ID high-risk patients, get them home safe, make sure they take their meds

Readmissions Reduction Pilot Hinges on Pharma

By Todd Neff

A pharmacy-focused pilot at University of Colorado Hospital is showing promise as a way to reduce readmissions and improve the health of high-risk heart-failure and hospital-medicine patients. Those involved think the approach, if used house-wide, could improve care and reduce readmissions throughout the hospital.

The pilot, one of six initiatives funded in 2014 by the CU School of Medicine-UCH Clinical Effectiveness and Patient Safety (CEPS) Small Grants Program, launched in September 2014; Christine D. Jones, MD, MS, of UCH’s Hospital Medicine Group, leads the effort.

The work started late last summer, when David Kao, MD, a UCH cardiologist, and Jonathan Pell, MD, a UCH hospitalist and Epic physician champion, spearheaded the addition of readmission-risk data in the hospital’s electronic health record.

That data would be derived from a model published in 2010 by a University of Texas Southwestern Medical Center/Parkland Health and Hospital System team in Dallas. That team focused on heart failure patients, identifying 29 risk factors ranging from whether patients had a history of depression or anxiety to demographic and economic factors, as well as behavioral and health care utilization history. The factors were weighted, with things such as a history of substance use, missed clinic visits, Medicare payment status, and being male increasing a patient’s risk.

In addition to their implications for patient health, readmissions absorb precious UCH provider time — and, increasingly, money. The Centers for Medicare and Medicaid Services (CMS) docks reimbursement payments to hospitals with readmission rates CMS deems too high. For fiscal 2015, excessively high 30-day...
readmission rates were part of the reason CMS will withhold from the hospital about $2 million in reimbursement.

With the UT Southwestern model and its Epic reporting in place, the pilot went into gear. It is, in practice, two pilots, one focusing on heart failure patients, the other on medicine patients on Hospital Medicine services.

On, Pharma! Pharmacists are front and center, with Shakowski and Go focusing on heart failure patients and Klein on general medicine patients. Shakowski, Go, and Klein first consider patient risk scores as presented in Epic, identifying candidates for the pilot. If patients consent to join, the pharmacists do what Jones called “intensive medication reconciliation” up front, which can involve consulting with both patients and physicians as well as with community retail pharmacies where the patients have prescriptions filled. They then spend about 30 minutes with patients before discharge, explaining more than just how and when to take their medications.

“I think often we have patients who don’t understand why they’re taking them, especially in heart failure,” Shakowski said.

The pharmacists also alert case managers, clinical social workers, and the Patient Resident Liaisons to these patients so these staff can do an early evaluation and help organize home health care or other needed services.

The pharmacists aren’t done when the patients do leave. Two to three days after discharge, they call the patient to confirm they’re taking their meds and answer questions. All told, Shakowski said, it takes about an hour per patient. Of the 30 patients enrolled so far, she figures she’s handled about 10 with heart failure, with Klein taking the rest.

What’s ahead. The program’s success metrics include patient satisfaction, Emergency Department visits, and hospital readmissions out to 90 days, Jones said. She’s hoping to see a 20 percent drop in readmissions as compared to statistical averages. The official, statistically significant results are not yet in, she said. But the data on the Hospital Medicine side in particular show lower-than-average readmission rates since the pilot began, she noted.

“Part of the measure of success will be developing a sustainable model for us to improve care transitions for the whole hospital,” Jones said. “What kind of personnel do you need to make something like this sustainable and something we can provide for all of our high-risk patients?”

A critical piece that enhances the pilot’s chances of sustainability is employing a multidisciplinary team, said Amanda Nenaber DNP, APRN, ACNS-BC, who is leading the pilot for the Heart Failure Program.

“Our vision for the pilot and potential future programs is to demonstrate this team-based approach and the effect it will have not only on reducing readmissions, but also on improving the care we provide and the satisfaction of our patients,” Nenaber said.

Going from pilot to reality will require more personnel. Shakowski said she, Go, and Klein are working extra hours to accommodate the pilot’s high-risk patients because, as she put it, “We believe in the pilot and we believe in the success of the program. But “to do that with every pharmacist on the floor is unrealistic,” she added.

Shakowski points to the University of California, San Diego (UCSD), where she earned her doctorate. UCSD, which she described as a pioneer in care transitions from the pharmacist perspective, employs two full-time care-transition pharmacists. Adding a single, dedicated pharmacist would be a good start for UCH, she said.

As with other quality improvements, the ultimate decision will be a judgment call balancing added costs, savings from averted readmissions, and the perception of how much the pilot, which is slated to run through the end of this year, truly helped patients.
It Takes a Village…
The leaders of the pilot officially known as “A Targeted, Multidisciplinary Program to Improve Care Transitions for Heart Failure and Medicine Patients”:
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