Partnership for Patients - National Priorities Partnership©

Patient Safety Webinar Series
Creating and Sustaining Successful Partnerships between Hospitals and Community Organizations

February 15, 2012

Today’s Moderator

Camille Smith, MSPH, MSW
Project Manager, National Quality Forum
Today’s Featured Speakers

- David Nau, PhD, RPh, Senior Director, Quality Strategies, Pharmacy Quality Alliance
- Richard Antonelli, MD, MS, Primary Care Pediatrician, Medical Director for Integrated Care, Children’s Hospital Boston

Today’s Featured Speakers

- Heather O’Donnell, JD, Director of Planning for Health Care Reform, CJE Senior Life
- Melinda West, RN, BEd, Intermediate Care Unit Manager, Bay Area Hospital
Patient Safety Webinar Series:
Recurring Themes

- Creating culture change through organizational leadership and empowered frontline providers
- Engaging patients and families in a meaningful way
- **Coordinating the efforts of multidisciplinary teams and organizations**
- Designing payment models that promote and incentivize quality and safe practices
- Measuring quality consistently and reliably within and between organizations

Objectives for Today’s Webinar

1. Provide an opportunity for thought leaders in patient safety to share best practices, success stories, and strategies for improving systems of care
2. Provide an overview of the PfP-NPP public-private partnership and collaborative efforts under way to improve patient safety in alignment with the National Quality Strategy
3. Generate action in organizations and communities nationwide
4. Provide examples of hospitals and community organizations working collaboratively to achieve results for patients
### About the Audience

**Type of Organization by Percentage**

<table>
<thead>
<tr>
<th>Organization</th>
<th>Percentage</th>
</tr>
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<tbody>
<tr>
<td>Hospital</td>
<td>24%</td>
</tr>
<tr>
<td>Healthcare System</td>
<td>11%</td>
</tr>
<tr>
<td>Quality Improvement Organization</td>
<td>11%</td>
</tr>
<tr>
<td>Non-profit</td>
<td>10%</td>
</tr>
<tr>
<td>Other</td>
<td>9%</td>
</tr>
<tr>
<td>Government Agency</td>
<td>8%</td>
</tr>
<tr>
<td>No Answer</td>
<td>7%</td>
</tr>
<tr>
<td>Home Health, Long Term Care, Skilled Nursing Facility</td>
<td>5%</td>
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<tr>
<td>Health Insurance or Healthcare Provider</td>
<td>5%</td>
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<tr>
<td>Academic or Research Institution</td>
<td>5%</td>
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<tr>
<td>Primary Care</td>
<td>2%</td>
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<tr>
<td>Patient Advisory/Advocacy</td>
<td>1%</td>
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<tr>
<td>Pharmaceutical</td>
<td>1%</td>
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</tbody>
</table>

### About the Audience

**Role in the Organization**

- **Quality Improvement**: 34%
- **Non-clinical Professional**: 27%
- **Other**: 12%
- **No Answer**: 8%
- **Manager**: 7%
- **Board Member**: 7%
- **Frontline Provider**: 5%
About the Audience

Regional Location

- Northeast: 21%
- Midwest: 21%
- South: 32%
- West: 16%
- US Territories: 1%
- International: 1%
- No Answer: 5%
- US Territories: 1%

Audience Feedback

Tell us about your experience

If you have any questions or comments for today’s speakers, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 877-681-3376, confirmation code 9148953.

Your questions will be answered throughout the webinar and during the audience discussion.
Featured Speaker

David Nau, PhD, RPh
Senior Director, Quality Strategies
Pharmacy Quality Alliance
NPP Partner Organization

NPP Input into the National Quality Strategy

- **October 2010**: NPP provides input to HHS to inform the development of the NQS
- **March 2011**: HHS issues NQS based on the triple aim
- **September 2011**: NPP input to HHS helps to make NQS more actionable:
  - Identification of goals and measures
  - Recommendation of strategic opportunities
  - Consensus across key leaders about where they should drive their organizations
  - Full report is available from the Links tab in the upper left corner of your screen
HHS’s National Quality Strategy Aims and Priorities

Goals:
- Reduce preventable hospital admissions and readmissions*
- Reduce the occurrence of adverse healthcare associated conditions*
- Reduce harm from inappropriate or unnecessary care

Measure Concepts:
- Hospital admissions for ambulatory-sensitive conditions
- All-cause hospital readmission index*
- All-cause healthcare-associated conditions*
- Inappropriate medication use and polypharmacy
- Inappropriate maternity care
- Unnecessary imaging

*Aligned with HHS’s Partnership for Patients initiative. Healthcare-associated conditions include adverse drug events, catheter-associated urinary tract infections, central line bloodstream infections, injuries from falls and immobility, obstetrical adverse events, pressure ulcers, surgical site infections, venous thromboembolism, and ventilator-associated pneumonia.
Partnership for Patients Goals

- **Keep patients from getting injured or sicker.** By the end of 2013, preventable hospital-acquired conditions would decrease by 40% compared to 2010.

- **Help patients heal without complication.** By the end of 2013, preventable complications during a transition from one care setting to another would be decreased so that all hospital readmissions would be reduced by 20% compared to 2010.

Partnership for Patients Ten Areas of Focus

- Catheter-associated urinary tract infections (CAUTI)
- Central line-associated bloodstream infections (CLABSI)
- Injuries from falls and immobility
- Adverse drug events
- Improving Maternal/Fetal Outcomes
- Pressure ulcers
- Surgical site infections (SSI)
- Venous thromboembolism
- Ventilator-associated pneumonia (VAP)
- 30 day readmissions
And how will it happen at scale?

- There is no “silver bullet,” but we know we must:
  - Engage leadership
  - Engage patients and families, authentically
  - Work together
  - Provide thoughtful incentives
  - Assist in the painstaking work of improvement
On the Road to Accountability

Achieving Optimal Outcomes: Creating and Sustaining Effective Linkages Between Patients/Families, Hospitals and Community Partners

Partnership for Patients—National Priorities Partnership
February 15, 2012

Richard C. Antonelli, MD, MS
Medical Director of Integrated Care and Physician Relations and Outreach
Children’s Hospital Boston
Acknowledgements

• Gina Rogers, Project Director, MA Child Health Quality Coalition Massachusetts Health Quality Partners
• Patricia A. Branowicki, MS, RN, NEA-BC, Vice President, Medicine Patient Services, Children's Hospital Boston
• Judith Vessey, PhD, MBA, FAAN, Lelia Holden Carroll Professor in Nursing Boston College, Nurse Scientist, Children’s Hospital Boston
• Elizabeth R. Woods, MD, MPH, and Shari Nethersole, MD and Community Asthma Initiative team
• Jay Berry, MD, MPH, Division of General Pediatrics, Harvard Medical School
• Julia Hickey, BS
Family-Centered Community-Based System of Services for Children and Youth

- Patient- and family-centeredness require understanding of non-medical determinants of health
- Life course approach is essential for long term, optimal outcomes
- While essential, Medical Home model is not sufficient for long term success
Definition of Integrated Care

Integrated care is the seamless and coordinated provision of health care services, from the patients’ perspective, across the entire care continuum. It includes the work done by all providers, irrespective of institutional and departmental boundaries.

Characteristics of an Integrated Health System

• Patient- and Family-Centered
• Shared Quality Goals– across providers
  – Clinical outcomes
  – Reduced variation in patterns of service delivery
• Shared Fiscal Accountability Across all Stakeholders
  – Community-based
  – Hospital-based
• Patient Receives the Right Care at the Right Time in the Right Place
Children’s Hospital Boston Integrated Care: Elements Which Support a Network of Care Across the Community

- Clinical Communications
  - Care Plans
  - Structured Referrals
  - "Warm" hand-offs
- Optimal Models of Care
  - Disease Specific Care Pathways
  - Collaborative Care Models
- Interoperable IT Infrastructure for IP and OP settings:
  - E-prescribing
  - Test & Referral Tracking
  - Personal Health Record (PHR)
- Utilization Management
- Performance Reporting
  - Quality/Outcomes
  - Finance
- Accessibility
- Care Coordination
- Tracking & Registry
- Linkage to Community Based Organizations
- EMR

MEDICAL HOME
(Typically, PCP; may be sub-specialist)

A Core Element of Integration: Care Coordination

Pediatric care coordination is a patient- and family-centered, assessment-driven, team-based activity designed to meet the needs of children and youth while enhancing the care giving capabilities of families.

Care coordination addresses interrelated medical, social, developmental, behavioral, educational, and financial needs in order to achieve optimal health and wellness outcomes.

Source:
MAKING CARE COORDINATION A CRITICAL COMPONENT OF THE PEDIATRIC HEALTH SYSTEM: A MULTIDISCIPLINARY FRAMEWORK
Antonelli, McAllister, and Popp, The Commonwealth Fund, May 2009
Alignment with Measure Applications Partnership (Convened by National Quality Forum)

Table 2. System-Level Framework for Care Coordination in Pediatric Health Care

<table>
<thead>
<tr>
<th>Level</th>
<th>Functions of Care Coordination</th>
<th>Enabling Factors for Care Coordination</th>
<th>Family Experience of Care</th>
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<tbody>
<tr>
<td>National</td>
<td>Quality focused organizations define and endorse care coordination functions at national, federal, state, regional, practice, and family levels. Professional organizations define, develop, and implement quality standards for care coordination across environments of care. Public-private partnerships seek to jointly design and align care coordination demonstration projects. Commercial and public payers support principles to improve equitable access to care coordination services.</td>
<td>Opportunities are created for family and consumer groups to articulate their needs and expectations for care coordination.</td>
<td></td>
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<tr>
<td>Organizations</td>
<td>Standards for care coordination financing are adopted.</td>
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<tr>
<td>Federal</td>
<td>Monitoring system-level care coordination performance.</td>
<td>Medicaid policies support care coordination framework.</td>
<td>Opportunities are created for families to provide input into federal policies related to care coordination, and to develop measures of quality, safety, equity, efficiency, and transparency.</td>
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<tr>
<td>Government</td>
<td>Tracking system performance - quality and cost outcomes.</td>
<td>Unintended policies affect care coordination</td>
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<tr>
<td></td>
<td>Education and training for practices</td>
<td>Public and commercial payers support efforts to integrate care coordination into existing systems.</td>
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<td></td>
<td>Evaluation includes satisfaction, clinical, functional, and cost outcomes.</td>
<td>Fiscal support promotes system-level care coordination with quality improvement efforts.</td>
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<td></td>
<td></td>
<td>Interagency collaborations to align care coordination efforts are identified and supported including Title V Early Intervention, Education, CMS, AmeriCorps, Medicaid, and others.</td>
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<tr>
<td>Family</td>
<td>Feedback on system of care coordination is in community level.</td>
<td>Medicaid policies affect care coordination framework.</td>
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Antonelli, McAllister, and Popp, Making Care Coordination a Critical Component of the Pediatric Health System: A Multidisciplinary Framework, CMWF, 2009
An Evaluation of RN Telephone-Initiated Encounters in Improving Care Coordination

Purpose: To describe the clinical and economic impact of Patient-Parent Telephone-initiated Encounters managed by registered nurses and their role in improving Care Coordination.

Judith A. Vessey, PhD, FAAN and the MPS Care Coordination Research Team

Medical Home Care Coordination Measurement Tool

Adapted for use in primary care, subspecialty (pediatric, adult; mental health; surgical, medical), nursing, and community agency settings.

http://www.ahrg.gov/qual/careatlas
The Quality Problem: Parents Not Ready for Discharge Were Discharged

- Parents of readmitted children were more likely to feel that...
  - Child’s illness was not resolved
  - Child was not healthy enough for discharge
  - Child should have stayed in the hospital
  - They did not know how to manage their child’s health
  - Did not have all the information they needed
- Action-- Personalized, patient-centered discharge readiness-- *mutual consent*
- Next Steps--
  - Correlation of readmission risk with discharge readiness perceptions at different times during hospital stay
  - Parent perceptions of when and how discharge readiness should be discussed

Jay Berry, MD MPH, Sonia Zniel, PhD, William Kaplan, BS, Linda Freeman, MBA
Rich Antonelli, MD, Eric Coleman, MD, Don Goldmann, MD
Division of General Pediatrics, Children’s Hospital Boston,
Institute for Healthcare Improvement, University of Colorado

Proactive, Non-Hospital Based Approach Community Asthma Initiative Addressing Multiple Levels of the Socio-Ecological Model

1. Individual and Family: asthma education, case management and home visiting by nurses and CHWs for children in Boston with previous hospitalizations and ED visits
   - asthma education, medications, home environmental assessments and remediation of triggers
2. Community: Educational workshops, social marketing, community asthma forums
3. Systemic: Garner support for innovative payment approaches
4. Successful expansion to primary care practices across MA in Medicaid 1115 waiver

Improvement in Health Outcomes

Any days/events) at 6 and 12 months (N=800, All p<0.001): ROI = 1.46, SROI=1.73

Significant Reductions (any days/events at 12 months of follow-up):
- 62% in ED visits
- 81% in admissions
- 43% in missed school days
- 47% in missed work days
- 31% in limitation of physical activity

Children’s Hospital Boston
Collaborative Center for Community Research (C-CORE)

- Community-based participatory research center aims to strengthen interest in and capacity for conducting research targeting health disparities among Boston youth, families, and communities
- Collaborative effort by Children’s Hospital Boston, Boston Public Health Commission, Boston Public Schools, Boston Conference of the Massachusetts League of Community Health Centers, and a diverse Community-Academic Advisory Board
- Funded by NIH, C-CORE activities include:
  - Working with communities to identify community health priorities and research opportunities through needs assessments and public forums;
  - Coordinating and facilitating partnerships between academic researchers and community stakeholders;
  - Providing pilot grants and support to community and academic stakeholders to design, implement, and evaluate new projects; and
  - Communicating information about research methods and research findings to community members, academic partners, and policy-makers

Director: Mark Schuster, MD, PhD, Associate Director: Laura Bogart, PhD
http://www.childrenshospital.org/ccore
Massachusetts Child Health Quality Coalition

Initiated at inception of MA CHIPRA Grant

Urgent Priorities
1. care coordination, especially linking mental/behavioral health and medical needs
2. Assuring that children are not left out or misrepresented in ACO/payment reform models

Massachusetts Child Health Quality Coalition

60-member coalition dedicated to improving and sustaining health quality across the continuum of care for children in Massachusetts

- Hospitals (all 4 tertiary, reps from community hospitals)
- Pediatric offices (medical groups, CHCs, provider organizations)
- Provider specialty organizations: AAP, AAFP, CHCs, NPs, School RNs, Social Workers, Psychologists, MHA, Behavioral Health Systems
- Public and private payers and employers, Parents
- Family and consumer advocacy groups and community agencies
- State agencies and local public health agencies
- QI and measurement organizations and academia
References


Featured Speaker

Melinda West, RN, BEd
Intermediate Care Unit Manager
Bay Area Hospital
Live Well and Live Strong with Heart Failure

Strong Heart Program

Care Transition GOALS

- Gain consistency of evidence based Heart Failure Care - across care continuum.
- Convey important NEXT STEPS at each and every transition of care.
- Avoid breakdown of care plan through all care transitions.
- Provide clear, consistent & useful discharge instructions at each care transition.
- Assure life-sustaining equipment an/or medications are in place prior to care transitions.
Community Partnerships
• Identified Care Transitions
• Built Relationships – One transition at a time
  • Learn about their WORLD
  • Meet their needs
  • Stay in touch

Clinical partners - play a critical role in the execution of the care plan in all care settings.

Communication - forms the a safety net for the patients transitioning between care settings.

Value - of different care settings promotes collaboration and fosters growth in best practices.

Resources – standardizing tool enhances patient, family/caregiver understanding of the plan of care as well as ability to comply with changing care needs.
Poorly executed transitions in care negatively impact patients' health and well-being, family resources and unnecessarily increase cost incurred by health care systems.

<table>
<thead>
<tr>
<th>Principle &amp; Secondary Diagnosis of Heart Failure</th>
<th>Readmission Prior to Partnership</th>
<th>Readmission Rate post Partnership</th>
</tr>
</thead>
<tbody>
<tr>
<td>30 – 90 day readmit From Skilled NRS Facility</td>
<td>69%</td>
<td>23%</td>
</tr>
<tr>
<td>30 – 90 day readmit From Home Health Agency</td>
<td>43%</td>
<td>34%</td>
</tr>
</tbody>
</table>

Guiding our community to better health through -

A comprehensive program

THAT DECREASES

acute care need

AND IMPROVES

quality of life

by creating a

safe support network

linda.mill@bayareahospital.org
Tell us about your experience

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Featured Speaker

Heather O’Donnell, JD
Director of Planning for Health Care Reform
CJE Senior Life
A Community-Led Hospital Collaborative to Reduce Avoidable Hospital Readmissions for High-Risk Elderly Patients

A Section 3026 Demonstration Project Awarded by the Center for Medicare and Medicaid Services

Presented By Heather O’Donnell
CJE SeniorLife, Director of Planning for Healthcare Reform

Helping At-Risk Elderly Patients Make the Transition From the Hospital Back Home or into a Nursing Home Setting

• Improving care transitions is a key component of the Partnership for Patients initiative. The Section 3026 Community-Based Care Transitions Program (CCTP) is the federal demonstration program testing community-led transitional care interventions aimed at improving care coordination between providers and reducing avoidable readmissions.

• Transitions from the hospital to the next care setting can be fraught with communication gaps between providers, and leave the patient/caregiver feeling overwhelmed on how to manage complex medical conditions and medications following hospital discharge.

• Evidence shows that transitional care – facilitating the patient transition from the hospital back home or into sub-acute or long-term care – significantly reduces costly avoidable readmissions through improved care coordination between providers and increased patient empowerment for self-management.
CJE’s Hospital Collaboration for Transitional Care

• **Who We Are:** CJE SeniorLife is a long-standing community-based elder care organization in Chicago. Our services span the full continuum of long-term care for the elderly. We intersect with medical providers regularly.

• **Our Partners:** CJE is leading a CCTP Collaborative funded through CMS in partnership with:
  - Northwestern Memorial Hospital, a major academic medical center
  - Provena-Resurrection Saint Joseph Hospital
  - Provena-Resurrection Saint Francis Hospital
  - Telligen, the Illinois Quality Improvement Organization
  - Local Care Coordination Units
  - Multiple skilled nursing facilities and home health agencies

CJE’s Transitional Care Collaborative

• **CJE’s intervention (Coleman Care Transitions Intervention)** picks up where the hospital discharge planning process leaves off (Project BOOST and Project RED), following the patient home or into the sub-acute or long-term care setting.

• **Goal of CJE’s CCTP Collaborative:**
  - Improve patient PCP and specialist follow-up post-hospitalization
  - Enhance provider communication/coordination and
  - Empower patients to self-manage medical conditions and medications following discharge
  - Ensure necessary home and community support services are available and in place

• Reducing readmissions for each of our hospital partners is a top priority in order to avoid Medicare penalties and improving the quality of care for patients.

• Program roll-out during the spring. Expect to provide transitional care services to over 2,700 patients/year.
CJE’s Transitional Care Program

• CJE is adopting the model developed by Dr. Eric Coleman. Transitional care nurses (TCNs) will be embedded in the hospital working closely with the discharge planning team. Upon hospital identification of older adult Medicare patients meeting our high-risk criteria, the TCN will meet with the patient and caregiver prior to discharge.

  • Home visit (home or nursing home) within 24-72 hours of discharge
    - Develop a person-centered care plan and 30-day health care goals
    - Teach patient to self-manage medical conditions
    - Support patient to adhere to medication regimen
    - Help patient attend follow-up medical appointments
    - Teach patient how to look for the red flags of a worsening condition and how to respond
    - Home evaluation for fall and other risks

  • Weekly follow-up phone calls over 30 days following discharge

  • Evidence-based model proven to reduce readmissions

Developing Sustainable Partnerships Across the Continuum is Critical in Bridging Care Silos

✓ Addressing a community need as well as hospital need (high-admission population; hospitals with high-readmissions)
✓ Identifying committed partners
✓ Commitment to quality improvement
✓ Picking up where the hospital discharge planning process leaves off
✓ Bridging silos (and the patient knowledge gap)
✓ Leadership support, discharge planner support, physician support as well as operational know-how
✓ Integration of effort
✓ Data sharing to monitor outcomes
✓ Ability to ramp-up quickly; continue momentum
✓ Ensure no duplication of services; reinforcement of effort
✓ Education, education, education
The Pharmacy Quality Alliance

- Established in April 2006, as a public-private partnership
- Consensus-based, non-profit, alliance with over 70 member organizations, including:
  - Health Plans & PBMs
  - Pharmacies & professional associations (AMCP, APhA, ACCP, NCPA)
  - Federal agencies (CMS, FDA)
  - Pharmaceutical mfrs
  - Consumer advocates
- Mission: to improve the quality of medication management and use across healthcare settings through a collaborative process to develop and implement performance measures, demonstrate improvements in patient care, and recognize examples of exceptional pharmacy quality being delivered
Team Roles

- Quality measures for pharmacy services and drug plans
  - Workgroups identify key measure concepts in areas such as safety, adherence, clinical appropriateness
  - Technical specifications are developed and tested
  - Approved measures are maintained and updated

- Demonstration projects for pharmacy quality measures

- Education for pharmacists on quality measures and performance improvement

- Connecting pharmacy to healthcare quality initiatives

Demonstration Projects

**Example from Pennsylvania**

- **Initiated in 2008**
  - Phase I Partners – CECity, Highmark, Rite Aid

- **“Phase II” PQA-supported demonstration project underway (began in June 2010)**
  - University of Pittsburgh added to partnership
    - School of Pharmacy (UPSOP) added for:
      - Interventional expertise and project evaluation
      - Motivational interviewing training and tools
      - Relationship with RTI to conduct health-focused economic analyses
Phase II Overview

The Phase II Demonstration involves:
- Focus on medication adherence for diabetes and CVD medications
- Continuous data aggregation & evaluation (monthly) of quality measures
- Identification of gaps relative to benchmarks and peers
- Dynamically linking interventions for performance improvement to quality measure gaps

- Evaluation of the impact of the pharmacist intervention on medical services utilization and total expenditures
  - Quasi-experimental design with 120 intervention pharmacies and 120 control pharmacies

- Modeling of P4P or other payment incentives for pharmacies based on performance improvement

Monthly Performance Report

- Identification of Measures & Goals - Detail drill down
- Reporting by Pharmacy
- Identification of Gap
- Indication of Improvement
- Access to Interventions
- Analyze history & peer comparison data
After examining the baseline data, intervention and control stores had the same opportunity for improvement.

Patient adherence for ACEI/ARBs, Beta-Blockers, Calcium Channel Blockers and Diabetes medications increased significantly more in intervention stores when compared with control stores.

The fact that improvements in medication adherence observed in the intervention stores accumulated over time suggests that patients may require sufficient exposure to the intervention over time for changes to occur (and that sustaining the intervention may be important).
E-QuIPP Initiative

- E-QuIPP = Electronic Quality Improvement Platform for Plans & Pharmacies

- The E-QuIPP Initiative is built on the model from the Pennsylvania demonstration wherein a health plan and pharmacies collaborated on quality improvement

- During 2012, the “beta phase” for the E-QuIPP Initiative will allow health plans and pharmacies in Pennsylvania, Alabama and Florida to view quality scores and benchmarks, and use tools for no cost (via grant support)

PQA relevance to PfP

- PQA’s “MTM & Care Transitions” Workgroup has been focusing its discussions on medication management during the transition of patients from hospital to home

- The evidence is clear that many hospital readmissions are due to medication-related problems that stem from poor reconciliation of medication regimens after discharge or poor adherence by patients

- The root causes of these problems include:
  - Lack of direct communication between hospital, primary care physician and community pharmacy
  - Lack of incentives/standards for medication reconciliation post-discharge
  - Lack of incentives for patient education
PQA relevance to PfP

- PQA’s workgroup is considering the following recommendation for high-risk patients being discharged:
  - A pharmacist should reconcile the pre- and post-hospital medication regimens in coordination with PCP and the patient’s pharmacy. This could be done at discharge by hospital pharmacist or immediately afterwards by community pharmacist. The patient’s pharmacy needs to be informed of the reconciled list of chronic medications, both new meds and discontinued meds.
  - When reconciling the drug list, the pharmacist should perform a “comprehensive medication review” (CMR) to identify potential problems
  - A pharmacist should advise the patient on the proper use of the new medications and about which medications to discontinue
  - If med reconciliation and CMR occur outside the hospital, the occurrence of should be transmitted to the hospital, PCP and patient’s pharmacy to “close the loop”

Summary

- PQA seeks to reduce hospital admissions and re-admissions through improved medication management
  - Community pharmacists working with primary care physicians and health plans can reduce medication-related problems and improve patients’ medication adherence
  - Pharmacists are an underutilized resource for medication reconciliation and patient education for patients who have been discharged from a hospital
  - PQA would be happy to collaborate with other initiatives to improve med mgmt and reduce readmissions
Tell us about your experience

If you have any questions or comments for today’s speakers, please type into the chat box at the bottom left corner of your screen. To dial into the discussion, call 877-681-3376, confirmation code 9148953.

Conclusion

Next Steps, Further Resources, and Concluding Remarks
Further Resources

Resources, links, and PDF documents are available now in the top left corner of your screen in the Links tab, including:

- Partnership for Patients website
- National Priorities Partnership (NPP) website
- National Quality Forum patient safety webpage
- NQF 2012 Annual Conference “Building a Patient and Family-Centered Health System” on April 4-5, 2012, in Washington, DC
- Information for both available online at www.qualityforum.org
- “Introduction to the Community Tool to Align Measurement” webinar on March 7, 2012

Thank You

A recording of this webinar will be available on the National Quality Forum website within a week. When you exit, you will automatically be directed to an evaluation about this webinar.

For further questions, please contact priorities@qualityforum.org