Optimizing Patient Medication Outcomes Through Cross-Continuum Care

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BACKGROUND

Review of Literature

Effective transition of care is widely reported as a key focus area to reduce readmissions, associated healthcare costs, and improve patient safety and clinical outcomes.

Centers for Medicare and Medicaid Services cites that approximately 2.6 million seniors who are discharged from a hospital are readmitted within 30 days at a cost of over $26 million annually (CMS, 2016).

Medication therapy is a significant risk factor in patient readmission.

Estimated 30% of patients have at least one medication discrepancy with the potential to cause harm following discharge form a hospital (Kwan et al, 2007).

Internal Findings

Care Coordination team data evidences high number of medication related safety catches during patient transitions.

ECUP Pharmacy team identification of opportunities for linkage with pharmacy services during patient transitions from hospital to clinic follow up.

PROJECT AIM

Aim

The aim of the project is to develop and implement a pilot study in order to identify the impact of cross continuum medication review and intervention for hospitalized patients.

Objectives:

- Identify target population / hospital unit.
- Identify 'triggers' for referral to ECUP Pharmacy Team
- Establish process for referral and follow up
- Determine metrics
- Identify stakeholders

PROJECT DESIGN/STRATEGY

Pilot Study design leveraging the resources of the Vidant Health Care Coordination team and the ECUP Pharmacy team to design and implement a cross continuum approach for medication planning for patients transitioning from hospital to home.

- Understanding the pharmacy related issues for patient population
- Intervening prior to discharge to ensure safe transition

CHANGES MADE (PDSA CYCLES)

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- Revision of process algorithm to enhance collaboration
- Expansion of pilot to other VMC units
- Longitudinal data collection for outcomes beyond 30 days
- Engagement in Project Unify pharmacy work

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- Primary team: Vidant Health Care Coordination, ECUP Pharmacy
- Ad Hoc members: VMC Pharmacy, Medical Directors, Case Management
- Target population: High Risk ECUP patients on VMC 2East
- Referral process algorithm

Data collection for metrics

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- Referral volumes manageable with current resources
- Role and linkage of Community Care Plan of Eastern North Carolina
- Multiple requests for services beyond pilot unit
- EHR documentation

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- Pilot on VMC 2East – Nov 2016
- Data collected on process and outcomes: referrals, interventions, admissions
- Biweekly phone huddles with team
- Potential duplication vs. coordination

LESSONS LEARNED

Medication adherence is multifaceted, includes areas of patient understanding and engagement, transportation considerations for obtaining medications, payor coverage and formulary requirements etc.

Strategies to improve adherence must include exploration and consideration of all factors.

Engage potential cross continuum stakeholders early in project planning to support and implement identified strategies.

Understand opportunities and limitations of EHR for cross continuum documentation.

Be prepared for requests to expand services across populations.

NEXT STEPS

Determine resources needed to expand services to Cardiac Service line.

Engage in Project Unify pharmacy work for transitions of care.

Longitudinal data collection for patient outcomes beyond 30 days after intervention.

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* References available upon request. Contact Pam Cowin at pcowin@vidanthealth.com

RESULTS/OUTCOMES