

The Pharmacist's Role in Reducing Readmissions

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Disclosure

I, John Vinson,
have no
financial relationships
to disclose

Irish proverb

“When you come upon a wall,
throw your hat over it, and
then go get your hat.”

Objectives

- Identify five common chronic diseases associated with a large percentage of hospital readmissions
- Explain the financial implications of a patient being readmitted to a hospital within 30 days of discharge
- Define the pharmacist's role within an interdisciplinary care team providing services to patients transitioning from the hospital back to a patient centered medical home.
- Identify five activities that community pharmacists can integrate into their workflow that will assist in reducing readmissions

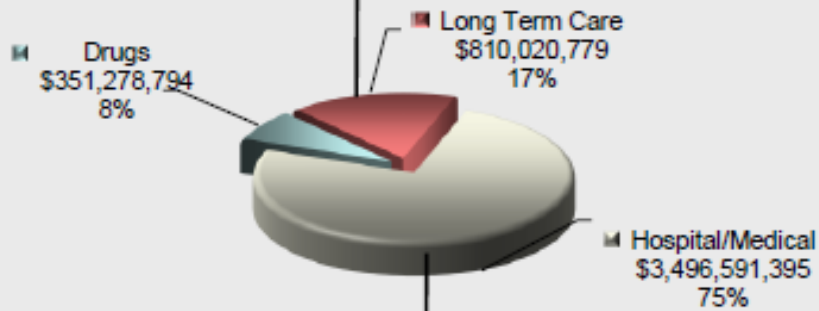
Background

- The United States healthcare system has inefficiencies and waste
- Our nation is studying strategies to address them
- In June 2013, the IMS Institute for Healthcare Informatics (largest vendor of U.S. physician prescribing data):
 - Avoiding Costs in U.S. Healthcare – The \$200 billion Opportunity from Using Medicines More Responsibly

\$

- The US health care system is the most costly in the world
 - accounting for 17% of GDP
 - estimates that percentage will grow to nearly 20% by 2020

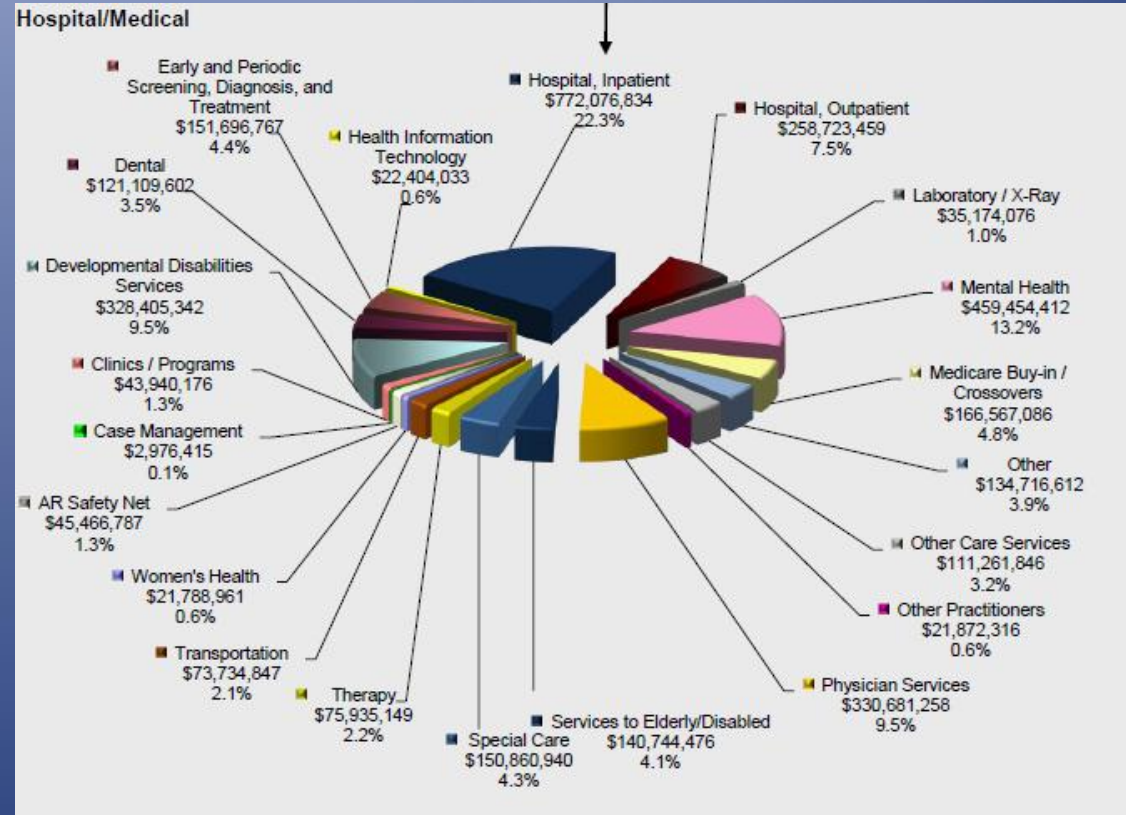
Total Medicaid Program



AR Medicaid 2013 Expenditures

Source: Arkansas Medicaid Category of Service Report

- \$4.6 billion
- 33 % hospital and LTC
- 8 % drugs



Triple Aim by IHI

Institute for Healthcare Improvement

- 1 - Improving the patient experience of care (including quality and satisfaction)
- 2 - Improving the health of populations
- 3 - Reducing the per capita cost of health care.



Payment Policy for Inpatient Readmissions: MedPAC - June 2007

Medicare Payment Advisory Commission

- Hospital readmissions are sometimes indicators of poor care or missed opportunities to better coordinate care.
- Research – Care Coordination and Quality
 - Better communication with patients and caregivers
 - Better communication with providers in transitions, pending lab tests, medication changes, studies and home health needs
 - improve the quality of care during the initial admission

MedPAC Report

- 17.6 percent of admissions result in readmissions within 30 days of discharge
- \$15 billion in spending
- Many are avoidable

- Research
 - estimates 20% readmission rate.
 - Estimate 50% avoidable
 - Certain Diagnosis – Heart Failure have 50% readmission

MedPAC Report

- Discharge is also a time when patients are more likely to be receptive to health care recommendations
- Long-term adherence to medication regimens are significantly higher when medications are prescribed at hospital discharge
 - this increased adherence is associated with decreased mortality rates

This is not new information

- Concerns about hospital readmissions have been reported in the literature for 40+ years
- Hospital based case management is not enough

- What is Changing?

New Sticks and Carrots

- Hospital Readmissions Reduction Program – 2013
 - \$\$\$ penalties
- Medicare D Star Ratings
 - Adherence and Disease Quality Outcomes
- Patient Centered Medical Homes
 - Arkansas Medicaid - 2014
 - Care Coordination Fees and Shared Savings to Primary Care - \$\$\$ incentives
 - Arkansas : THE HEALTH CARE INDEPENDENCE ACT OF 2013: quality data to providers, assignment to primary care, ACHI healthcare payment improvement participation, support for PCMH
- Accountable Care Organization Models (ACOs)
- Comprehensive Primary Care Initiative (CPCI)
 - Care Coordination Fees and Shared Savings to Primary Care – 2013 – 2016 - \$\$\$ incentives
- CMS higher reimbursement for Transition of Care Codes – 2013 - \$\$\$ incentives

Hospital Readmissions Reduction Program (*A Stick*)

- Section 3025 of the Affordable Care Act of 2010 added section 1886(q) to the Social Security Act
- Requires CMS to reduce payments to hospitals with “excessive” readmissions
- \$ penalties

Hospital Readmissions Reduction Program

- Penalties: *Based on the preceding 3 year rolling average*
 - 2013 – Max of 1%
 - 2014 – Max of 2%
 - 2015 – Max of 3%
- \$280 million in 2013 from 2217 hospitals, \$125,000 per hospital
- \$227 million in 2014 from 2225 of 5700 hospitals.
 - 18 lost 2% - max amount, 2 in Arkansas

Hospital Readmissions Reduction Program

- Conditions at Risk 2013 and 2014 :
 - heart failure, heart attack and pneumonia
- Conditions at Risk for 2015:
 - **Continue:** heart failure, heart attack and pneumonia
 - **New:**
 - (1) patients admitted for an acute exacerbation of chronic obstructive pulmonary disease (COPD)
 - (2) patients admitted for elective total hip arthroplasty (THA) and total knee arthroplasty (TKA)

CPCI

- Comprehensive Primary Care Initiative
- Multi-payer initiative fostering collaboration between public and private health care payers to strengthen primary care
- Bonus payments to primary care doctors who better coordinate care for their patients
- 497 participating sites, 69 in Arkansas
- 315,000 Medicare patients

CPCI

- CMS Innovation Center
- This test may inform national payment policy for primary care – “enabling legislation”
- 9 milestones
 - 2: Care Management
 - 80% of High Risk
 - Comprehensive Medication Management (1 of 3 options)
 - 5: Quality Improvement (including utilization)
 - 6: Care Coordination across the Medical Neighborhood

CPCI

- Mostly monthly coordination fees in 2013-2014
- \$\$\$ in potential “Shared Savings” in 2015-2016

AMBULATORY CARE SENSITIVE CONDITIONS (ACSC)

- Diabetes ACSC Composite
- Chronic Obstructive Pulmonary Disease (COPD) or Asthma ACSC
- Heart Failure ACSC
- Acute: dehydration, bacterial pneumonia, or urinary tract infection
- Total ACSC Composite

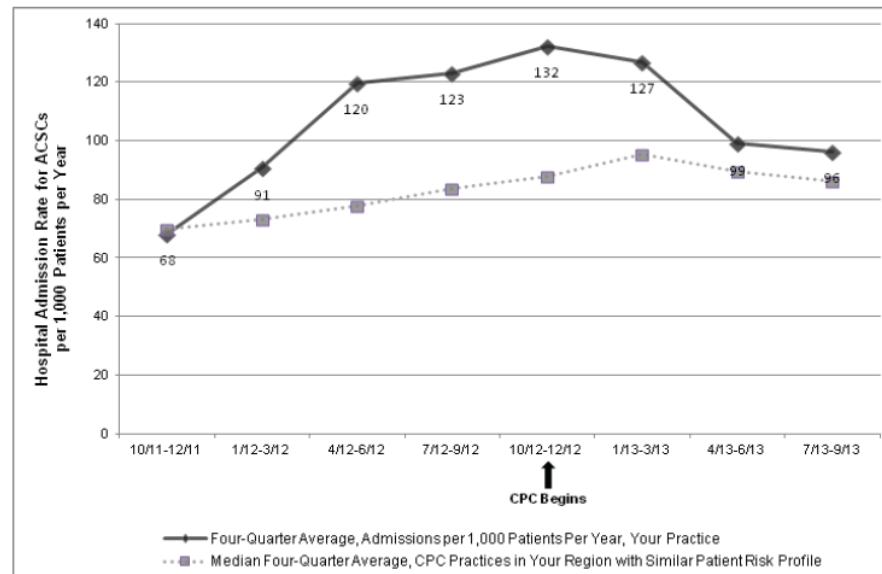
Feedback Reports – UAMS West Ambulatory Sensitive Conditions

CPC – Quarterly Practice Feedback Report, January 2014

Mathematica Policy Research

Figures 8 and 9 show quarterly trends in hospital admissions for ACSCs and 30-day unplanned readmissions, for your practice and for other CPC practices in your region with a similar patient risk profile, from October 1, 2011, through September 30, 2013. Because actual use rates can vary widely from one quarter to the next, the graph shows four-quarter averages, which are better indicators of trends.

Figure 8. Trends in Annualized Rate of Hospital Admissions for Ambulatory Care Sensitive Conditions (ACSCs) per 1,000 Medicare FFS Patients, from October 1, 2011, through September 30, 2013: Four-Quarter Averages



Source: Medicare claims data.

Notes: Data labels refer to averages among attributed Medicare FFS patients in your region.

Utilization data represent actual rates during the respective time periods and regions. Data are not risk-adjusted.

Pre-CPC data includes only attributed patients who were alive at the start of the demonstration.

For the current quarter, Medicare utilization rates are adjusted to account for underestimates due to the lag in filing and processing Medicare claims.

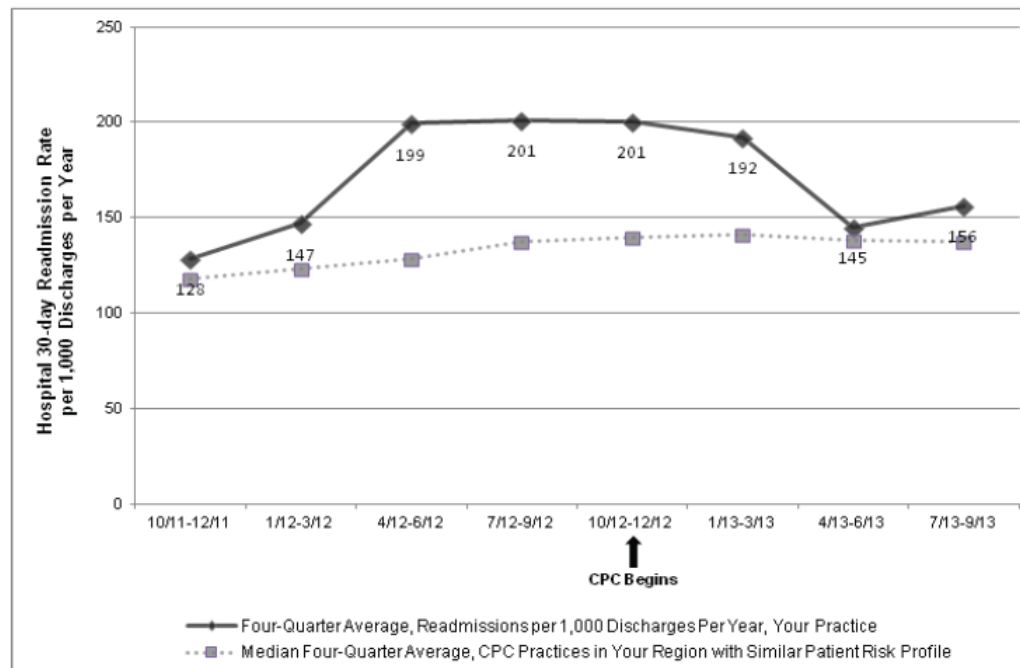
The Agency for Healthcare Research and Quality (AHRQ) developed measures of potentially avoidable hospitalizations for ACSCs, defined as conditions for which good outpatient care can prevent complications or more serious disease. These include chronic conditions (such as diabetes, chronic obstructive pulmonary disease, and heart failure) and acute conditions (such as pneumonia, urinary tract infection, and dehydration).

Feedback Reports – UAMS West 30 Day Unplanned Readmissions

CPC – Quarterly Practice Feedback Report, January 2014

Mathematica Policy Research

Figure 9. Trends in Rate of Hospital 30-Day Unplanned Readmissions per 1,000 Medicare FFS Discharges, from October 1, 2011, through September 30, 2013: Four-Quarter Averages



Source: Medicare claims data.

Note: Data labels refer to averages among attributed Medicare FFS patients in your region.

Utilization data represent actual rates during the respective time periods and regions. Data are not risk-adjusted.

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Transition of Care - Codes

- 99495 – Moderately Complex (\$150) - Medicare
- 99496 – Highly Complex (\$212) - Medicare
- Billed on Day 30
- Requires TOC phone call within 2 BUSINESS days
- Requires certain “Non face to face” services
- Requires face to face office visit with CMS “qualified” provider
 - within 7 calendar days for 99496 – High Complex
 - within 14 calendar days for 99495 – Moderate Complex

TOC Care NON Face to Face

- **Services Furnished by Physicians or NPPs**
 - You may furnish the following non-face-to-face services:
- Obtain and review discharge information (for example, discharge summary or continuity of care documents)
- Review need for or follow-up on pending diagnostic tests and treatments
- Interact with other health care professionals who will assume or reassume care of the beneficiary's system-specific problems
- Provide education to the beneficiary, family, guardian, and/or caregiver
- Establish or re-establish referrals and arrange for needed community resources
- Assist in scheduling required follow-up with community providers and services

TOC Care Face to Face

- **Services Furnished by Licensed Clinical Staff Under the Direction of a Physician or NPP**
 - Licensed clinical staff under your direction may furnish the following face-to-face services:
- Communicate with agencies and community services used by the beneficiary
- Provide education to the beneficiary, family, guardian, and/or caretaker to support self-management, independent living, and activities of daily living
- Assess and support treatment regimen adherence and medication management
- Identify available community and health resources
- Assist the beneficiary and/or family in accessing needed care and services.

TOC Workflow

48 hour phone call



Pre-Visit Planning (Suggestions Flag)



Team Discussion



Office Visit / Medication Management



Follow Up

TOC Med Management



- Prior to Admission, Hospitalization Orders, Discharge Orders and Post Discharge Reality
 - Discontinued
 - Discontinued but should be restarted
 - Dose changes
 - Formulary Challenges of inpatient care
 - New Therapy - Indication, duration, education

Therapy

- Prevention Screenings – USPSTF
- Immunizations
- Medication Discrepancy Tool
- Under Utilization
 - Dose Optimization
 - Missing Therapy

State Action on Avoidable Rehospitalizations – STARR

How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations

IHI – Institute for Healthcare Improvement

- Schall M, Coleman E, Rutherford P, Taylor J. *How-to Guide: Improving Transitions from the Hospital to the Clinical Office Practice to Reduce Avoidable Rehospitalizations*. Cambridge, MA: Institute for Healthcare Improvement; June 2013. Available at www.IHI.org.

- Tips for Certain Diseases

Chest Pain

- Drug Therapy teaching
 - Beta Blockers
 - Calcium channel blockers
 - Long acting isosorbide
 - Rapid acting nitroglycerin
 - Ranolazine
 - High Intensity Statin
 - Blood Pressure Control
 - Antiplatelet Use
 - Immunizations
- Smoking Cessation
- Lifestyle modifications
- Mental health screenings
- Self Management and educational support for chest pain

Chest Pain

- **The 4 E's include:**
 - Eating a large meal
 - Exercise and other physical activity
 - Emotions
 - Extremely cold weather
 - If you experience angina with any one of these triggers, be aware that having two triggers at once (such as exercising in extremely cold weather) may cause you to have angina more easily

Chest Pain

- Sample
- <http://pcna.net/>
- Preventive Cardiovascular Nurses Association

How to Grade Your Angina

"1" is very mild and "4" is the worst angina that you have ever had.

Grade	Angina
1	Mild angina that goes away when you slow down or rest.
2	Slightly worse than grade 1; it also goes away with rest and / or nitroglycerin.
3	Worse than grade 2; it may spread to the neck, jaw, back, shoulders, or arms. You may be short of breath.
4	The worst angina you have ever had.

If you have grade 3 or 4 angina:

- STOP what you are doing
- Take nitroglycerin (if prescribed)

If your angina is not relieved in 5 minutes, CALL 911.



COPD

- Pneumococcal and Influenza Vaccines
- Spirometry – post bronchodilator FEV1
- Inhaler Technique
- Pulmonary Rehabilitation
- Evaluation for Oxygen
- Treatment Goals with bronchodilators
- Smoking Cessation
- BMI
- Mental health and support
- Co-morbid: Sleep Apnea / Heart
- Steroids

COPD Assessment

- COPD Assessment Test – “CAT”

Heart Failure

- Baseline Ejection Fraction with 2D Echo
- NYHA classification
- Diastolic vs Systolic
- Symptom Prevention
- Comorbid – COPD, etc
- Optimize Drug Therapy with Target Doses
- Self Management Skills – Daily weights – 3 lb
- Immunizations

Diabetes

- Meal Planning – Identify
- Insulin Injection Technique
- Insulin needle or pen needle selection
- Dose optimization of insulin
- Restart medications held during hospitalization
- Immunizations
- Mental Health Screening
- Education and Self Management Support

<http://www.youtube.com/user/ACPFoundation>

- Inhaler Use
- Insulin Injections
- Pain – fentanyl patch

Quality Based Payment

- Federal, state and private payers as well as providers are changing the landscape of health care in terms of value or quality, rather than strictly cost
- Fee For Service or volume based reimbursement is NOT in vogue
- The National Quality Foundation now has over 700 plus measures

Community Pharmacy

Walgreens

- Part of 3 ACOs
- **Walgreens WellTransitions[®] program**
- **Medication alignment and prescription therapy planning.**

Our clinicians review existing prescriptions with new prescriptions issued in the hospital, to recommend proper alignment. This process is essential to patient safety, helps adherence and satisfaction, and reduces potential errors.

Walgreens

- **Bedside medication delivery.**
Upon discharge, we ensure patients receive their prescriptions, establishing an accurate start to medication therapy.
- **Patient counseling and clinical follow-up.**
We extend care by following up with primary care providers, counseling patients on medication regimen, and increasing patients' connection with the extended care team immediately after discharge

Walgreens

- **Bridge to the community.**
We contact the patient 9 days after discharge, and again at 25 days, to reinforce patient understanding, promote adherence, offer disease-specific consultation, encourage contact with physicians, and assess satisfaction.
- **Joint outcomes reporting.**
Walgreens works with you to produce monthly joint outcome reports to assess program effectiveness, in terms of both cost and readmission reductions, which impacts HCAHPS scores.

Walgreens: Goals of WellTransitions

- WellTransitions provides access, reach and resources.
 - Walgreens collaborates with your health system to help you achieve critical goals:
 - **Reduce** the number of preventable hospital admissions.
 - **Reinforce** your HCAHPS scores and Joint Commission accreditation through increased patient satisfaction.
 - **Raise** health awareness and optimize the community healthcare support system to improve patient outcomes.
- WellTransitions leverages a range of Walgreens resources and services to your advantage:
- - Convenient locations close to your health system and patients
 - - Simplified access to specialty pharmacy medications

Community Pharmacies

- 1. Consider Contracting with a CPCI site or a PCMH to provide consultative services
- 2. Consider a workflow to identify patients presenting to the pharmacy from a recent ER visit or Hospitalization
 - Train Staff
 - Train your Patients – Phone menus, website, drop off
- 3. Work with pharmacy software vendors to allow active or inactive medications with the click of a button to assist with reconciling medication lists at the community pharmacy

Community Pharmacies

- 4. Provide Opportunities for Self Management Education – Videos , Wi-Fi access, Handouts, and patient counseling from the pharmacist / disease educator
- 5. Pneumococcal, Influenza and Herpes Zoster Immunizations – Population Based, Transition of Care, and Point of Care
- 6. Adherence – Refill synchronization with processes to identify transitions of care changes

Community Pharmacies

- 7. Advocate for additional MTM billing code opportunities after transitions of care from hospitalizations.
- 8. Consider Secure Messaging and the Arkansas state health information exchange SHARE for access to patient Virtual Health Records with Admit-Discharge-Transfer documents

