Medication Management During Transitions of Care: Incorporating a Pharmacist Into the Patient's Care Team

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Objectives

- Describe how the pharmacist can assist with medication management at a patient's transition from the nursing home and home health care
- Identify patients who can benefit from a Medication Therapy Management (MTM) referral
- Hear practical lessons from a home health agency's referrals to MTM
- Identify resources to help you connect your patient to a MTM pharmacist

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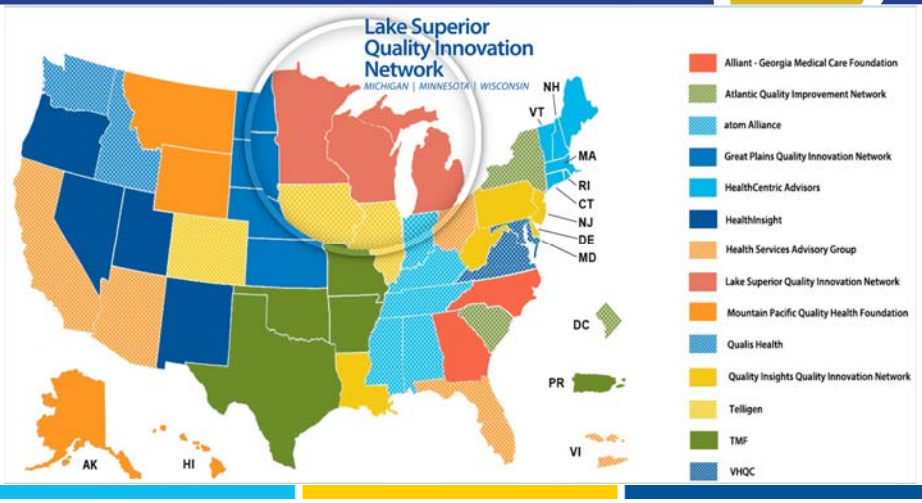

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Coordination of Care Initiative Goals

- Improve quality of care for Medicare beneficiaries who transition among care settings
- Reduce 30-day hospital readmission rates and admission by 20% by 2019
- Increase the number of days at home
- Establish sustainable, transferrable transition practices across the spectrum of care

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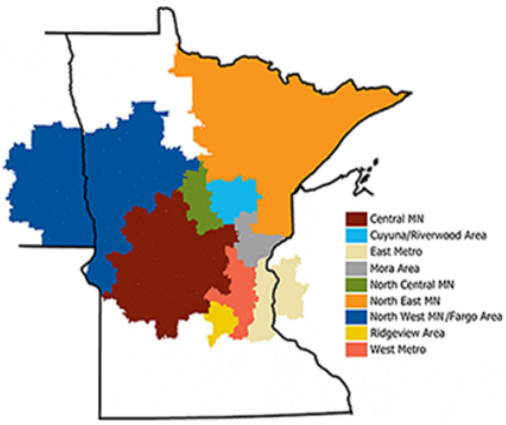
Coordination of Care Communities



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Coordination of Care Communities

- 10 communities
- 940+ participants
- 30+ workgroups

- 367+ organizations
  - 20 assisted living facilities
  - 25 clinics
  - 61 home health agencies
  - 11 hospice programs
  - 70 hospitals (39 PPS; 28 CAH; 2 Acute LTC; 1 VA)
  - 121 nursing homes
  - 62 pharmacists
  - 28 community organizations/ government groups

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Focus Areas

- Medication-related issues – 12
- Advance Care Planning – 5
- Communication - 5
- Discharge processes - 4
- Care Pathways – 2
- Mental health/chemical dependency/homelessness - 2
- Care Transition Education
- Exacerbation of Chronic Conditions (CHF/COPD)
- Health Literacy
- Lack of resources/pt engagement
- NH Capabilities
- Social support
- Risk Identification across the Continuum
- Transition of Care
- Treat in place
- Discharge readiness

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Interventions

- Advance care planning
- Care Teams
- Consistent Care Path
- Consistent CHF care guidelines
- EMR read-only access
- Medication education to consumers
- Medication reconciliation by pharmacists
- Medication therapy management (MTM) expansion
- Nurse to nurse handoff
- Care Partner ID in EMR
- Pharmacist f/u calls
- SBAR communication for change in condition
- Standard hospital to SNF referral form
- Teach back
- Use of home care med list with hospital med rec process
- Facility capabilities

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What is Medication Therapy Management (MTM)?

- A comprehensive review of a patient's medications to assess for:
  - Appropriateness
  - Efficacy
  - Safety
  - Convenience

Med Rec vs. MTM

- Medication Reconciliation involves creating a list of medications the patient is taking
- MTM involves medication reconciliation, but takes it a step further to assess the medications for appropriateness, efficacy, safety and convenience
- During MTM, the pharmacist works with other health care professionals to adjust medication problems that are found during the assessment

Why is it important?[1]

- Medications are involved in 80% of all treatments of diseases
- Drug-related morbidity and mortality costs exceed $200 billion annually in the U.S.
  - Medicare beneficiaries with multiple chronic illnesses see an average of 13 different physicians and have 50 different prescriptions filled per year

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Who benefits from MTM?

- Those who have not reached or are not maintaining the intended therapy goal
- Those who are experiencing adverse effects from their medications
- Those who have difficulty understanding and following their medication regimen
- Those in need of preventive therapy
- Those who are frequently readmitted to the hospital

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Benefits of MTM on Hospital Readmissions

- One study looked at hospital readmission among 895 elderly home health patients.[2]
  - The patients received a minimum of 2 MTM phone calls within 30-days of hospital discharge
  - Patients at low-risk of readmission had a 6-fold risk reduction within 30 days and a 3-fold risk reduction within 60 days

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Benefits of MTM on Hospital Readmissions

- Another study assessed hospital readmission rates in 90 primarily elderly patients discharged to home.[3]
  - Patient received MTM at 72-hr, 2 weeks and 30-days after discharge
  - Patients participating in MTM had a readmission rate of 7% compared to 20% in patients that did not meet with the pharmacist

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Who does MTM and how do patients get an appointment?

- Many community pharmacies provide this service
- Most health systems have pharmacists that provide this service

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Referring to MTM

Health System	*MTM Scheduling Line*
Patient's Preferred Pharmacy	Call to Schedule - Number in Patient Record or check online
Allina Health System	Internal Referral Only
CentraCare	River Campus IM 320-252-5131 Northway Clinic FM 320-240-3157
Essentia Health	218-576-0130
Fairview Health	612-672-7005 1-866-332-3708
First Light	320-225-6030
Health East	651-326-5650
HealthPartners	952-967-7969
Hennepin County Medical Center	612-873-2195
Mayo Health System	1-800-266-5311
North Memorial	763-581-2153
Olmsted Medical Center	507-535-1974
Park Nicollet	952-993-9488
Ridgeview Medical Center	952-361-2450

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What is the cost for a visit?

- Required benefit for Medicare Part D patients
  - Most plans provide this for no charge to the patient
- Contact the clinic the patient is seen at for costs

MTM at Successful Patient Transitions

- Post Discharge from a Skilled Nursing Facility Transitional Care Unit
- Home Care Referral

References

1. *Patient-Centered Primary Care Collaborative. Integrating Comprehensive Medication Management to Optimize Patient Outcomes: Resource Guide. Second Edition. June 2012*
2. Zillich AJ, et al. A randomized, controlled pragmatic trial of telephonic medication therapy management to reduce hospitalization in home health patients. Health Serv Res 2014; 49:1537-54. DOI: 10.1111/1475-6773.12176
3. Luder HR, Frede Sm, Kirby JA, Epplen K, Cavanaugh T, Martin-Boone JE, Conrad WF, Kuhlmann D, Heaton PC. TransitionRx: impact of community pharmacy post-discharge medication therapy management on hospital readmission rate. J Amer Pharm Assoc 2015;55:246-54. DOI: 10.1331/JAPhA.2015.14060.

Questions?

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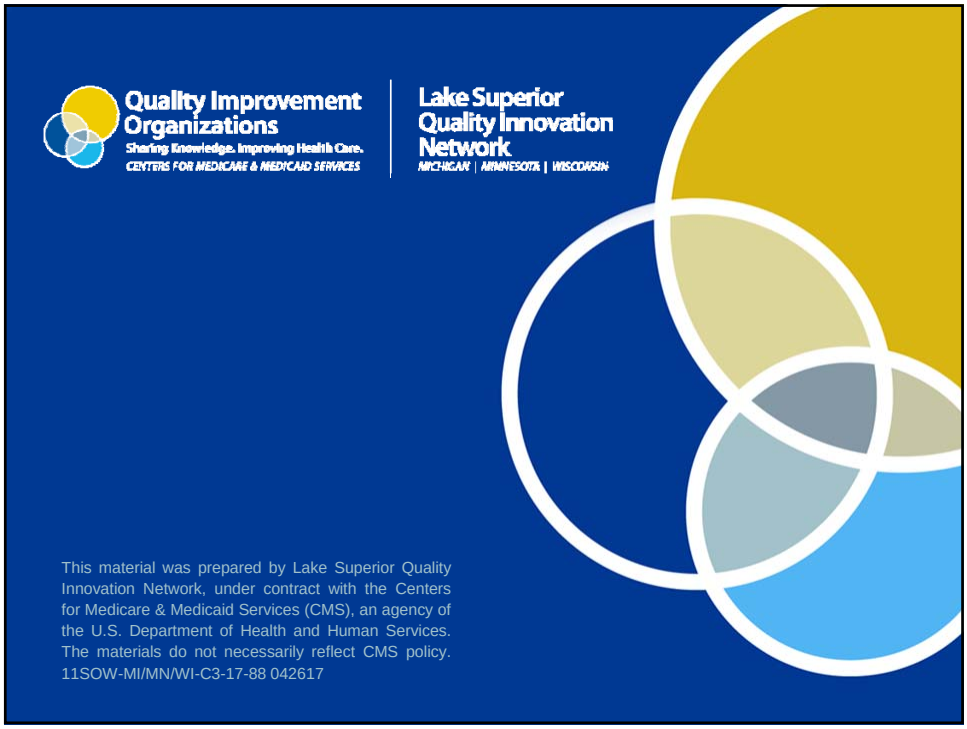
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