# *Transitional Care: How Pharmacies Can Impact Outcomes for Discharged Patients*

The American Society for Automation in Pharmacy

2014 Midyear Conference

June 26-28, 2014

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# *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

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# *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…"

Source: Coleman EA, Boult CE on behalf of the American Geriatrics Society Health Care Systems Committee. Improving the Quality of Transitional Care for Persons with Complex Care Needs. Journal of the American Geriatrics Society. 2003; 52(4): 556-557

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# *Hospital Transition Impact on Medication Use*

**72%** of post-discharge adverse events are medication-related

**"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

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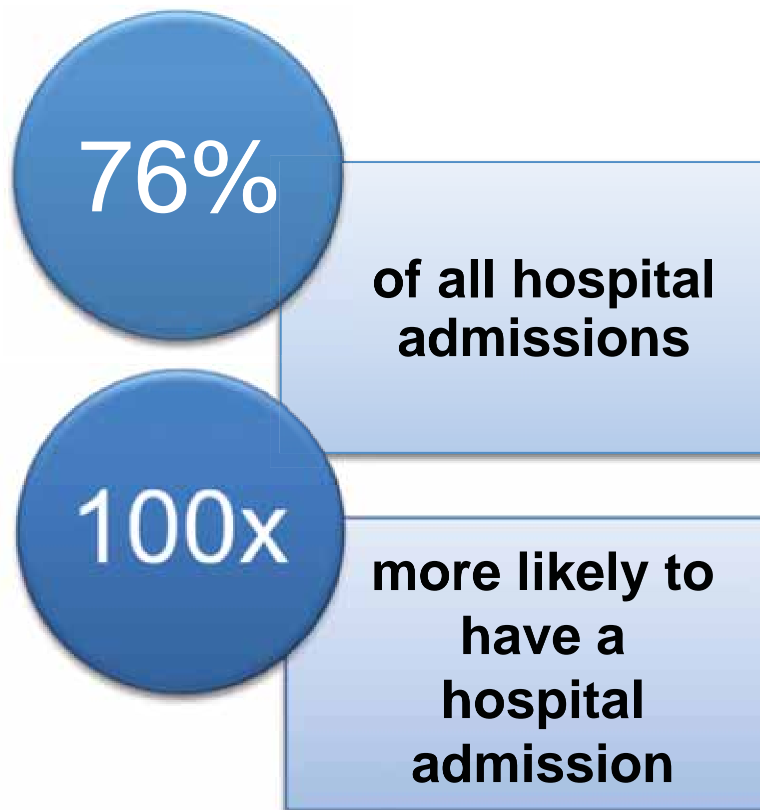
# *Hospital Transition in Medicare Beneficiaries with Multiple Illnesses*



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

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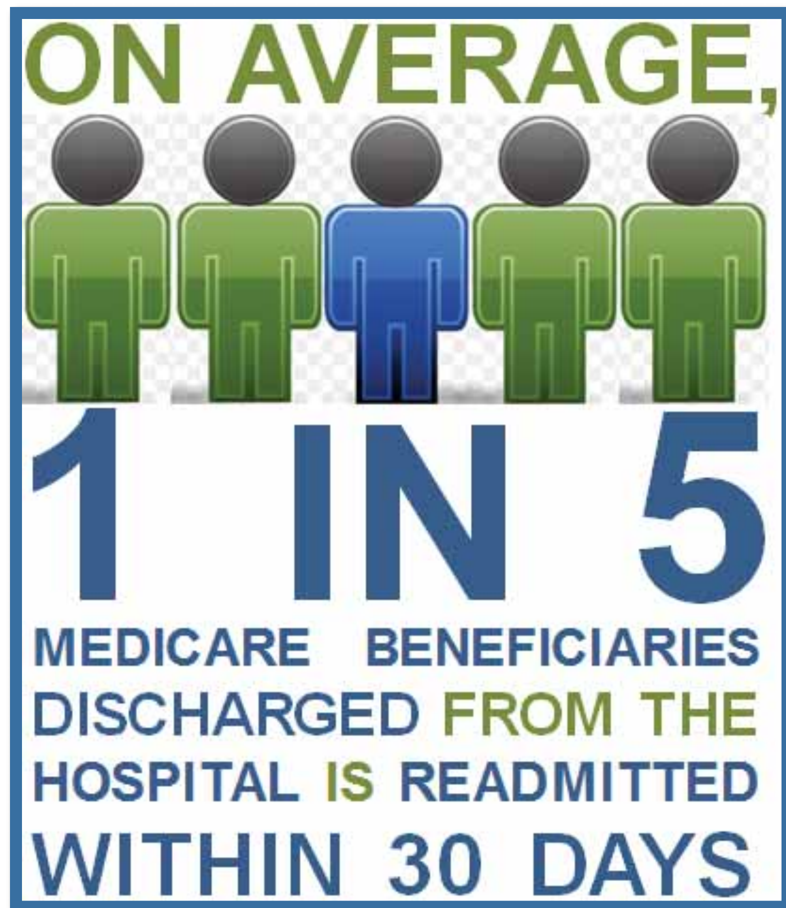
# *Readmission Rates Among Medicare Beneficiaries*



Jencks, Stephen F., Mark V. Williams, and Eric A. Coleman. "Rehospitalizations among Patients in the Medicare Fee-for-Service Program." New England Journal of Medicine 2009; 360:1418-28

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## Unplanned Hospital Readmissions

# $15B

2005 data

# 76%

**Preventable**

# =$12B

1. http://go.nationalpartnership.org/site/DocServer/Healthy_Hospital_Initiative_Fact_Sheet_2011.pdf?docID=8484
2. http://njhimss.org/images/documents/whitepapers/Solving-Preventable-Readmissions-White_Paper.pdf

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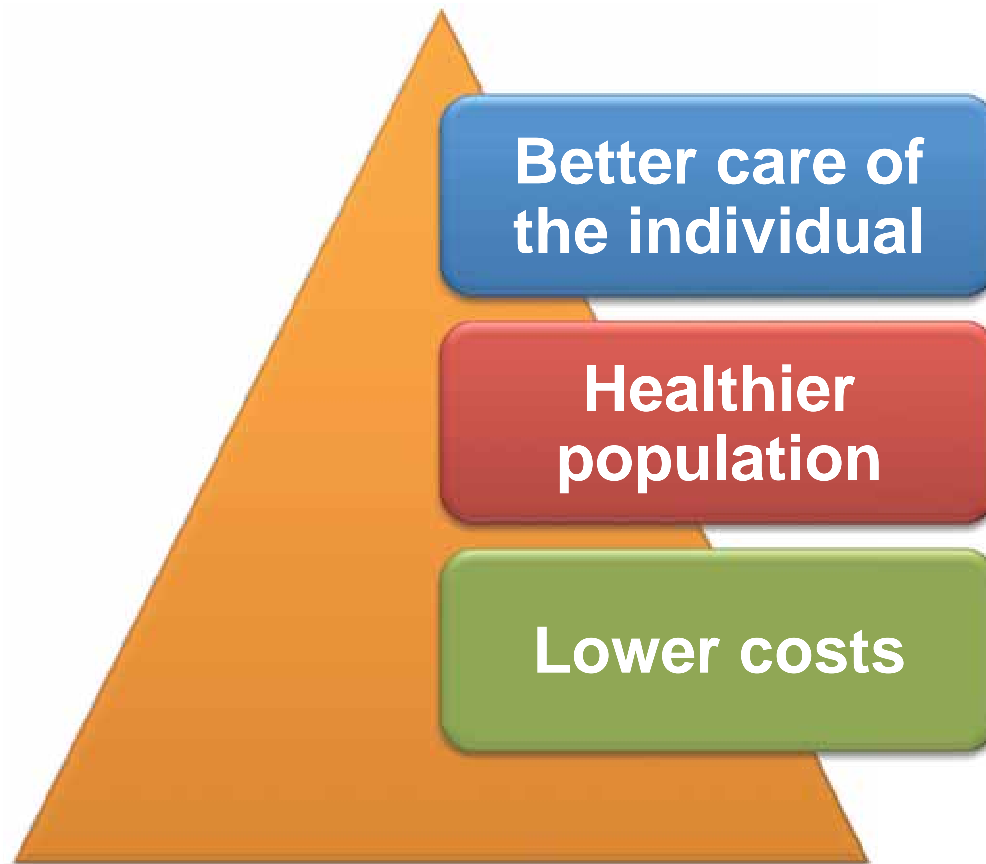
# *National Quality Strategy "Triple Aim"*




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

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## *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

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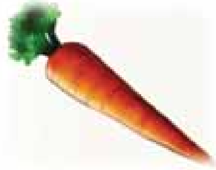
# *Hospital Readmission Incentives*



- 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

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# *Hospital Readmission Reduction Program: Years 1 & 2*

| Year | 2013 | 2014 |
|---|---|---|
| Maximum Penalty (%) | 1% | 2% |
| Conditions | Heart Attack<br>Heart Failure<br>Pneumonia | + Chronic Obstructive Pulmonary Disease (COPD) |
| # Hospitals Penalized | 2,213 | 2,225 |
| Total Penalties ($) | $280,000,000 | $227,000,000 |
| Average Penalty/ Hospital ($) | $126,525 | $102,022 |
| Average Penalty/ Hospital (%) | 0.42% | 0.38% |

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

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# ***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."

The American Geriatrics Society (2003)
www.transitionalcare.info

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# *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

Chen D, Burns A. Summary and Recommendations of ASHP-APhA Medication Reconciliation Initiative Workgroup Meeting, February 12, 2007.

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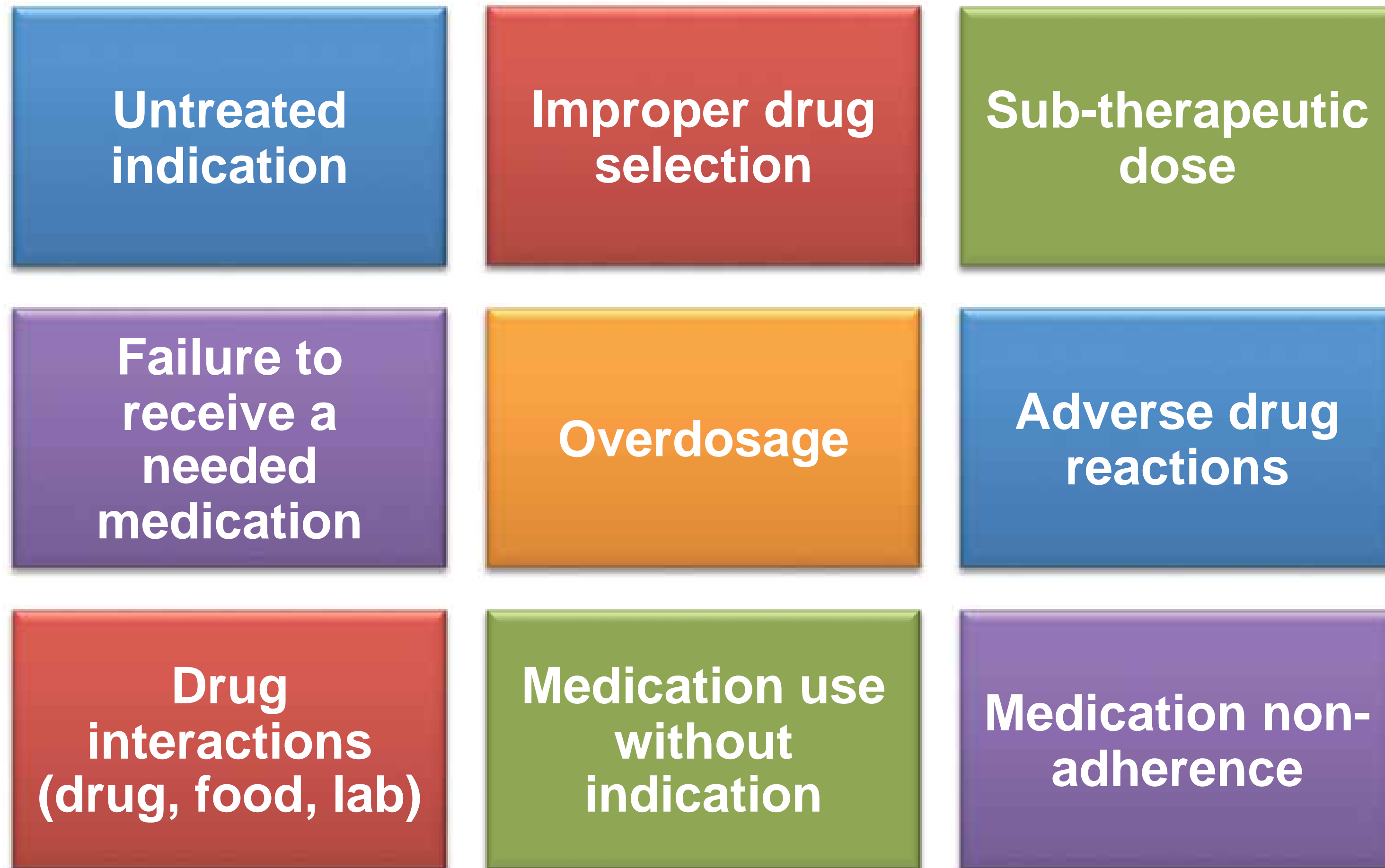
# *Medication-Related Problems*




Johnson and Bootman, Drug-related Morbidity and Mortality: A Cost of Illness Model, Yo\. 2, No.1 jan/Feb 1996 JMCP Journal of Managed Care Pharmacy

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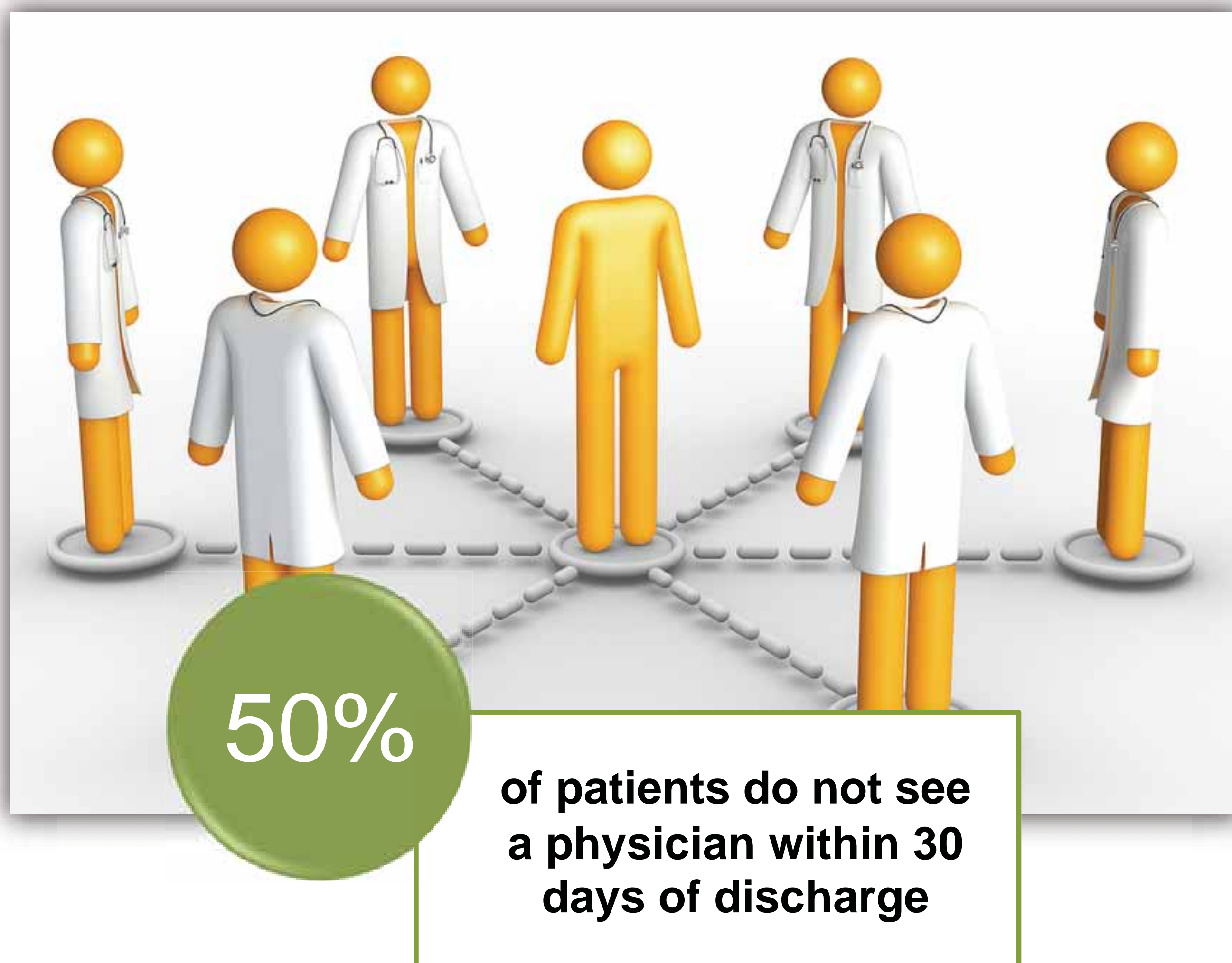
# Post-Discharge Follow-Up

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# *Unplanned Readmissions: Pharmacist Impact Potential*

# 50%

Reduction in preventable 30-day readmissions due to pharmacist intervention

Source: FPA/UCare Fairview Transition Pilot

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# ***Forbes on Pharmacists, Transitional Care***

**Meet The Newest Member Of Your Personal Healthcare Team**

Robert J. Szczerba, Contributor
6.5.14

As most patients in the American healthcare system know, it's gotten harder and harder to maintain regular, detailed communication with your doctor. At least in terms of medication, pharmacists have begun to address this gap through regular, direct contact with their patients. In Medication Therapy Management (MTM), a pharmacist evaluates a patient's prescriptions and how the patient is feeling to identify and resolve issues including: untreated conditions, drug interactions, adverse drug reactions, inappropriate drugs or doses, and whether a patient is taking the medications as prescribed. The pharmacist is rapidly becoming the newest member of your personal healthcare team.

MTM has the potential to alleviate some glaring problems in America's healthcare system. For example, about one-third of people over age 65 who take five or more medications experience some sort of adverse drug event, such as a bone-breaking fall, disorientation, inability to urinate, or heart failure.

Part of this problem is the cost of hospital readmissions, which is generally defined as a patient being hospitalized within 30 days of an initial hospital stay. If a hospital has a high proportion of patients readmitted within a short time frame, it may be an indication of inadequate quality of care in the hospital or a lack of appropriate coordination of post-discharge care.

The Centers for Medicare and Medicaid Services (CMS) estimate hospital readmissions cost the program $17.5 billion a year, at an average of $10,000 – $13,000 per patient readmitted. In many cases, readmissions are the result of adverse effects of medication therapies due to improper or non-adherence to medication regimens. Reflecting the importance of that last point, in October 2012, CMS began reducing Medicare payments for hospitals with excess readmissions (as compared to other hospitals with similar patient profiles). Because of this, there is a renewed focus on hospitals to continue to reduce their readmission rate.

To help address these issues, a new study evaluated the effectiveness of MTM on reducing hospital readmissions utilizing phone calls to patients from their pharmacist. Dr. Alan Zillich, study co-lead and Associate Professor of Pharmacy, Purdue University, explains the need driving this research. "Enhancing the quality of care for patients has always been the goal of healthcare providers, but the growing costs of Medicare and healthcare in general have put an even brighter spotlight on strategies to improve patient outcomes and reduce unnecessary costs."

The study identified 232 out of 895 patients, or 26%, as "risk-level 1 patients" who are capable of basic functions, including the ability to dress themselves, answer the phone, etc. One of the key findings was that risk-level 1 patients in the MTM group experienced an 86% reduction in readmissions compared to the control group. To put it another way, the group receiving MTM was three times more likely to remain out of the hospital after 60 days. Patrick Dunham, study co-author and CEO of Curant Health, calls this "another powerful proof point for the value of MTM and its capability to simultaneously reduce costs and improve care across the healthcare continuum."

## "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

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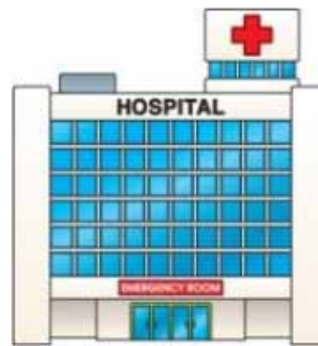
# *Transitional Care: Community Pharmacy – Hospital Collaboration*

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



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

**Transitional Care Planning**

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

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# *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

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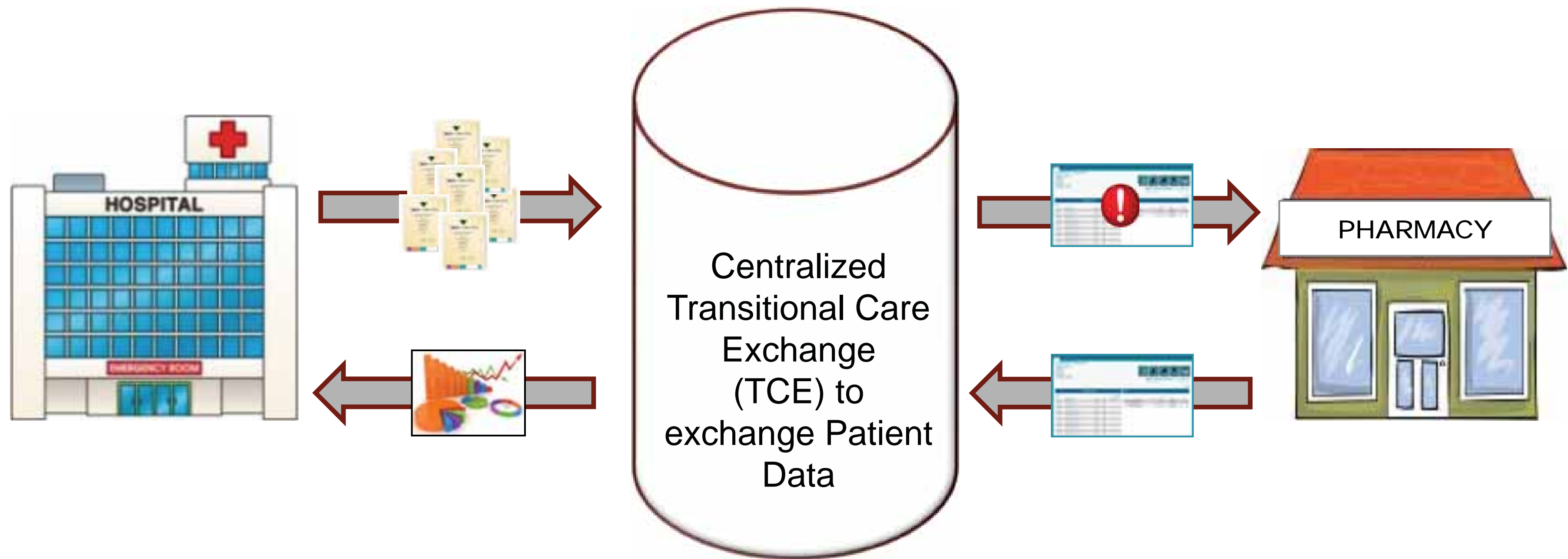
# Transitional Care Exchange (TCE)




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

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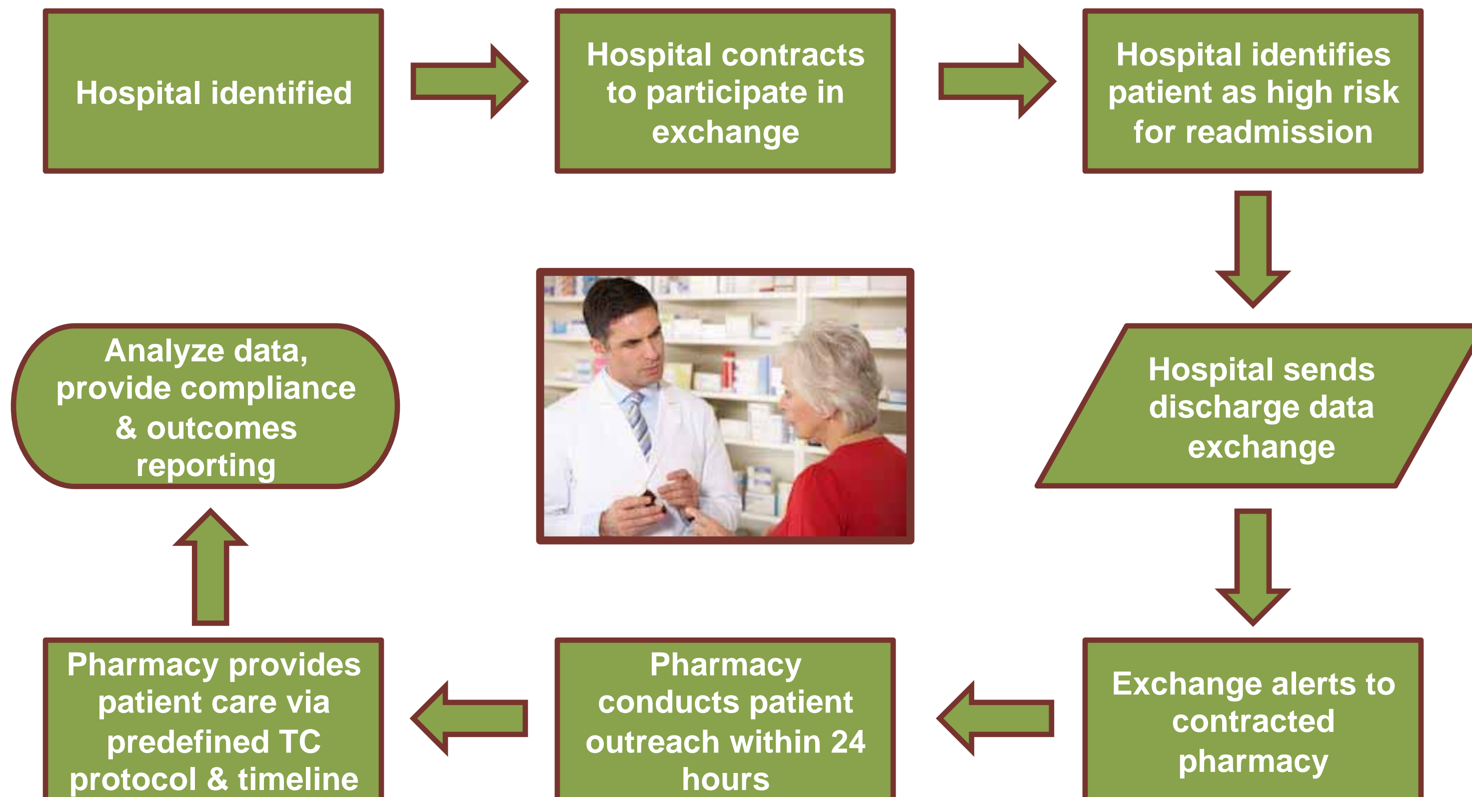
# TCE Process Flow

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# *Targeting Patients*

- Readmission Diagnoses
  - Heart Failure
  - Pneumonia
  - Heart Attack
- Complex Medication Regimens
- Particular Payers
- Predictive Modeling

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# *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

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# *Sample Integration of Live and Automated Tasks*

| Message | Day | Type |
|---|---|---|
| Welcome & Appointment Schedule Call | 1 | Live, pharmacist |
| Appointment #1 | 3 | Live, pharmacist |
| PCP Visit Reminder | 5 | Automated |
| Check-In Call #1 | 7 | Live, non-pharmacist |
| Check-In Call #2 | 10 | Live, non-pharmacist |
| Appointment Reminder | 12 | Automated |
| Appointment #2 | 14 | Live, pharmacist |
| Check-In Call #3 | 21 | Live, non-pharmacist |
| Refill Reminder | 25 | Automated |
| Check-In Call #4 | 28 | Live, non-pharmacist |
| Check-In Call #5 | 42 | Live, non-pharmacist |
| Refill Reminder | 55 | Automated |

**Automated messaging by:**

- **Text**
- **Phone**
- **Email**

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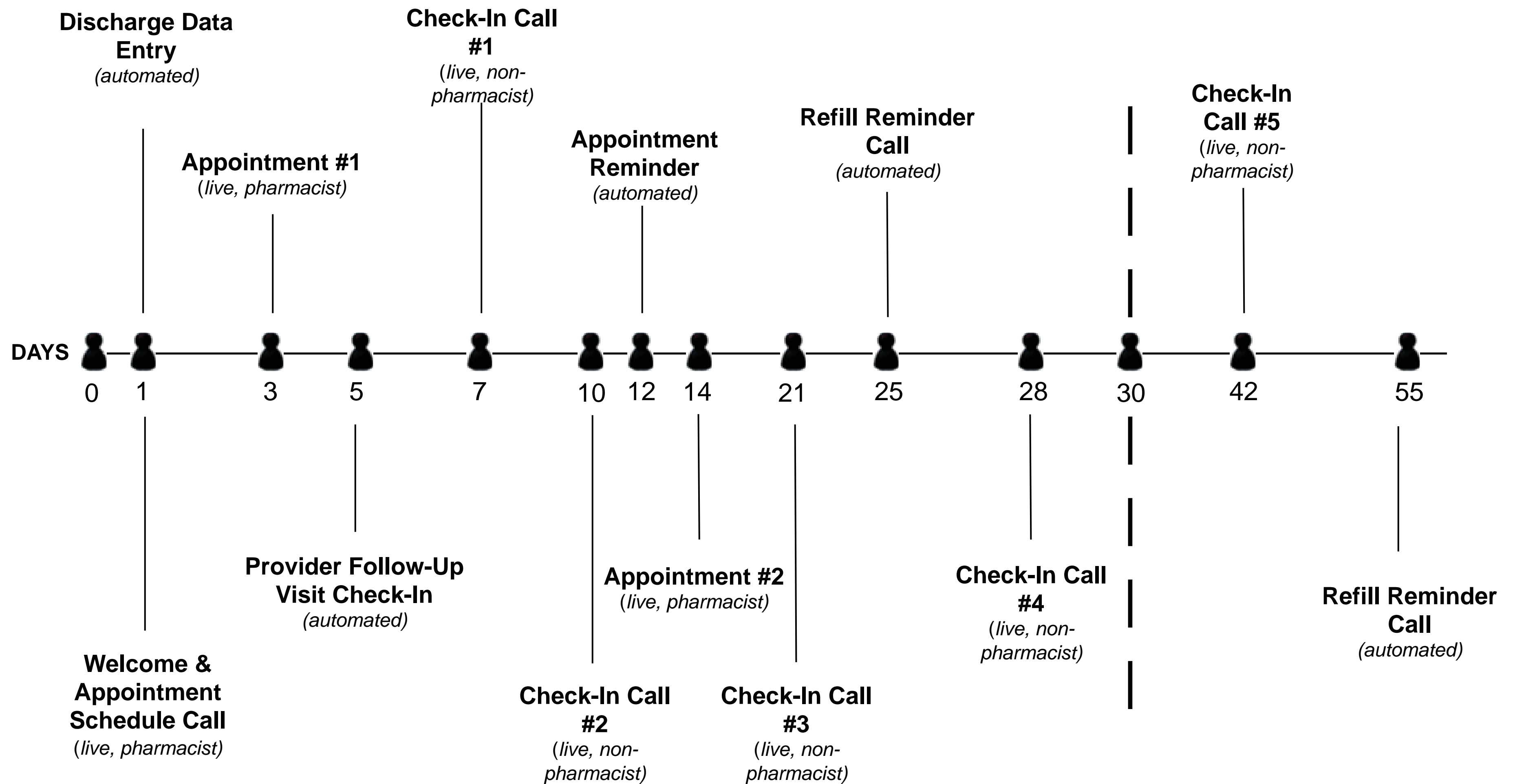
# Transitional Care Timeline

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# *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

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# *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 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.

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# *Patient Portal*

- Powerful tool to improve patient engagement
- Smartphone portal access
- Self-reported biometric data
  - Weight
  - Blood Pressure
  - Blood Glucose

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# 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 |

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# ***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%**

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# ***Learning Assessment Question #2***

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

A. 42%

B. 52%

C. 62%

**D. 72%**

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## ***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**

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## *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%

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## ***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%

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