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
Care Transitions
Healthcare Reform

- Legislation
- Private Third Party Payers
- Patient Satisfaction
- Centers for Medicare and Medicaid (CMS)
- Budget
Transitions of Care (TOC)

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

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

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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
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
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
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
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
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
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
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
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
Program Development

November 2014
Grant search began

June 2015
SNF workgroup began

July 2015
TOC collaboration with pulm. group began

September 2015
Medication reconciliation technicians started in ED

July 2016
TOC pharmacist began full-time

January 2015
Received grant for part-time pharmacist

July 2015
TOC pharmacist began part-time

August 2015
Standardization of TOC programs in health system began

February 2016
Full-time TOC pharmacist approved
Results

Medicare 30-Day Readmission Rates

COPD
- January 2014-May 2015: 28.34%
- June 2015-December 2016: 17.53%
p = 0.004

Pneumonia
- January 2014-May 2015: 17.42%
- June 2015-December 2016: 16.12%
p > 0.05
Results

Medicare 30-Day Readmission Rates from SNF Facilities

- COPD: 18.87% (p= NS)
- Pneumonia: 27.27% (p= NS)

- January 2015-May 2015: 34.62%
- June 2015-December 2016: 60%
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
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
Value of Services

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

**Inpatient**
- Pushback
  - “Poaching patients”
- Missed patient opportunities
- Language barriers
- Understanding and acceptance of disease state

**Outpatient**
- Access to Care
  - Insurance coverage
  - Affordability
  - Transportation
- Patient Perception
  - Adverse reactions
  - No benefit
  - Adherence
- Payment
  - Form
  - Patient perception
- Timing
  - Delay in prescription
  - Wait times
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
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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