



Pharmacist-Led Transition Services to Avoid Costly Readmissions

April 29, 2009

dovetail

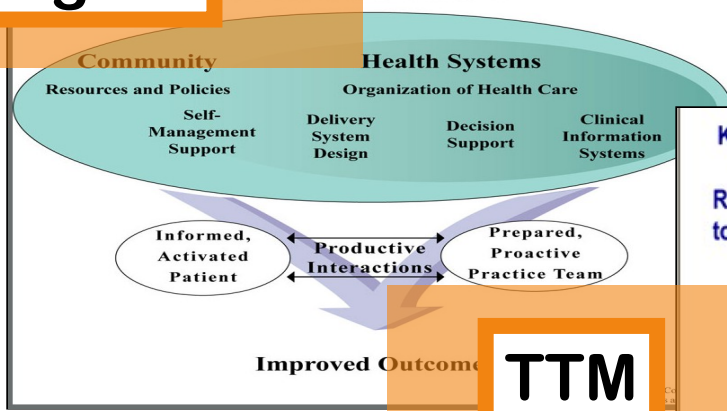
Dovetail Health

- ◇ **Based in Needham, MA**
- ◇ **Dovetail has been in business for over 5 years**
- ◇ **Delivering turnkey health and medication management programs for providers, payers and other organizations**
 - **In-Home Chronic Care (ongoing coaching and management)**
 - **Transition Management (30 day post-discharge support)**
- ◇ **What is Dovetail?**
 - **An extraordinary health service that joins physicians, family, and other caregivers to ensure that patients receive the personalized health, medication and transition support they need to remain safe and avoid hospitalizations**

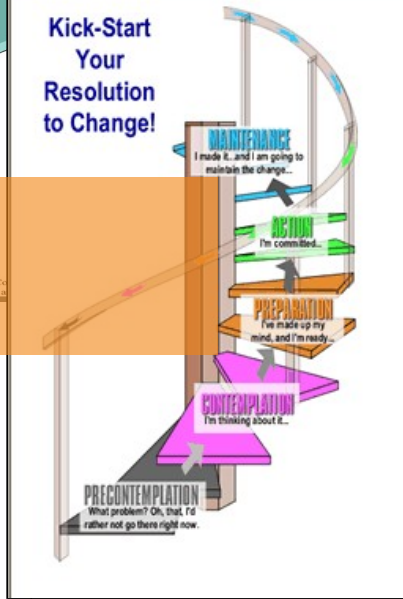
Industry champions have built proven care models

Wagner

The Chronic Care Model



Naylor



In the Literature

What Works in Chronic Care Management: The Case of Heart Failure

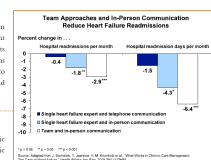
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Synopsis
 A study that examined data from 10 clinical trials of care management programs for heart failure patients found that multidisciplinary teams and in-person communication led to fewer hospital readmissions and readmission days.

The Issue
 Private health plans and public payers have implemented chronic care management programs with the goals of improving quality and health outcomes and saving money. Results range from encouraging to disappointing, with little conclusive evidence on what works. To determine which programs are most effective for managing heart failure—the leading cause of hospitalization among the elderly—this study assembled some of the world's top heart failure experts to examine data from notable randomized trials.

Key Findings

- Program patients had 20 percent fewer readmissions and 30 percent fewer readmission days than patients receiving routine care.
- Patients in chronic care management programs carried out by a single heart failure expert (acting on telephone follow-up) did not see a significant reduction in hospital readmissions and readmission days over patients in routine care.



The Four Pillars of Care Transition Activities

1. Medication Self-Management

Goal: Patient is knowledgeable about medications and has a medication management system.

Home Health Activities:

- Discuss importance of understanding medications and having a system in place.
- Reconcile medication regimens after any handover, identify and correct any discrepancies.
- Assist with medication simplification to support a manageable system.

Follow-Up: Answer any remaining medication questions.

2. Patient-Centered Record

Goal: Patient understands and utilizes a personal health record (PHR) to facilitate communication and ensure continuity of care planning across settings. The patient manages the PHR.

Home Health Activities:

- Explain PHR and its components.
- Review and update PHR after any handover.
- Encourage patient to update and share the PHR with primary care practitioners (PCP) and/or specialists at follow-up visits.

Follow-Up: Discuss outcome of visits with PCP and/or specialists.

3. Physician Follow-Up

Goal: Patient schedules and completes follow-up visit with PCP/specialist and is empowered to be an active participant in these interactions.

Home Health Activities:

- Emphasize importance of the follow-up visit and the need to provide PCP with recent health status information.
- Practice and role play questions for PCP/specialist.

Follow-Up: Provide advice in getting prompt appointments, if necessary.

4. Red Flags

Goal: Patient is knowledgeable about indicators that their condition is worsening and how to respond.

Home Health Activities:

- Collaboratively develop an emergency care plan (ECP).
- Discuss signs and symptoms indicating health status.
- Reinforce call and follow-up review ECP patient contact.

Coleman

ABSTRACT

BACKGROUND: Reducing rates of rehospitalization has attracted attention from policymakers as a way to improve quality of care and reduce costs. However, we have limited information on the frequency and patterns of rehospitalizations in the United States or aid in planning the necessary changes.

DESIGN: Used Medicare claims data from 2003–2004 to describe the patterns of rehospitalization to demographic characteristics and characteristics of the hospital.

SETTING: The study used data from 11,955,762 Medicare beneficiaries who had been hospitalized within 30 days and 34,676 were rehospitalized within 30 days after discharge with conditions and 53.6% of those who had been discharged after surgical care were rehospitalized or died within the first year after discharge. In the 80.2% of the patients who were rehospitalized within 30 days after a medical stay in the community, there was no 30-day visit to a physician's office between the time of discharge and rehospitalization. Among patients who were rehospitalized within 30 days after a surgical discharge, 78.7% were rehospitalized for a medical condition. We estimate that about 5% of rehospitalizations were being rehospitalized within the average stay of rehospitalized patients was 6.6 day longer than that of patients in the same diagnosis-related group whose most recent hospitalization had been at least 6 months previously. We estimate that the cost to Medicare of unplanned rehospitalizations in 2004 was \$274 billion.

CONCLUSIONS: Rehospitalizations among Medicare beneficiaries are frequent and costly.

The Care Transitions Intervention

Results of a Randomized Controlled Trial

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Background: Reducing rates of hospital readmissions is a key goal of health care reform. The Care Transitions Intervention (CTI) is a patient-centered, nurse-led program designed to improve the quality of care for patients with chronic conditions who are being discharged from the hospital. The CTI includes a home visit, a telephone call, and a follow-up visit with the primary care provider.

Methods: Randomized controlled trial. Between September 1, 2005, and August 1, 2007, patients were randomized to either the CTI or usual care. The CTI group received a home visit, a telephone call, and a follow-up visit with the primary care provider. The usual care group received a home visit, a telephone call, and a follow-up visit with the primary care provider.

Results: The intervention patients had fewer hospital readmissions (18.7% vs 23.5%, P<.01) and fewer readmission days (10.7 vs 13.4, P<.01) than the control patients. Intervention patients had lower rehospitalization rates for the same condition that put them in the study (16.2% vs 20.4%, P<.01) and for all causes (18.2% vs 23.5%, P<.01) than the control patients. The mean hospital charges were lower for the intervention patients (\$37,350 vs \$40,640, P<.01) and for all causes (\$37,350 vs \$40,640, P<.01).

Conclusions: Care transitions intervention reduced hospital readmissions and readmission days and reduced hospital charges for patients with chronic conditions who are being discharged from the hospital.

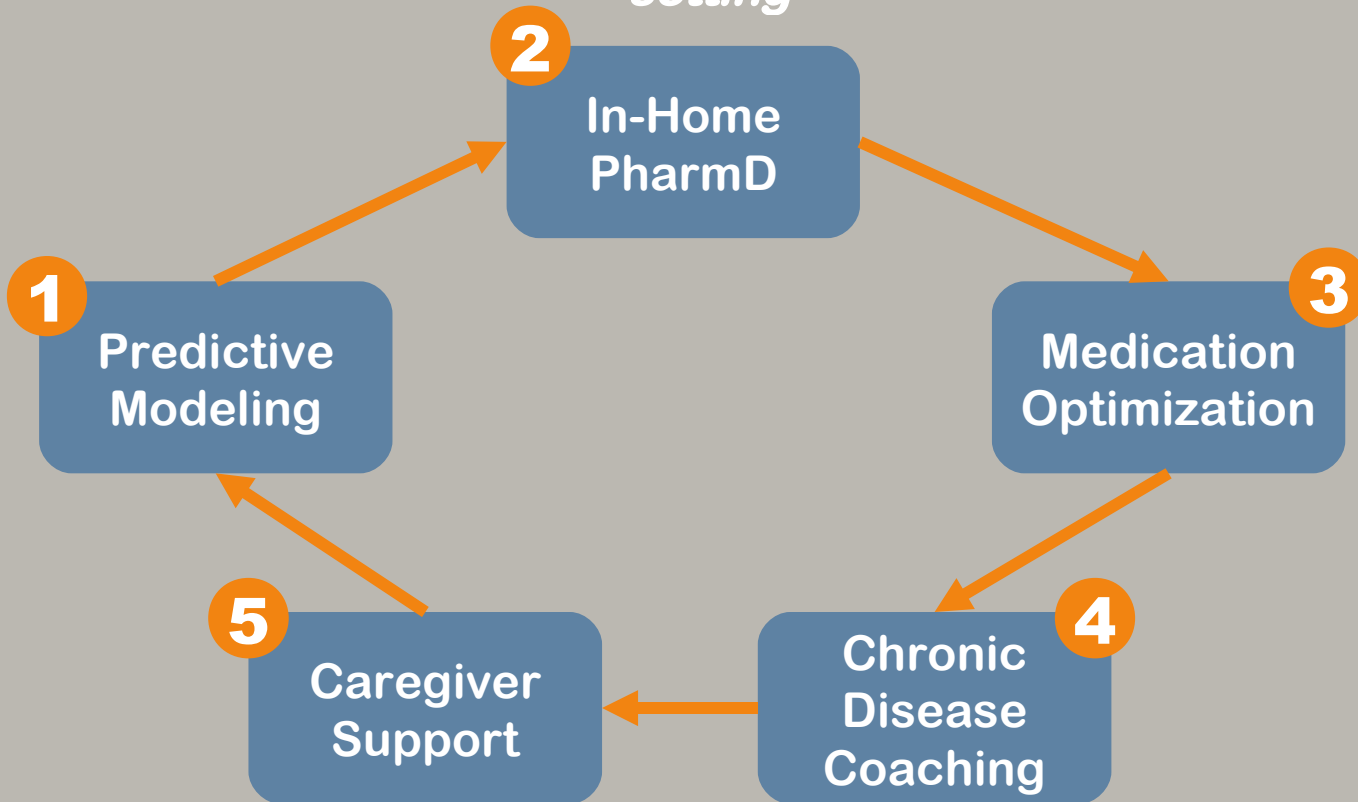
Word Count: 1000 words

Key Words: Care Transitions Intervention, hospital readmissions, patient-centered care, nurse-led program

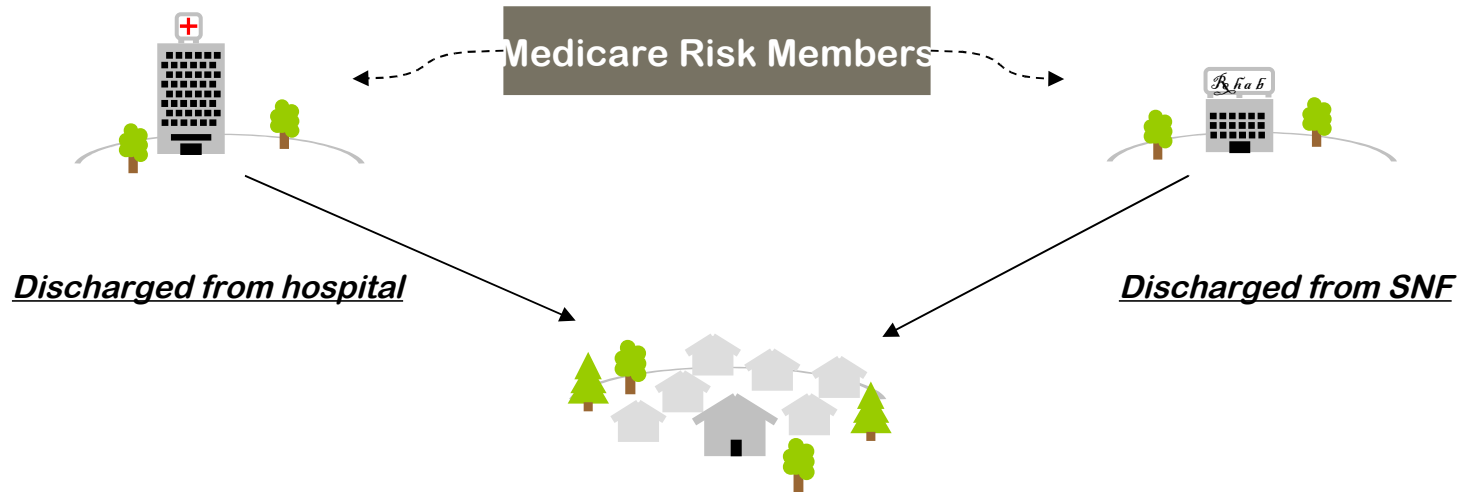


Dovetail's transition program operationalizes best practices

Enhancements designed to deliver success in commercial setting



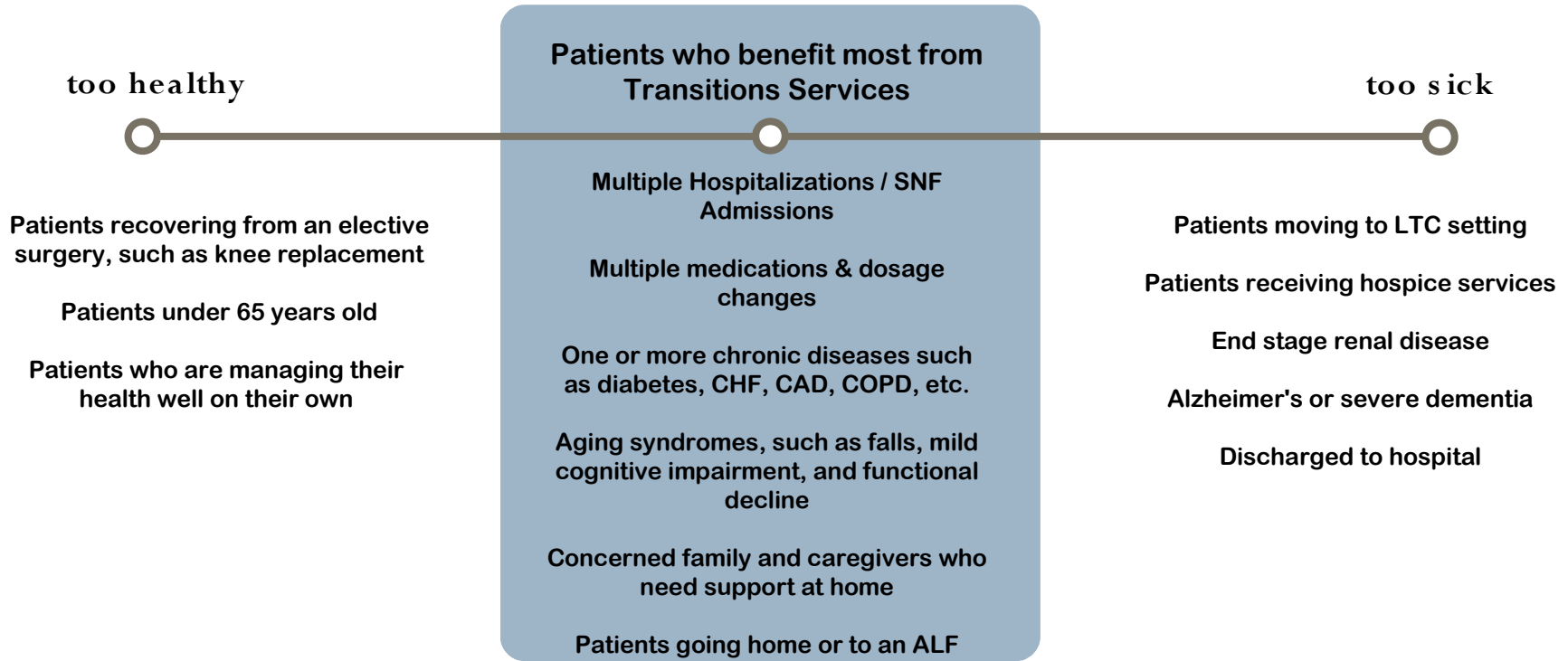
Dovetail's clinical program



After being identified as high-risk for re-admission patients receive the following services over a 30 day period:

- ◇ Dedicated transition team led by PharmD, with support from Nurse Care Manager and Transition Care Coordinator
- ◇ In-home visit by a PharmD (and RN as needed) to reconcile and optimize prescription and over the counter medications
- ◇ Personalized chronic illness coaching to ensure patient is knowledgeable about health management
- ◇ Ongoing telephonic management with the transition team to monitor progress and answer questions
- ◇ Focus on timely PCP visit, including preparation of health and medication report and questions to ask their doctor
- ◇ Referrals to support services as required: i.e. wellness programs, OT/PT services, and other provider resources

Selecting the right patients to ensure return on investment



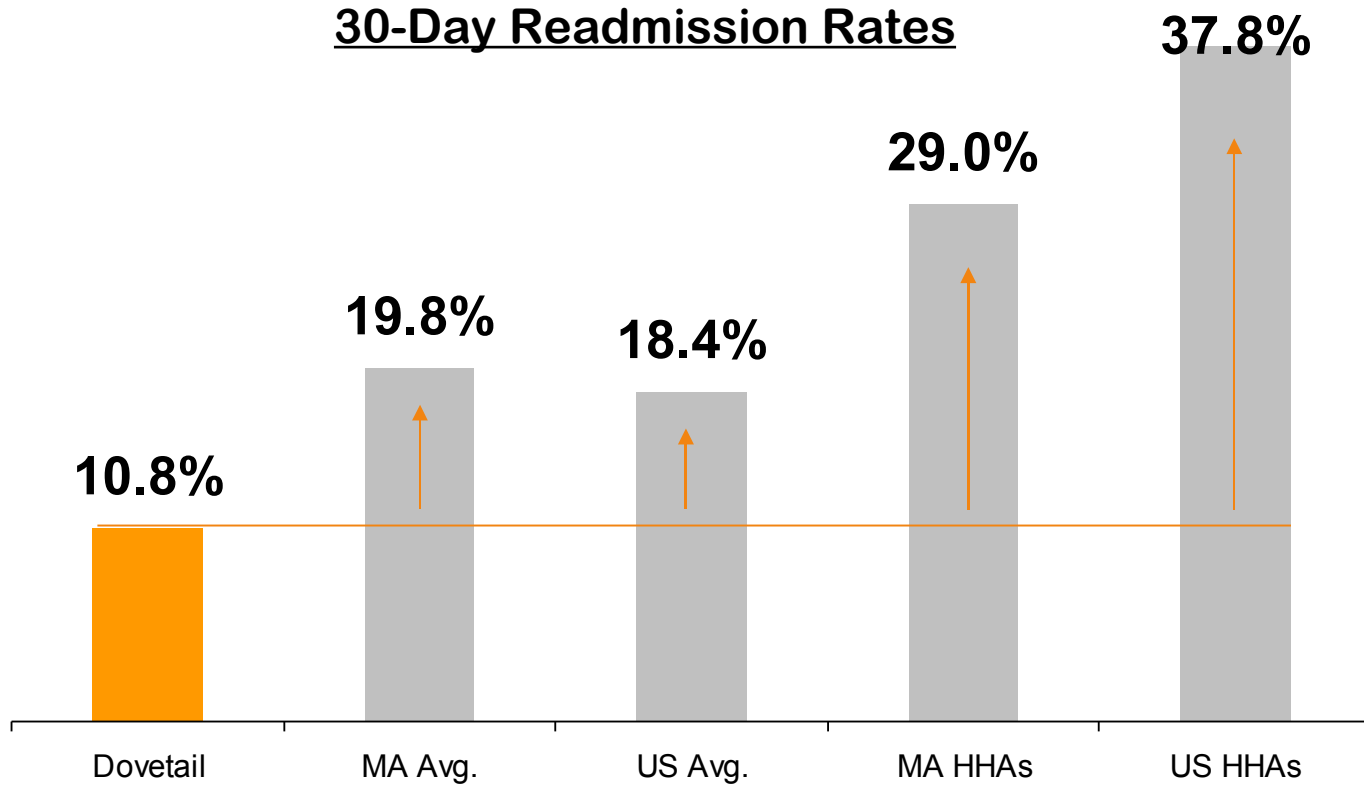
Dovetail 30-Day Transition Program

Self-Management

Partner Programs

In-Home Chronic Care

Delivering unmatched outcomes



76% of Dovetail patients have medication reconciliation issues

87% of Dovetail patients have medication adherence issues

