Medication Therapy Management (MTM) in transitions of care

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RARE Reducing Avoidable Readmissions Effectively

Series Objectives

At the conclusion of this learning activity, participants will be able to:

1. Identify key changes and strategies that were used to reduce avoidable readmissions.
2. Describe how the program was developed and tools the team used.
3. Discuss the outcomes of the program.
4. Discuss how these best practices may be applied in their own organization.

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Objectives

- Discuss medication related readmissions and 5 key areas to reduce them
- Review the MTM practice model
- Discuss how the MTM model may prevent medication-related admissions/readmissions
- Highlight medication related problems encountered during transitions of care

Statistics

- Improper medication use by patients has been estimated to cost the health system up to $290 billion a year
- Drug expenditures comprise 15.5% of healthcare premium
- This represents the third most costly component of the nation's health spending behind hospital care (31%) and physician and clinical services (21%)

Current State of hospital discharges & readmissions

- > 34 million hospital discharges each year
- ~20 % are complicated by a post discharge adverse event
  - About 2/3 are medication related
    - 60% could be prevented or avoided
- National Medicare 30 day readmission rate: 20%
  - >$17 billion each year

Hospital Readmissions

- Hospital readmissions reduction program
  - Beginning in 2013 higher than expected rates will reduce payments on all Medicare discharges
  - Hospitals will not be paid for readmissions within 30 days of discharge for specified conditions
  - Initial evaluation based on heart attack, heart failure and pneumonia
    - 2015 will add COPD, CABG, PTCA and other vascular categories

5 key areas to reduce avoidable readmissions

- Comprehensive discharge planning
- **Medication management**
- Patient and family engagement
- Transition care support
- Transition communications

Medication Management

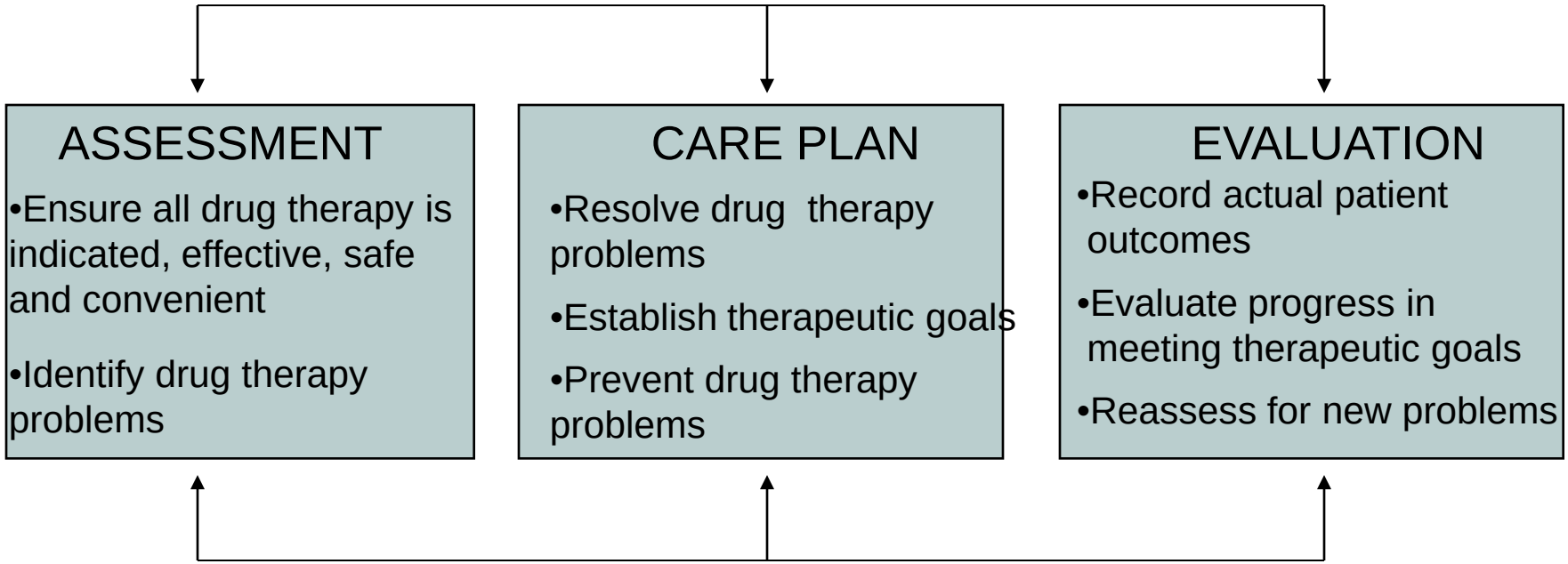
- Medication reconciliation
- Patient/family education on medications
- Adherence counseling
- Disease state management

- Where does Medication Therapy Management (MTM) fit in?
  - Transitions of Care (TOC)
  - Post discharge follow-up

Medication Therapy Management

Built upon the philosophy and process of "pharmaceutical care practice"

ESTABLISH A THERAPEUTIC RELATIONSHIP



Continuous Follow-up

Working in collaboration with all members of the healthcare team

Assessment of Drug Related Needs

APPROPRIATENESS	• Unnecessary drug therapy? • Additional drug therapy needed?
EFFICACY	• Ineffective drug? • Dosage too low? • Drug interaction reducing efficacy?
SAFETY	• Adverse drug reaction? • Dosage too high? • Drug interaction increasing toxicity?
COMPLIANCE	• Willingness to take medications? • Ability to take medications?

Who is an appropriate MTM patient?

- Patients at high risk or have frequent ED/ hospitalizations
- Chronic disease states that are not at goal/in control
- Poly-provider patients
- Poly-pharmacy (>7 medications)
- Patients with a recent change in their health/medication status- involving multiple medication changes
- Patients taking high risk medication classes
- Patient referred due to medication concerns/ questions

Program Goals of MTM

- **To reduce overall health care costs**
- **To empower patients to take a more active role in their health.**
- **To improve the overall health and wellness of patients**.

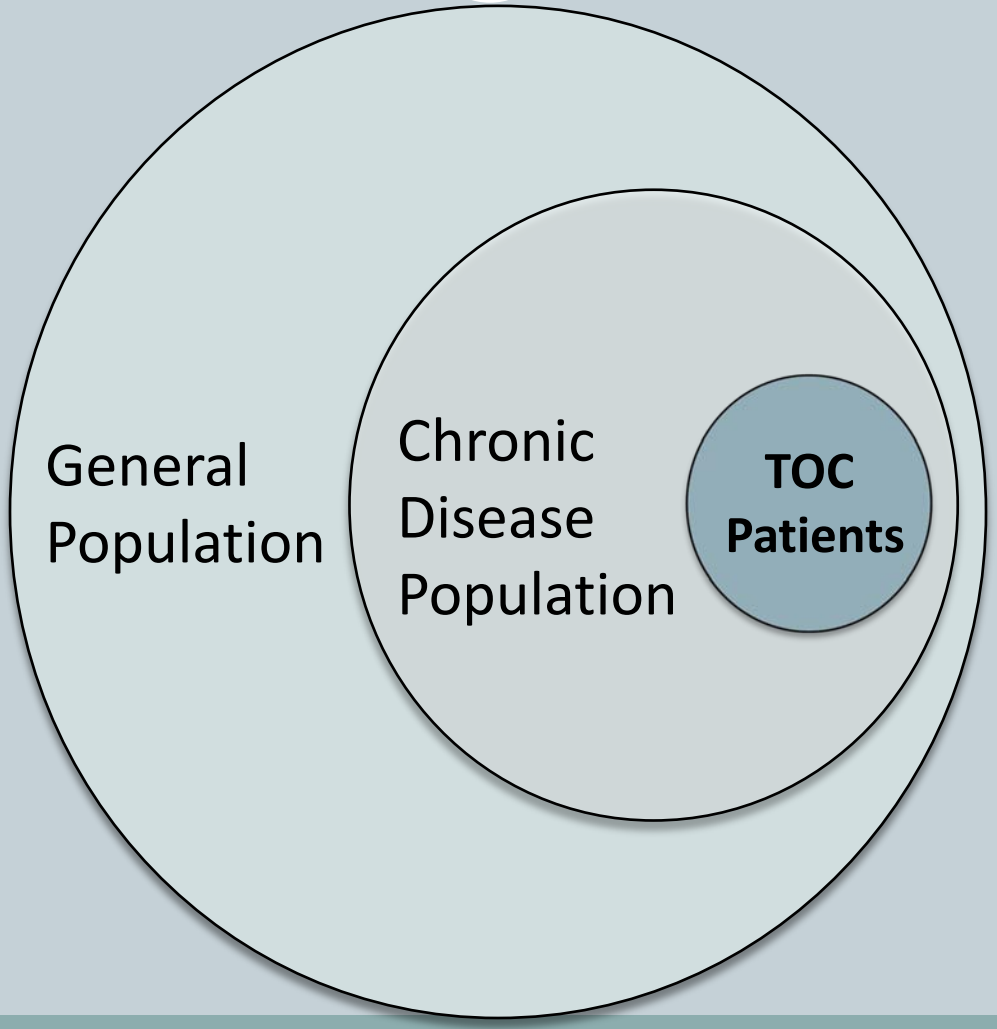
Fairview Results:

61,946 Drug Therapy Problems Resolved

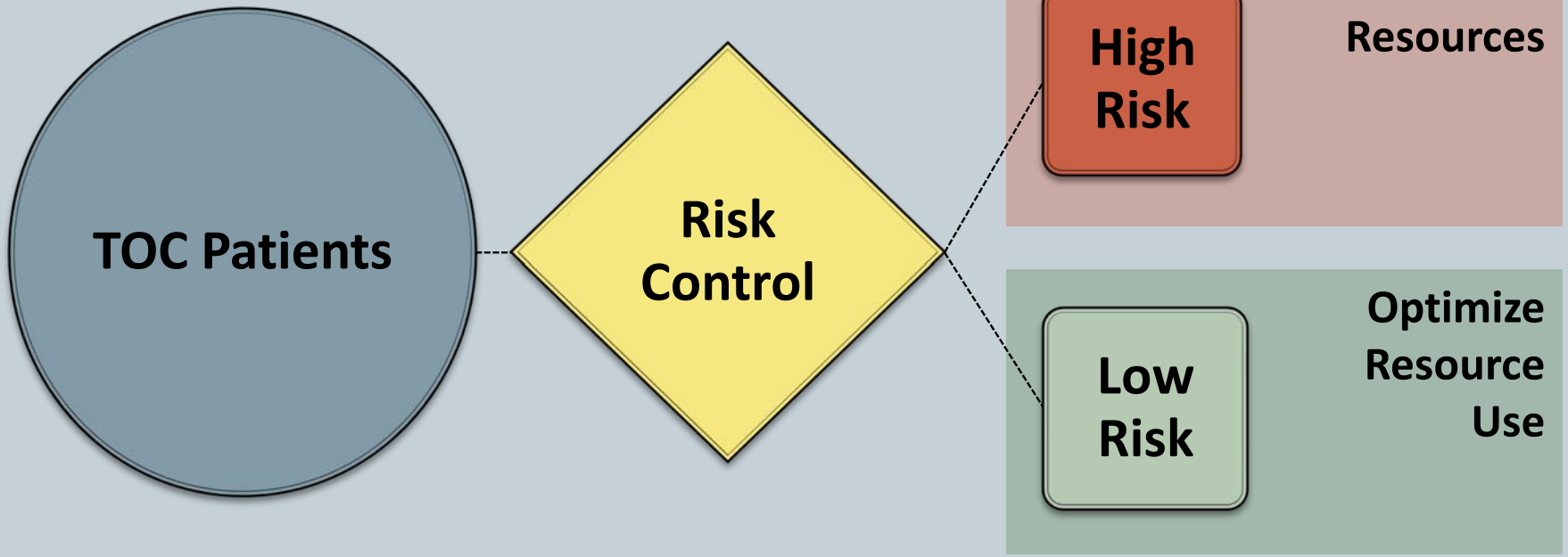
(13,283 MTM Patients, Sept 1998 – Dec 2010)

- **86% of patients had ≥ 1 drug therapy problems**
- **53% of patients had ≥ 3 drug therapy problems**
- **32% of patients had ≥ 5 drug therapy problems**

Basic Population Strategy



Basic Population Strategy



Transitions in Care

Inpatient and Outpatient Pharmacy Services

Working to reduce readmissions through improved medication management, reconciliation, and patient education…

- Hospital pilot
- FPA/Ucare pilot
- CHF home visit pilot
- Clinic Based Pilot

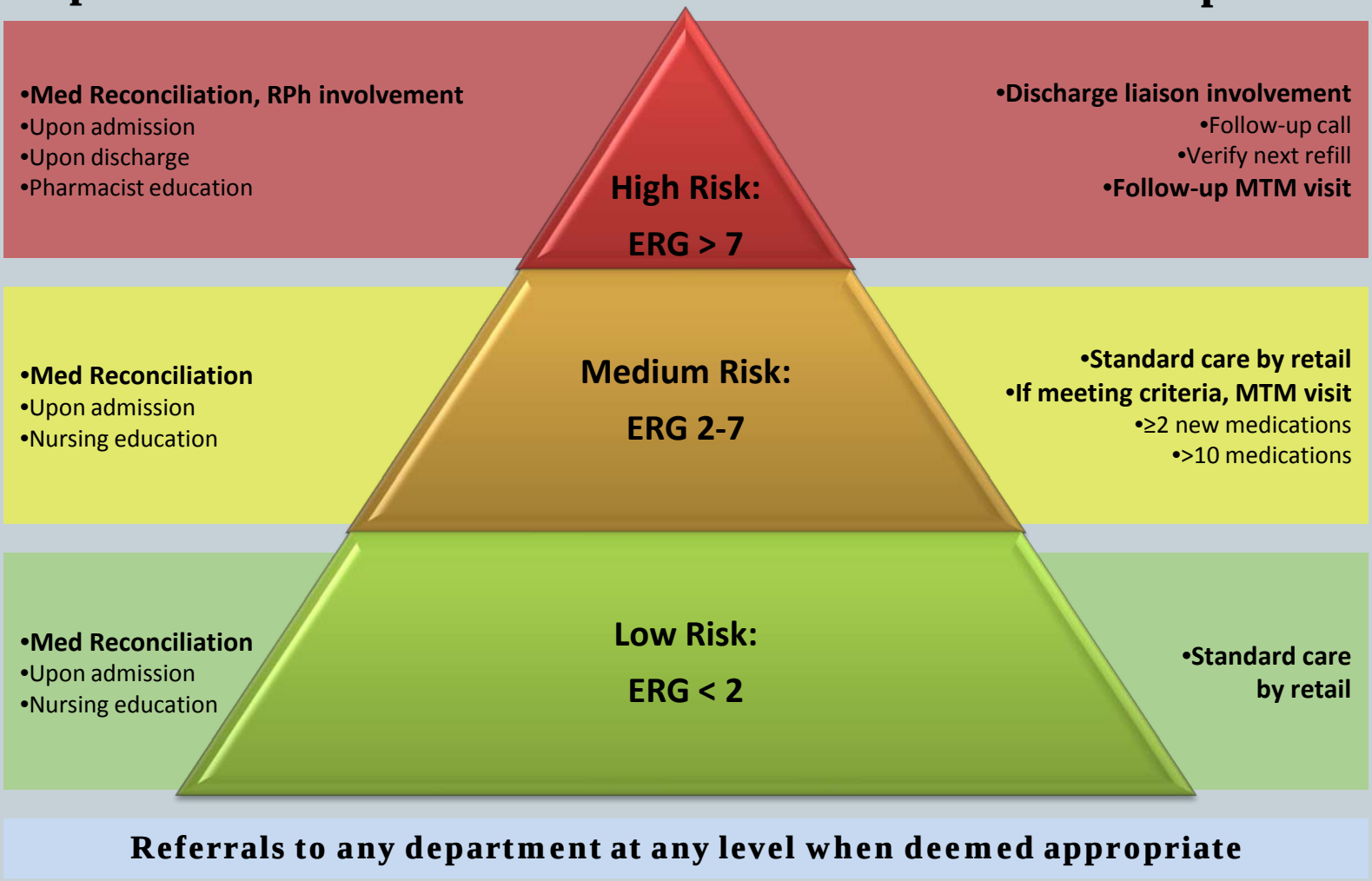
Pilot findings used to move toward a high-level model of strategic care based on patient risk of returning to hospital

Developing a Transitions of Care Model

In reviewing pilots, transitional model requires:

- Timely follow-up after admission
- Exceptional communication and hand-offs
- Targeting of patients at high risk of returning to hospital
- Leveraging the “Continuum of Care Resources”
  - ✓Inpatient
  - ✓MTM
  - ✓Retail
  - ✓Specialty

Transitions of Care Model



ERG: Episode Risk Groups
MTM: Medication Therapy Management

Project RED (Re-Engineered DC)

- Target Population: Psychiatry

- Medication Reconciliation upon discharge
- Clinic follow-up one week post-discharge
  - Utilize consistent pharmacist provider
  - Training of inpatient staff to provide MTM
    - Medication education
    - Medication reconciliation
    - Adherence assessment

Enhanced Discharge Clinic

- Target Population: General Medicine Patients
- Discharge Advocate, RN
- Inclusion criteria:
  - three or more admissions in the last year
  - admission diagnosis of congestive heart failure, pneumonia or acute myocardial infarction
  - one readmission within last 30 days
- Clinic follow-up within 5 days post-DC
  - CNP & PharmD
    - Medication reconciliation
    - Adherence assessment
    - Medication education
    - Ensure appropriate drug monitoring
    - Ongoing follow-up with MTM provider

Problems Encountered During Transitions of Care

- Incomplete medication reconciliation upon admission
- Inaccurate medication reconciliation upon discharge
- Absence of/poor discharge counseling
- Insurance problems preventing appropriate discharge medications
- Lack of clarification regarding follow-up plan
- Lack of common language

Planning Pearls

- Multidisciplinary team approach
- Defined target population
  - Risk stratification of patients
- Enhanced communication between inpatient and outpatient
- Following the patient through the “black hole”

QUESTIONS

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Next Webinar

December 14th 12:00 – 1:00 p.m.
Home Care and Reducing Hospital Readmissions
Speaker: Jennifer Sorensen,
Minnesota HomeCare Association

To suggest future topics for this series,
Reducing Avoidable Readmissions Effectively "RARE" Networking Webinars, Contact:
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