International Journal of Integrated Care

Miller, R et al 2017 The Development and Refinement of a Regional Model for Medicines Optimisation in Older People in the Intermediate Care Setting. *International Journal of Integrated Care*, 17(5): A120, pp. 1-8, DOI: dx.doi.org/10.5334/ijic.3425

CONFERENCE ABSTRACT

The Development and Refinement of a Regional Model for Medicines Optimisation in Older People in the Intermediate Care Setting

17th International Conference on Integrated Care, Dublin, 08-10 May 2017

Ruth Miller[1,3], Carmel Darcy[1], Nuala McGeough[1], Anne Friel[1], Helen Graham[2], Maureen Hetherington[2], Hilary McKee[2], Michael Scott[2]

1: Western Health and Social Care Trust, United Kingdom;
2: Northern Health and Social Care Trust, United Kingdom;
3: Ulster University, United Kingdom

Introduction: In December 2011, the Compton Review 'Transforming Your Care' (TYC) outlined the remodelling of Health and Social Care in Northern Ireland (HSCNI)1.

Target Population: In line with TYC, the Western Health and Social Care Trust (WHSCT) introduced a consultant pharmacist led medicines optimisation case management service for older people (aged ≥65 years) admitted from acute into intermediate care (IC).

Practice Change: Prior to this, pharmacy had a supply-only role in IC. The consultant pharmacist assumed pharmaceutical care responsibility of patients throughout their stay in IC and for 30 days post-discharge. Data collected over a 12-month period (2012 to 2013) demonstrated improvement in appropriateness of drugs prescribed together with drug cost savings (£68k pa) and cost avoidance due to subsequent reduced healthcare resource usage (£63k to £144k)2.

This model was then refined to reflect IC services delivered anywhere in Northern Ireland. The main refinement involved the 'origin of admission' which may include: Acute care; Rapid Access Clinics; Older People Assessment Liaison Services; or GP requests for a step-up bed.

Timeline: In August 2015 two specialist pharmacists were employed under the mentorship of a consultant pharmacist, one based in the WHSCT and the second based in the Northern Health and Social Care Trust (NHSCT) where the service was to be rolled out. Data collection is ongoing until December 2016; full results will be reported early 2017.

Aim: The aim of this work was to test the refined model for reproducibility in another trust so as to inform the Department of Health on the ability to extend the service throughout Northern Ireland.

Highlights: The WHSCT have reported interim results on patients (aged 82.1 ± 7.2 years, n=210) seen over six months whilst the NHSCT have data on patients reviewed over a 12 month period (aged 82.1± 7.8 years, n=322). In both trusts, there has been a significant improvement in the appropriateness of prescribing [measured using the Medications Appropriateness Index

(MAI)3] with estimated drug cost savings of £103k to £107k pa should the service be delivered to 500 patients annually. Cost avoidance due to reduced healthcare resource usage via application of the ScHARR model4 to clinical interventions made by the pharmacists is in the range of £260 344 - £505 700 (WHSCT) and £328 580 - £542 740 (NHSCT).

Sustainability/Transferability: Interim results suggest the refined model is both reproducible and transferable.

Lesson Learnt/Conclusion: This innovative pharmacy service can be integrated into existing pharmacy services in other trusts whilst continuing to deliver positive clinical and economic outcomes.

References:

1- Compton J. Transforming Your Care. Available at: https://www.health-ni.gov.uk/topics/health-policy/transforming-your-care [Accessed 24th November 2016]

2- EF Ruth Miller et al. Consultant pharmacist case management of older people in intermediate care: a new innovative model. European Journal for Person Centered Healthcare, 2016; 4(1): 1-7.

3- Hanlon JT et al. A method for determining drug therapy appropriateness. Journal of Clinical Epidemiology, 1992; 45 (10): 1045-51.

4- Karnon J et al. Modelling the expected net benefits of interventions to reduce the burden of medication errors. J of Health Serv Res and Pol, 2008;13(2): 85-91.

Keywords: intermediate care; medicines optimisation