Pharmacy’s Role in Decreasing Hospital Readmissions

ACPE UAN 107-000-11-004-L04-P & 107-000-11-004-L04-T 0.15 CEU/1.5 Hr

Activity Type: Knowledge-Based

Program Objectives for Pharmacists: Upon completion of this program, participants should be able to:
1. List two major health conditions that are the focus of readmission reporting.
2. Identify areas in the institution where pharmacists can be an integral part of the team designed to prevent readmissions.
3. List at least two main reasons for preventing readmissions.

Program Objectives for Technicians: Upon completion of this program, participants should be able to:
1. Identify areas where technicians should be an active member of the team designed to prevent readmissions.
2. List at least two main reasons for preventing readmissions.

Speaker: Brian D. Benson, PharmD, is Executive Director of Pharmacy for Iowa Health Systems-Des Moines, Iowa. He received his BS in Pharmacy degree from Drake University College of Pharmacy in 1996, and received his PharmD degree from the University of Kansas School of Pharmacy in 2006. Dr. Benson is Chair-Elect of the Section Inpatient Care Practitioners for ASHP and has served as Director-at-Large of this Section. Dr. Benson has been involved with IPA in a variety of roles including representing Iowa as a delegate at ASHP, current service as a Trustee at Large on IPA’s Board of Trustees, and receipt of IPA’s Health-System Pharmacist of the Year Award in 2010.

Speaker Disclosure: Brian Benson reports he has no actual or potential conflicts of interest in relation to this program. The speaker has indicated that off-label use of medications will not be discussed during this presentation.
Pharmacy’s Role in Decreasing Hospital Readmissions

Brian D. Benson, R.Ph., PharmD.
Executive Director of Pharmacy
Iowa Health-Des Moines

Faculty Disclosure

- Brian reports he has no actual or potential conflicts of interest associated with this presentation.

Learning Objectives

- Upon completion of this program pharmacists (or pharmacy technicians) will be able to:
  - Describe Health Conditions that are initial focus of readmission
  - Understand various models Project RED, Project Boost, CTI and how these can be implemented in various settings
  - Be familiar with screening tools to help with readmission prevention
  - Identify ways pharmacy can impact patient care across the continuum of care
  - Understand impact of readmissions with respect to quality indicators
  - Have knowledge of Key takeaways from Reducing Preventable Readmissions
  - Work through medication reconciliation example using pre-hospital and current hospital med list

Pre-Assessment Questions

1. True or False - Some of the initiatives for readmission include project Boost, RED and CTI.
2. What are the four main health conditions with readmission focus beginning 2012-2014?
3. Circulation Focused Update 2009 indicates this “service” as one of the key components in preventing readmissions.
4. True or False – All patients have the same risk of being readmitted within 30 days
5. According to an article in JAMA, May 5, 2010 percent of patients are readmitted within 30 days of discharge.
   A. 15%, B. 20%, C. 25%, D. 30%

Overview

- CMS information and review
- Reducing preventable readmissions executive summary
- National Patient Safety Goals
- Review of CTI, RED, BOOST
- Identify areas for pharmacy involvement
- Look at IMMC DC med rec project
- Ending assessment
- Questions

Readmission general information

- Complex patients
  - Health conditions
  - Accountability
  - Willing and able to participate in getting better
  - Resources
- Complex Systems
  - Many care providers
  - Many tools to help
  - Confusion reigns info overload
  - Hand-offs – poor coordination
  - No integration
Reasons for readmissions

- Fragmented care
  - Providers paid for separate services
  - Patient hand off is not "covered"
- Primary care visit
  - DC plan may not emphasize follow-up visit
  - Doctor office not very receptive or ready to receive dc information
  - Summaries not getting to primary care
  - Hospitals not able to answer questions post dc.
    - During our med rec process it was noted that pm calls to nursing unit stopped

CMS Readmission Target

- Address the issue through payment, audits, public reporting and coaching
- 30 day readmissions are tied to poor quality according to CMS
- CMS investing in strategies to lower readmissions
  - Care Transitions Theme
  - Medicare QIO for Colorado
  - Coaching during and after decreased readmits by 50%
  - Readmits "cost, quality and patient safety"
- ACA Section 3026
  - Continuum of Care and readmissions

CMS targets

- Readmits are not hospital mistakes
- Effective transition is community issue
- Patient care issue
  - Chronic conditions and frailty
- Medicare shows 18% readmitted within 30 days potentially avoidable
  - $12 billion - $17 billion

Recommendations from CMS

- Two "simple" activities for hospitals
  - Establish emergency call number
    - To help patients answer questions until primary physician can take over
    - First hand testimonial from physician
  - Ensure follow up appointment is made
    - Significant chronic condition appointment in 1st week
    - This also helps identify possible barriers to care
  - Be ready to offer options or contacts
- Medication Reconciliation
  - Something mentioned in almost every model, article or survey

Pharmacist’s Role Identified

- Circulation Focused Update 2009
  - "medications should be reconciled in every patient and adjusted as appropriate on admission to and discharge from the hospital"
  - Class 1; Level of evidence:C
- One year Rate of Hospitalization
  - 12% versus 5% review group; n=5717
  - Review group pharmacist med rec and communication to physician
  - Complete med rec process to include outpatient

Pharmacists in Readmission

- Promote coordination of care across multiple settings
- Developed rapport with patient
- More visible and accessible
- Conduit for all healthcare information
- Not specific to hospital
  - Community pharmacy role
Reducing Preventable Readmissions

- Executive Summary from 2009-2010 Cardiovascular Roundtable National Meeting
- A must read
- Eight Key Takeaways for reducing readmissions
  - Iowa is represented in this summary
- Identifies key elements of high performing programs
  - No need to re-invent the wheel

Takeaways

- Cardiovascular readmissions are target
  - 5 of top 7 reasons are CV
- Opportunities to inflect readmissions exist
  - Self management by patient
- Discharge process
  - Communication among providers (pharmacy)
- Renewed interest in Disease management
  - Pharmacy already in the process
- Remote Disease Management
  - Small and rural a huge opportunity

ACOs and Medication Homes

- ACA emphasizes integrated models
- Similar goals but different roads
- One is financial other is care delivery
- Pharmacy can play integral role in one
- Pharmacy might be contracted in one model
- Grant opportunity galore
  - Health teams must include pharmacist
  - Designed to patient centered med homes

Patient-centered Medication Homes

- Primary care provider
- Whole-person orientation
- Coordinated and integrated care
- Safe, high-quality care
  - HIT, Evidence based medicine, CQI
- Increased access to care
- Payment that recognizes value of PCC

Accountable Care Organizations

- Financial model
- Provider groups accountable
- ACO can be Med Home depending on delivery model
- Pharmacists not likely a part
  - Pharmacists maybe contracted to assist

Medical Homes

- Team based care
- Compensation for care coordination
- Health Affairs – 2010;29:906-913
  - Pharmacists...key roles in Med homes
    - Therapy reviews
    - Optimize complex regimens
    - Adherence programs
    - Cost effective therapy recommendations
- Assist with transition of care
  - Med Rec – admit, discharge and beyond
ACA Section 3024
- Home based primary care teams
- Patients to remain at home
  - Avoid hospital and nursing home
- Independence at home model
  - Specifically lists pharmacists
  - Role not defined – can develop this
- Goal of this section
  - Decrease readmissions, ED visits and costs
  - Outcomes, efficiency, and satisfaction

ACA Section 3025
- Hospital Readmission Reduction Program
- Excessive readmission = reduced payment
- Formula that accounts for actual and expected
- Many projects designed for Discharge prep

ACA Section 3026
- Community Based Care Transition focus
- Funding for hospitals with high readmissions
- Continuum of care interventions
  - Medication reviews
  - Medication management
  - Self management support

Benchmarks in Reducing Readmissions
- The top strategies reported by hospitals
  - Improving discharge instructions (46.7 percent)
  - Tighter care transition management (55.6 percent)
  - Telephonic monitoring of discharged patients/case management (44.4 percent).
- Top three tasks performed each patient
  - Review of the medication plan (83.3 percent)
  - Review of discharge instructions (75 percent)
  - Confirmation of understanding of red flags of health (75 percent).

Hospitals are directing Efforts
Source: HIN Hospital Readmissions Survey November, 2009

Tools Used by Hospitals
- Risk Stratification - 53.7%
- Health Claim Analysis - 51.9%
- Chart Review - 46.3%
- Predictive Modeling - 37.0%
- Electronic Health Record - 31.5%
Source: HIN Hospital Readmissions Survey November 2009
National Patient Safety Goals

- Reconciling Medication Information (NPSG.3.06.01) - replaces Goal 8
- Field review to confirm Medication Reconciliations
- Effective 1 July 2011
- NPSG.08.01.01 A process exists for comparing the patient’s current medications with those ordered for the patient while under the care of the hospital.
- Note: This standard is not in effect at this time.

Check Patient Medications

- Find out what medicines each patient is taking. Make sure that it is OK for the patient to take any new medicines with their current medicines.
- Give a list of the patient’s medicines to their next caregiver or to their regular doctor before the patient goes home.
- Give a list of the patient’s medicines to the patient and their family before they go home. Explain the list.
- Some patients may get medicine in small amounts or for a short time. Make sure that it is OK for those patients to take those medicines with their current medicines.

Models

- Care Transition Intervention
  - Overview
- Project Boost
  - U Penn and others Overview
- Project Red
  - Overview
- Accidental Boost at IH-DM

Care Transitions Interventions

- Model at University of Colorado Health Sciences Center
  - Focus is on Coaching
    - Coach (nurse) visits patient once in hospital and once at home w/in 48h
    - Three calls – patient focused results
- Four Pillars
  - Med self management
  - Patient-centered record
  - Follow-up with pcp or specialist
  - Red Flag signals
    - Scale with weight ranges yellow and red

CTI program

- Nurse (coach) spends time on med list
  - Pharmacist opportunity here
  - Hospital format for DC list
  - Community Pharmacy review with
  - New meds, changes old rxs
  - Coach quizzes
  - Problems are referred to primary care doc

CTI Results

- 8% coached readmitted, 17% uncoached readmitted in 14 days
- 13% coached readmitted, 20% uncoached readmitted in 30 days
- 15% coached readmitted, 29% uncoached readmitted in 60 days
- 248 patients
Society of Hospital Medicine

- Project Boost - collaborative
  - Better Outcomes for Older adults through Safe Transition
  - Developed through $1.4 m grant and funded by tuition, California HCF, Blues of Michigan
- 5 key Elements
  - Comprehensive Intervention
  - Comprehensive Implementation Guide
  - Longitudinal Technical Assistance
  - Boost Collaboration
  - Boost Data Center

SHM and Project Boost

- Six site results
  - Decrease 30 day readmission from 14.2% - 11.2%
  - A 21% decrease in 30 ALL-CAUSE readmission

Project Boost and U Penn

- Pharmacists as drug advisors to patients and med staff
- Patients screened using 7P tool for high risk patients
- Screening – (anticoag, dig, narcs), polypharmacy, stroke, COPD, heart disease, diabetes, cancer.
- Also included depression, poor health literacy and lack of caregiver or support.
- Antibiotics were also considered

Screening tool 7P

- Prior hospitalization
- Problem medication
- Punk (depression)
- Principle diagnosis
- Polypharmacy
- Poor health literacy
- Patient support

Project Boost and U Penn

- Pharmacists round
- Perform DC med rec and dc counseling on high risk pts
- Wallet card with dosing schedule and tablet pictures
- 354 patients – 37% had unintended med errors
  - Missing meds, incorrect dose, change in instruction, stopping meds, duplicate therapy

Project Boost and U Penn

- Future initiatives to focus on communication
- Linking hospital, community and primary care providers for medication information
Project RED – Boston University Med Center

- Patient education focus
- Nurses
  - Follow-up appointments
  - Medication routines
  - Teach patients about their condition with a personalized booklet
- Pharmacist
  - Contacts patient 2-4 days post DC for med questions, reinforce med plan and answer questions

Project RED Results

- 370 patients in program – 368 not in program
- Program patients – 30% fewer ER and readmissions
  - Lower per patient cost $412 (ann intern med 2009:150:178-187)
- 94% in RED had appointments; 35% not in RED did
- 91% had information sent to PCP in 24 hours of DC

IH-DM Accidental Boost

- Initial formation of medication reconciliation group
  - Cardiovascular, pharmacy, clinical quality
- Looked strictly med rec and developed a process for DC med rec
  - Tracked number of meds, interventions, time to complete
  - Freed up nursing to focus on DC activities
  - Medication information more clear
- Satisfaction
  - patients increased (more medication information and not as many questions)
  - Nurses increased
  - Pharmacist satisfaction – not so much –
    - bad tools
    - everybody dc at once
    - Many clarifications

Medication reconciliation

<table>
<thead>
<tr>
<th>TEAM MEMBERS</th>
</tr>
</thead>
<tbody>
<tr>
<td>Team Members: Diane Van Gorp, Kathy Quick, Steve Sanders, Laura Elliott, Chris K. Angie Aarhus</td>
</tr>
<tr>
<td>PI Advisor: Sammy Jayakhumar</td>
</tr>
<tr>
<td>Senior Team Sponsor:</td>
</tr>
</tbody>
</table>

Case Presentation

- Identify problems associated with the following patient case:
  - Admit med list and DC Med List
    - Scan image of pre and dc med list
    - Hospital pharmacist and admit date of today
  - Community pharmacy
    - Patient conversation – recent DC from hospital
    - Did the hospital give you a medication list?
    - Use to update current profile
    - This is an area we professionally can work on
Discussion

- Considerations for current systems
  - Interchanges
    - How do this show in your systems
  - Discharge lists both brand and generic
    - List both
  - New, start, stop and continue sections
    - Helps clarification
  - Do DC people know about tools to help with monitoring
    - Home Care, Nursing homes, Pharmacies, Physician, patients

Post-Assessment Questions

1. Project Red has what primary focus for reducing readmissions?
2. Name three health conditions that are the focus for CMS Readmission data.
3. Are readmissions strictly a hospital problem?
4. What is the most common service or intervention mentioned to help reduce readmissions?

Conclusion

- Preventing Readmissions is major focus
- While tends to be hospital in nature it is a community health issue
- Pharmacy has multiple areas of which to impact patient care
- Pharmacy has the unique position to enable hand-offs and follow-up care appointments
- Pharmacists will be leaders in readmission programs
- What can we do to change our current model, remove silos so to speak, to develop a more robust transition model for our patients?