Transitional Care: How Pharmacies Can Impact Outcomes for Discharged Patients

The American Society for Automation in Pharmacy
2014 Midyear Conference
June 26-28, 2014
**Learning Objectives**

At the conclusion of this presentation, participants should be able to:

- Define transitional care
- Explain why transitional care is focused on Medicare hospital readmissions
- Understand the impact of avoidable readmissions on hospitals
- Describe methods by which pharmacists/pharmacies can reduce readmission rates
- Provide examples of what systems vendors inside and outside pharmacy can do to facilitate the pharmacists’ role
Transitions of Care

“The movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness…”

“Many patients are discharged without understanding their illness or treatment plans, or inadvertently discontinue important medicines needed to stay well”

1. Improving Care Transitions: Optimizing Medication, March 2012, APhA/ASHP
2. After Hospitalization: A Dartmouth Atlas Report on Readmissions Among Medicare Beneficiaries
Hospital Transition in Medicare Beneficiaries with Multiple Illnesses

76% of all hospital admissions

100x more likely to have a hospital admission

"The Future of Medicare: Recognizing the Need for Chronic Care Coordination", Serial No. 110-7, pp. 19-20 (May 9, 2007)
Readmission Rates Among Medicare Beneficiaries


Unplanned Hospital Readmissions

$15B

2005 data

76% Preventable

$12B

2005 data
National Quality Strategy “Triple Aim”

Better care of the individual

Healthier population

Lower costs

www.healthcare.gov/center/reports/nationalqualitystrategy032011.pdf
Game Changer

“Medicare is no longer a program that just pays the bills.”

-Dr. Patrick Conway, Chief Medical Officer, CMS

Rewards higher quality care, penalizes sub-standard performance
Hospital Readmission Incentives

- Hospitals receive higher Medicare payments by achieving/exceeding quality measure performance targets
  - Review of symptom/problem expectations with patients post-discharge
  - Question patients about help needed at home
  - Provide discharge instructions to patients with heart failure

- 1% payment reduction to hospitals with re-admission rates above particular targets for:
  - Heart failure
  - Heart attack
  - Pneumonia

- Penalties increase to 3% by 2015 or higher for Chronic Obstructive Pulmonary Disease (COPD) or cardiovascular disease

The Joint Commission Hot Topics in Health Care: Transitions of Care: The need for a more effective approach to continuing patient care
**Hospital Readmission Reduction Program: Years 1 & 2**

<table>
<thead>
<tr>
<th>Year</th>
<th>2013</th>
<th>2014</th>
</tr>
</thead>
<tbody>
<tr>
<td>Max Penalty (%)</td>
<td>1%</td>
<td>2%</td>
</tr>
<tr>
<td>Conditions</td>
<td>Heart Attack Heart Failure Pneumonia</td>
<td>+ Chronic Obstructive Pulmonary Disease (COPD)</td>
</tr>
<tr>
<td># Hospitals Penalized</td>
<td>2,213</td>
<td>2,225</td>
</tr>
<tr>
<td>Total Penalties ($)</td>
<td>$280,000,000</td>
<td>$227,000,000</td>
</tr>
<tr>
<td>Average Penalty/Hospital ($)</td>
<td>$126,525</td>
<td>$102,022</td>
</tr>
<tr>
<td>Average Penalty/Hospital (%)</td>
<td>0.42%</td>
<td>0.38%</td>
</tr>
</tbody>
</table>

283 new hospitals penalized Year 2
1,074 hospitals penalized Year 1 received higher penalties Year 2
Transitional Care

• Solution to existing problems caused by changes that occur during transitions in care

• “A set of actions designed to ensure the coordination and continuity of health care as patients transfer between different locations or different levels of care within the same location.”

www.transitionalcare.info
Medication Reconciliation

- Comprehensive evaluation of a patient’s medication regimen any time there is a change
- Goals: avoid or detect and correct medication errors
- Should include comparison of existing and previous medication regimens
- Should occur at every care transition involving new medication orders, re-written or adjusted existing orders, or if the patient has added nonprescription medications to [his or her] self-care

Medication-Related Problems

- Untreated indication
- Improper drug selection
- Sub-therapeutic dose
- Failure to receive a needed medication
- Overdosage
- Adverse drug reactions
- Drug interactions (drug, food, lab)
- Medication use without indication
- Medication non-adherence

Johnson and Bootman, Drug-related Morbidity and Mortality: A Cost of Illness Model, Vol. 2, No.1 Jan/Feb 1996 JMCP Journal of Managed Care Pharmacy
Post-Discharge Follow-Up

50% of patients do not see a physician within 30 days of discharge
Unplanned Readmissions: Pharmacist Impact Potential

50%

Reduction in preventable 30-day readmissions due to pharmacist intervention

Source: FPA/UCare Fairview Transition Pilot
Forbes on Pharmacists, Transitional Care

“The Newest Member of Your Personal Healthcare Team”

Pharmacist MTM services yielded **86% reduction in readmissions** compared to the control group.

Patients receiving MTM were **3 times more likely to remain out of the hospital after 60 days**.

http://www.forbes.com/sites/robertszczerba/2014/06/05/meet-the-newest-member-of-your-personal-healthcare-team
Transitional Care: Community Pharmacy – Hospital Collaboration

- High-Risk Patient Identification
- Transitional Care Program Enrollment
- Verification of Medication List

- Medication Reconciliation
- Medication Therapy Management
- Reinforcement of Discharge Plan

Pharmacist Integration in the Transitional Care Plan Reduces Preventable Readmissions and Improves Health Outcomes
Challenges and Opportunities

Challenge:

• Less than 1/3 of hospitals involve their pharmacists in discharge counseling or post-discharge follow up with high-risk patients
• Emerging FFS and Shared Savings Pilots involving pharmacy segmented and/or unscalable

Solution: Connectivity, cooperation, and care coordination between hospitals and community pharmacies within their catchment area
Transitional Care Exchange (TCE)

Bidirectional Data Flow through Common Centralized Data Exchange with Participating Hospitals and Pharmacies
TCE Process Flow

1. Hospital identified
2. Hospital contracts to participate in exchange
3. Hospital identifies patient as high risk for readmission
4. Hospital sends discharge data exchange
5. Exchange alerts to contracted pharmacy
6. Pharmacy conducts patient outreach within 24 hours
7. Pharmacy provides patient care via predefined TC protocol & timeline
8. Analyze data, provide compliance & outcomes reporting
Targeting Patients

• Readmission Diagnoses
  – Heart Failure
  – Pneumonia
  – Heart Attack
• Complex Medication Regimens
• Particular Payers
• Predictive Modeling
Post-Discharge Information
Communicated by Hospital to TC Exchange

• Patient demographic information
• Contacts
  – Primary Care Provider
  – Hospital Coordinator
  – Non-professional Caregiver
• Medication list
• Diagnoses
• Lab values
• Hospital-identified issues for resolution
# Sample Integration of Live and Automated Tasks

<table>
<thead>
<tr>
<th>Message</th>
<th>Day</th>
<th>Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Welcome &amp; Appointment Schedule Call</td>
<td>1</td>
<td>Live, pharmacist</td>
</tr>
<tr>
<td>Appointment #1</td>
<td>3</td>
<td>Live, pharmacist</td>
</tr>
<tr>
<td>PCP Visit Reminder</td>
<td>5</td>
<td>Automated</td>
</tr>
<tr>
<td>Check-In Call #1</td>
<td>7</td>
<td>Live, non-pharmacist</td>
</tr>
<tr>
<td>Check-In Call #2</td>
<td>10</td>
<td>Live, non-pharmacist</td>
</tr>
<tr>
<td>Appointment Reminder</td>
<td>12</td>
<td>Automated</td>
</tr>
<tr>
<td>Appointment #2</td>
<td>14</td>
<td>Live, pharmacist</td>
</tr>
<tr>
<td>Check-In Call #3</td>
<td>21</td>
<td>Live, non-pharmacist</td>
</tr>
<tr>
<td>Refill Reminder</td>
<td>25</td>
<td>Automated</td>
</tr>
<tr>
<td>Check-In Call #4</td>
<td>28</td>
<td>Live, non-pharmacist</td>
</tr>
<tr>
<td>Check-In Call #5</td>
<td>42</td>
<td>Live, non-pharmacist</td>
</tr>
<tr>
<td>Refill Reminder</td>
<td>55</td>
<td>Automated</td>
</tr>
</tbody>
</table>

Automated messaging by:
- Text
- Phone
- Email
Transitional Care Timeline

Discharge Data Entry (automated)

Check-In Call #1 (live, non-pharmacist)

Appointment #1 (live, pharmacist)

Check-In Call #2 (live, non-pharmacist)

Appointment Reminder (automated)

Appointment #2 (live, pharmacist)

Check-In Call #3 (live, non-pharmacist)

Provider Follow-Up Visit Check-In (automated)

Check-In Call #4 (live, non-pharmacist)

Welcome & Appointment Schedule Call (live, pharmacist)

Check-In Call #5 (live, non-pharmacist)

Check-In Call #6 (automated)

Refill Reminder Call (automated)
Transitional Care Appointment #1 – Set Up

A few things to cover during patient appointment:

- **Hospital Stay**
  - Your stay at the hospital and the medications you are on before and after the visit

- **Your Medications**
  - How to take them
  - Why you take them
  - Side effects to watch for
  - Results you hope to see

- **Self-Management**
  - What you can do to keep yourself healthier

- **Follow-Up**
  - With your healthcare provider
Day 42 Check-In Call (Heart Failure Example)

Review important topics during check-in:

Medication Adherence
- Take your medication even if you are not experiencing any symptoms.
- Consistently taking your medication will help you feel better and healthier.
- Talk to your doctor or pharmacist before changing the way you take your medications.

Side Effects
- If you are having any symptoms that you think may be related to your medication, be sure to notify the pharmacist.

Exercise
- It is important to learn how to slowly increase your exercise and how to take care of your heart disease.
- Avoid heavy lifting.
- Be sure your home is set up to be safe and easy for you to move around in and avoid falls.
- If you are unable to walk around very much, ask your doctor for exercises you can do while you are sitting.
Patient Portal

- Powerful tool to improve patient engagement
- Smartphone portal access
- Self-reported biometric data
  - Weight
  - Blood Pressure
  - Blood Glucose
Building Blocks for Operationalizing Improved Patient Care & Increasing Revenue

- Task Queue
- Medication Synchronization
- High Risk Medications
- Gaps-In-Therapy
- Automated Messaging
- Educational Content
- Comprehensive Medication Review
- Medication Action Plan
- Appointment Scheduler
- Comprehensive Patient Care Programs
- Medicare Stars Solution
- IVR Interactive Patient Messaging
- Data Integration
- Platform Integration with MTM
- Adherence Scorecards
- Mobile App
- Transitional Care Exchange
- Patient Management Access Portal
- Robust Analytics
- Patient Portal
Learning Assessment Question #1

Which of the following best represents 30-day readmission rates of Medicare patients?

A. 5%
B. 10%
C. 15%
D. 20%
Learning Assessment Question #2

The percentage of post-discharge adverse events that are medication related is:

A. 42%
B. 52%
C. 62%
D. 72%
Learning Assessment Question #3

Medication Reconciliation:

A. Includes a comparison of existing and previous medication regimens
B. Helps avoid, or detect and correct, medication errors
C. Should occur at every care transition
D. All of the above
Learning Assessment Question #4

The percentage of hospitals that currently involve their pharmacists in discharge counseling or post-discharge follow up with high-risk patients is:

A. 10%
B. 30%
C. 50%
D. 70%
Learning Assessment Question #5

In 2015, what percentage of their Medicare reimbursement do hospitals with excessive readmissions stand to lose?

A. 1%
B. 2%
C. 3%
D. 4%