Resources for Pharmacists in Transitions of Care: How to Implement and Enhance a Transition of Care Program
Overview

Implementing and Enhancing Transitions of Care

Deborah Hauser, RPh, MHA
Mariel Sjeime, PharmD, BCACP
Einstein Medical Center Philadelphia

Community Pharmacy and Transitions of Care Plans

Tamara Fox, BSPharm, RPh; Community Pharmacy Initiatives Project Manager
Purdue University College of Pharmacy
Implementing and Enhancing Transitions of Care

Einstein Medical Center Philadelphia
Deborah Hauser, RPh, MHA
Mariel Sjeime, PharmD, BCACP
Needs Assessment

- **Medication non-adherence:**
  - 20-50% of patients do not take prescription medications as directed (1)
  - 36% of Americans have basic or below basic health literacy (2)
  - Costs estimated between $100-$300 billion dollars annually. (3)

- **Medication reconciliation:**
  - 50% of all hospital related medication errors & 20% of adverse drug events attributed to poor communication at transitions of care. (4)
  - 30-70% occurrence of medication discrepancies at hospital admission. (5)

- **Emerging Evidence:**
  - Patients receiving detailed patient centered instructions, comprehensive discharge planning, and post discharge reinforcement are 30% less likely to be readmitted. (6)
Medication REACH Program

Pilot study: Admission to telemetry/cardiac care unit, 48 hours of hospitalization, ≥ 5 medications, discharge to home

**Goal:** to enhance the patient discharge process through multi-disciplinary communication and direct pharmacist involvement in an effort to reduce adverse medication events, and hospital readmissions

- Validate medication **RECONCILIATION**
- Deliver patient centered **EDUCATION**
- Resolve medication **ACCESS** issues during transition
- Coordinate a comprehensive **COUNSELING** approach
- Equates to a **HEALTHY** compliant patient at home
Workflow:

- Patients identified through discharge rounds
  - Multidisciplinary team: care managers, nurses, medical residents, physician assistants
- Screening completed by pharmacy resident/s
  - Contact information
  - Insurance information
  - Assess the patient
    - Health literacy
    - Compliance
- Complete REACH Intervention
Medication REACH Program

Reconciliation
- Compare home, hospital and discharge medication lists
- Verify accuracy and completeness

Opportunities for involvement
- Collaborate and communicate with medical team
- Medication related interventions
  - Optimization of therapy
  - Deletion of unnecessary therapy
  - Addition of therapy
Medication REACH Program

Education

- In person pharmacist medication education
  - Review indications, dosing, and possible adverse effects
  - Utilize the teach back method

Patient Tool kit ([www.ahrq.gov](http://www.ahrq.gov))

- Pictorial-based personalized medication card
- Medication organized (pill box)
- Medication education leaflets
<table>
<thead>
<tr>
<th>Name</th>
<th>Used for</th>
<th>Instructions</th>
<th>Morning</th>
<th>Afternoon</th>
<th>Evening</th>
<th>Night</th>
</tr>
</thead>
<tbody>
<tr>
<td>Insulin 70/30</td>
<td>Helps control your blood sugar</td>
<td>2 X’s daily</td>
<td>Inject 15 units</td>
<td></td>
<td>Inject 20 units</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Store in refrigerator once in use.</td>
<td>before breakfast</td>
<td></td>
<td>before dinner</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Keep at room temperature.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Check your blood sugar as directed by</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>your doctor.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Prasugrel</td>
<td>Helps to prevent blood clots, heart</td>
<td>1 X daily</td>
<td>Once before</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>attack, stroke, or other vascular</td>
<td></td>
<td>breakfast</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>events.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rosuvastatin</td>
<td>Lowers your cholesterol</td>
<td>1 X daily</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

http://www.ahrq.gov/qual/pillcard/pillcard.htm
Medication REACH Program

**Access**

- Verified prescription insurance coverage
- Communicated with patient’s pharmacy or the hospital outpatient pharmacy
- Assisted with insurance formulary restrictions and approvals before the patient left the hospital
- Social workers assisted with uninsured patients and patient assistance program enrollments
Medication REACH Program

Counseling Questionnaire
- Two follow-up phone calls
  - Within 72 hours of discharge
  - Close to 30 days post discharge
- Have you been taking your medications?
- Have you missed any doses of your medications?
- How do you feel since taking your medications?
- Are you having any unwanted reactions?
- Do you have a follow-up appointment scheduled with your primary doctor?
- Do you understand how to take your medications?
- Do you have any questions about your medications?

Healthy patient at home
Results

30 Day Readmission Rate (%)

Control Group: 21.4%
Medication REACH Group: 10.6%

Pharmacist Interventions

- Optimization of Therapy: 25%
- Optimization of Dose: 19%
- Deletion of Therapy: 23%
- Initiation of Therapy: 25%
- Other: 8%

Total number of patients = 47
Total number of Interventions = 59

* National Average for AMI = 19.9 % and for HF = 24.5 %
Lessons Learned

• **Potential for Pharmacists Clinical Interventions**
  - Medication therapy management
  - Medication reconciliation
  - Direct pharmacist to patient education

• **Myriad of Access to Care Issues**
  - Lack of prescription benefit insurance
  - Formulary restrictions
  - Prior-authorization process or step therapy
  - Co-pay burden
  - Socio-economic barriers
  - Need for outpatient pharmacy services

• **Multidisciplinary collaboration**
Expansions and Enhancements

Einstein Apothecary
Discharge Pharmacy Service:

- Outpatient pharmacy services discharged patients
- First 30-day fill
- Meet with the pharmacist
- Cost effective medications
- Patient invoice/bill
- Discharge courier service

Benefits:
- Strategic asset
- Return on investment
- Expansion of services
Expansions and Enhancements

Ambulatory Pharmacy Patient Liaison Empowerment (APPLE) Technician

- Address medication “disconnect” at discharge
- Increase capacity for pharmacist medication therapy management
- Increase discharge patients prescription capture rate
- Navigate patient access issues more effectively

Medication Reconciliation Technician

- Address medication related discrepancies upon admission
- Obtain complete and accurate home medication list
- Allow pharmacist to focus on clinical activities
- Decrease medication related adverse events during transitions of care
Community Care Transitions Program

- CMS Grant focuses on the elderly patient population
- Patients at high risk for readmission
  - ≥50 years of age
  - Moderate to severe functional defects
  - Active behavior or psychiatric health issue
  - ≥4 active co-existing medical conditions
  - ≥6 prescribed medications
  - ≥2 hospitalizations within the past 30 days
  - Low health literacy
  - Documented history of non-adherence to a therapeutic regimen
  - No PCP
Community Care Transitions Program

Transition of Care Pharmacist
Medication Therapy Management

- Medication reconciliation
- Follow patient throughout hospital stay
- Discharge counseling
- Medication Action Plan (MAP)
- Ensure prescriptions are filled
  - Pharmacy Technician Discharge Liaison
- Address medication related issues after discharge
  - Bridge care coordinators

Patient navigator

- Identify patients at high risk for readmission
- Educate patient on their disease states

Bridge care coordinators

- One home visit within 72 hours of discharge
- Weekly phone calls for 30 days
Medication Action Plan (MAP)

Goals:
- Blood pressure, cholesterol levels, blood sugar values, A1C
  - Example: Goal A1C: <7%; Your A1C on 4/1/2013: 8.4%

Changes in medication regimen
- Addition of therapy, discontinuation of therapy, changes in regimen
  - Example: Before you came to the hospital you were Injecting Insulin glargine 20 units subcutaneously at bedtime. During your hospital stay we found your blood sugar to be high, so we increased your Insulin glargine to 30 units subcutaneously at bedtime. You should now inject Insulin glargine 30 units subcutaneously at bedtime.

Education
- Indication, administration, adverse effects, interactions, monitoring, adherence, duration of therapy
  - Example: Insulin glargine is used to lower your blood sugar. It is important to look for signs of low blood sugar (<70-80 mg/dL). If your blood sugar drops too low you may feel dizzy, shaky, hungry, or start to sweat. If you experience this it is important to check your blood sugar and see if it is too low. The quickest way to increase your blood sugar is with 3 glucose tablets, half a cup of fruit juice, or 5-6 pieces of hard candy.

Contact information
Community Care Transitions Program

30 Day Readmission Rate (%) July 2012 – June 2013

- Comparator: 23.0%
- CCTP Grant (Full Pharmacy Intervention): 10.1%

Pharmacist Clinical Interventions

- Optimization of Therapy: 27.4%
- Optimization of Dose: 21.0%
- Deletion of Therapy: 21.6%
- Initiation of Therapy: 22.6%
- Access: 7.4%

Total number of patients = 347
Total number of Interventions = 486
Summary

• **Challenges Addressed** - Discontinuity of care and Medication related readmissions

• **Steps/Process Created** - Medication REACH program, Discharge Pharmacy Services, Advanced Pharmacy Technician Role, Transition of Care Medication Management Model

• **Outcomes Achieved** - Sustained 50% or greater reduction in 30-day inpatient readmissions

• **Success Factors/Pre-Requisites** - Commitment of resources to support a medication management care transitions model, integration into the multidisciplinary discharge process
References


Images:
Contact Information

• Deborah Hauser, RPh, MHA
  Phone: 215-456-6486
  Email: hauserd@einstein.edu

• Mariel Sjeime, PharmD, BCACP
  Phone: 215-456-8402
  Email: sjeimema@einstein.edu
Community Pharmacy and Transitions of Care Plans

Tamara Fox, BSPharm, RPh
Community Pharmacy Initiatives Project Manager
Purdue University College of Pharmacy
Indiana Medication Management Partnership

- An Engagement Program of Purdue University in collaboration with the Indiana Pharmacists Alliance
- Seeks opportunities for pharmacists to provide high value, patient-centered, MTM services
- Serves as a conduit for payors to more readily access MTM services for beneficiaries
- Offers both Chronic Care and TOC plans
IMMP TOC Plan Structure

• TOC program:
  • Provides short term MTM services to patients for 30 days post hospital discharge.
  • Pharmacist conducts at least two consultations with the patient and/or caregiver:
    • First consultation: 48 hour time frame
    • Second consultation: within 7 days
Transitions of Care Plan cont’d

- Pharmacists are reimbursed on a FFS model for the initial and first follow-up consultations following discharge.

- Additional FFS reimbursement is allowed if pharmacist deems patient needs more care (limit 3 additional reimbursable consultations); pharmacist may continue consultations at their discretion and professional judgment.

- Incentive bonus payment for pharmacists:
  - Billable one time only
  - Payable only if patient has not been readmitted to hospital within 30 days

- Service is considered complete for a patient on the thirty-first day following a patient’s hospital discharge date.

- Patient may move into the Chronic Care Plan if payor’s contract permits such action.
Resources and Examples

- Review other programs
  - Ex: Minnesota, Wisconsin, Arizona
- MTM programs can sometimes be inconsistent, because they are individualized
- What is consistent within the program(s)
Community Pharmacy Challenges for Establishing TOC Plans

• Business Model
• Determine the market need and demand
  • Identify potential opportunities locally
  • Work with your current patients
• Establish relationships
• Create Demand
The Future

• Most things come full circle
• Pharmacists started by talking to the patients
• Start talking to patients again
Contact information:

• Tammy Fox, BSPharm, RPh
  • tammyfox@purdue.edu

• Indiana Medication Management Partnership
  • www.immpserves.com
  • immp@purdue.edu
Thank you!
APhA Academy of Pharmacy Practice and Management

The APhA Academy of Pharmacy Practice and Management (APhA-APPM) is dedicated to assisting members in enhancing the profession of pharmacy, improving medication use, and advancing patient care.

APhA-APPM Special Interest Groups (SIGs)

Compounding SIG

Webinar Opportunities
Policy topic CPE sessions: The Sale of Cannabis in Pharmacies and National Drug Monitoring Program
NEW THIS YEAR! CPE Credit
Available! In addition to the HOOD Open Forum Webinars, subject matter experts will provide educational sessions.

http://www.pharmacists.com/apha-appm?is_sso_called=1
Transitions of Care SIG

Log in to join the Transitions of Care SIG e-Community!

Mission

The mission of the APHA-APPM Transitions of Care SIG is to create a professional network of pharmacists and technicians who are working to overcome the transitional challenges and enhance the collaboration among pharmacists in all practice settings as they provide care to patients during transitions to/from various healthcare settings.

Purpose

The purpose of the APHA-APPM Transitions of Care SIG is to provide a community where pharmacists and technicians in all practice settings can navigate the complex healthcare system by sharing ideas on how to collaborate in order to optimize the care that patients receive during transitions of care.

SIG Leaders

The SIG is led by a volunteer Coordinator and Coordinator-elect. Leaders are available to answer SIG member questions.

Coordinator: Shelley Otsuka, PharmD, BCACP
Coordinator-elect: Stephanie Kienyman, BS, PharmD

APHA-APPM Transitions of Care SIG Volunteer Opportunities

The APHA-APPM Transitions of Care SIG is seeking SIG members for future volunteer opportunities. Interested members are encouraged to take advantage of this member benefit and to share their voice within the SIG. Members will be contacted as opportunities become available. For any questions please contact the SIG Coordinator or Coordinator-elect.
• Practice→ Topics in Practice→ More Topics in Pharmacy Practice
Continue the Conversation

Transitions of Care SIG

Log in to join the Transitions of Care SIG e-Community!

Mission
The mission of the APHA-APPm Transitions of Care SIG is to create a professional network who are willing to overcome the transitional challenges and enhance the collaboration at all settings as they provide care to patients during transitions to/from various healthcare settings.

Purpose
The purpose of the APHA-APPm Transitions of Care SIG is to provide a community for all practice settings, helping to navigate the complex healthcare system and collaborate in order to optimize the care that patients receive during transitions of care.
Thank you!

**Shelley Otsuka, PharmD, BCACP**  
Assistant Professor of Clinical Pharmacy;  
University of the Sciences  

Transitions of Care Special Interest Group Coordinator;  
American Pharmacist Association  

600 S. 43rd Street, Box 34  
Philadelphia, PA 19104  
O: 215-596-7207  
s.otsuka@usciences.edu

**Stephanie A. Kleyman, PharmD.**  
Hook Drug Foundation Fellow in Community Practice Research; Purdue University College of Pharmacy  

Transitions of Care Special Interest Group Coordinator-Elect;  
American Pharmacist Association  

640 Eskenazi Drive. Indianapolis, IN. 46240  
Work: (317) 880-6434  
Cell: (636) 219-6237  
skleyman@purdue.edu