Pharmacist – Led Transitional Care Program

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Objectives

At the end of this presentation the audience will understand:

- The history of “Care Coordination” at Jefferson
- The players
- The role of each player
- How the patient benefits
- Outcomes
- The future of “Care Coordination” at Jefferson

Where we started

Develop Transitions of Care Programs

- CMS changes
  - Reporting hospitals' 30-day readmission rates in 2009
    - **Heart Failure**
    - **AMI**
    - **Pneumonia**
  - Adjustment of hospital reimbursement rates in 2013 for above diagnosis
  - 2015 expanding diagnosis to
    - **COPD**
    - **CABG**
    - **Percutaneous Coronary Interventions**
    - **Vascular Procedures**

Where we started

- Culture driven Performance Model
- Mission, Vision, and Values
  - **S**ervice Excellence
  - **C**ollaboration
  - **O**wnership
  - **R**espect

Where we started

Did not re-create the wheel

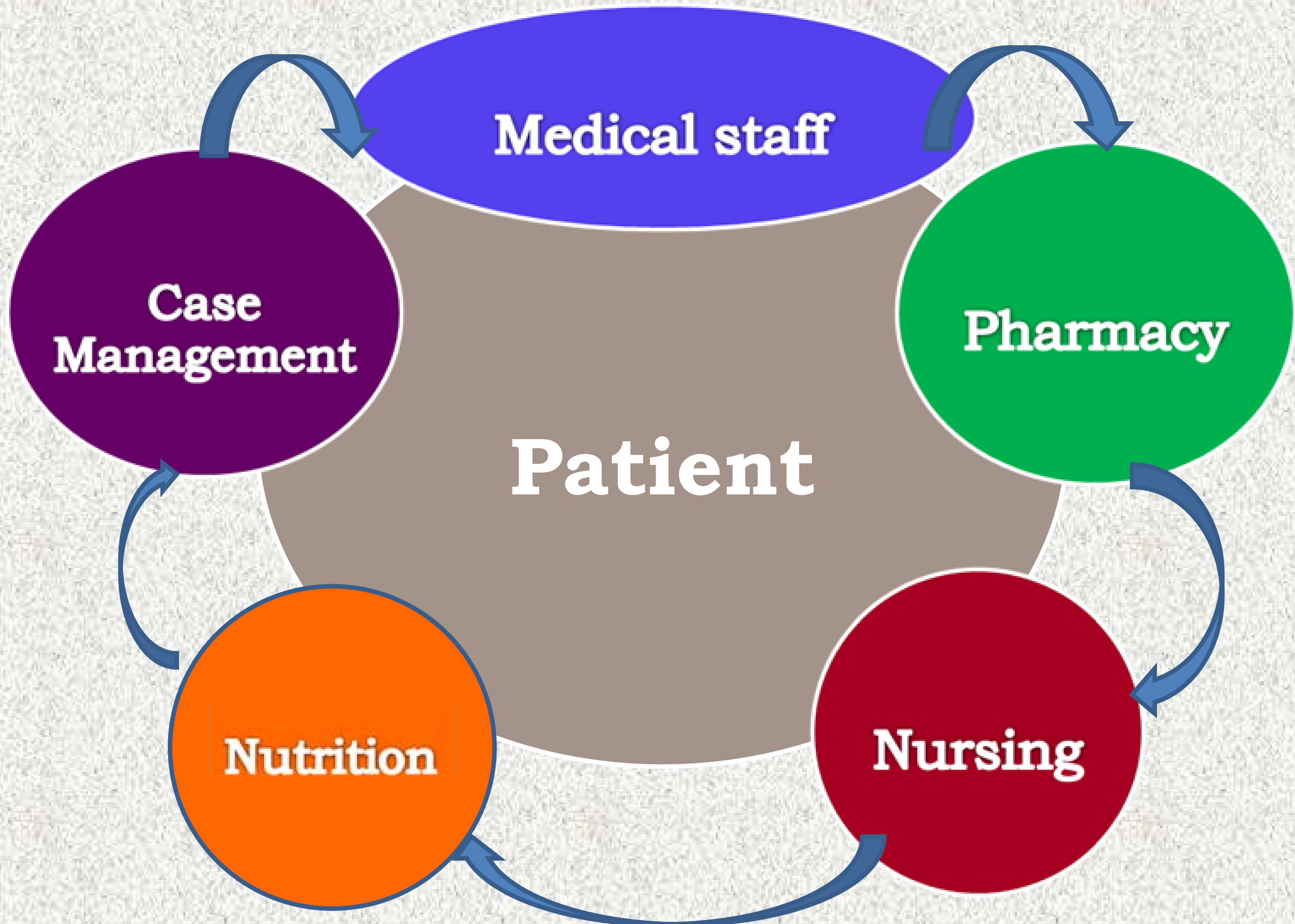
- HFTOC pharmacy orientation\project RED.pdf

Who are we?

Collaboration of multidisciplinary professionals

- Excellent quality health care
- Working to achieve the same outcome
  - Prevent the “**Black hole**” effect

Transition of Care Team

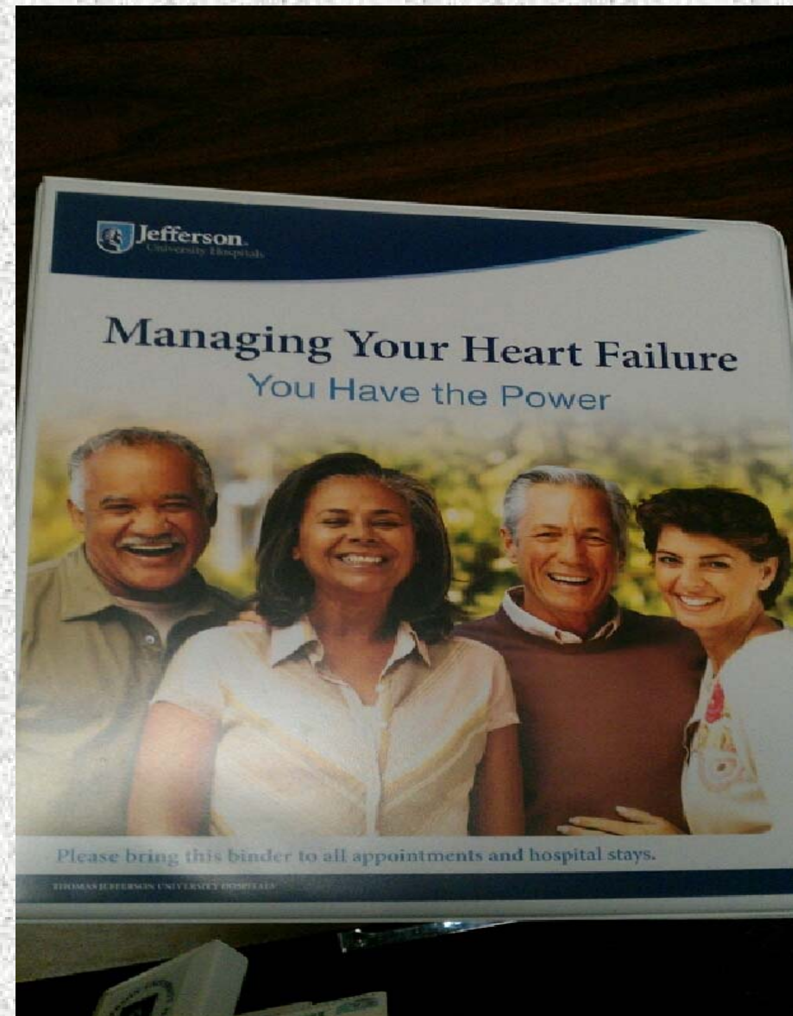


What do we do?

- Medical staff enrolls patient
  - ***All*** patients with heart failure
- Pharmacist/Nursing educate
- Dietician educates
  - Reading labels
  - Salt restrictions
  - Good/Bad foods
- Case manager establishes appointment within 7 days

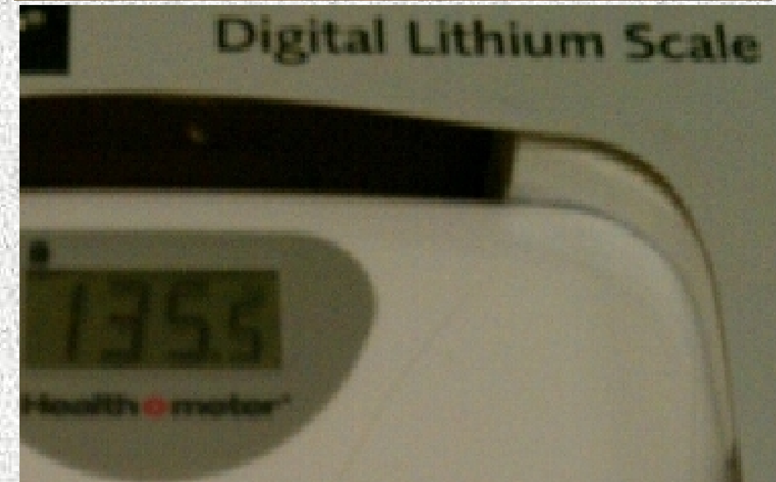
Education

- Binder provided
- Teach-back method
  - Project BOOST
    - Heart Failure
    - Diet
    - Exercise
    - Medications
    - Resources
- Heart Failure video



Pharmacist role

- Medication reconciliation
  - Upon admission and discharge
- Medication education
  - Why, When, How
  - Pillbox
- Scale
- Reinforce education
- 24 hour resource available



Why the Pharmacist

- Pharmacy Practice Model Initiative
  - "Hospital and health-system pharmacists need to engage now in the development of a future practice model that is responsive to healthcare reform and the health system of the future."
    - http://www.ashp.org/PPMI
- Pharmacist Weekly News Update (May 23, 2012)
  - "Blood Pressure Dropped When Pharmacists Gave Patients a Ring"

What happened to the "Black Hole"?

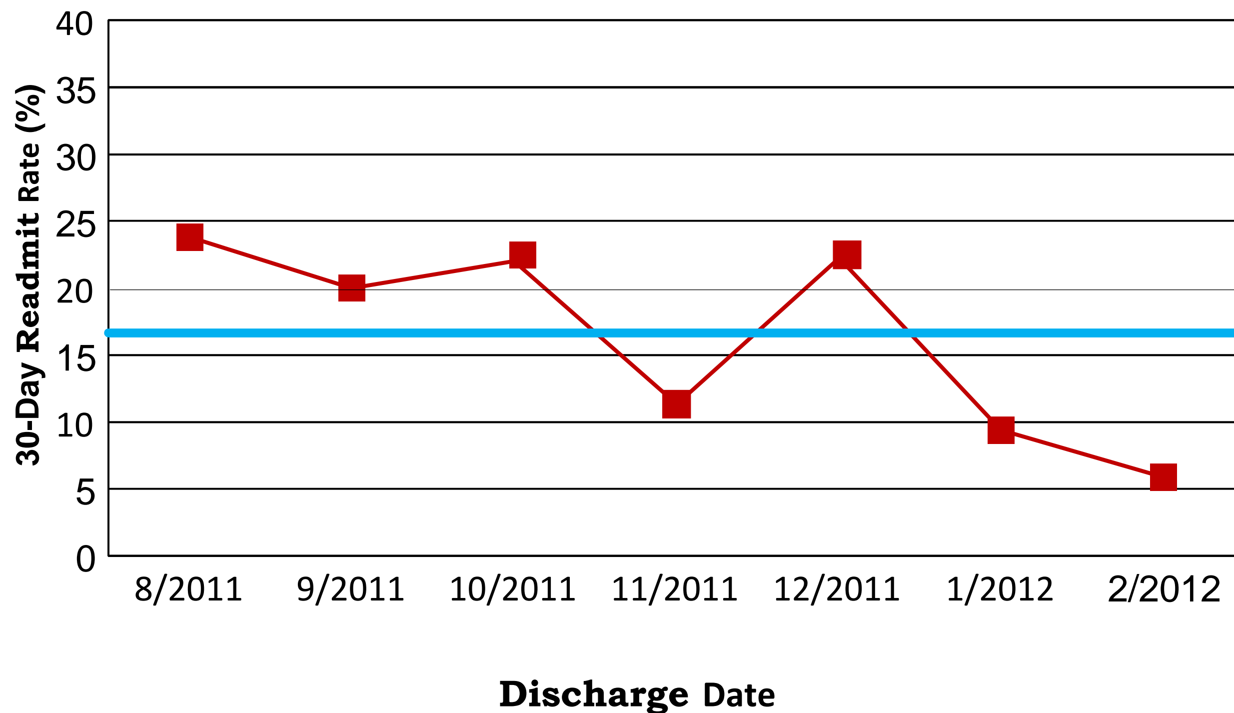
Pharmacist driven Transition of Care

- Phone calls on days 2, 7, 14, 21, and 30 post discharge
- Focus on ease of transition, medications, diet, exercise, follow up appointment
- Direct connection to physicians and/or case management
- 24 hour phone line

Where are we going?

- Pharmacy as a whole
  - Readjusting the way we look at patient care
- TJUH
  - Transitions of Care programs
    - Pneumonia, MI, CABG
      - Multidisciplinary collaboration
- Development of Pathways
  - Best Practices

Readmission trend



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- Jack BW, Veerappa KC, Anthony D, et al. A reengineered hospital discharge program to decrease rehospitalization. Annals Intern Med. 2009;150:178-187.
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Thank You!