Transitions of Care and the Pharmacy Practice Model Initiative

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Objectives
- Describe the Affordable Care Act and its implications on current healthcare and practice
- Discuss the impact of transitions of care on continuity of patient care
- Identify innovative practice models to improve the transition of care process
- Apply the current and potential roles of pharmacists during transitions of care to current practice

Affordable Care Act: Improving the Quality & Efficiency
- Transforming the Health Care Delivery System
  - Linking Payment to Quality Outcomes Under the Medicare Program
  - National Strategy to Improve Health Care Quality
  - Encouraging Development of New Patient Care Models

www.healthcare.gov/law/full/index.html

Critical Point
- Transitions
  - “Handoffs”
  - Vulnerable exchange points
  - Adverse clinical events
  - Unmet needs
  - Poor patient satisfaction

Level of Access Effect on Readmission
- Level of Access Influence
  - Low access
    - Higher/lower readmission rates?
  - High access
    - Higher readmission rates
- Socioeconomic status
  - Needs evaluated!

Health Affairs 2011;30(4)
JAMA 2011;306(16)
Transitional Care
- Avoid preventable poor outcomes in **high risk populations**
  - Identify early!
- Multidisciplinary
- Patient advocates
  - Patient/caregiver goal setting
- Pharmacist discharge counseling
- Post-discharge follow-up

Health Affairs 2011; 30(4) & JAPHA 2011;51(4)

POP Quiz
- Which of the following is a diagnosis that is part of the Hospital Readmissions Reduction Program under the ACA as of October 2012?
  a. COPD
  b. CHF
  c. CABG
  d. Asthma

Hospital Readmissions Reduction Program
- Started October 1, 2012
- Heart failure (HF), acute myocardial infarction (AMI), and pneumonia (PN).
  - Future Expansions likely in 2015 include:
    - Atrial fibrillation
    - COPD
    - CABG
    - PCTA

ACA Sec. 3023, MedPac June 2007 Report

Definition of Readmission
- “as occurring when a patient is discharged from an applicable hospital and then admitted to the same or another acute care hospital, that is, another applicable hospital, within a specified time period (30 days) from the date of discharge from the initial index hospitalization.”

FY 2012 IPPS/LTC FFS final rule (76 FR 51466)

Medicare Hospital Readmission Rates

<table>
<thead>
<tr>
<th>TABLE 5-1</th>
<th>Hospital readmission rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percent of patients readmitted to hospital within:</td>
<td>7 days</td>
</tr>
<tr>
<td>Total</td>
<td>6.2%</td>
</tr>
<tr>
<td>Non-ESRD</td>
<td>6.0</td>
</tr>
<tr>
<td>ESRD</td>
<td>11.2</td>
</tr>
</tbody>
</table>

Note: ESRD (end-stage renal disease).

MedPac June 2007 Report

Potentially Preventable

<table>
<thead>
<tr>
<th>TABLE 5-2</th>
<th>Potentially preventable hospital readmission rates</th>
</tr>
</thead>
<tbody>
<tr>
<td>Patients readmitted to hospital within:</td>
<td>7 days</td>
</tr>
<tr>
<td>Rate of potentially preventable readmissions</td>
<td>5.2%</td>
</tr>
<tr>
<td>Spending on potentially preventable readmissions [in billions]</td>
<td>$5</td>
</tr>
</tbody>
</table>

Source: HHS analysis of 2005 Medicare discharge claims.

MedPac June 2007 Report
E1  I have always been wondering this, and I don't know how I ever got this far without knowing the answer...but does ANY readmission count against the hospital? If the patient is sent home after CHF exac but comes back in 2 weeks with DKA, is the hospital penalized?

Emily, 4/16/2013
Potential Economic Impact

- COPD Example
  - Preventing any exacerbations in patients with both severe and moderate exacerbations could save $13,296/patient/year
  - Reducing the severity of exacerbations from severe to moderate could save $9409/patient/year
  - Direct costs
    - 18 billion in 2002 → 29.5 billion in 2010

Community-Based Care Transitions Program

- Goals
  - Improve transitions of care
  - Improve quality of care
  - Reduce readmissions for high risk beneficiaries
  - Document measurable savings to the Medicare program

Community-Based Care Transitions Program Requirements

- Transition services that begin no later than 24 hours prior to discharge
- Timely and culturally and linguistically competent post-discharge education
- Timely interactions between patients and post-acute and outpatient providers
- Patient-centered self-management support and information specific to the beneficiary’s condition
- A comprehensive medication review and management

Community-Based Care Transitions Program Proposals

- Identify community-specific root causes of readmissions, define the target population, and strategies for identifying high risk patients
- Specify care transition interventions and services that will address readmissions, including strategies for improving provider communications and improving patient activation
- Be culturally appropriate, beneficiary-centric
- Describe prior experience with managing care transition services and reducing readmissions

Other Programs

- Section 3021
  - CMS Innovation Center offers grant money for innovative care delivery and payment models (2011-2019)
- Section 2602
  - Federal Coordinated Health Care Office
    - Designed to foster integration of Medicaid/Medicare
- Section 3022
  - Medicare Shared Savings Program
    - Accountable Care Organizations/PCMH/Transitions of Care

Emily Bennett, PharmD
Transitions of Care and Innovation

- Critical to discover new ways to keep patients out of the hospital
- From here:
  - PPMI
  - Studies
  - Future directions
  - Activity

PPMI

- Goal:
  - “Significantly advance the health and well-being of patients by developing and disseminating a futuristic practice model that supports the most effective use of pharmacists as direct patient care providers”
  - Transitions of care
  
  [Link: http://www.ashpmedia.org/ppmi/rationale.html]

Coleman, et al.

- Personal Health Record
  - Patient-centered document with important core elements
- Transition coach (RN)
  - Tools to promote cross-site communication
  - Encouragement to take a more active role in their care and to assert their preferences
  - Continuity across settings and guidance


Balaban, et al.

- Intervention
  - Patient Discharge Form
  - Telephone outreach from a nurse
- Four undesirable outcomes were measured after hospital discharge
- Only 25.5% of intervention patients had 1 or more undesirable outcomes compared to 55.1% of the concurrent and 55.0% of the historical controls


Jack, et al.

- Nurse discharge advocate
  - Create After Hospital Care Plan
  - Arrange follow-up appointments
  - Confirm medication reconciliation
  - Conduct patient education
- Clinical pharmacist
  - Called patients 2 to 4 days after discharge to reinforce the discharge plan and review medications


Hospital to Home (H2H) Initiative

- Nationwide quality campaign led by the American College of Cardiology (ACC) and the Institute for Healthcare Improvement
- Wiggins, et al.
  - Principles in discharge medication counseling
  - Transitions of care and pharmacist role
  - Individualization

Ongoing research

- Discharge medication counseling and its correlation with reducing readmission rates in patients with chronic obstructive pulmonary disease exacerbations
  - Funded by the ASHP Foundation through the Pharmacy Resident Practice-Based Research Grant
- Design and Methods
- Results?

Group Discussion

- Groups of 5
- Brainstorm changes you can implement at your own practice site
- Write them out on the provided sheet and hang around the room
- Share ideas

References


Questions?