



Coordination & Continuity Required

Bridging gaps as patients move from hospital to home

by Kevin C. Day, PharmD

Part of the Patient Protection and Affordable Care Act (PPACA, typically referred to as “ObamaCare”) established the Hospital Readmission Reduction Program (HRRP) to help address the alarmingly high number of patients who are readmitted to the hospital in the first 30 days after discharge. Historically, around 20 percent of all patients discharged from the hospital are readmitted within 30 days. Not only do these patients suffer negative clinical outcomes when readmitted, they undergo additional, undue stress from the process. And patients are not alone, as this the stress also affects families and caregivers.

In the past, hospitals had what worked out to be an incentive for patients to return to the hospital. They maximized their revenues by filling all of their beds and billing for services. Doing so with patients who were recently discharged is, in some cases, actually easier, as charts are already prepared and the hospital staff is familiar with the patients’ histories. The HRRP is designed to not only remove this incentive, but add a disincentive for a hospital’s patients returning in this 30-day window. The program penalizes hospitals that have readmission ratios for certain disease states that are higher than a national threshold.

Editor’s Note: This article launches a full NCPA Transitions of Care Toolkit available to members online at www.ncpanet.org/TOC.

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The program launched in 2012 with a 1 percent maximum penalty. The maximum penalty has grown each year to a current 3 percent for hospitals that have dramatically worse readmission ratios compared to the threshold. This penalty is a percentage reduction off the entire Medicare reimbursement for the hospital, not just off those patients who are readmitted. The Centers for Medicare and Medicaid Services (CMS) estimates the fiscal year 2015 penalties total \$428 million among the 2,500 hospitals being penalized. This averages out to approximately \$175,000 per hospital, per year in readmission penalties.

Community pharmacies are in a position to work with hospitals to keep patients who have been recently hospitalized from being readmitted, in the process improving care for the patients, reducing long-term financial penalties for the hospital, and increasing business for the pharmacy—a win-win-win.

UNDERSTANDING THE HOSPITAL'S POSITION

When the readmission reduction program was announced, hospitals across the country took notice. There was an observable drop in 30-day readmissions even before the penalties took effect, at least in those disease states initially announced as the targets of the program. In 2012, there were three disease states targeted: acute myocardial infarction (AMI), heart failure (HF), and pneumonia (PN). For 2016, there are five disease states that hospitals' penalties are based on, as chronic obstructive pul-

monary disease (COPD) and elective total hip or knee arthroplasty (THA/TKA) were added in 2015. In 2017, patients admitted for coronary artery bypass graft (CABG) surgery and additional pneumonia patients—sepsis patients with pneumonia coded on admission and patients with aspiration pneumonia—will also be included in the evaluation of hospitals. (*America's Pharmacist* will publish an article on each of these disease states over the next six months.)

Hospitals are being compared to an average of similar hospitals across the country, which both lends itself toward continuous improvement, yet also creates frustration as hospitals could improve significantly year after year, yet see an increase in the penalty assessed against them. Hospitals still face the challenge of maximizing their revenue while minimizing costs as their margins continue to narrow. Certainly, they want to provide the best care possible for their patients, but the cost of care can sometimes be unsustainable, especially for smaller hospitals and health systems. A program that targets readmissions must be cost-effective and preferably cost-saving, including the readmission penalty. Unfortunately, since the goals are moving with the national average, it is hard to know if a program will actually end up saving on penalties.

There is also the issue that—although many hospitals are bursting at the seams—not all have a waiting list of patients to be admitted. If an effective transitions of care program reduces readmissions by half, a hospital may

lose a substantial part of its expected census, which also reflects back on their total revenue. The business side of hospital administration is certainly complex, but hospitals across the country are investing in methods to reduce readmissions; the growing CMS penalty is certainly pushing that along. As the payment mechanisms for hospitals evolve over the coming years, new variables may be introduced that either increase or reduce a hospital's motivation to reduce readmissions, improve prevention of primary hospitalizations, and contribute to the decrease of the overall cost of care. Using the momentum currently in the marketplace, community pharmacies can position themselves as invaluable allies for health systems looking for inexpensive, effective ways to reduce readmissions.

HOW COMMUNITY PHARMACIES CAN HELP

Already, there is a substantial amount of research that has been published about pharmacists in different settings impacting a hospital's readmission rate for specific disease states and in global readmission measurements. Much of it stems from pharmacists (or so-called 'pharmacist-extendors', including pharmacy students and technicians) being involved in the medication reconciliation processes throughout a hospital. Whether on admission, during transfer from one unit to another, or at discharge, numerous studies have shown that pharmacy's role in medication reconciliation dramatically increases the accuracy of the reconciliation and therefore reduces problems down the line.

For example, if a family member or paramedic grabs a basket of medication bottles from a patient's counter, the admission medication reconciliation will most likely be limited to the medications in the basket. If the patient had insulin in the refrigerator, it would not make the basket or the

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initial medication list. This omission, if not caught, can easily lead to a dangerous hypoglycemic situation after discharge if a prescriber adds additional antidiabetic agents to the patient's discharge instructions without accounting for the insulin.

The use of a pharmacist and an emphasis on confirming the accuracy on all medication reconciliations may catch such an omission long before it causes patient harm. Accurate

and effective medication reconciliation is certainly a cornerstone of the transitions of care process, but there are other issues which commonly lead to readmissions that must also be addressed. Medication reconciliation improves discharge accuracy and ideally prevents discrepancies that lead to medication use errors, but it has not been shown to dramatically impact outcomes by itself. Other issues that must be included in a collaborative discharge include the

patient's understanding of discharge instructions, the patient's access to medication at discharge, and the patient's completion of follow-up care. Community pharmacists have the education to understand and explain discharge instructions, can ensure access to discharge medications and can facilitate follow-up, especially when medication adherence or managing adverse effects are a priority.

IMPROVING MEDICATION RECONCILIATION

Even with the research showing pharmacy's positive impact on medication reconciliation, many hospitals have still not implemented this service upon admission or discharge. Community pharmacists may be able to improve these reconciliations, even



if the time-table for their completion has to be changed. It is unlikely a community pharmacist can assist with medication reconciliations upon admission into an ER in real time, but they may be able to double-check such a reconciliation within 48 hours of admission and still provide improved records. If the admitted patient is also a patient of the community pharmacy, having access to the patient's full pharmacy record may improve the accuracy of the admission medication list. As pharmacy systems and provider EHRs continue to share increasing amounts of data, all parties will have more complete information about a patient's medication history. Regardless of the wealth of information available, patient-centered medication reconciliation is still critical to accurate information as patients often do not take medications as they are prescribed and may take additional

over-the-counter medications and supplements that will not likely be recorded in the available system. Employing or contracting a pharmacist for discharge medication reconciliation, especially in advance of discharge, can improve the patient's discharge processes by comparing admission and discharge medication lists and clarifying duplicates, dosage changes, and discontinued medications. When the reconciling pharmacist practices in a community pharmacy, there is an opportunity to address potential access issues before discharge, thus eliminating times when patients are unable to get their new medications. Finally, utilizing a community pharmacist in the medication reconciliation process improves their awareness of the patient's condition and improves the quality of the pharmacy record, thereby reducing questions and confusion down the line.

IMPROVING PATIENT EDUCATION

As we know from numerous studies, any variety of interventions may be made to improve adherence and outcomes, but very few interventions are effective if they fail to improve patients' understanding of the situation and help them to engage in their own care. Education about new disease states, medications, and treatment plans can be overwhelming for patients and caregivers, especially toward the end of a long hospital stay. However, without solid patient understanding, there is only a small likelihood of improved outcomes (in this case, reduced readmissions). Community pharmacists can leverage their existing relationships and skills at quickly building rapport with these patients to provide discharge educa-

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tion in a way that very few members of the hospital team can emulate. Any existing awareness of the patient's housing status, their family or caregivers, their attitudes or beliefs about medications, and their overall health can help a pharmacist cater education to the patient's specific situation, instead of educating uniformly for all patients with a similar disease. Education can be particularly effective if it starts in the hospital by a community pharmacist—this lends credibility as the patient can trust that the pharmacist and the hospital team are on the same page—and continues post-dis-

charge in the familiar pharmacy space or even in the patient's home. Again, the relationship of the community pharmacist and the availability to offer both pre- and post-discharge education face-to-face on a longitudinal basis makes the community pharmacist an ideal candidate to carry out this service.

IMPROVING PATIENT'S ACCESS TO MEDICATION

Too often, a patient is discharged on a busy Friday afternoon with a stack of discharge orders and prescriptions and an intense desire to go home. This leads to patients who neglect to pick-up their discharge medications. In

one study, only 40 percent of patients reported filling their prescriptions on the day of discharge and another 40 percent waited at least nine days, with 22 percent not picking up new prescriptions in the first 10 days after discharge. Even for those who go to the pharmacy, prescriptions sent electronically may not be ready, they might require prior authorization, they may require a call for a clarification, or they might not be in stock and require a special order for dispensing.

Even if all of these issues are avoided, there are patients who may not be able to afford their new medications. These issues can all be resolved by incorporating a community pharmacist in the discharge plan and working to improve the discharge processes. Knowing a few days ahead of discharge what medications will be prescribed allows the pharmacist to check for and resolve insurance issues, clarify any prescriptions to

be sure the patient instructions for use are accurate, get the medication in stock, verify the patient is able to afford the medications, and even fill them for bedside delivery at discharge so the patient has them in hand when he is going home. Reducing this barrier for patients' compliance to discharge orders is a huge assist in terms of reducing readmissions.

IMPROVING FOLLOW-UP CARE

Included with a patient's discharge orders are almost always instructions to follow-up with primary care physicians and/or certain specialists. Research shows these follow-up visits often are missed and, even when the patient schedules and makes the appointment, are less impactful than they could be because the physician does not have an accurate report from the hospitalization. Community pharmacists

can improve this process by bridging the patient from the hospital to their outpatient physicians. This includes both education about and assistance in making follow-up appointments in a timely manner and sending the provider an easy-to-use outline of the hospitalization, current medications, and what is expected for the patient's continuing care.

CHALLENGES AND SOLUTIONS

Setting up a transitions of care program can be a win for patient care, a win for hospitals, and a win for community pharmacies, but that does not mean it is going to be a seamless process. For most pharmacies, the first challenge will be entering the discussion with the hospital you hope to partner with to reduce readmissions. Scheduling the meeting with the right person and preparing your pitch in a compelling fashion are both variables

that may seem daunting. Luckily, pharmacists have had success with a variety of types of hospital administrators and with a variety of proposals. Just like in any business deal, it is important to work with someone you trust and are able to communicate with easily. Often, the best person to approach is the director of pharmacy. This person's experience with pharmacy and what pharmacists are capable of can make him or her a valuable ally. Depending on the hospital, other personnel may be the key person to push for incorporation of your program. These personnel may include nursing staff or administrators, social workers, discharge planners, and a hospital's chief financial officer. If the program you are looking to propose focuses on a specific disease state or diagnosis, such as heart failure, it can

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be valuable to have the head of the department, in this case cardiology, be on board from the start and help champion your program.

The proposal that you bring to the hospital, more than anything, must be malleable. Unless you have a vast understanding of the inner-workings of the hospital you are meeting with, you need to be willing to adjust your goals and program design to meet their needs. For a program like this to be successful, it must be truly collaborative with both sides being willing to pitch in for success. Once the program is ready to take off, the next challenge is implementation and, in particular, patient adoption. Regardless of the methods you are planning to use to recruit patients, you are running a brand-new system that may require patients to voluntarily opt-in—this creates a challenge. Having the entire team on board before the program launches is critical to improve patient opt-in rates, but it is likely that it is going to take time for the team to find and consistently use the right message when proposing the program. There may be styles of a program that encompass all patients from a certain unit, with a certain disease state, or that are referred by a prescriber, but most of the programs that have studied community pharmacies' impact on transitions of care utilize an opt-in model. Along with potentially changing the way patients are enrolled in the program, as the program develops it may be likely that the communication methods which were discussed in planning will run into some hitches. Again, all of this reinforces that the agreement needs to be collaborative and allows for growth in a variety of situations. To help you get started, NCPA has launched a Transitions of Care Toolkit which includes concept documents, sample contract language, information for

In a Patient's Shoes

Imagine you are experiencing a hospitalization spanning eight days, including a weekend. It is the eighth day, a Friday, and the hospital team has been saying since Tuesday that you should be discharged on Friday. You awake Friday morning feeling energized and ready to get home to your pets, your family, and normal life. After waiting all day and being educated several times on a huge variety of information from reducing salt in your diet and walking more, to taking four new medications once or three times a day, to weighing yourself every morning—something you haven't done since your first child was born—you are finally wheeled down and out of the hospital. It is now after 6 p.m. and you want to get home for dinner. You go home, eat, and visit with family, then rest, forgetting that a week in the hospital is exhausting. You wake up on Saturday realizing you were supposed to take new medications that you did not go to the pharmacy to pick up the night before. You are able to get a ride there and drop off the prescriptions, only to find out that the discharge physician incorrectly wrote one prescription and another needs a prior authorization from the insurance company before it can be filled. By the time these two issues are resolved and you get the medications—let's say Wednesday—it has been almost an entire week since you left the hospital and you have forgotten the discharge instructions. You try to figure it out but, to be safe, you only start one of the new medications and start back on the other medications you were on before you went to the hospital.

accessing hospital data, technology and financials articles, additional education articles, and testimonials from pharmacy owners who have successfully implemented transitions of care programs in their stores. Additional information about how to implement transitions of care into your pharmacy will be offered at the 2016 NCPA Annual Convention Oct. 15-19 in New Orleans (www.ncpanet.org/convention). Be sure to register today!

ADDITIONAL TRANSITIONS, ADDITIONAL OPPORTUNITIES

Although hospital to home transitions are those studied, written, and talked about most frequently, transitions between other levels of care, including hospital to long-term care facility, long-term care to home, and home to hospital, often come with similar medication discrepancies, miscommunication, and patients who have a less than perfect understanding of the situation. The IMPACT Act, which goes into effect in October 2016, will, over time, add similar Medicare penalties to long-term care facilities as described above for hospitals. These penalties will again offer an opportu-

nity for community pharmacists, especially hybrid retail-LTC shops, to collaborate with health systems and improve the care of patients. As health care systems continue to consolidate and become more intertwined through the growth of accountable care organizations (ACOs), patient-centered medical homes (PCMHs), and other innovative models, there are a variety of spaces where community pharmacies by themselves and in networks can work to play a critical role in the improvement of health for patients and populations. Bridging gaps in transitions of care is a great place for pharmacists to show their value, become an integrated part of the team, and transform their profession into that of true health care providers. ■

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***Editor's Note:** For information on reference material used in this article, contact America's Pharmacist Managing Editor Chris Linville at 703-838-2680 or chris.linville@ncpanet.org*