CARE TRANSITIONS PRACTICE PEARLS: FROM MEDS TO BEDS TO HOMES

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Objectives

- Define transitions of care
- Discuss common best practice models within care transitions
- Identify opportunities to incorporate stakeholders into care transitions
- Review care transitions initiatives at SBMC
- Identify care transitions related barriers and resolution methods

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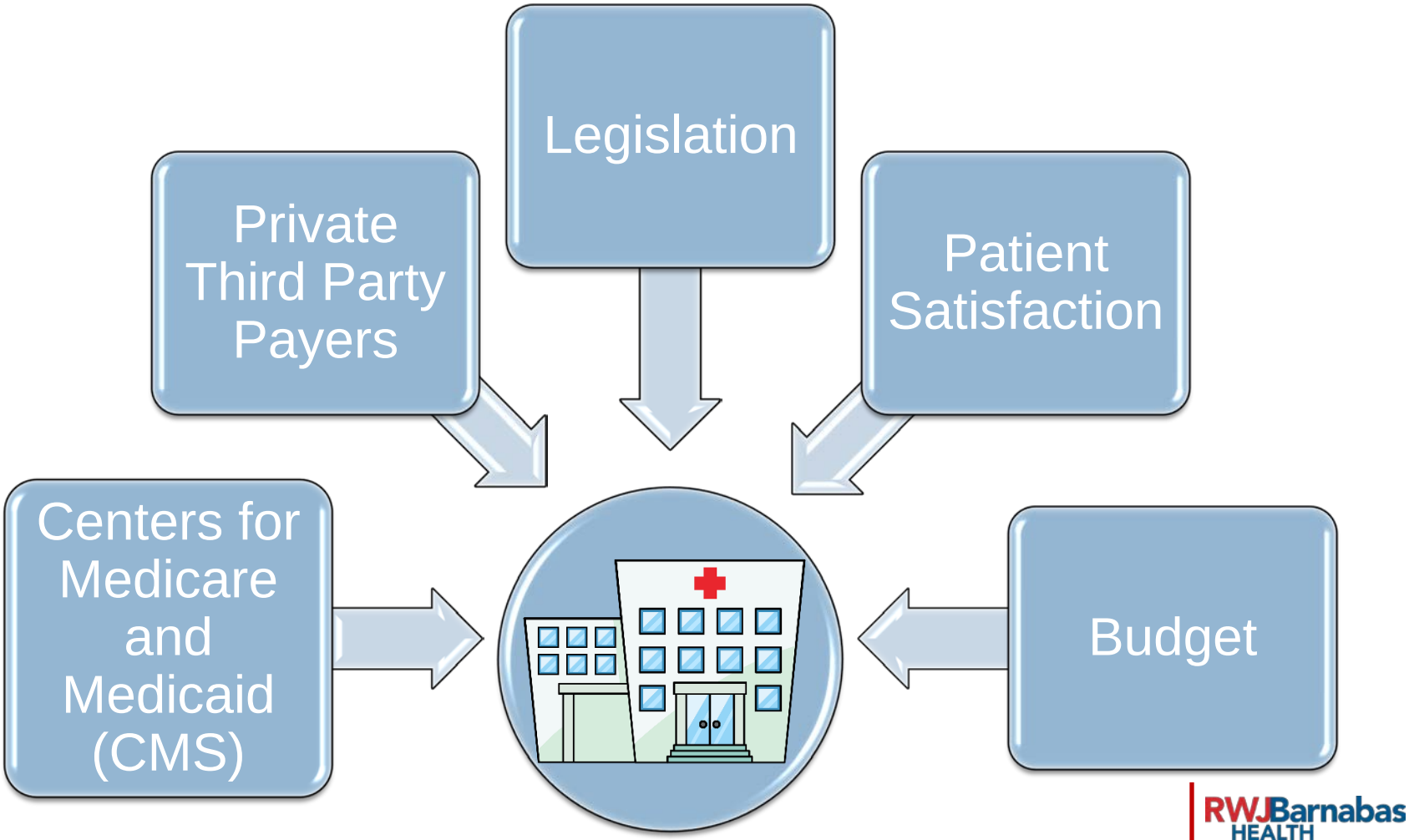
Care Transitions

Healthcare Reform



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Transitions of Care (TOC)

Defined as the movement of a patient from one healthcare provider or setting to another

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Hot Topics in Health Care. Transitions of Care: The need for a more effective approach to continuing patient care. Retrieved February 20, 2016

Transitions of Care Models

- Transitional Care Model
  - Led by nurse
  - 8-week follow-up
- Care Transitions Intervention®
  - Transitions Coach®
  - 4-week follow-up
- Project Re-Engineered Discharge (Project RED)
  - Nurse discharge advocate
  - Clinical pharmacist follow-up call

Ann Intern Med. 1994;120:999- 1006
Arch Intern Med. 2006;166:1822-8
Ann Intern Med. 2009;150:178-87

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Transitions of Care Models

- No single discipline, intervention, or model is considered “best practice” in care transitions
- Multidisciplinary TOC programs are recommended
  - In 2011, of 537 hospitals surveyed
    - 56.5% of hospitals had a multidisciplinary team to manage patients at high-risk for readmission
    - 65.5% of hospitals included pharmacists in measures to improve heart failure readmission rates

Cleveland Clinic Journal of Medicine. 2014; 81(5):312-320
J Am Coll Cardio. 2012; 60(7):607-614

Stakeholders

Hospital-based

- Physicians
- Nursing staff
- Social work
- Case management
- Palliative care
- Hospice
- ***Pharmacy services***

Community-based

- Primary care providers
- Specialists
- Surgical supply stores
- Visiting nurse services
- Skilled nursing facilities
- Physical therapy
- Caregivers
- ***Community pharmacies***

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Pharmacy Roles

Pharmacy Roles

Who can help?

- Pharmacists
- Pharmacist extenders
  - Residents
  - Students
  - Interns

How can they help?

- Medication reconciliation
- Patient counseling
- Follow-up phone calls
- Home visits
- Physician offices

Pharmacy Roles

Who can help?

- Technicians

How can they help?

- Medication reconciliation
- Prescription acquisition process
  - Insurance verification
  - Bedside delivery
- Coordinating follow-up care
- Medication therapy management

ASHP-APHA Medication Management in Care Transitions Best Practices
Malacos, K. (2016, May 18). Pharmacy Technicians in Transitions of Care.

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TOC at SBMC

Our Institution

- Saint Barnabas Medical Center, Livingston, NJ
- 600-bed community teaching hospital
- Part of RWJBarnabas Health, the largest health care system in NJ
- Community (“retail”) pharmacy
  - Barnabas Health Retail Pharmacy
    - 6 locations

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Our TOC Services

- Transitions of Care Program
  - Advanced Practice Nurse (APN) & Pharmacist
- Discharge advocate
  - Pharmacy technician from BHRP
- Medication reconciliation technicians in ED
- Patient counseling to high-risk patients
  - LACE tool
  - Medication questions

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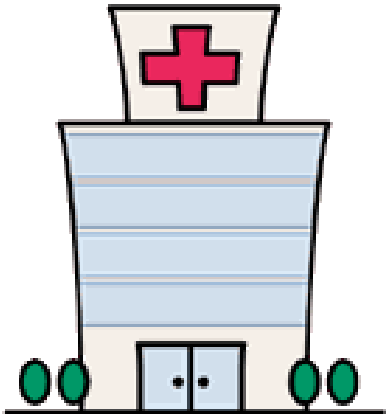
Inpatient TOC Program



Inpatient TOC Program

- Model
  - Hybrid of the Coleman Model® and the Transitional Care Model
- Team members
  - APN and pharmacist
- Collaborations
  - Social work and case management
  - Palliative care and hospice services
  - Community (retail) pharmacy
  - Local sub-acute rehabilitation facilities
  - Local surgical supply stores
  - Pulmonologists

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Patient Population

- Chronic obstructive pulmonary disease (COPD) and pneumonia
  - Heart failure, acute myocardial infarction, and stroke upon referral
- Focus on Medicare and uninsured
- High-risk identified by LACE tool

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Exclusion Criteria

- Discharged to a skilled nursing facility (SNF), nursing home, or assisted-living facility
- Discharged with hospice services
- Language other than English and without a caregiver
- Advanced dementia and without a caregiver
- Patient refuses

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Patient Follow-up

- Initial meeting during inpatient admission
  - TOC APN educates patient on disease-state and conducts physical assessment
  - TOC pharmacist reconciles home medications and counsels patient on current therapy
- Discharge phone calls
  - 1-2 days after discharge then days 7, 14, 21, and 28

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Patient Follow-up

- Home visit or clinic visit
  - 1-2 weeks after discharge
  - TOC APN performs physical assessment
  - TOC pharmacist reconciles medications in the home and provides patient with updated medication list
- Day 31…
  - Patients can reach out to us if they have questions or concerns

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Measurements and Goals

- Pharmacy measurements
  - Patients seen
  - Medication reconciliation sessions performed
  - Medication errors identified
  - Home visits attended
- Goals
  - Reduction in Medicare 30-day readmission rates

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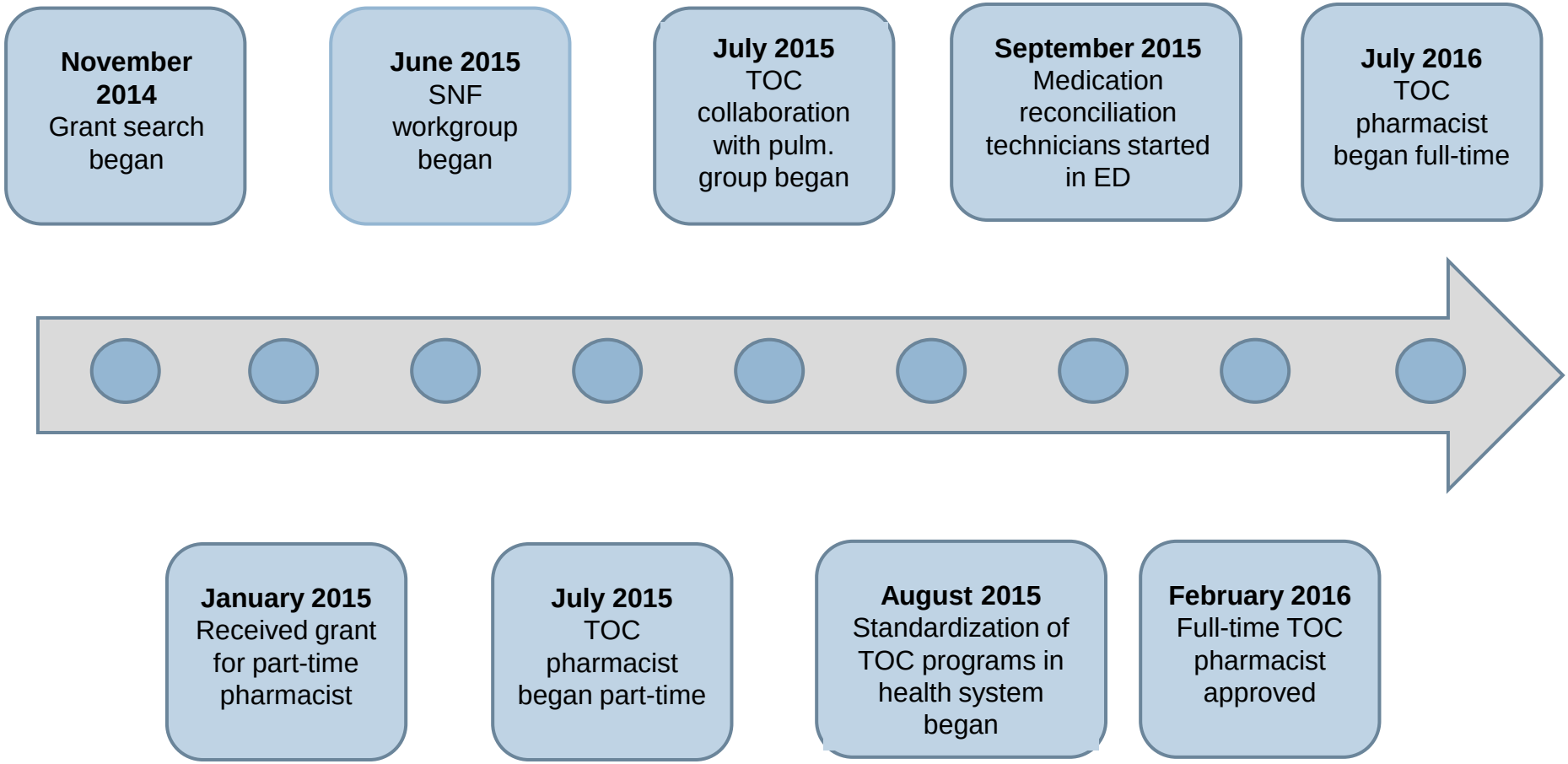
Program Development



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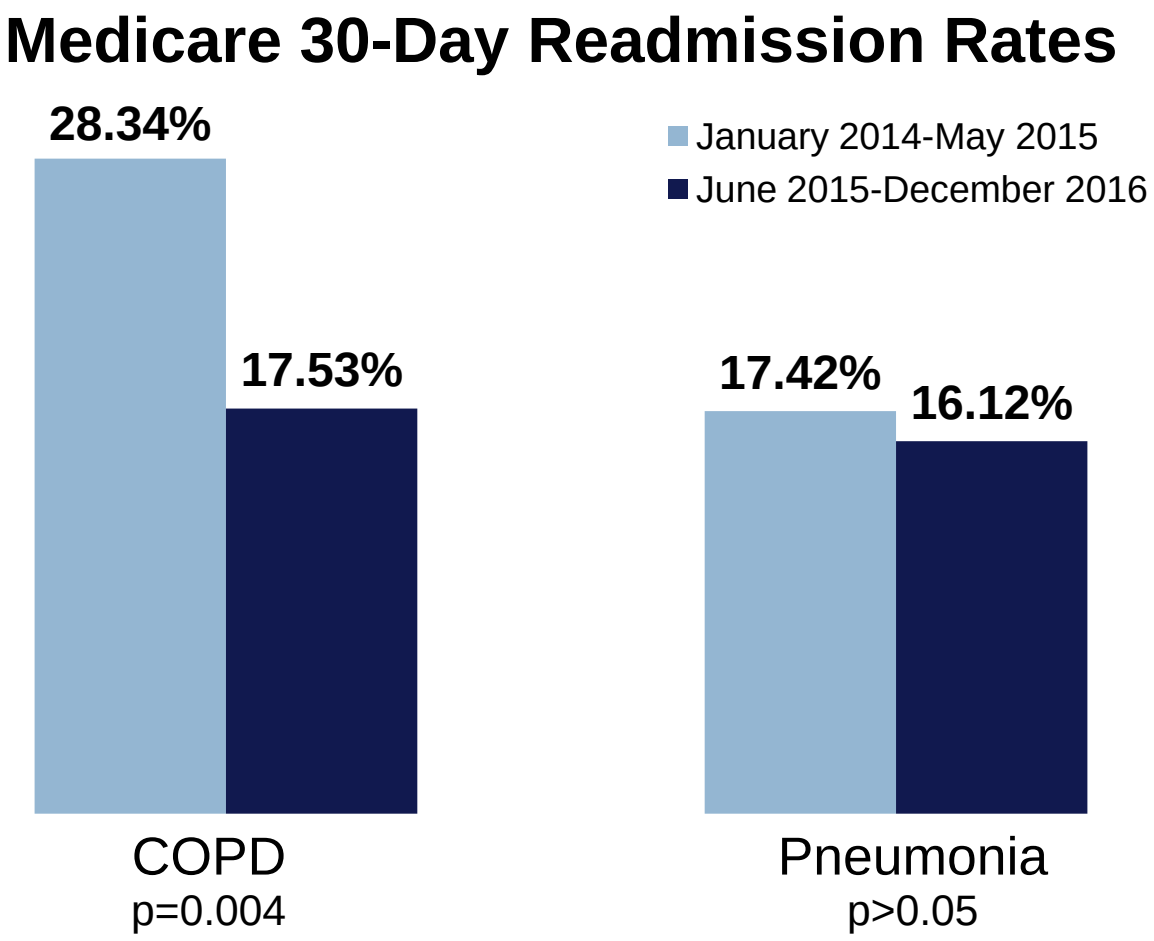
Results



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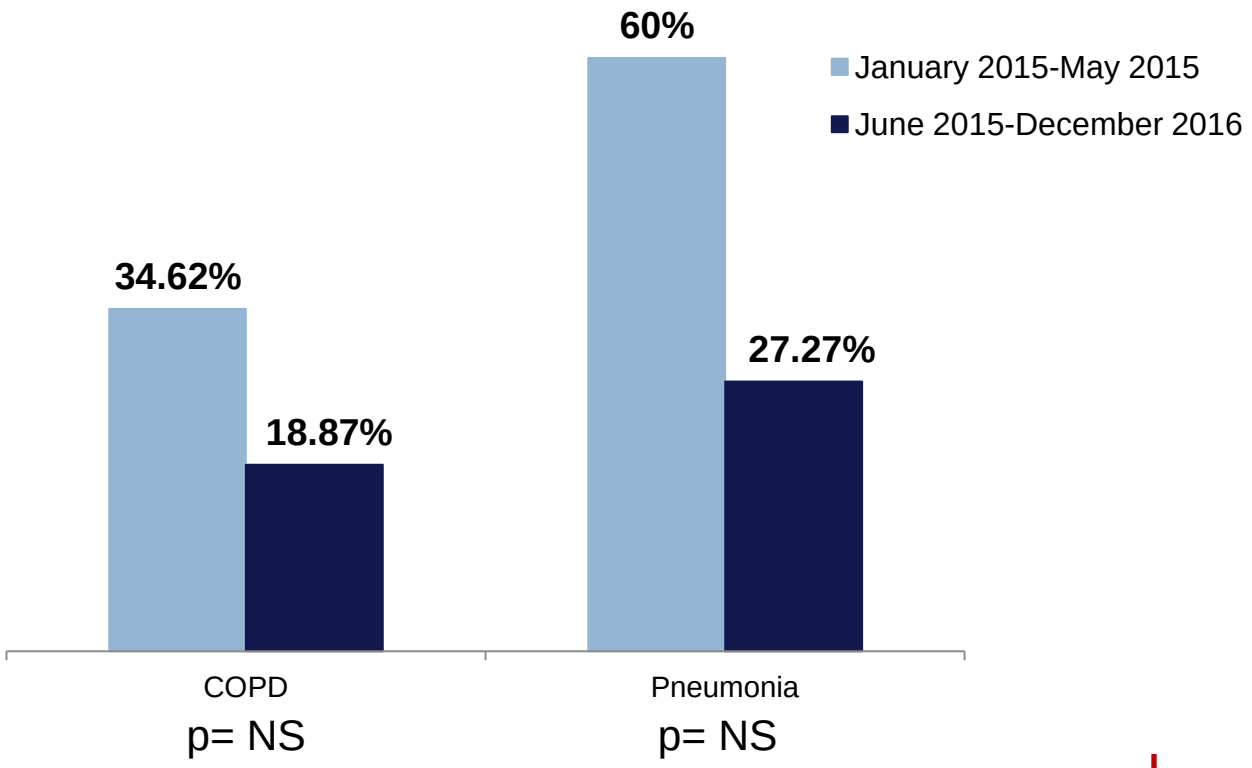
Results

Medicare 30-Day Readmission Rates from SNF Facilities



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Outpatient TOC Program

Community Pharmacy Role

- Facilitate medications to patients
- Ensure patient understanding of medication use
- Improve adherence
  - Cost
  - Adverse events
  - Medication value (risk versus benefit)
- Reduce preventable readmissions and help facilitate care to PCP and community pharmacy
- Improve health outcomes

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Bridging the Gap

- Discharge Advocate
  - Awareness to staff
  - Meds to bed
  - Copay assistance and drug coverage
  - Potential high risk patients
- Clinical Pharmacist
  - Program development, immunizations, patient education, Medication Therapy Management
- Pharmacy Residents

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Value of Services

- Convenience
- Ensure patients have their medication(s)
- Provide support
  - Specialty medications and quantities
  - Hospital
  - Employees
  - Surrounding clinics and facilities

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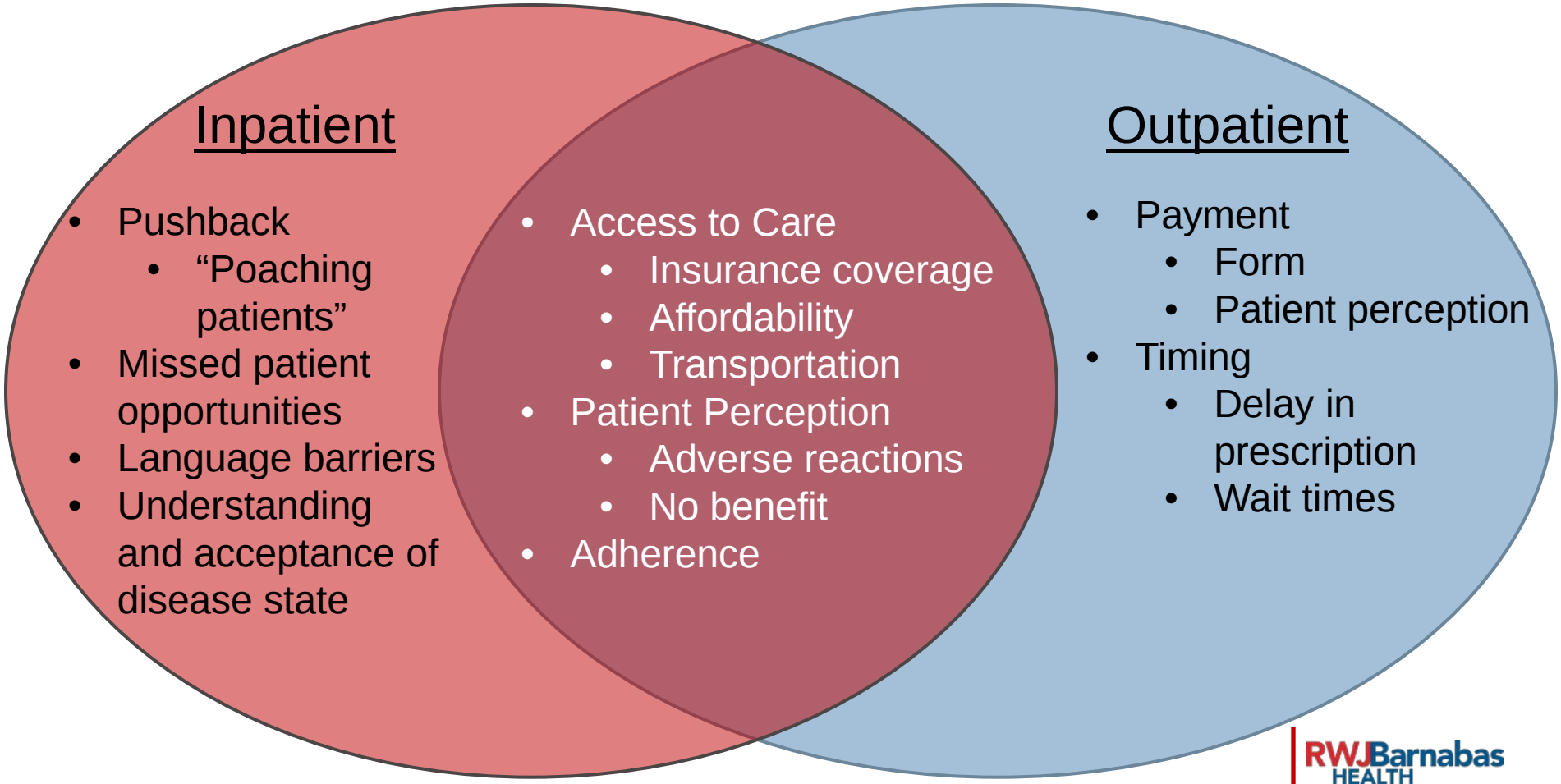
Roadblocks

Obstacles



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Future Opportunities

- Discharge counseling to ensure continuity of care
- Collaboration with inpatient pharmacy
- Follow-up phone calls
  - High risk patients
  - Frequent/chronic readmissions
- Employee-based medication review and assessment

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Summary

- No single discipline, intervention, or model is considered “best practice” in care transitions
- All levels of pharmacy staff can play a role in Transitions of Care
- Anticipating and addressing potential obstacles may simplify program implementation and improve outcomes

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