Interventions with Home Health Service Patients



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## **BACKGROUND**

- Discrepancies in a patient's medication list are more likely to occur during transitions of care; medication reconciliation can improve the safety and quality of healthcare provided.
- By identifying medication discrepancies, pharmacy teams may help reduce the number of hospital readmissions.
- Utilizing pharmacy technicians to gather medication histories may maximize
  patient encounters by allowing the pharmacist to focus on resolving
  discrepancies and addressing medication therapy problems.

## **OBJECTIVES**

- To determine the number of medication therapy problems (MTPs) identified during a technician-driven medication reconciliation process.
- To analyze 30-day hospital readmission rates.

# **METHODS**

Study Design	Prospective, cohort study
Study Location	Independent community pharmacy in partnership with a home health agency
Inclusion Criteria	<ul> <li>≥ 18 years</li> <li>Live at home</li> <li>Receive skilled nursing services</li> <li>High- to very-high-risk based on LACE tool</li> <li>Medicare or Medicare-like insurance</li> </ul>
Exclusion Criteria	<ul> <li>Live in skilled nursing or assisted living facility</li> <li>Unable or unwilling to provide medication list via phone</li> <li>Unable to reach after 3 attempts</li> </ul>
Study Timeframe	December 1, 2018 through January 27, 2019
Analysis	Descriptive statistics

Patient referred to pharmacy team by home health agency transition specialist Pharmacist determines information to be gathered by technician during medication history

Technician contacts patient to obtain allergies, medications, and vaccines; conducts falls risk and depression screening

Pharmacist reviews history and contacts provider for clarifications or recommendations

Pharmacist documents education to be conveyed to patient by home health nurse in the electronic health record

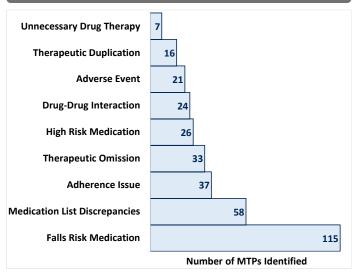
30-day hospital readmission data provided by third party administrator

## RESULTS

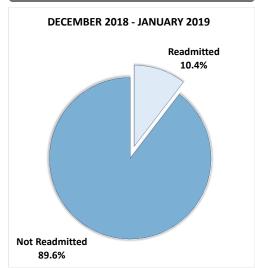
#### **STUDY SAMPLE** 25 Patients Declined Review 144 Patients 213 Patients 33 Patients Unable to Interacted Referred to Reach After 3 Attempts Pharmacv 9 Patients Readmitted Pharmacist/ Team Before Review Technician 2 Patients Lost to Follow-Team up

# DEMOGRAPHICS Characteristic (N=144) N (%) Age, Mean (±SD) 72 (13.1) Gender 78 (54.2%) Female 78 (54.2%) Male 66 (45.8%) LACE Score, Median 12

# MEDICATION THERAPY PROBLEMS IDENTIFIED (N=337)



# **30-DAY READMISSION RATES (N=144)**



### **DISCUSSION AND NEXT STEPS**

- Pharmacist-pharmacy technician teams were able to identify an average of 2.3 medication therapy problems per patient; an average of 7 updates were required for each patient's medication list.
- 30-day readmission rates for high- to very-high-risk patients receiving intervention by the pharmacy team was 10.4%.
  - Based on data provided by the third party administrator, overall readmission rates for high- to very-high-risk patients pre-study (September 2018) was 30.7% (63/205 patients readmitted; mean length of stay = 50 days). Sixty-day readmission data for our cohort of patients is pending and will allow for a better comparison.
- Further research is necessary to determine the cost saving potential of utilizing a pharmacy technician to complete the medication history compared to utilizing a pharmacist.

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