Orlando

POST MIDYEAR2017

CREATING THE FUTURE

13 FEBRERO 2018

AMBULATORY CARE PRACTICES

Manuel Vélez Díaz-Pallarés
Hospital Universitario Ramón y Cajal
13 de febrero de 2018

sefh
Sociedad Española de Farmacia Hospitalaria

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Sunny Days and Seniors: When Less Is Better in Medication Management

ashp CELEBRATING 75 YEARS

ashp MIDYEAR 2017
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Stop the Benzodiazepines:

Identifying High-Risk Patient Populations to Successfully Taper These Medications

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Clinical Pharmacy Specialist – Mental Health
Northern California VA Health Care System
Martinez, CA

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¿Según las revisiones sistemáticas cuál de los siguientes efectos adversos tiene una relación causal dudosa con el uso de benzodiazepinas?

1. Fractura de cadera
2. Accidentes de tráfico
3. Deterioro cognitivo irreversible
4. Caídas

¿Cómo se define la desprescripción?

- El proceso planeado de reducir o eliminar medicamentos que ya no aportan beneficio o que están causando daño. El objetivo es reducir la carga de medicamentos o daño a la vez que se mejora la calidad de vida.

Patient Case: Think-Pair-Share

Identify medications that our patient is taking that may have contributed to her fall.

- HCTZ
- Metoprolol
- Lisinopril
- Zolpidem
- Insulin glargine
- Glyburide
- Acetaminophen
- Levothyroxine
- Paroxetine

www.deprescribing.org

Prescripción inapropiada ¿qué es?

- El **uso de un fármaco con un perfil beneficio/riesgo desfavorable** para un paciente concreto por:
  - No tiene indicación/Otra indicación/Contraindicado
  - Demasiado tiempo…o demasiado poco
  - Posología diferente a la recomendada (edad, función renal, etc)
  - Elevado riesgo de RAM / Interacciones / Duplicidad
  - Innecesariamente caro
- Un paciente que
  - **NO recibe un fármaco INDICADO** para la prevención o el tratamiento de la enfermedad

Spinewine et al. The Lancet, 2007.

Pilares de la desprescripción

- Mayor riesgo
- Simplificación o reducción más fácil
- Preferencias del paciente
- Decisión colaborativa

PRIORIZAR

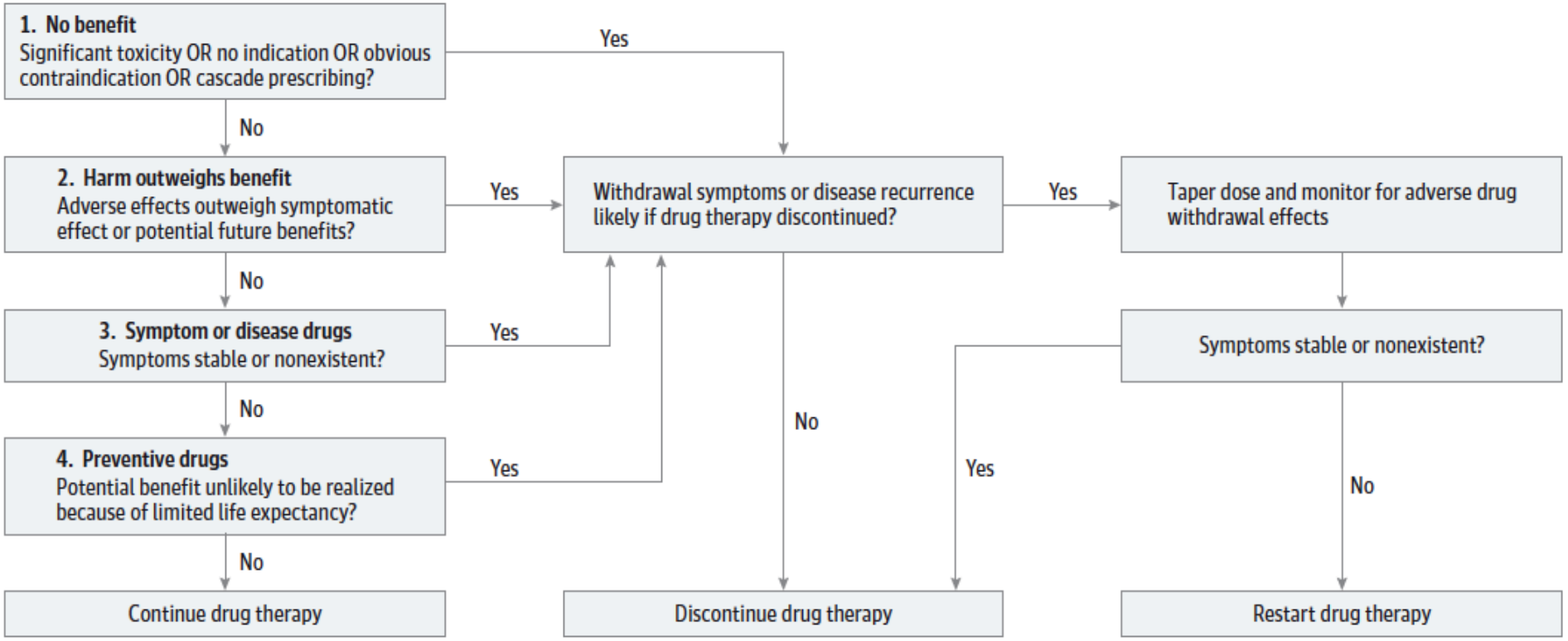
Metodología

- Cada cambio / reducción de forma escalonada
- Comunicar y dejar por escrito los cambios que se realicen
- Monitorizar al paciente

Reeve E et al. Deprescribing: A narrative review of the evidence and practical recommendations for recognizing opportunities and taking action. Eur J Intern Med 2017

Reducing Inappropriate Polypharmacy
The Process of Deprescribing

Figure. Algorithm for Deciding Order and Mode in Which Drug Use Could Be Discontinued



Scott I et al. JAMA Intern Med 2015; 175:827-34

Guías de desprescripción

- http://www.deprescribing.org/

- Guías para:
- 1. IBPs
- 2. Antipsicóticos
- 3. Antidiabéticos
- 4. Benzodiazepinas

Why is patient taking a PPI?

If unsure, find out if history of endoscopy, if ever hospitalized for bleeding ulcer or if taking because of chronic NSAID use in past, if ever had heartburn or dyspepsia

Indication still unknown?

- Mild to moderate esophagitis or
- GERD treated x 4-8 weeks (esophagitis healed, symptoms controlled)

- Peptic Ulcer Disease treated x 2-12 weeks (from NSAID; *H. pylori*)
- Upper GI symptoms without endoscopy; asymptomatic for 3 consecutive days
- ICU stress ulcer prophylaxis treated beyond ICU admission
- Uncomplicated *H. pylori* treated x 2 weeks and asymptomatic

- Barrett's esophagus
- Chronic NSAID users with bleeding risk
- Severe esophagitis
- Documented history of bleeding GI ulcer

Recommend Deprescribing

Strong Recommendation (from Systematic Review and GRADE approach)

Decrease to lower dose (evidence suggests no increased risk in return of symptoms compared to continuing higher dose), or

Stop and use on-demand (daily until symptoms stop) (1/10 patients may have return of symptoms)

Stop PPI

Continue PPI

or consult gastroenterologist if considering deprescribing

Monitor at 4 and 12 weeks

If verbal:
- Heartburn
- Dyspepsia
- Regurgitation
- Epigastric pain

If non-verbal:
- Loss of appetite
- Weight loss
- Agitation

Use non-drug approaches
- Avoid meals 2-3 hours before bedtime; elevate head of bed; address if need for weight loss and avoid dietary triggers

Manage occasional symptoms
- Over-the-counter antacid, H2RA, PPI, alginate prn (ie. Tums®, Rolaids®, Zantac®, Olex®, Gaviscon®)
- H2RA daily (weak recommendation – GRADE; 1/5 patients may have symptoms return)

If symptoms relapse:

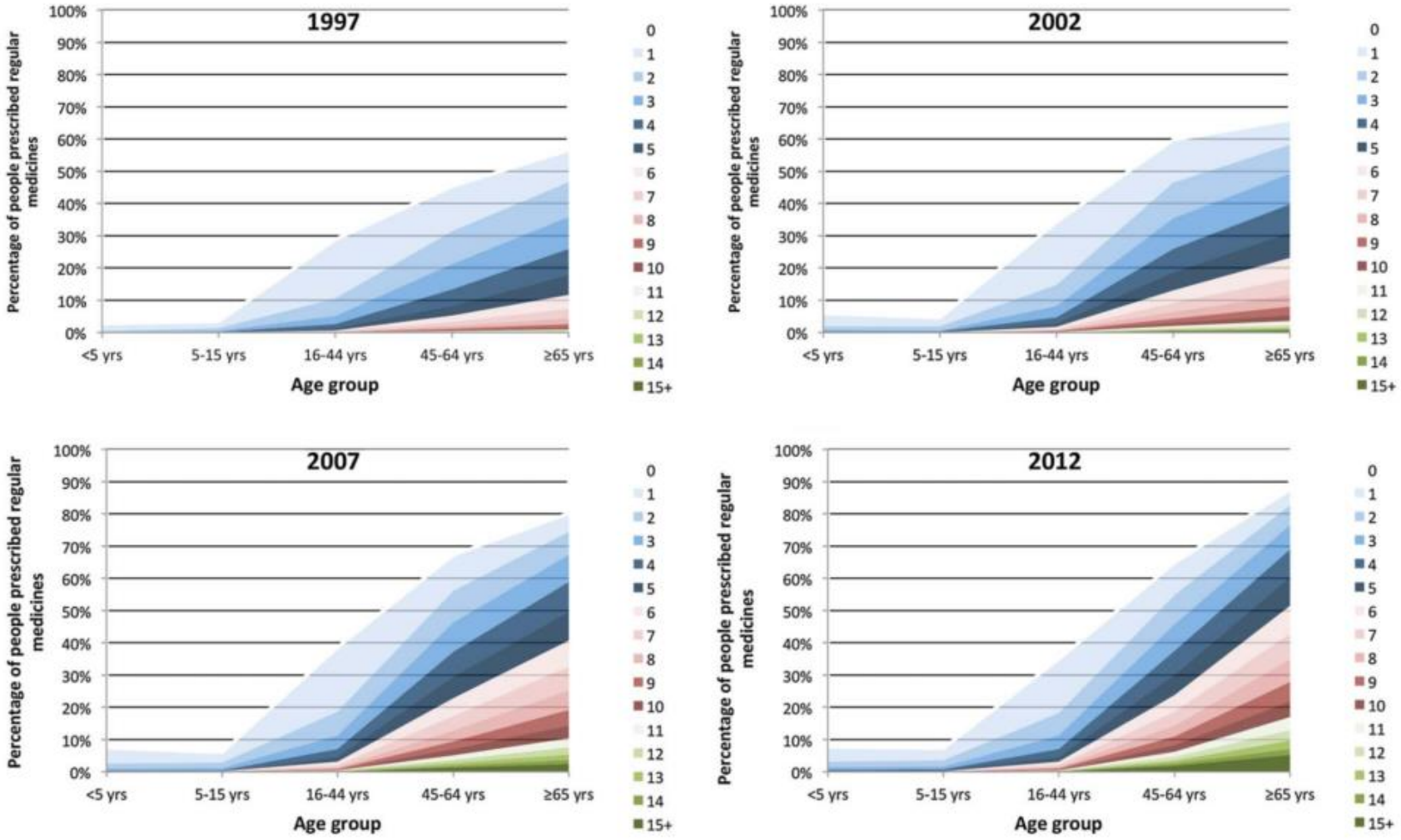
If symptoms persist x 3 – 7 days and interfere with normal activity:

1) Test and treat for *H. pylori*

2) Consider return to previous dose

Farrell B, Pottie K, Thompson W, Boghossian T, Pizzola L, Rashid FJ, et al. Deprescribing proton pump inhibitors. Evidence-based clinical practice guideline. *Can Fam Physician* 2017;63:354-64 (Eng), e253-65 (Fr).

La polifarmacia y el envejecimiento



Moriarty F, Hardy C, Bennett K, et al. Trends and interaction of polypharmacy and potentially inappropriate prescribing in primary care over 15 years in Ireland: a repeated cross-sectional study. BMJ Open 2015;5: e008656.

Prescripción inapropiada ¿es frecuente en España?

	Prevalencia - criterios STOPP (%) Internacional	España
Comunidad	21-69	21-51
Residencias	24-98	48-79
Hospital de agudos	16-77	25-58
Media estancia		53
	Prevalencia - criterios START (%) Internacional	España
Comunidad	0-26	20-54
Residencias	34-42	29-74
Hospital de agudos	15-65	31-57
Media estancia		46

Delgado-Silveira E, Montero-Errasquín B, Muñoz-García M, Vélez-Díaz-Pallarés M, Lozano-Montoya I, Sánchez-Castellano C, Cruz-Jentoft,AJ. Mejorando la prescripción de medicamentos en las personas mayores: una nueva edición de los criterios STOPP-START. Revista Española de Geriatría y Gerontología. 2015;50(2):89-96

Esperanza de vida / longevidad

- Estatinas como profilaxis primaria en pacientes con una esperanza de vida < a 5 años
- Bifosfonatos en pacientes de bajo riesgo de fractura con una esperanza de vida < a 5 años

Sección A. Sistema cardiovascular

1. Antagonistas de la vitamina K, inhibidores directos de la trombina o inhibidores del factor Xa en presencia de fibrilación auricular crónica
2. AAS (75–160 mg/día) en presencia de fibrilación auricular crónica cuando los antagonistas de la vitamina K, inhibidores directos de la trombina o inhibidores del factor Xa están contraindicados

5. Estatinas con antecedentes bien documentados de enfermedad vascular coronaria, cerebral o periférica, salvo que el paciente esté en situación de final de vida o su edad sea > 85 años

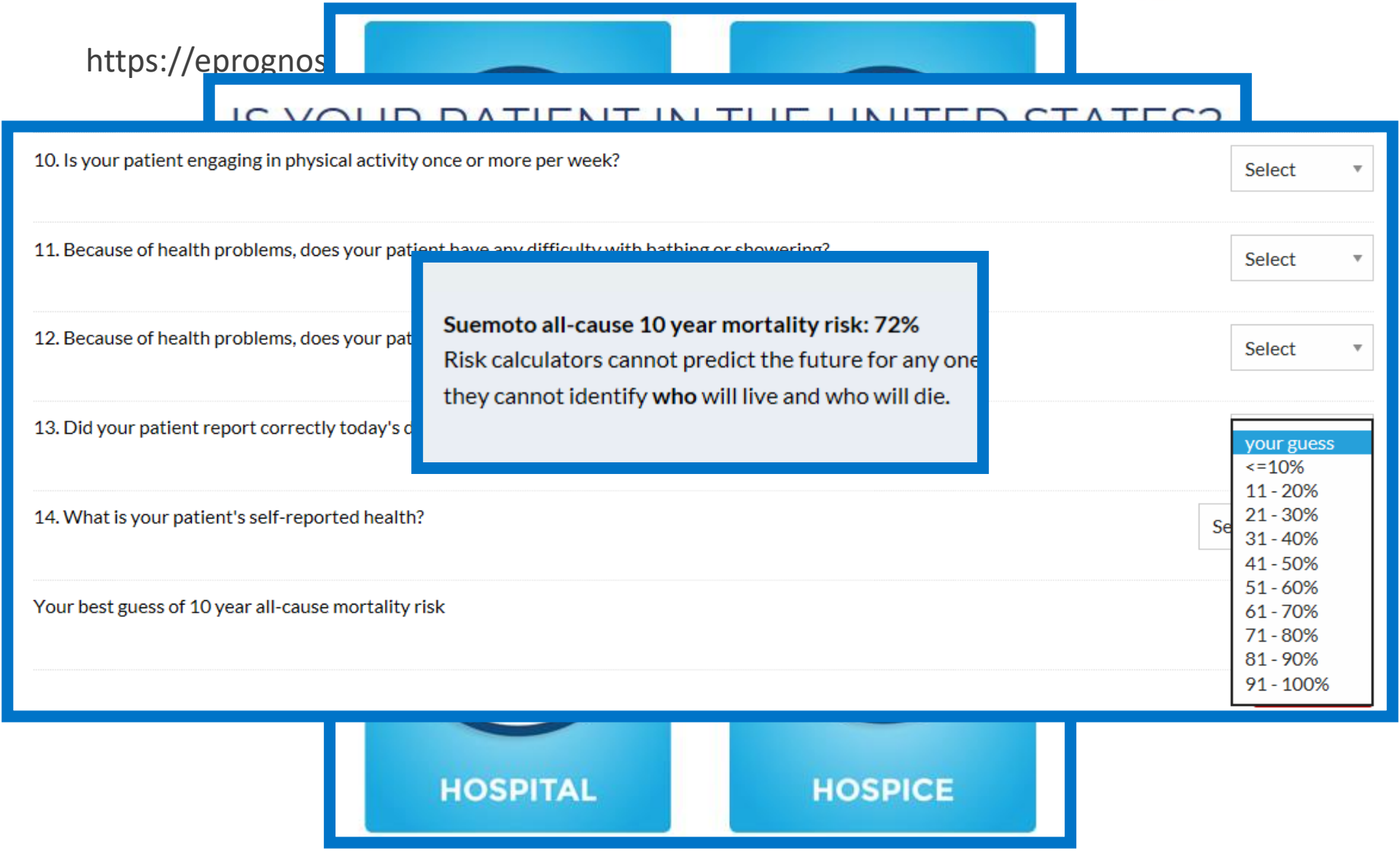
final de vida o su edad sea > 85 años

6. IECA en la insuficiencia cardiaca sistólica y/o cardiopatía isquémica bien documentada
7. Betabloqueantes en la cardiopatía isquémica
8. Betabloqueantes apropiados (bisoprolol, nebivolol, metoprolol o carvedilol) en la insuficiencia cardiaca sistólica estable

Delgado Silveria et al. Improving drug prescribing in the elderly: a new edition of STOPP/START criteria. Rev Esp Geriatr Gerontol. 2015 Mar-Apr;50(2):89-96.

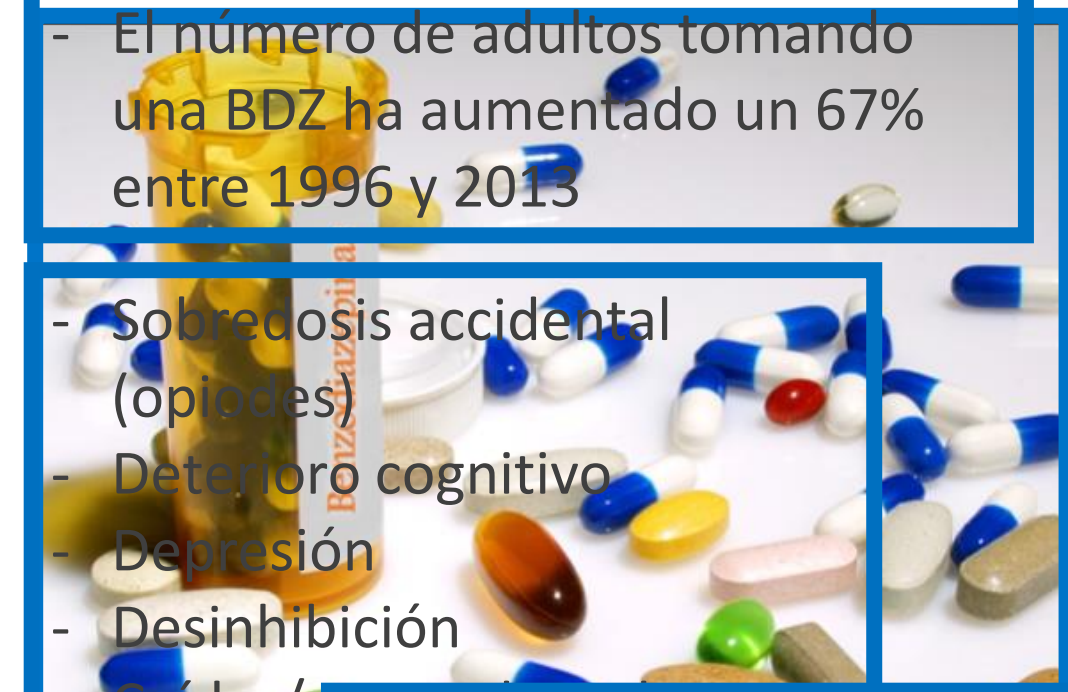
Cálculo de esperanza de vida

https://eprognos

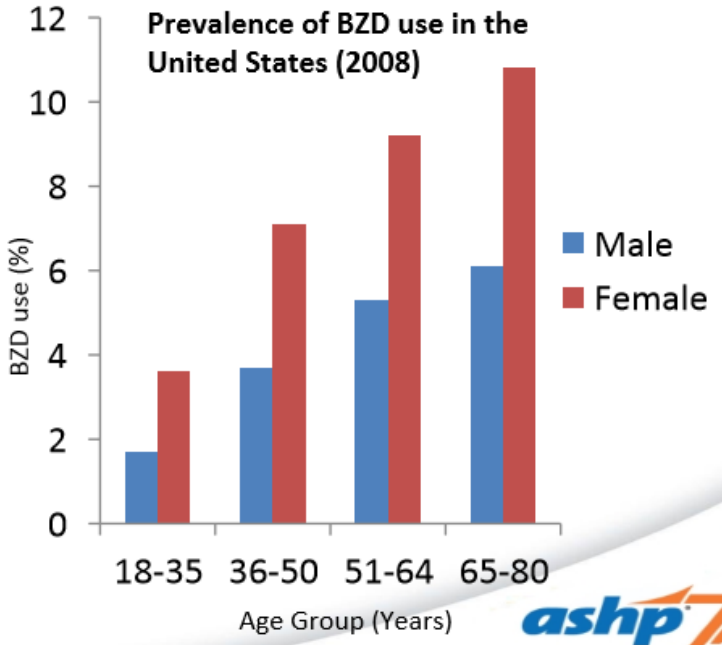


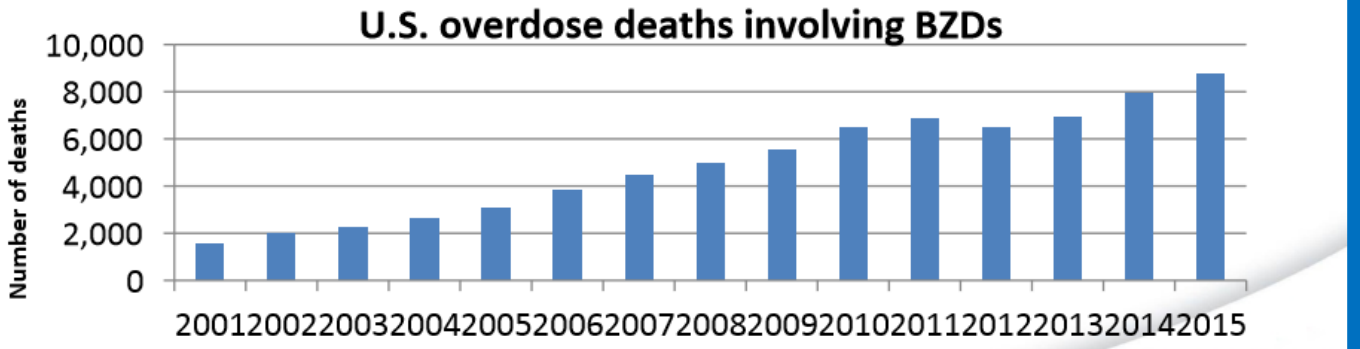
El problema de las benzodiazepinas

- El número de adultos tomando una BDZ ha aumentado un 67% entre 1996 y 2013



- Sobredosis accidental (opiodes)
- Deterioro cognitivo
- Depresión
- Desinhibición
- Caídas/r
- Tolerand
- Accident





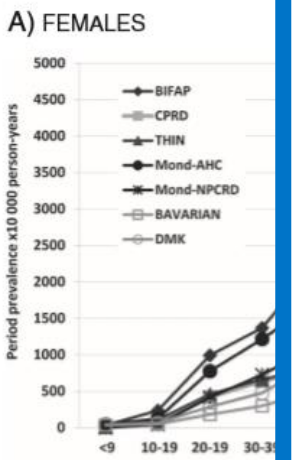
Bachhuber MA, et al. AJPH, 2016. 106(4):p. 686-8.
Jones, CM, et al. JAMA, 2013. 309(7): p. 657-659.
NIDA. *National Center for Health Statistics, CDC Wonder. National Overdose Deaths*

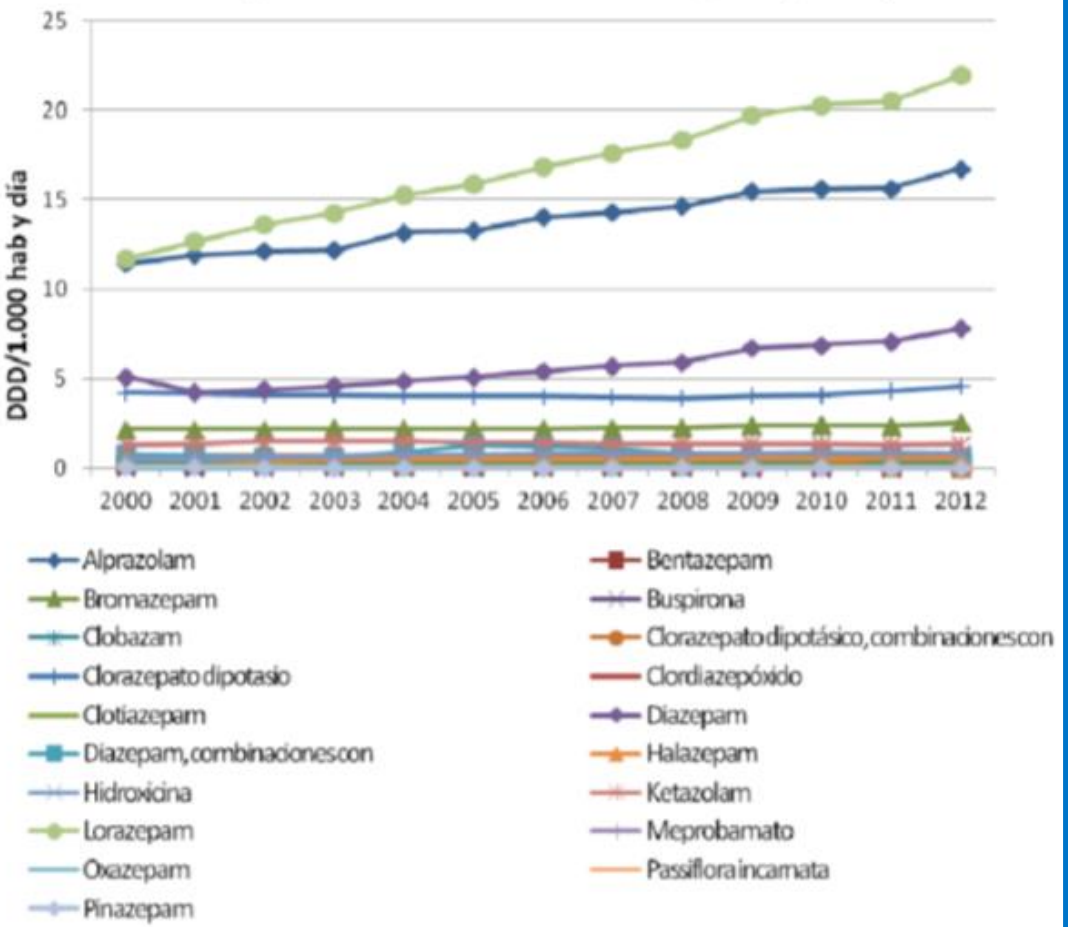
PHARMACOEPIDEMIOLOGY AND DRUG SAFETY 2016; 25(Suppl. 1): 56–65
Published online 7 July 2015 in Wiley Online Library (wileyonlinelibrary.com) DOI: 10.1002/pds.3825

ORIGINAL REPORT

Exposure to benzodiazepines (anxiolytics, hypnotics and related drugs) in seven European electronic healthcare databases: a cross-national descriptiv

Consuelo Huerta[1]*, Victoria Abb
Helga Gardarsdottir[2,5], Montserra
Jim Slattery[4], Mark C. H. De Gr
Andrew Bate[12], Ana Ruigomez[13]
Raymond G. Schlienger[17], Robe



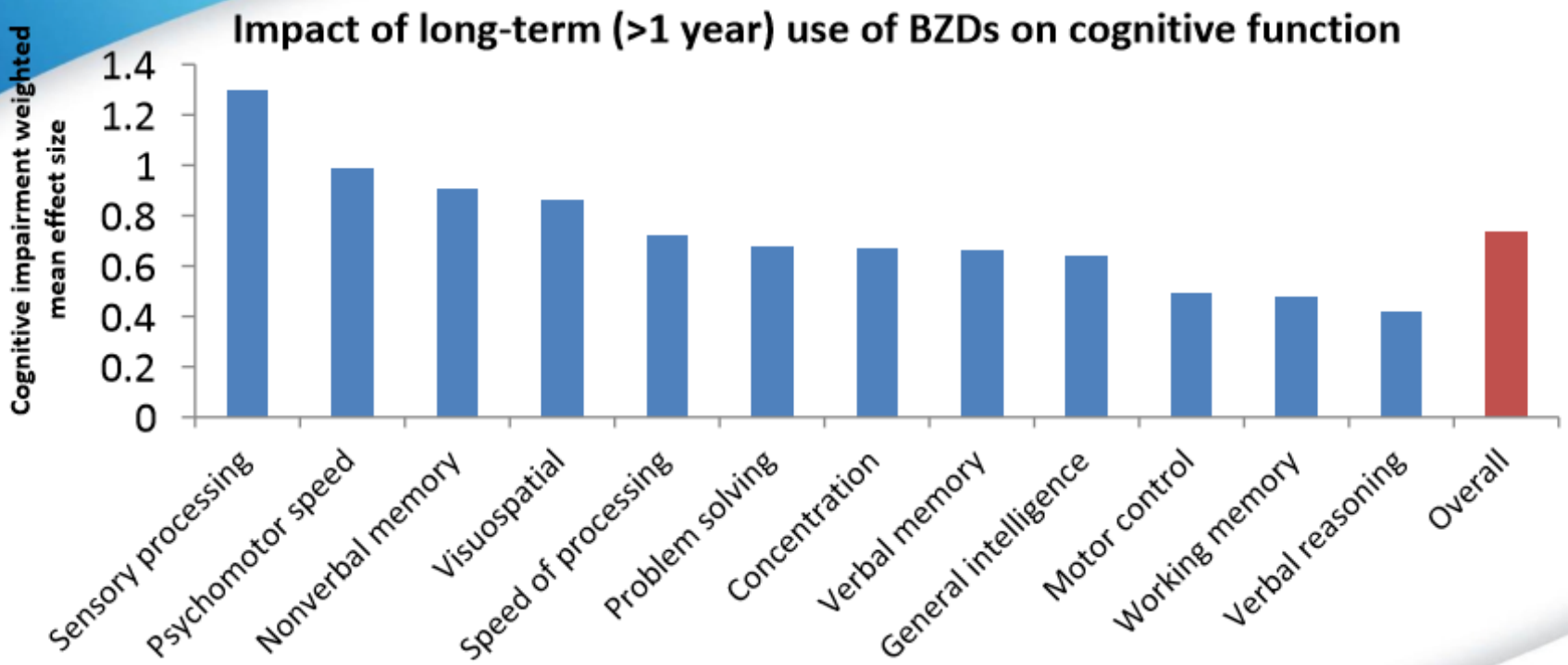


creased in the (+13%) and UK es (+2% and +8%) study period, ey decreased in the tabases (-4% and - e German (-12%) sh (-26%) e. Data (2001-2009)

INFORME DE UTILIZACIÓN DE MEDICAMENTOS U/HAY/V1/17012014. Informe del Ministerio de Sanidad e Igualdad

Deterioro cognitivo de las BZDs

BZDs and Cognitive Function



Barker, M.J., et al., CNS Drugs, 2004. 18(1): p. 37-48.
Markota M, et al., Mayo Clinic Proc, 2016. 91(11):p. 1632-39.
Bierman, E.J., et al., Int J Geriatr Psychiatry, 2007. 22(12): p. 1194-200.
Tannenbaum, C., et al., Drugs Aging, 2012. 29(8): p. 639-58.

Población de riesgo

1. Enfermos con enfermedad respiratoria crónica
2. Coadministración con opioides
3. Demencia
4. Ancianos (mayores de 65)
5. Estrés postraumático
6. Historia de abuso de sustancias

Papel en terapéutico de las BZDs

- Control sintomático rápido de:

- 1 Ansiedad severa / ataques de pánico
- 2. Insomnio
- 3. Convulsiones
- 4. Sdre. Abstinencia del alcohol / BDZs

No hay evidencia de que el uso crónico de benzodiazepinas mejore el insomnio o la ansiedad

The Maudsley Prescribing Guidelines in Psychiatry 12th Edition. 2015.

Tapering doses

- No published evidence exists to suggest switching to long-acting BZRAs reduces incidence of withdrawal symptoms or is more effective than tapering shorter-acting BZRAs
- If dosage forms do not allow 25% reduction, consider 50% reduction initially using drug-free days during latter part of tapering, or switch to lorazepam or oxazepam for final taper steps

Recomendaciones para la deprescripción de benzodiacepinas INFAC 2013:

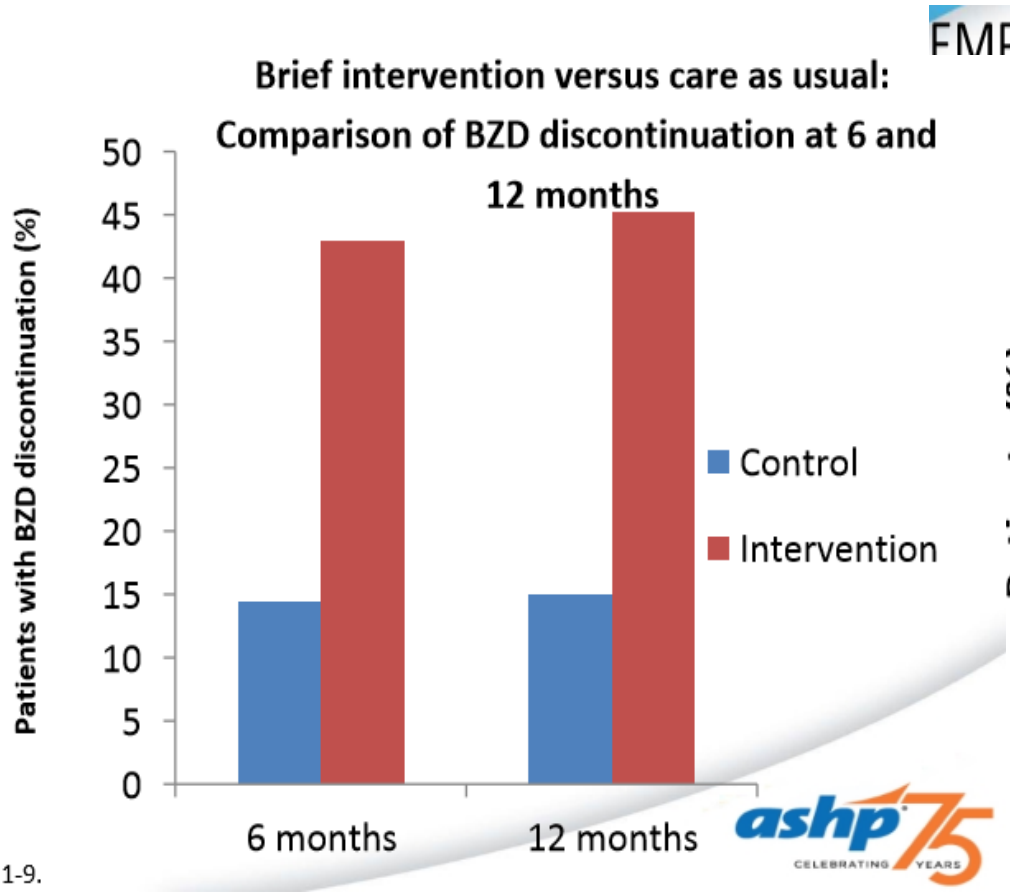
- Reducir la dosis total diaria entre un 10-25% en intervalos de 2 a 4 semanas, especialmente con los de vida media corta.
- Alternativa: sustituir por diazepam a dosis equivalentes y reducción gradual de diazepam entre 2 y 2,5 mg cada 2 ó 4 semanas.

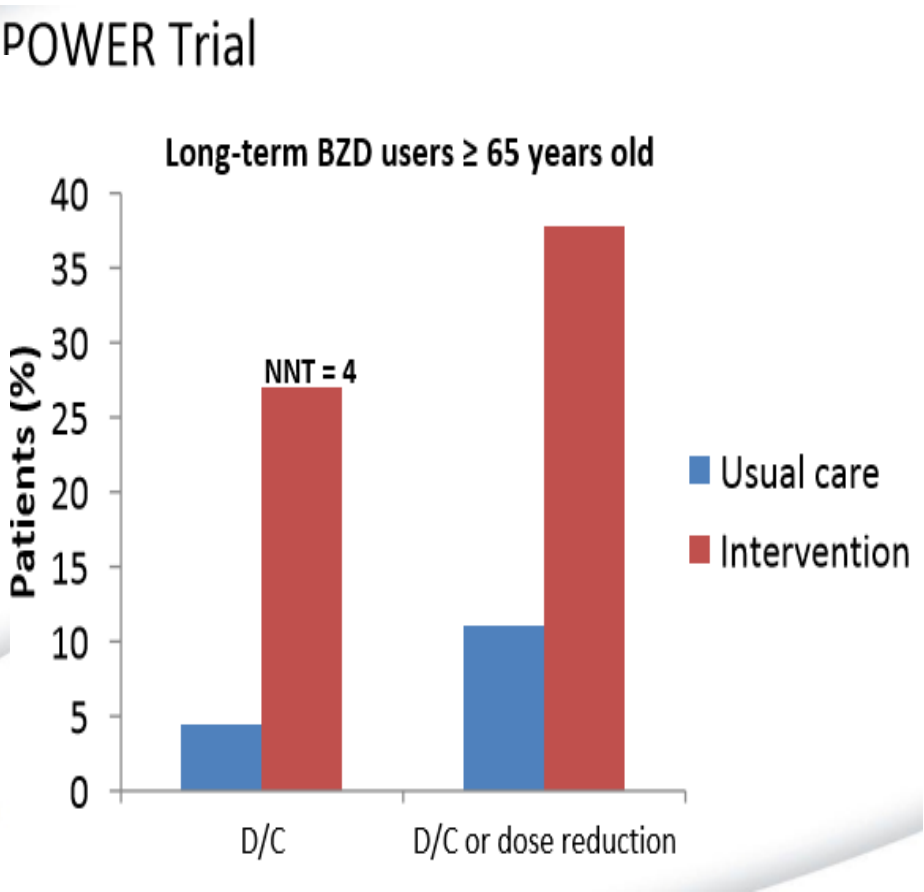
La pauta de retirada consiste en una disminución de la dosis total diaria que tome el paciente, de entre un 10% y un 25%, según el grado de dependencia. La dosis resultante se mantendrá unas 2-3 semanas. La retirada se realiza con la misma benzodiazepina o sustituyéndola por una dosis equivalente de diazepam, que tiene una vida media larga y que está comercializado en varias dosis, lo que permite disponer de dosis distintas. El cambio a diazepam es también ventajoso en aquellos pacientes que presentan una fuerte dependencia psicológica a "la pastilla de dormir". Aunque debemos evitar las benzodiazepinas de vida media larga, el objetivo de esta sustitución es la retirada del fármaco y no el cambio de una benzodiazepina por otra.[15]

Sch
Lor
Bob
Hac

1. Deprescribing.org
2. Boletín de información farmacoterapéutico de Navarra. Abril Junio 2014
3. Recomendaciones del portal de Salud de Castilla y León.

Estudios de desprescripción





1-9.

Vicens C, et al., Br J Psychiatry, 2014. 204(6): p. 471-9.

Tannenbaum C, et al., JAMA Intern Med, 2014. 174(6):p 890-8.

Riesgos de las benzodiazepinas (I)

- Riesgo de rotura de cadera

Both BNZ, and Z-drug use respectively, were significantly associated with an increased risk of hip fracture (RR = 1.52, 95% CI 1.37-1.68; and RR = 1.90, 95% CI 1.68-2.13). Short-term use of BNZ and Z-drugs respectively, was also associated with the greatest risk of hip fracture (RR = 2.40, 95% CI 1.88-3.05 and RR = 2.39, 95% CI 1.74-3.29).

The literature review showed an increased risk of hip fractures in benzodiazepine users (RR = 1.4, 95 % CI 1.2-1.6)

- Accidentes de tráfico

The risk-benefit analysis of Z-drugs in the treatment of insomnia, particularly in the elderly, may not favor treatment due to the increased risks of falls and motor vehicle collisions. Prescribers should warn patients taking Z-drugs of minimum time thresholds before they operate machinery or drive motor vehicles.

BZDs approximately doubles the risk of motor vehicle accidents

- Donnelly K et al. Benzodiazepines, Z-drugs and the risk of hip fracture: A systematic review and meta-analysis. PLoS One. 2017 Apr 27;12(4):e0174730.
- Khong TP. Potential impact of benzodiazepine use on the rate of hip fractures in five large European countries and the United States. Calcif Tissue Int. 2012 2012 Jul;91(1):24-31
- Gunja N. In the Zzz zone: the effects of Z-drugs on human performance and driving. J Med Toxicol. 2013 Jun;9(2):163-71
- R. E. Thomas. Benzodiazepine use and motor vehicle accidents. Systematic review of reported association. Can Fam Physician. 1998 Apr; 44: 799–808.

Riesgos de las benzodiazepinas (II)

- Caídas

The main group of drugs associated with an increased risk of falling was psychotropics: benzodiazepines, antidepressants, and antipsychotics

Exposure to BZDs was associated with a higher risk of falls in older adults, which is consistent with the results reported in the literature and previous reviews and meta-analyses. BZDs increase the risk of falling when used either as monotherapy or in combined therapies.

Adjusting for confounders, use of diazepam at admission was positively associated with a history of falls compared with all other benzodiazepine users (odds ratio 3.0; 95 % CI 1.1-8.5; p = 0.036).

- Hartikainen S. Medication as a risk factor for falls: critical systematic review. J Gerontol A Biol Sci Med Sci. 2007 Oct;62(10):1172-81.
- Díaz-Gutiérrez MJ. Relationship between the use of benzodiazepines and falls in older adults: A systematic review. Maturitas. 2017 Jul;101:17-22.
- Ballokova A. Use of benzodiazepines and association with falls in older people admitted to hospital: a prospective cohort study. Drugs Aging. 2014 Apr;31(4):299-310

Riesgos de las benzodiazepinas (III)

- Deterioro cognitivo

Stronger links (between benzodiazepine therapy and cognitive decline) have emerged from studies examining longer- rather than shorter-acting benzodiazepines, longer rather than shorter durations of use, or earlier rather than later exposure.

Higher cumulative anticholinergic use is associated with an increased risk for dementia.

benzodiazepines provoke combined amnestic and non-amnestic impairments

An increased accumulative dose (zolpidem) might result in a significantly higher risk to develop dementia in patients with underlying diseases

- Picton JD. Benzodiazepine use and cognitive decline in the elderly. Am J Health Syst Pharm. 2018 Jan 1;75(1):e6-e12.
- Gray SL. Cumulative use of strong anticholinergics and incident dementia: a prospective cohort study. JAMA Intern Med. 2015 Mar;175(3):401-7.
- Tannenbaum C. A systematic review of amnestic and non-amnestic mild cognitive impairment induced by anticholinergic, antihistamine, GABAergic and opioid drugs. Drugs Aging. 2012 Aug 1;29(8):639-58.
- Mitsutaka Takada. Association between Benzodiazepine Use and Dementia: Data Mining of Different Medical Databases. Int J Med Sci. 2016; 13(11): 825–834.
- Hsin-I Shih. An Increased Risk of Reversible Dementia May Occur After Zolpidem Derivative Use in the Elderly Population. A Population-Based Case-Control Study. Medicine (Baltimore). 2015 May; 94(17): e809.

¿Según las revisiones sistemáticas cuál de los siguientes efectos adversos tiene una relación causal dudosa con el uso de benzodiazepinas?

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Transitions of Care Studies: Practical Lessons to Improve Inpatient and Outpatient Communications and Reduce Hospital Re-admission Rates

Pamela C. Heaton, R.Ph., Ph.D.
University of Cincinnati

Lauren Bloodworth, Pharm.D., BCPS
University of Mississippi

Sara E. Roszak, M.P.H., M.A.
NACDS Foundation

Eric Wright, Pharm.D., M.P.H.
Geisinger Health

ashp 75 CELEBRATING YEARS

Pamela C. Heaton, R.Ph., Ph.D.

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UNIVERSITY OF CINCINNATI

Objetivo

Desarrollar, implementar, y evaluar un programa farmacéutico de transición asistencial en la reducción de tasa de reingresos

Criterios de inclusión

- Mayores de 18 años
- Hablar ingles
- Alta a domicilio
- Diagnóstico de ICC, neumonía, diabetes, EPOC o IAM

Criterios de exclusión

- Deterioro cognitivo
- Alta a lugar de larga estancia

Grupo intervención

1. Cita a las 72 horas del alta hospitalaria

- Conciliación y revisión de la medicación prescrita
- Identificación de PRMs
- Consejo farmacéutico
- Planning de medicación, lista de citas
- Envío de fax de los resultados obtenidos a su MAP

2. Llamada telefónica a las 2 semanas.

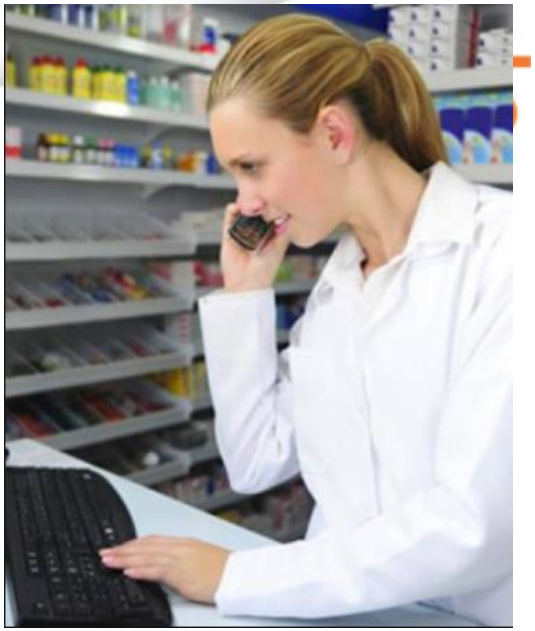
- Medir el grado de aceptación de las intervenciones farmacéuticas

Results – 30 Day Readmissions

Measure	All Patients N=403	Intervention ITT N= 214	Control ITT N= 189	p-value ITT		Intervention PP* N=65	p-value PP
Inpatient Readmission Yes	45 (11.2%)	24 (11.2%)	21 (11.1%)	0.55		2 (3.1%)	0.04

NNT=12.5 patients

- **404 intervenciones en 62 de los pacientes**
- Las intervenciones más comunes:
- 1. Monitorización (59)
- 2. Inmunización (56)
- 3. Necesita terapia (37)
- 4. Técnica de administración (24)
- 5. Terapia OTC (18)



- Acceptance Rates
  - Total acceptance rate for all interventions not lost to follow up was 82.9%
  - Patients accepted 85.6% of the 276 interventions that needed patient approval
  - Prescribers accepted 74% of the 104 interventions that required provider consent

Lauren Bloodworth, Pharm.D., BCPS

UNIVERSITY OF MISSISSIPPI

Objetivo

Mejorar los outcomes de los pacientes mediante la integración de farmacéuticos de hospital y de oficina de farmacia y otros profesionales durante el alta hospitalaria.

Allocation Process

- Patients targeted through the hospital computer database, Epic
- Daily reports allocated patients to the 4 diagnoses groups
- Control group managed by Honest Broker (study personnel blinded)

Distribution (control:intervention)

- 2:1 → 1:1 → 1:2

Study Duration: 12 months → 6 months

Criterios de inclusión

- IAM
- IC
- Neumonia
- EPOC

Criterios de exclusión

- No hablar inglés
- Problemas de comunicación
- Menos de 18 años

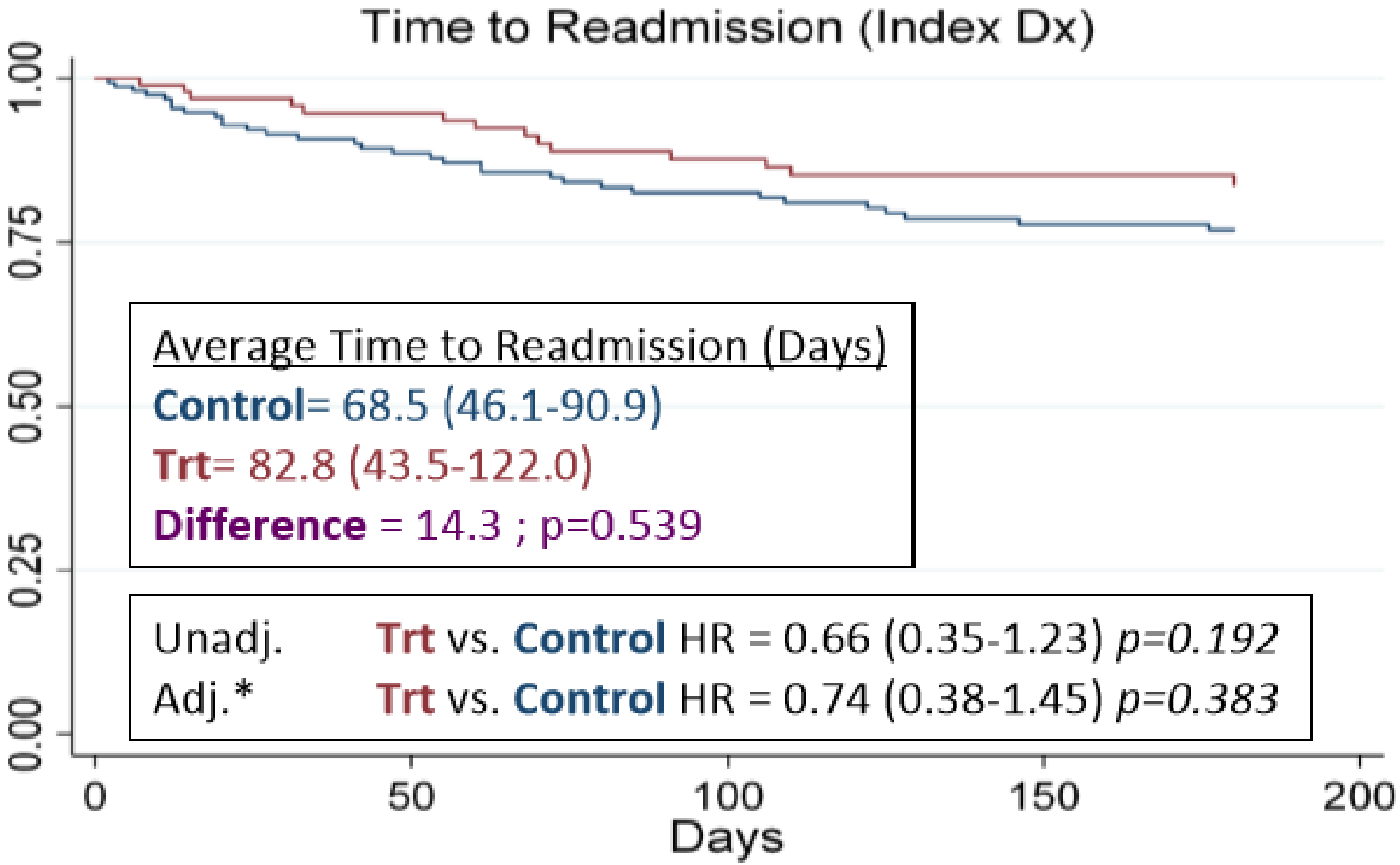
- **Grupo intervención**

- **1. Inpatient**

- - Colaborar en la historia clínica
- - Resolver discrepancias en el tratamiento
- - Educación farmácéutica
- - Organizar citas al alta
- - Dispensar 30 días de medicación
- - Planning de medicación, lista de citas

- **2. Outpatient**

- - Llamadas a las 48 horas, 9 días y 25 días
- - Revisión de la medicación
- - Resolución de síntomas
- - Visitas face-to-face a los 4-7 días y a los 90

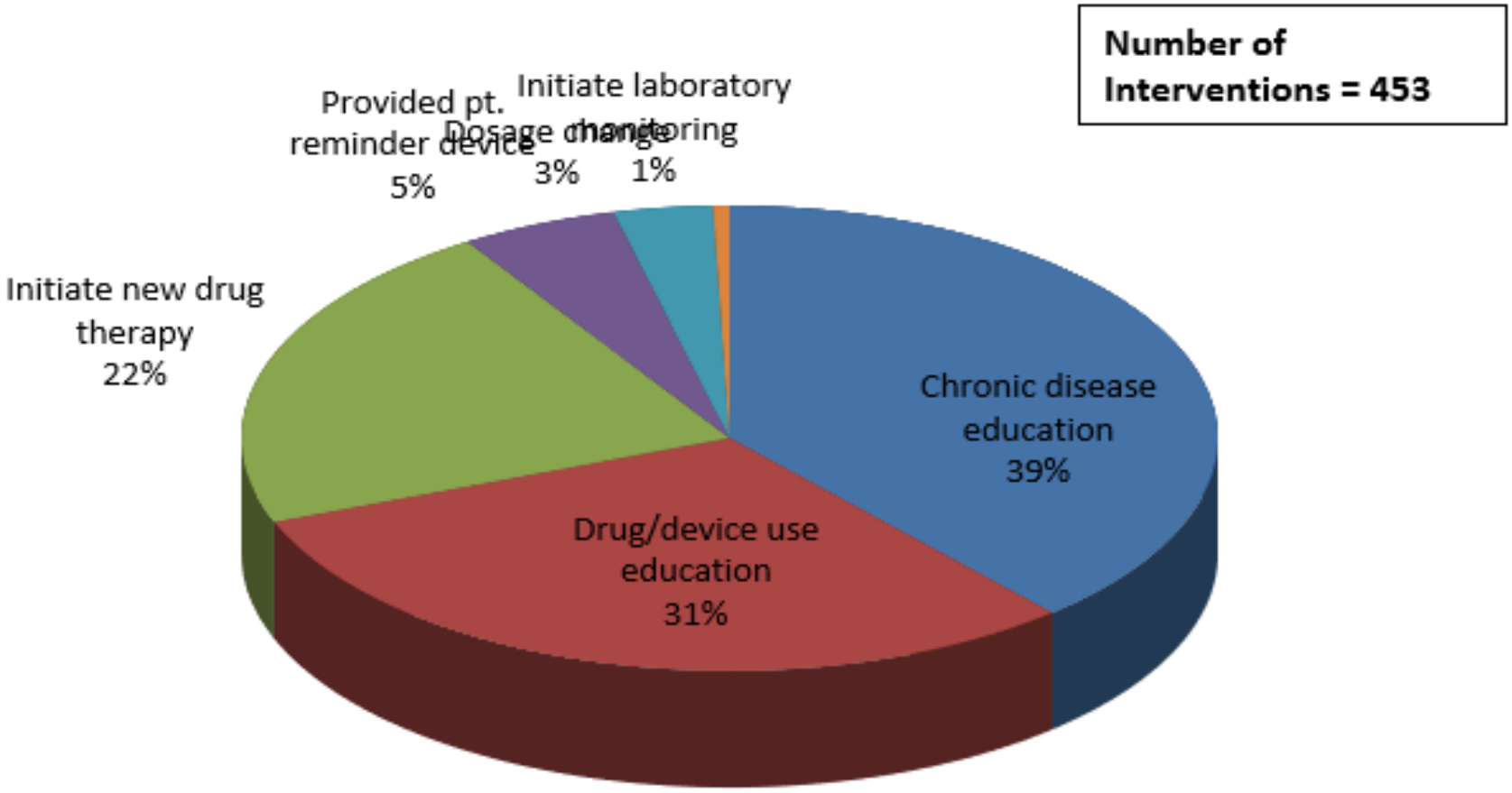

Time to Readmission (Index Dx)
1.00
0.75
0.50
0.25
0.00
0
50
100
150
200
Days
Average Time to Readmission (Days)
Control= 68.5 (46.1-90.9)
Trt= 82.8 (43.5-122.0)
Difference = 14.3 ; p=0.539
Unadj. Trt vs. Control HR = 0.66 (0.35-1.23) p=0.192
Adj.* Trt vs. Control HR = 0.74 (0.38-1.45) p=0.383

All Cause Readmission Rates and Odds Ratios for Trt vs Control

	Unadjusted			Adjusted*		
	Control	Trt	OR	Control	Trt	OR
30 Day	18.1%	8.3%	0.41 p=0.035	16.2%	10.5%	0.59 p=0.242
60 Day	26.3%	20.0%	0.69 p=0.242	24.5%	22.5%	0.89 p=0.725
90 Day	33.0%	26.0%	0.71 p=0.234	31.0%	29.5%	0.93 p=0.815
180 Day	43.8%	40.0%	0.84 p=0.514	41.3%	43.7%	1.12 p=0.706

*Adjusted for age, sex, race, dx, and type of insurance

Most Common Interventions by Pharmacists



Geisinger Legacy

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CREATING THE FUTURE

Objetivo

Determinar el impacto de la intervención de farmacéuticos hospitalarios y de OF en pacientes de alto riesgo

Criterios de inclusión

- IAM
- IC
- Neumonia
- EPOC
- Diabetes

Y además….

- Alta en uno de los 4 hopitales participantes
- Farmacia participante en el estudio

- **Grupo intervención**

1. Inpatient

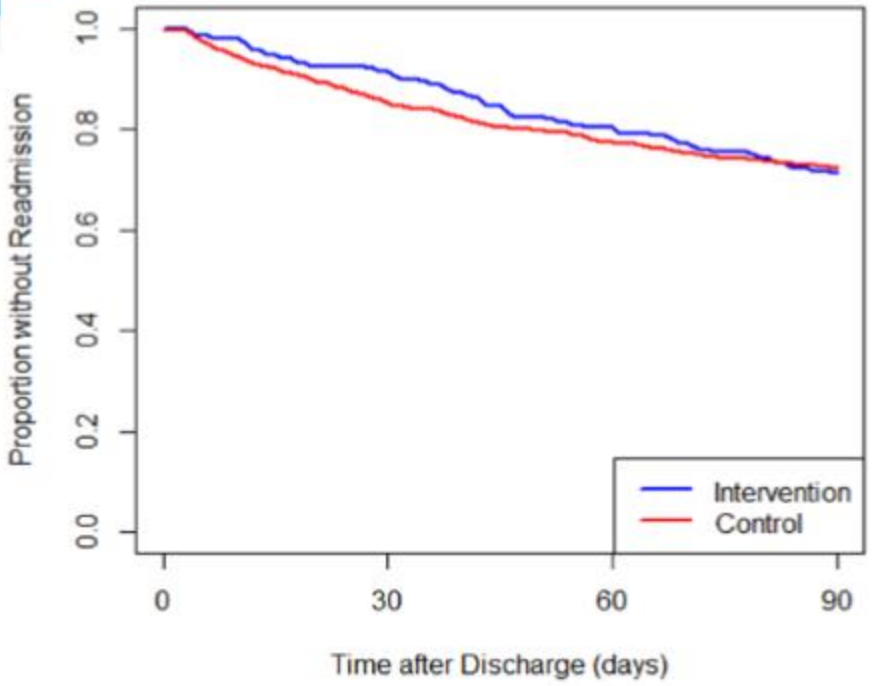
- - Conciliación farmacéutica al ingreso
- - Conciliación farmacéutica al alta
- - Consejo farmacéutico al alta
- - Comunicación directa vía mensaje con el farmacéutico de OF

2. Outpatient

- - 5 citas con farmacéutico OF (día del alta, a los 7 días y mensualmente (3)
- - Educación farmacéutica

	Intervention (ITT) (n=615)	Comparison (ITT) (n=3075)	p-value	Intervention (PP) (n=187)	Comparison (PP) (n=935)	p-value
30 day all-cause rehospitalization, N (%)	92 (15%)	461 (15%)	0.98	16 (9%)	138 (15%)	0.02
30 day ED visit (including IP transfers), N (%)	142 (23%)	659 (21%)	0.36	37 (20%)	207 (22%)	0.48
Post-hospital death within 30 days, N (%)	18 (3%)	145 (5%)	0.049	4 (2%)	46 (5%)	0.10
Composite all-cause rehospitalization, ED or death at 30 days, N (%)	158 (26%)	847 (28%)	0.35	42 (22%)	265 (28%)	0.09

Results - Readmissions among per -protocol patients over 90 days



	Hazard Ratio (Intervention vs. Comparison) [95% CI]	p-value
Readmissions		
30 day	0.56 [0.33, 0.94]	0.02
60 day	0.84 [0.59, 1.20]	0.29
90 day	1.01 [0.75, 1.35]	0.94

Outcomes Analysis – 30 Day All-Cause Readmissions

	Intervention	Comparison	P-Value	Number Needed to Treat
Cincinnati	2 (3.1%) N = 65	21 (11.1%) N = 189	0.04 (PP)	12.5
Mississippi	8.3%* N = 96	18.1%* N =160	0.035	10.2
Geisinger	16 (9%) N= 187	138 (15%) N= 935	0.02 (PP)	16.1

*Unadjusted

Impact of pharmacist home visits on the readmission rate of a community health system

- Tuesday, Dec 5 2:30 PM - 4:00 PM
- Primary Author(s): Amy Lemieux - Staff Pharmacist, Hallmark Health System, Wakefield, Massachusetts

Purpose: One in five Medicare patients is readmitted to a hospital within 30 days of discharge. The length of stay of readmitted patients is on average longer than the length of stay of hospitalized patients with the same diagnoses and patient satisfaction rates are much lower in patients that require readmission. With nearly two-thirds of post discharge adverse events attributed to medications, it is a reasonable hypothesis that pharmacists have an integral role preventing unnecessary hospital readmissions. This examines how pharmacist home visits impacted the readmission rate of the target population on a care transition team.

Methods: This is a retrospective cohort study comparing the readmission rate of patients with intervention by pharmacy to patients without intervention by pharmacy from January 28th 2015 to January 28th 2017. The primary endpoint was to determine whether a difference exists in hospital readmission rates at 30 days post discharge between patients who were contacted by a pharmacist and those that were not. Secondary endpoint was to determine if there was a difference in outcomes between patients that were contacted via phone versus those patients that were visited in their home by a pharmacist. Patients were included if they were 60 years of age or older with Medicare and admitted to a community health system. Patients were excluded if they had been hospitalized in the prior six-month period. Each discharged patientâ€™s medication list was reviewed by a pharmacist, who performed medication therapy management assessment to identify any drug related issues that could potentially lead to readmission. Any high risk patients identified by the pharmacy designees were called and a home visit was offered. In addition, both Transition Facilitators and Nurse Practitioners submitted referrals in response to patient request or following identification of drug related issues. If a patient was readmitted within 30 days, the process was repeated.

Results: From January 28th, 2015 to January 28th, 2017 4096 patient encounters were recorded in the Care Transition Program. If a patient was readmitted within the 30 day period following discharge or after six months, they were counted as a new encounter. Several patients required multiple home visits for a total of 167 home visits recorded for a total of 517 pharmacy outreaches completed (32.3% home visits and 67.4% phone consults). Of the 4096 patients, 436 patients were readmitted within a 30 day period. This did not include Emergency Room Visits or Observation Visits and represents a 10.64% readmission rate. Of the 4096 patients, 460 patients were outreached by pharmacy (11.2%). Of the 460 patients, 350 received phone consults and 110 received pharmacy home visits. Several patients required multiple home visits for a total of 167 home visits. There was a total of 517 pharmacy outreaches completed (32.3% home visits and 67.4% phone consults). In the two year study period, 28 patients were readmitted following pharmacy outreach representing a 6% readmission rate. Following a pharmacy home visit, 4 patients were readmitted, representing a 0.9% readmission rate. The primary endpoint will be evaluated using Chi-square test at the level of significance alpha=0.05.

Conclusion: Pharmacists have an opportunity prevent unnecessary hospital readmissions through pharmacy home visits. Many readmissions are preventable and result in unnecessary health expenditures estimated at nearly 17 billion dollars annually. The addition of a pharmacist on a care transition team impacted the readmission rate of our target population. The readmission rate appeared considerably lower when a pharmacist performed a home visit as compared to a phone call (0.9% versus 6%). This novel use of a pharmacist has the potential to change the traditional role of the pharmacist on a care transition team to include pharmacist home visits.

Mensajes de fuerza

- Como farmacéuticos debemos revisar las indicaciones de todos los fármacos que un paciente tiene prescritos, en particular aquellos cuyo balance beneficio / riesgo pueda ser más dudoso.

- Especial atención a la prescripción de benzodiazepinas, incluso aquellas pautadas bajo indicación y durante cortos periodos de tiempo, especialmente en poblaciones de riesgo: ancianos, enfermos con enfermedad respiratoria crónica, pacientes con demencia, historia de abuso de sustancias, coadministración con opioides, o estrés postraumático.

- Debemos impulsar el uso de nuevas tecnologías como apoyo en las transiciones asistenciales con el fin de mejorar la comunicación entre profesionales y así obtener mejores resultados en salud en los pacientes.

- ICC: Insuficiencia Cardíaca Cognitiva
- EPOC: Enfermedad Pulmonar Obstructiva Crónica (COPD)
- IAM: Infarto Agudo de Miocardio
- IC: Insuficiencia Cardíaca