Transitional Care Pharmacy
Kaiser Permanente San Jose Medical Center

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Goals for Today

- Background of TCP
- Kaiser Permanente Models
- San Jose Structure
- Quality Analysis
- Learnings from TCP
- Planning a Local Program
- Questions
About Kaiser Permanente…

- **Kaiser Permanente**
  - Founded in 1945
  - Comprised of three entities
    - Kaiser Foundation Hospitals
    - Kaiser Foundation Health Plan
    - The Permanente Medical Groups
  - Serves more than 8.9 million members

- **San Jose Medical Center**
  - 197,000 members
  - 242 Licensed Beds
  - 2 Medical Office Buildings
    (San Jose & Gilroy)
Why Transitional Care Pharmacy?

- 1 in 5 elderly patients readmitted to the hospital within 30 days
- 2.3 million readmissions per year
- 17 BILLION annual Medicare costs*
- Furthermore, the Food and Drug Administration estimates 1.3 million people in the United States are injured each year by medication errors **

** Food and Drug Administration (FDA) website, www.fda.org
Why Transitional Care Pharmacy?

- The Voice of the Patient:
  - Readmission Diagnostic project in Q1 & Q2 of 2010
  - 433 interviews conducted with members and family
  - Sample quotes:
    - At the last admission, she was started on steroids, we did not understand the reason for the med, she did not take it...this caused her to come back to the hospital
    - Last time I was in the hospital, they made changes to the meds I was on...I sort of understood; no not really, I did not know what the bitter pills were for...
TCP Across CA Kaiser Permanente

- SCAL: MD-RN Discharge Call Back Program
  - Significant reduction in 3-days, 7-days and 30-days readmission rates

- NCAL: Transitional Care Pharmacy (TCP) Program
  - Decrease in 30-days readmission
  - Improve patient satisfaction which further contributes to increase in total HCAHPS Score
Critical Moves

Critical Moves: Beta Site Testing

- Coordinated discharge planning
- Medication clarity
- Follow-up and information handoffs
- Risks and root causes

Introduction and Background

- Clear and frequent communication to patient or “healthcare agent” (After Visit Summary, and teach back methods used)
- Diagnosis in patient-friendly language
- Red flag symptoms to act on

- Transitional Care Pharmacy (TCP) program implemented to conduct medication reconciliation, patient education (with teach back), and medication delivery at discharge
- TCP consult tailored based on risk
- Accurate and clear medication list
- In-home medication follow up

- Follow-up phone call within 72 hours
- Follow-up phone call tailored based on risk
- Follow up phone call script and escalation process developed
- Follow-up appointments
- Who to call if symptoms worsen

- All 30-day readmissions reviewed in real time with root cause analysis performed; information routed to appropriate parties
- Forum in place to review trends and patterns of root causes
- Risk of readmission identified early; plan modified to fit risk

Kaiser Permanente
TCP Standard Activities

- Review discharge orders and medication list
- Intervene BEFORE patient is discharged
  - Clinical interventions
  - Medication reconciliation
  - Adverse drug reaction prevention
  - Referrals to pertinent clinics (Outpatient Anticoagulation)
- Provide bedside discharge consultation
- Post discharge follow-up phone calls to targeted patients
  - Address medication related questions/concerns
  - Early detection of inappropriate drug use
  - Reinforce compliance
San Jose Program: 3 Phases

Transitional Care Program (TCP) Overview: Start Date April 2011

STEP 1: Identifying TCP Pts
- 1030 am: Check with DC pharmacy if d/c meds ready
- Nurse to call Spectra # 708020 for new discharge

STEP 2: Beside Med Delivery & Counsel
- Discharge Pharmacy Process: Discharge instructions released in PIMS queue
- Discharge Pharmacy fills meds
- Inpt RPh coordinate w/Discharge Pharmacy for Med Pick-Up
- Upon med pick up, Outpt clerk to print out PTBill

STEP 2: Beside Med Delivery & Counsel (continued)
- Inpt RPh to provide Med Delivery and Discharge Counseling, using teach back method; Provide pt with bill
- Document in Medici
- Inpt RPh gives bill to pt and obtains a signed copy of bill to Discharge Pharmacy
- Return meds refused by pt and signed copy of bill to Discharge Pharmacy

STEP 3: Post Discharge Phone Follow-Up
- PCC + HBS, based on criteria, identify patients for FU phone calls post discharge
- Phone calls by PCC includes:
  - FU Apt?
  - Correct Contact Info
  - Concerns regarding hospitilization
  - Performs Service Recovery
  - NEVH Any Medication Related Questions

STEP 3: Post Discharge Phone Follow-Up (continued)
- PCC transfers names of patients with Med Related Questions to the "Discharge Phone Calls - Requiring Pharmacy Follow-Up" HC list
- Yes, Pt Has Med Related Questions
- Document in Medici
- Pharmacist will access the HC post-discharge list; call patient with 24 hours after PCC referral; keep the list updated

Exclusions:
- SNF Patients
- Hospice Patients
- MCH and Labor and Delivery
- HPS
San Jose Medical Center TCP Journey: Phase 1 TCP Initiation

- April 2011-January 2012
  - Monday-Friday 4-hours service
  - Inclusion criteria: New meds, poly pharmacy for new & home meds, high risk meds, *Beers list for elderly*
  - Discharges from all floors, exclusion SNF& Hospice, and L&D
  - Budget neutral

- Role of the TCP pharmacist:
  - Review medication orders and document intervention
  - Provide bedside consultation

- Patient, physician and nursing suggestions for program improvement:
  - Provide bedside consultation *with* discharge medication delivery
  - Extend TCP service to evening hours for late discharge
Phase 2 Service Expansion

- January 2012 expansion of TCP
  - 8 hours per day, 7 days a week
  - Added FTE
  - Delivery of medications to bedside

- Exclusion criteria minimized:
  - SNF and hospice patients
  - Mother Baby
  - Emergency department and observational patients
Phase 3: Post-Discharge Phone Call

- Goal: To enrich care experience and communication between the entire inpatient care team and the patient; provide appropriate handoffs to the ambulatory care team

- Calls from various sources:
  - Patient Care Coordinator (PCC)
  - Nurses
  - Hospitalists
  - Pharmacists (new, for targeted patients)

- SJO pilot: Referrals from PCC and Med/Surg nurses
Metrics of Success

- **Quality Indicator**
  - Decrease 30 day readmission rate
  - Decrease medication errors (intervention prior to discharge)
  - Increase medication adherence/compliance

- **Service Indicator**
  - Patient Satisfaction Survey (PSS) used as local indicator
  - Streamline the discharge process: Patients go home directly from the hospital floor with correct medications without having to stop by a pharmacy
Interventions Data

TCP Intervention Data April 2011 thru January 2012
Total # of Patients = 914
Total # of Interventions = 3232

Cost Avoidance per prevented ADE $6484
99 cases x 6484 = $641,916 cost avoidance from preventing ADE

PSS Results

- Patient Satisfaction Survey Results:
  - Sample Size 496 patients
  - 100% satisfaction with bedside counseling by pharmacist
  - 99.5% felt more comfortable managing medications at home due to TCP
Learnings from TCP

- Expansion of inclusion criteria between Phase 1 to Phase 2
- Increased total number of patients provided bedside discharge counseling
- Identified issues:
  - Discharges occur in clusters
  - Creates a bottle-neck with 1 TCP pharmacist
  - Patients who are high risk for readmission may miss out on TCP medication review and consultation
- Next Steps:
  - Optimal method for risk stratification of patients
  - Optimal process for low-risk patients
Planning a Local Program

- Operational Considerations:
  - Resources (staffing, unit based Rph, space at nursing station)
  - Hours (Evenings? Weekends?)
  - Backfill
- Coordination with PCC, Hospitalists and Discharge Pharmacy
- Discharge prescriptions at outside pharmacies
- Post-discharge follow-up:
  - Resources
  - How to handle non-pharmacy issues
  - A single point of phone contact
Metrics of Success

- Patient satisfaction
  - HCAHPS versus PSS

- Accurate process for identifying readmission reason

- Program expansion
  - Phase 1: Clinical review and bedside consultation
  - Phase 2 & 3: Meds delivery and post discharge follow up calls

- Cost-avoidance/savings from TCP
  - Reduction in readmission
  - Prevention of ADE
Questions