# Transitions in Care:
## Making a Case for Pharmacist Involvement

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## Disclosure

- The speaker is a consultant / clinical investigator for Joint Commission Resources.
- Any conflicts were resolved through peer review of the presentation.

## Objectives of this Presentation

At the end of this presentation, the participant will:

- Name 4 adverse patient outcomes that result from poor transitions of care.
- Describe 3 risk factors for poor medication outcomes with transitions of care.
- Identify 3 national initiatives that provide a methodology for redesign of the discharge process.
- Describe 2 potential practice models for pharmacist involvement in transitions of care.

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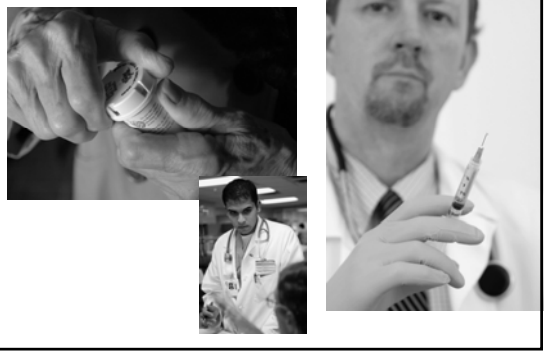
## Putting a Face on the Transition of Care Problem

## So many doctors, so little communication...



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## They didn't tell me to take my blood thinner when I got home…

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**Two pills for my heart? Why? One should be just as good….**

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**The names on the prescription bottles don't match what they told me…**

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**What Happens When Patients are Discharged?**

- 19.6% of Medicare beneficiaries re-hospitalized within 30 days of discharge (34% within 90 days of discharge)[1]
  - 90% of the readmissions deemed unplanned
  - Only 50% of those readmitted had seen their physician prior to readmission
  - These readmissions estimated at $17.4 billion for one year (2004)

1. Jencks SF et al. N Engl J Med 2009;360:1418-28.

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**What do we mean by Transitions in Care*?**

- Movement of patients between locations or internally as conditions and care needs change
- Set of actions designed to ensure coordination and continuity
- Include logistical arrangements and education of patients and family in addition to coordination of health care providers

10 * National Transitions of Care Coalition definition

**Common problems with Transitions of Care**

- Communication between caregivers
- Patient experience: participation and understanding of their condition
- Medication errors

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**Exploring the Risk Points: Communication**

- Complex patients with multiple caregivers
- Specialists, hospitalists, PCPs
- Incomplete information
- Delayed provision of discharge summary

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**Exploring the Risk Points:**
**Patient Experience and Participation**

- Patients and families feel ill-prepared for self-care
- Lack of understanding and clarity about diagnosis, self-care requirements and follow up
- Lack of assurance that patient understands
- Health literacy and general literacy problems contribute to poor understanding

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**Exploring the Risk Points:**
**Medication Errors and Adverse Drug Events**

- Health literacy
- Late discharge planning
- Less than optimal med reconciliation processes
- Patients with chronic disease or complex regimens most vulnerable

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**Is Your Organization Currently Re-designing its Discharge Process?**

1. Yes
2. No

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**Regulators and Payers Respond**
**-Federal (CMS) Actions -**

- Gradual ramp up of expectations for provider organizations to submit data for standardized quality measures
- Payment penalties for non-submission of data
- Public posting of organizations' performance rates (HospitalCompare.gov)
- Increasing number of standardized measures

**Medicare Payment Advisory Committee (MedPAC)**

- 2007 Report to Congress
  - Readmissions affect patients and are costly
  - 7 conditions contribute to 30% of readmissions and may be preventable
    - Heart Failure
    - Acute M.I.
    - COPD
    - Pneumonia
    - CABG
    - PTCA
    - Other vascular procedures
- CMS adds 3 readmission measures to reporting requirements (HF, AMI, Pneumonia)

**Readmission Reduction Program**
**Proposed Regulations**

- FY 2012 – submission of data for HF, AMI, and Pneumonia readmission measures
- FY 2013 – payment penalty for 'excess readmission rates"
  - up to 1% reduction of Medicare payment
  - will apply to entire related DRG for one year
- FY 2014- possible increase of penalty up to 2%
- FY 2015 – possible increase of penalty up to 3% and addition of more readmission measures

**Value-Based Purchasing Proposed Regulations**

- FY 2013 –continuing submission of clinical, patient satisfaction, healthcare-acquired conditions
- FY 2014 – addition of 'efficiency' measure
  - Medicare Spending per Beneficiary
    - Calculation of hospital mean value will include Medicare costs from 3 days prior to admission through 90 days post discharge
    - Intended to promote greater attention to the prevention of post-discharge adverse events and readmission

**Private Purchasers and Payers Respond**

- Business coalitions educating purchaser (employer) members about value-based purchasing, readmission and healthcare acquired conditions
- Health insurance industry:
  - Has implemented payment penalties for adverse events
  - Has called for greater use of evidence-based health care

**Health Care Providers Respond**

- Transitional Care Model
- Care Transitions Program
- Project BOOST
- Project RED
- National Transitions of Care Coalition

## Is Your Organization Participating in One of these National Initiatives?

- Transitional Care Model
- Care Transitions Program
- Project BOOST
- Project RED

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## Transitional Care Model

- Nurse-led, multidisciplinary approach to preparing patient for discharge and providing post-discharge support
- Focused activity begins during hospitalization
- Same nurse works with patient after discharge and continues to coordinate care to emphasize continuity.

## Transitional Care Model: Specifics

- Targeted patients are elderly with ≥2 risk factors:
  - Multiple chronic conditions
  - Recent hospitalizations
  - Poor self health ratings
- Transitional Care Nurse:
  - Visits patient in hospital
  - Home visit within 48 hours
  - Weekly visits for one month
  - Semi-monthly visits until patient discharged from program
  - Focuses on transitions: coordination, consistency, communication, comprehensiveness and multidisciplinary involvement to engage patient and family

## The Care Transitions Model

- Developed in response to growing concern about quality of care provided to older adults
- 4 week intervention
- Transition Coach who teaches patient self-management skills

## The Care Transitions Model Four Pillars

- Assistance with medication self-management
- Patient-centered record owned and maintained by the patient
- Timely follow up with primary or specialty care
- A list of 'red flags'

## Project BOOST

- **B**etter **O**utcomes for **O**lder adults through **S**afe **T**ransitions
- Aims to improve discharge process:
  - Reduce readmission rates
  - Improve patient satisfaction
  - Improve flow of information between care setting and providers
  - Target specific interventions for high-risk patients
  - Improve patient/family preparation for discharge

## Project BOOST: Tools

- TARGET: **T**ool for **A**ddressing **R**isk: A **G**eriatric **E**valuation for **T**ransitions
  - Comprehensive assessment tool for identifying and addressing risk points of elderly patient
  - 8 P's: problem medications, psychological, principal diagnosis, polypharmacy, poor health literacy, patient support, prior hospitalization, palliative care
- Patient PASS: A transition record
- Teach-Back Process
- Risk Specific Interventions
- Written Discharge Instructions

## Project RED

- **R**e-**E**ngineered **D**ischarge
- Patient-centered, standardized intervention
- Discharge Advocate- key role
- Development of an After Hospital Care Plan
- Adopted by NQF as a Safe Practice for Better Healthcare in 2007

## Project RED
## 11 Components Address:

- Comprehensive patient education about diagnosed condition, self-care, signs and symptoms warranting medical attention
- Provision of a written self-care plan to the patient
- Medication reconciliation
- Follow up activities: appointments made for patient, phone call 48 hours after departure, pending test results tracked, home services required
- Use of national guidelines
- Provision of timely, complete information to the next caregiver

## Project RED: Follow Up Contact with Patients

- Follow up phone call 48-72 hours following discharge
- "Clinical" call to assess:
  - patient's status,
  - understanding of and adherence to self-care instructions,
  - intent to keep follow up appointments

## National Transitions of Care Coalition

- Formed in 2006 by Case Management Society and Sanofi-Aventis US LLC
- Coalition of 30 organizations interested in topic
- Multiple tools and resources available to help improve transitions of care
- Care Transition Bundle
- Transitions of Care Compendium of resources

## Websites for Models

- www.transitionalcare.info/
- www.caretransitions.org
- www.hospitalmedicine.org/BOOST/
- www.bu.edu/fammed/projectred/
- www.ntocc.org

## Where are the Pharmacists?

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## Gaps between Ideal and Reality

- Only 22% of hospitals report that pharmacists provide discharge counseling for at least 75% of high-risk patients
- Only 23% of hospitals report that at least 50% of discharged patients or their caregivers recall speaking with a pharmacist while in the hospital
- Only 21% of pharmacists who work in hospitals with electronic medical records use the medication-relevant portions for managing patients' medical therapy

Ref: American Society of Health-System Pharmacists. ASHP Health-System Pharmacy 2015 Initiative: baseline statistics. *Am J Health-Syst Pharm.* 2005; 62:1393-7.

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## A Role for Pharmacists in Ensuring Good Transitions

- Involvement in redesign of the discharge process
- Care coordination
- Influence of medications- need for expertise
- Preventing adverse events does not stop at discharge
- Where should the presence be?
  - At the hospital
    - At admission- to collect a thorough medication history
    - At discharge- to be part of the discharge process
  - At the ambulatory center
    - To facilitate communication at the medical home

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## Examples of Pharmacist Involvement

- Northwestern Memorial Hospital
  - Involvement of pharmacist in discharge process for high risk patients
- University of Wisconsin Medical Center
  - Involvement of pharmacist in discharge process
- University of Michigan Medical Center
  - Unique model of placing pharmacist in medical home- to facility coordination in ambulatory setting

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## Pharmacy Organizations and Transitions of Care

- ASHP and American Pharmacist Association working together
- MCM program focused on defining the issues and providing input to ASHP
- Expect significant activity in the future by both organizations

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## Questions

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Post-test Questions

1. Common features of each national initiative for improving transitions of care include:
    a. Patient/family education, improving communication between providers, pharmacist involvement, follow up post discharge with the patient
    b. Hospital-initiated discharge planning, improving communication between providers, patient/family education, follow up post discharge with the patient
    c. Laboratory monitoring, improving communication between providers, patient/family education, follow up post discharge with the patient
    d. Patient/family education, improving communication between providers, post discharge care plan, follow up post discharge with the patient
    e. Patient/family education, improving communication between providers, pharmacist involvement, follow up post discharge with the patient

2. Which of the following are recognized consequences of poor transitions of care:
    a. Failure to take medication as instructed
    b. Failure to follow up on outstanding laboratory studies
    c. Readmission to hospital within 30 days post discharge
    d. Adverse events relating to poor disease management
    e. All of the above

3. Medications represent a key challenge with transitions of care primarily because:
    a. Financial burden of prescription cost
    b. Side effects that patients are not able to manage
    c. Patient confusion about proper use of medications
    d. Confusion between brand names and generic names
    e. Difficulty in accurately measuring liquid medications

4. Pharmacists may improve transitions of care by:
    a. Participating in redesign of the discharge process
    b. Direct involvement in patient teaching prior to discharge
    c. Follow up contact with patients post discharge
    d. Supporting patients in the ambulatory setting
    e. All of the above