Medication Management to Avoid Readmissions

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Health Care and the Economy: International Perspective

Health Expenditure as a Share of GDP, OECD Countries, 2008

System of CARE Value in the Post-Reform Era

*Expect to take on more financial risk and to be held accountable, clinically and economically, for what happens across the continuum of care—whether we ‘own’ the continuum or not.*

---Michael Sachs, Chairman and CEO, Sg2

IP = inpatient; SNF = skilled nursing facility; OP = outpatient
Causes of Readmission Differ by 7, 14 and 30 Days Postdischarge

<table>
<thead>
<tr>
<th>7 Days</th>
<th>14 Days</th>
<th>30 Days</th>
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<tbody>
<tr>
<td>• Incomplete medical management</td>
<td>• Medication problems</td>
<td>• Patient noncompliance</td>
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<tr>
<td>• Wrong site of post-acute care</td>
<td>• Socio-economic factors</td>
<td>• Disease trajectory</td>
</tr>
<tr>
<td></td>
<td>• Physician follow-up</td>
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Transitions of Care: The critical elements of success Naylor found include:

- A comprehensive assessment of an individual’s health goals and preferences, physical, emotional, cognitive and functional capacities and needs, and social and environmental considerations;
- Implementation of an evidence-based plan of transitional care;
- Care that is initiated at hospital admission, but extends beyond discharge through home and telephone visits;
- Mechanisms to gather and appropriately share information across sites of care;
- Engagement of patients and family caregivers in planning and executing the plan of care; and
- Coordinated services during and following the hospitalization by a healthcare professional with special preparation in the care of chronically ill people, often a master’s prepared nurse.

According to Naylor, the Transition of Care Model “results show that properly designed and executed transitional care improves quality outcomes and achieves cost savings.”


Financial Impact

Unplanned readmissions (all cause) cost Medicare $17.4 billion in 2004, with 20% of the Medicare fee-for-service patients readmitted within 30 days of discharge.
CMS Levies Readmission Penalties on More Than 2,000 Hospital Facilities

Medicare last month began levying financial penalties against hospitals that do not meet certain standards for readmissions, Kaiser Health News/New York Times reports.

A total of 2,217 hospitals have been penalized, with 307 facing the maximum punishment of a 1% reduction in Medicare payments over the next year.

About 20% of Medicare beneficiaries are readmitted to the hospital within one month of their original visit, costing the federal government about $17 billion annually (Rau, Kaiser Health News/New York Times, 11/26).

A misunderstanding or misuse of medication often results in hospital readmissions, according to the Times’ “The New Old Age.” According to a survey published in the Journal of General Internal Medicine, 81% of older patients discharged from the hospital:
- Do not understand what their prescriptions are for;
- Were prescribed the wrong dosage or drug;
- Were taken off of a medication they needed; or
- Never filled a new prescription.


Readmissions Effort Central to ACA Goal

The effort to curb readmissions is central to the Affordable Care Act’s goal of eliminating unnecessary care and reducing Medicare spending, which reached $556 billion in 2012.

Hospital inpatient costs make up about 25% of those costs, and they are expected to grow by 4% annually, according to the Congressional Budget Office.

CMS will recoup about $300 million from the penalties this year. The maximum penalty will increase to 2% in October 2013 and 3% in October 2015. In addition, CMS will consider more types of conditions when assessing readmissions in the future – the agency currently only evaluates readmissions for heart attack, heart failure and pneumonia patients.

Hospitals Make Efforts To Reduce Readmissions

Hospitals have begun making more concerted efforts to prevent readmissions, according to KHN/Times. To do so, hospitals are focusing on follow-up care by offering:
- Home visits from nurses;
- Transportation services;
- Culturally specific diet tips;
- Free medications; and
- Bathroom scales.

While most hospitals have attempted to reduce the number of readmissions, some are suspected of cutting patient stays to fewer than 24 hours to avoid billing for a hospital admission (Kaiser Health News/New York Times, 11/26).

Strategies for Transition of Care Innovations

- Reducing the time for dictations, editing and signing of discharge summaries
  * Use of EMR and completion of discharge summary prior to discharge
  * More stringent criteria of medical staff suspension of privileges
  * Med staff charging physicians, loss of parking, etc for delinquent medical records. Housestaff proposed for probation, loss of vacation days, etc
  * Hospital Medicine groups requiring discharge summaries to completed at the time of discharge in order to enhance communication with the follow-up physician
  * Involving GME and Program Directors in the process with policies and enforcement guidelines has reduced delinquencies by 90% at one institution, Key is to get stakeholders on the same page.

- Follow-up appointments
  * Post-hospital follow-up clinics
  * Appointments made at the time of discharge
Strategies for Transition of Care Innovations

Care Transition Coaching – Reduces Readmissions for the Elderly

4 coaching-based approaches to coordinating care across healthcare settings from Oxford Health and the impact that these programs are having on healthcare utilization:

1. Transition coach program for Medicare beneficiaries that includes patient education and empowerment, health record creation, medication management, communication with physicians, and home visits and follow-up;
2. Advanced illness and coordinated care program for seriously ill patients who do not yet meet hospice criteria but require assistance with medical symptom management as it impacts end-of-life comfort care and proactive decisions about end-of-life healthcare services;
3. Health coaching and pharmacy outreach for Medicare members designed to break down barriers to medication adherence — drug and food interactions, functional issues and socioeconomic factors; and
4. Options for Living self-management classes for Medicare members living with diabetes, lung conditions and chronic pain.

Focuses on Care Team Centered Approach to:
A. Identify the high-risk population
B. Develop a Care Plan
C. Provide ongoing health maintenance and acute problem management

Strategies for Transition of Care Innovations

CMS (Medicare) Community-Based Care Transitions Program

"Today’s Carrot May Be Tomorrow’s Stick"

- Based on the success of demos at 14 test sites, $500 million in funds are earmarked for CCTP through the Affordable Care Act to support care-transitions projects by community-based organizations partnering with hospitals and by eligible hospitals with community-based partners.
- CCTP and its $500 million recently were rolled into a five-year, $1 billion federal reform initiative called Partnership for Patients, which was announced last month by Health and Human Services Secretary Kathleen Sebelius. Its goals are to save 63,000 lives and $35 billion in healthcare costs by reducing preventable hospital-associated injuries by 40% and reducing overall hospital readmissions by 20%, both targets to be achieved by the end of 2013.

Strategies for Transition of Care Innovations

Boston University’s Project RED - Reengineered Hospital Discharge (RED)

Components of Project RED:
1. Educate the patient about his or her diagnosis throughout the hospital stay.
2. Make appointments for clinician follow-up and post-discharge testing and
   * Make appointments with input from the patient regarding the best time and date of the appointment.
   * Coordinate appointments with physicians, testing, and other services.
   * Discuss reason for and importance of physician appointments.
   * Confirm that the patient knows where to go, has a plan about how to get to the appointment; review transportation options and other barriers to keeping these appointments.
3. Discuss with the patient any tests or studies that have been completed in the hospital and discuss who will be responsible for following up the results.
4. Organize post-discharge services.
   * Be sure patient understands the importance of such services.
   * Make appointments that the patient can keep.
   * Discuss the details about how to receive each service.

https://www.bu.edu/fammed/projectred/components.html

Strategies for Transition of Care Innovations

Boston University’s Project RED - Reengineered Hospital Discharge (RED)

Components of Project RED:

5. Confirm the Medication Plan.
   * Reconcile the discharge medication regimen with those taken before the hospitalization.
   * Explain what medications to take, emphasizing any changes in the regimen.
   * Review each medication's purpose, how to take each medication correctly, and important side effects to watch out for.
   * Be sure patient has a realistic plan about how to get the medications.

6. Reconcile the discharge plan with national guidelines and critical pathways.
7. Review the appropriate steps for what to do if a problem arises.
   * Instruct on a specific plan of how to contact the PCP (or coverage) by providing contact numbers for evenings and weekends.
   * Instruct on what constitutes an emergency and what to do in cases of emergency.

https://www.bu.edu/fammed/projectred/components.html


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Strategies for Transition of Care Innovations

Boston University’s Project RED - Reengineered Hospital Discharge (RED)

Components of Project RED:

8. Expedite transmission of the Discharge Resume (summary) to the physicians (and other services such as the visiting nurses) accepting responsibility for the patient’s care after discharge that includes:
   * Reason for hospitalization with specific principal diagnosis.
   * Significant findings. (When creating this document, the original source documents e.g. laboratory, radiology, operative reports, and medication administration records should be in the transcriber’s immediate possession and be visible when it is necessary to transcribe information from one document to another.)
   * Procedures performed and care, treatment, and services provided to the patient.
   * The patient’s condition at discharge.
   * A comprehensive and reconciled medication list (including allergies).
   * A list of acute medical issues, tests, and studies for which confirmed results are pending at the time of discharge and require follow-up.
   * Information regarding input from consultative services, including rehabilitation therapy.

https://www.bu.edu/fammed/projectred/components.html


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Strategies for Transition of Care Innovations

Boston University’s Project RED - Reengineered Hospital Discharge (RED)

Components of Project RED:

9. Assess the degree of understanding by asking them to explain in their own words the details of the plan.
   * May require removal of language and literacy barriers by utilizing professional interpreters.
   * May require contacting family members who will share in the care-giving responsibilities.

10. Give the patient a written discharge plan at the time of discharge that contains:
    * Reason for hospitalization.
    * Discharge medications including what medications to take, how to take them, and how to obtain the medication.
    * Instructions on what to do if their condition changes.
    * Coordination and planning for follow-up appointments that the patient can keep.
    * Coordination and planning for follow-up of tests and studies for which confirmed results are not available at the time of discharge.

11. Provide telephone reinforcement of the discharge plan and problem-solving 2-3 days after discharge.

https://www.bu.edu/fammed/projectred/components.html

Strategies for Transition of Care Innovations

Boston University’s Project RED - Reengineered Hospital Discharge (RED)

- Cardiovascular related diseases have significant readmission risk.
- Of that population (17.6%), 76% were deemed preventable readmissions.
- The theoretical conclusion was that cardiovascular readmission could potentially be reduced from 17.6% to less than 5%. A 30% reduction was realized with the RED (Reengineered Hospital Discharge) project.
- Post-discharge follow-up only included telephonic follow-up 2-4 days after discharge.

Project RED

- Consists of 11 actions that the hospital undertakes during and after the hospital stay to ensure a smooth and effective transition at discharge.

Components of RED

- Make appointments for follow-up appointments and post discharge tests
- Plan for follow-up of results from labs or studies
- Organize post-discharge outpatient services/equipment
- Identify correct meds and obtainment of meds
- Reconcile discharge plan with national guidelines
- Teach written discharge plan to patient
- Educate patient about diagnosis
- Assess degree of patient understanding
- Review with patient what to do if there are problems
- Expedite transmission of discharge summary to clinicians
- Provide telephone reinforcement of discharge plan
Why Hospitals should use RED

• Improve clinical outcomes:
  • Decreases 30 day re-hospitalization by 25%
  • Decreases ED use from 24% to 16%
  • Improves patient “readiness for discharge”
  • Improves PCP follow-up

What is the After Hospital Care Plan?

• All patients will leave the hospital with a printed discharge plan; distinct from the discharge summary that is intended for medical providers

• Components
  – Personal cover page - upcoming appointments
  – Patient activation - medical equipment list
  – Medicines - medical allergies
  – 30-day calendar - diagnosis info
  – Outstanding test result(s)
  – Diet modifications

EACH DAY follow this schedule:

MEDICINES

<table>
<thead>
<tr>
<th>What time of day do I take this medication?</th>
<th>Why am I taking this medicine?</th>
<th>Medication name</th>
<th>How often do I take it?</th>
<th>How do I take this medicine?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Morning</td>
<td></td>
<td></td>
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Medication Management as it Relates to Reducing Readmissions
Typical Medication Transition Failures

**Oversight of Medication List**
- Interaction of medications from multi-prescribers is not assessed
- Medication list is incorrect
- Inpatient list of medications is not accurate and patient is sent home with an incorrect list
- EMR does not match what medications the patient is actually taking
- There is no care provider assigned for accountability of the patient’s medications

**Prescribed Medications**
- Chronic medications not adjusted for acute episode
- Discharge medication orders are incorrect
- Medication is not available to the patient due to formulary differences
- Provider does not know if patient filled prescriptions

**Communication**
- Lack of communication with caregivers across the continuum of care
- Medication list is not available to the next care provider
- Next point-of-care provider does not have access to the previous care provider or records
- Next point of care does not confirm receipt of information to previous care provider
- Community pharmacies are not included as a care team member and do not receive information
Typical Medication Transition Failures

**Patient/Family Engagement**

- Lack of engagement of patient and/or family in the discharge plan
- Understanding of the patient’s ability to take medications is not assessed
- Family is not prepared or able to assist patient with the medications, and patient abilities are not assessed
- Patient fails teach-back
- Patient does not have resources to obtain medications after discharge
- Patient does not understand new medications and continues to take old medications

**Strategies for Improvement**

- Assess the patient’s knowledge of medications on admission using teach-back, communicate this information to other care providers, and include this in the care plan. Information from the assessment is put into the care plan and action is taken to resolve issues.
- Reconcile medications on admission with input from the patient and family.
- Medications ordered for patient during hospitalization are compared to the medication list obtained on admission to ensure chronic medications are given during hospitalization.
- Discrepancies such as omission, duplications, adjustments, deletions, and additions are resolved during the hospitalization.
- On transition, provide the patient’s most current reconciled medication list to the next care provider.

**Strategies for Improvement (cont’d)**

- On transition, have the sending organization inform the next provider of how to obtain medication clarification.
- Through the teach-back process, assess the patient’s level of understanding following comprehensive medication education.
- Provide a written listing of medications to the patient and family upon transition—which includes the name of the medication, the dose, the route, the purpose, side effects, and special considerations—in language that is easy for the patient to understand.
- Have the pharmacy perform patient education, medication review, follow-up phone calls, and in-home visits for patients with complicated medication regimes.
- For patients with complex medications, refer for Medication Therapy Management and have this available for both inpatient and outpatient settings.
Definition of Prescription:
A written order issued by a physician or other qualified practitioner that authorizes a pharmacist to supply a specific medication for a patient, with instructions on its use.

A Prescription is Composed of Four (4) Parts:
- Superscription
- Inscription
- Subscription
- Signature

What is Required on Rx?
- Name of patient
- Date the prescription is written
- Name of medication
- Strength of medication
- Quantity of medication
- Sig including route of administration
- Number of refills
- Doctor’s signature
Examples:

- 7,000 people are killed every year.
- Approx. 2 million people are harmed every year.
- 12% of all prescriptions written contain errors.
- Economic toll: $3.5 billion/yr.
- Statistic numbers keep increasing.

Errors:
- Inadequate knowledge of the pt and their clinical status.
- Inadequate drug knowledge.
- Calculation errors.
- Drug name confusion (sound a like/look a like) drugs.
- Fatigue and workload.
- Illegible handwriting/Abbreviations.

Common Errors:
- Inadequate knowledge of the pt and their clinical status.
- Inadequate drug knowledge.
- Calculation errors.
- Drug name confusion (sound a like/look a like) drugs.
- Fatigue and workload.
- Illegible handwriting/Abbreviations.
Goals in Avoiding Ambiguities and Misinterpretations

The 5 R’s

- Right Patient
- Right Drug
- Right Dose
- Right Route
- Right Time

Problem

Problem Statement:
- National Readmission Rate for Heart Failure is 24.7%.
Problem & Goal

Problem Statement:
• National readmission rate for Heart Failure is 24.7%. Our institution has an Heart Failure readmission rate of 20.2% in FY 2011 resulting in increase in adverse outcomes, including mortality, poor patient satisfaction, increase in cost and a loss of revenues.

Goal:
• To reduce all cause UCIMC 30 Days Heart Failure readmission rate by 6.5% by end of FY 2012 (06/30/12)