Transitions of Care: Policy, Regulation, Opportunities, & Challenges for Pharmacy

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Objectives

- Interpret policies and regulations involving transitions of care
- Discuss potential pharmacists’ and pharmacy technicians’ roles and opportunities in transitions of care
- Describe challenges associated with implementation of a transitions of care program
Introduction

Efficient care coordination leads to:

- Improved clinical outcomes
  - Reduced hospital readmissions
  - Reduction in adverse drug events
- Prudent use of resources
- Cost savings

Certain populations are at higher risk

- Geriatric patients
- End-of-life care
- Patients with limited health literacy
- Adults and children with special needs
- Homeless patients
- Polypharmacy (>5 drugs)
Importance of Proper Care Transitions

- 20% of readmissions occur due to a medication error
- Study found 36% of patients had medication errors at admission
  - 85% originated from the patient’s medication history
  - Unintended medication discrepancies at the time of hospital admission range from 30% to 70%
- 60% of all medication errors occur during times of care transitions
- 1.5 million preventable adverse drug events/year accounts for > $3 BILLION/year in health care dollars
Think & Share

- How are you implementing transitions of care in your practice setting?

- What specific outcomes are most pertinent in your area?
Setting the Landscape: Transitions of Care Policy
Section 3025 Affordable Care Act

Hospital Readmissions Reduction Program (HHRP)

- Centers for Medicare and Medicaid Services (CMS) reimbursement penalties
  - 30 day hospital readmission
- Calculation of excess readmission ratio for each applicable condition
  - Compared to national average
- FY 2015-2016 Fiscal Year (FY)
  - 54% of hospitals penalized
    - 38 hospitals received the maximum 3% reimbursement penalty
  - Florida
    - 154 hospitals penalized
Conditions under HRRP

FY 2012
• Acute myocardial infarction (AMI)
• Heart failure (HF)
• Pneumonia (PN)

FY 2014
• Chronic Obstructive Pulmonary Disease
• Total hip arthroplasty (THA)
• Total knee arthroplasty (TKA)

FY 2016
• Expanded pneumonia diagnosis
• Aspiration pneumonia
• Sepsis patients coded with pneumonia

FY 2017
• Coronary artery bypass graft (CABG) surgery
Transitions of Care: Post-acute & Long-term Care Policy

- Protecting Access to Medicare Act (PAMA) of 2014
- Improving Post-Acute Care Transformation (IMPACT) Act
- Value-based purchasing programs for Skilled Nursing Facilities (SNFs)
  - Beginning in 2018
    - Incentives and penalties for SNFs failing to meet all-cause, all-condition hospital 30-day preventable readmission
Transitions of Care Billing Codes

- Transitional Care Management Services (TCM)
  - Healthcare professional accepts are for beneficiary post-discharge from the facility without a gap
  - 30-day begins on day of discharge from
    - Inpatient acute care hospital
    - Inpatient psychiatric hospital
    - Long term care
    - Post acute care
    - Observation or partial hospitalization
Transitions of Care Billing Codes

- Services billed by:
  - Physicians
  - Clinical nurse specialists
  - Nurse practitioners
  - Physician assistants
- Where are the pharmacists?
Transitions of Care Billing Codes

CPT Code 99495
TCM with moderate medical decision complexity
Face-to-face visit within 14 days of discharge

CPT Code 99496
TCM with high medical decision complexity
Face-to-face visit within 7 days of discharge
Key Organizations & Resources

- Centers for Medicare and Medicaid Services
  - Community-based Care Transitions Program
- The Joint Commission
  - Transitions of Care Portal
- Agency for Healthcare Research and Quality
  - Project RED (Re-Engineered Discharge) Training Program
- National Transition of Care Coalition (NTOCC)
  - NTOCC’s Transitions of Care Evaluation
  - TOC Compendium
Opportunities for Implementation
Opportunities

- Increased pharmacist involvement in development of TOC initiatives
  - Advocate for pharmacist involvement
  - Advancement of health information technology
- Interprofessional approach to patient care
  - Accountable Care Organizations
  - Patient Centered Medical Home
  - Patient-centered care
- Cost-effectiveness/savings
  - TOC billing codes
- Accountable Care Organizations
Pharmacists’ Roles in Care Transitions
Best Practices – Institutional Settings

- Prompt admission medication history
- Medication reconciliation at every level of care to avoid discrepancies
- Discharge counseling to communicate vital components of the care plan with patients/caregivers
  - Assess health literacy
  - Promote adherence and importance of timely follow up
  - Focus on high risk specialty areas (transplant, HIV, etc.)
- Pharmacist-to-pharmacist hand-offs between practice settings
- Interprofessional practice
  - Pharmacist involvement in medical rounds to anticipate and resolve medication problems
  - Ensuring adequate and timely follow up
Best Practices – Ambulatory Care Settings

- Medication reconciliation upon discharge to avoid discrepancies
  - “Medication reconciliation is not an event, but an enduring activity.” - American Medical Directors Association
- Direct communication among healthcare providers between settings
  - Discharge notes and proper hand-offs
  - Discontinuation of old medication regimen from community pharmacies
- Evaluation of patient ability and caregiver availability
- Discontinuation of old medication regimen from community pharmacies
- Pharmacist-run clinics within interprofessional settings
  - Chronic disease state management
Best Practices – Community Pharmacy Settings

- Patient empowerment through counseling and education
  - Reiterate importance of care coordination
- Patient advocacy in seeking clarification from clinics as necessary
- Vital role in providing accurate information for proper medication reconciliation
Best Practices – Telemedicine

- Post-discharge follow up
  - Reiterate key counseling points
  - Ensure timely follow-up appointments made
- Chronic disease monitoring
- Beneficial for patients who have limited transportation or live in rural areas
- Includes three main distinctions:
  - Asynchronous shared EMRs
  - Remote patient monitoring
  - Real-time, interactive services
Opportunities for Pharmacy Technicians & Interns

- Pharmacy technicians
  - Medication reconciliation
  - Meds-to-beds programs
  - Assistance with prior authorizations and referrals
- Pharmacy interns
  - Extend pharmacist services while enhancing competence
Pharmacy Residency Programs

- ASHP accreditation for PGY2 residencies - potential for new areas of post-graduate training opportunities

- Example daily activities:
  - Attending multidisciplinary rounds and ambulatory clinics
  - Making post-discharge telephone calls
  - Performing medication reconciliation
  - Participating in patient education and counseling
  - Collaborating with other HCPs
Transitions of Care Models
Better Outcomes for Older Adults through Safe Transitions (BOOST)

- Aim to establish a national standard for discharge processes
- Multidisciplinary team focuses on discharge education
- Currently offer an implementation toolkit for various disease states
Care Transitions Intervention

- Self-management program for patients with complex needs and their caregivers
- Four week period
- Focus on
  - Medication self-management
  - Use of dynamic personal health record
  - Timely follow up after discharge
  - Knowledge of red flags indicating worsened condition and next steps
Guided Care Model

- Led by a guided care nurse in primary care office
- Works with patients, caregivers, and physician
- Focus on care of chronic diseases:
  - Assessing patient/caregiver in home environment
  - Create evidence-based care plan
  - Monthly monitoring of patients
  - Promote self management
  - Care coordination among providers
  - Transition support between care sites
  - Caregiver support
Transitional Care Model

- Led by transitional care nurse
- Focus on high risk, geriatric patients with chronic disease hospitalized for medical or surgical conditions
- Involves inpatient planning and home follow-up
Think – Pair – Share

- What types of transitions of care initiatives have you developed at your sites?

- What challenges have you encountered?

- What are your future plans for enhancement?
Challenges with Program Implementation
Barriers to Implementation

- Lack of interface and interoperability among health information technology systems
  - Various electronic medical record programs
    - Hospital to hospital
    - Hospital to long-term care facility
    - Hospital to ambulatory care clinic
  - Multiple pharmacy dispensing systems
- Lack of standardized processes among institutions
- Insufficient coordination and communication
- Inadequate financial resources
- Inadequate staffing resources (time allocation)
- Misaligned incentives for stakeholders
Barriers to Implementation (cont.)

- Limited patient knowledge leading to reduced demand for a care plan
- Lack of a single clinician or team with definitive responsibility for care continuation
Student Preparation at the USF College of Pharmacy
Didactic Curriculum

P2 Year
• Pharmaceutical Skills series
  • Medication reconciliation
  • Interprofessional education
• Medical Informatics course
  • Transitions of care simulation
  • Medication reconciliation simulation

P3 Year
• Pharmaceutical Skills series
  • Transitions of care and medication reconciliation lecture
  • Transitions of care simulations
  • Interprofessional education (special populations)
• Cardiology elective
  • Transitions of care simulation

P4 Year
• Advanced Pharmacy Practice Education (APPE)
  • Adult medicine
  • Cardiology
  • Long term care
Transitions of Care Simulations

- Two simulations in the P3 year and conducted at the Center for Advanced Clinical Learning & Simulation (CAMLs)
- Patient case involved atrial fibrillation and anticoagulation
- Objectives
  - Identify pharmacist roles in various practice settings
    - Clinic, ER, ICU, IV room, inpatient pharmacy, medical floor, long term care facility
    - Discuss pharmacist involvement in care transitions
  - Assessment categories were based on various concepts regarding pharmacist roles in:
    - Medication reconciliation
    - Reduction of medication errors and readmissions
    - Interprofessional involvement
    - Information technology utilization
Our Endeavors in Transitions of Care
Practice site at Tampa General Hospital
  - Medication reconciliation at admission
  - Rounds on the inpatient medicine service
  - Discharge counseling
  - Clarification of discharge orders and communication with ambulatory care clinics for follow up

Academic endeavors
  - Curricular development and enhancement
Practice Site at Morsani Center – Cardiology
- Pharmacotherapy Clinic (focus is on anticoagulation)
- Student-led medication reconciliation for high-risk patients (general cardiology patients)

Practice Site of Florida Hospital – Tampa
- Interdisciplinary rounds in CCU/CSU
- Outpatient Heart Failure Transitions Program
- Heart failure/MI discharge counseling
- Future opportunities
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- Former Practice Site: University of Pennsylvania Health System
  - Interprofessional Post-Acute Care Clinic
  - Referral for continuity of care to pharmacist-run clinic
  - Project: The clinical and economic outcomes of utilizing pharmacist interventions associated with an outpatient post-acute care clinic
- Former Practice Site: Fletcher Health and Rehabilitation Center
  - USF Health Interprofessional initiative
  - Project: A Pilot Interprofessional Transfer Triage Protocol in Post-Acute Care
  - Transitions of Care Elective Course
Questions?
References