Transitions of Care (TOC) Quality Guide

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Purpose

- This toolkit is intended to be a reference guide to those who are looking to reduce avoidable hospital readmissions.
- Avoidable hospital readmissions is a challenge physicians, hospitals, and health plans continually face.
- Identifying patterns of use and guiding members to appropriate sites of care may reduce costs and improve care.
- The intent of this guide is to aid in avoiding readmissions through the application of evidence-based materials and clinical experiences.

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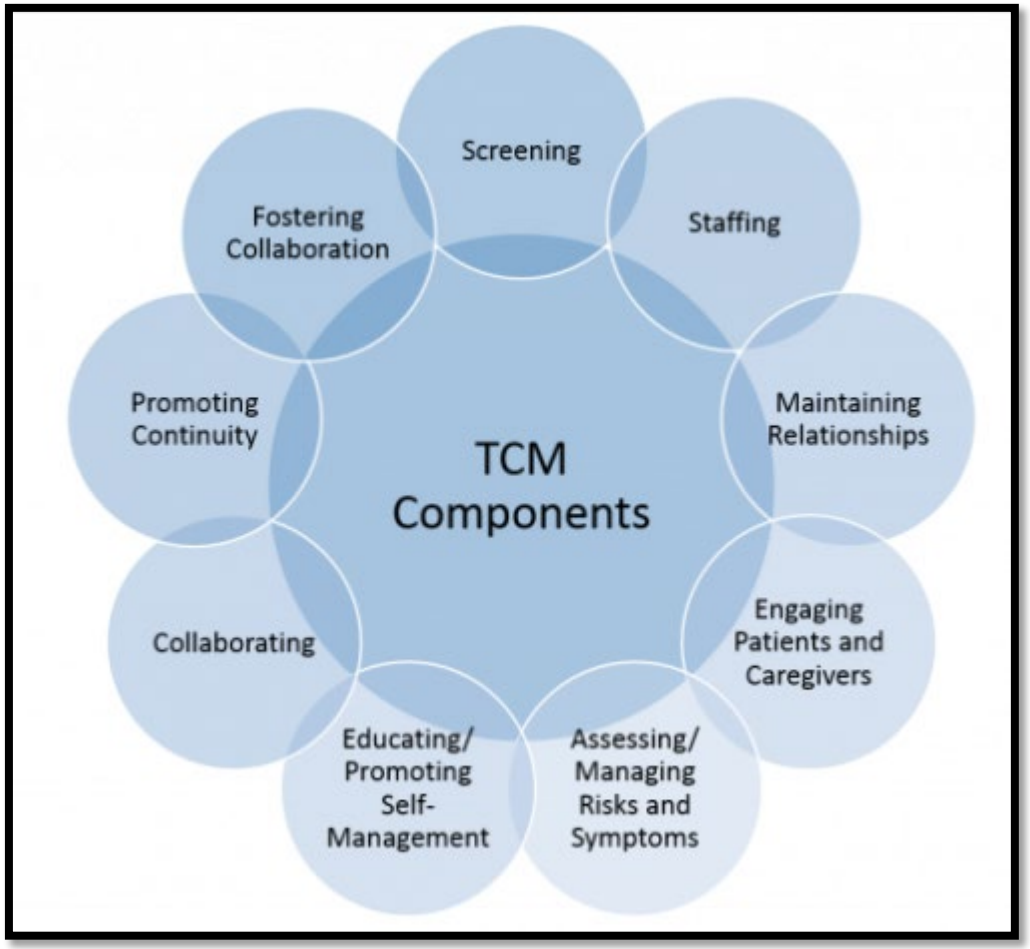
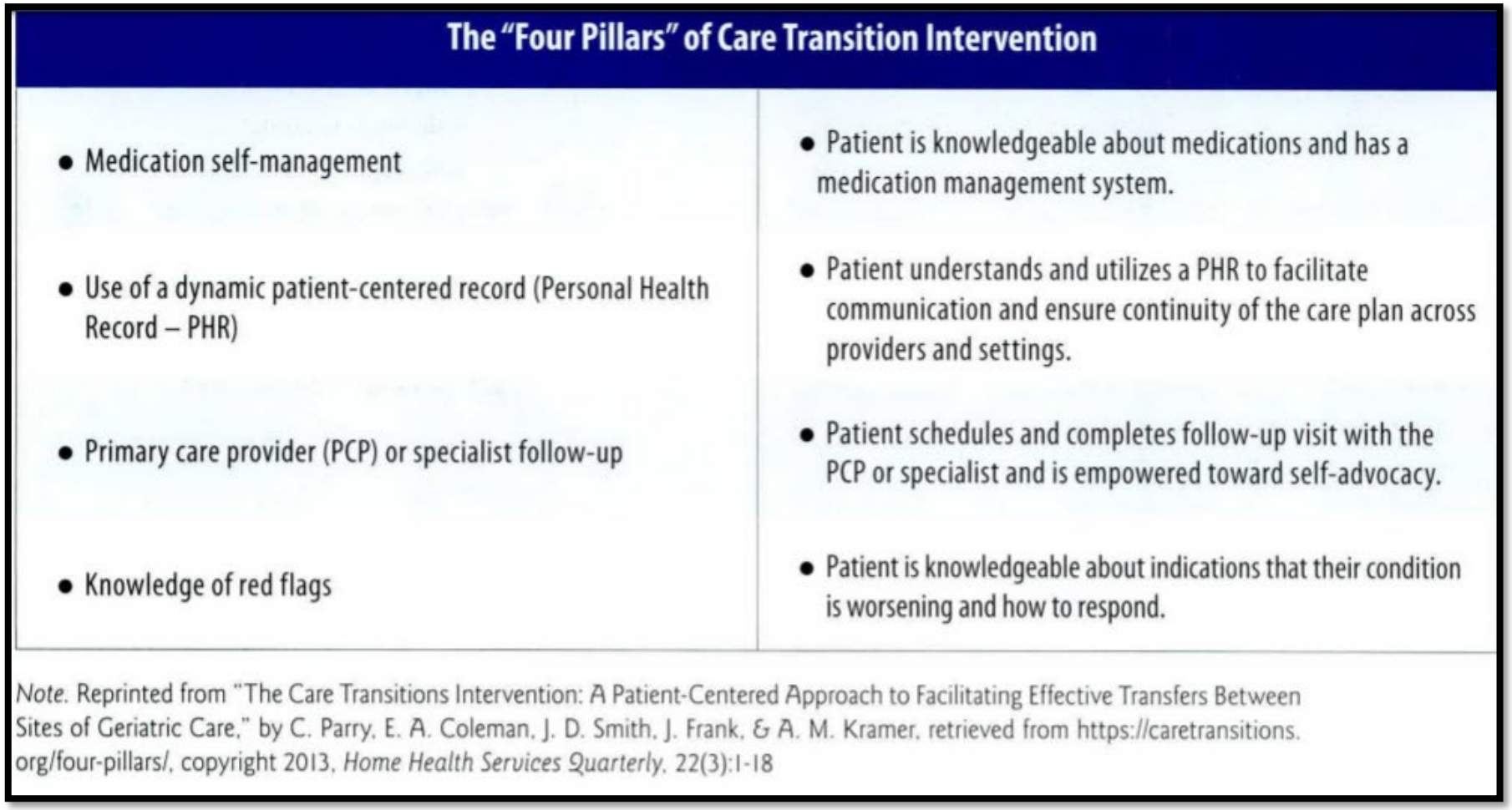
Components of a Transition of Care Process

Transitional Care Model (TCM) - Evidence Based[1]



Component	Definition
Screening	Targets adults transitioning from hospital to home who are at high risk for poor outcomes.
Staffing	Uses APRNs who assume primary responsibility for care management throughout episodes of acute illness.
Maintaining Relationships	Establishes and maintains a trusting relationship with the patient and family caregivers involved in the patients' care.
Engaging Patients and Caregivers	Engages older adults in design and implementation of the plan of care aligned with their preferences, values and goals.
Assessing/ Managing Risks and Symptoms	Identifies and addresses the patient's priority risk factors and symptoms.
Educating/ Promoting Self-Management	Prepares older adults and family caregivers to identify and respond quickly to worsening symptoms.
Collaborating	Promotes consensus on plan of care between older adults and members of the care team.
Promoting Continuity	Prevents breakdowns in care from hospital to home by having same clinician involved across these sites.
Fostering Coordination	Promotes communication and connections between healthcare and community-based practitioners.

The Four Pillars of Transitional Care[2]



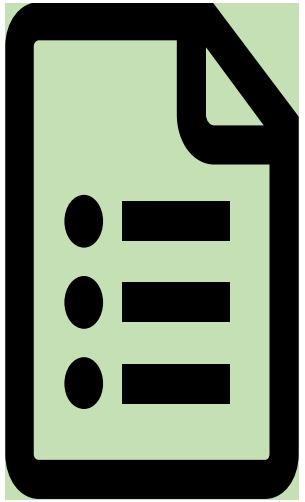
The "Four Pillars" of Care Transition Intervention	
• Medication self-management	• Patient is knowledgeable about medications and has a medication management system.
• Use of a dynamic patient-centered record (Personal Health Record – PHR)	• Patient understands and utilizes a PHR to facilitate communication and ensure continuity of the care plan across providers and settings.
• Primary care provider (PCP) or specialist follow-up	• Patient schedules and completes follow-up visit with the PCP or specialist and is empowered toward self-advocacy.
• Knowledge of red flags	• Patient is knowledgeable about indications that their condition is worsening and how to respond.

Note. Reprinted from "The Care Transitions Intervention: A Patient-Centered Approach to Facilitating Effective Transfers Between Sites of Geriatric Care," by C. Parry, E. A. Coleman, J. D. Smith, J. Frank, & A. M. Kramer, retrieved from https://caretransitions.org/four-pillars/, copyright 2013, *Home Health Services Quarterly*, 22(3):1-18

Practice Self Assessment

Practice Self Assessment

Practice Self-Assessment		
The entity/practice performs TOC visits.	Y	N
TOC visits are performed on all lines of business.	Y	N
A standardized written TOC policy exists across the entity.	Y	N
TOC's are completed on indirect transitions to home, i.e., Hospital -SNF-Home	Y	N
TOCs are completed for post-op discharges.	Y	N
Pre-op education includes importance of the follow up appointment with the PCP post-op.	Y	N
A process is in place to ensure discharge instructions/notifications are timely and complete to faciliate the TOC process.	Y	N
A tracking system is in place to monitor the TOC process end to end.	Y	N
TOC phone scripting is utilized to promote the post-discharge conversation with patient.	Y	N
TOC template is incorporated into the EMR to facilitate documentation.	Y	N
Barries and obstacles to effective TOC completion are tracked.	Y	N
TOC rates are used to facilitate healthy competition and best practice sharing between providers.	Y	N
All staff members are educated on the importance of the TOC process and play their role in the success of the process.	Y	N
Staff is routinely educated on patient engagement techniques.	Y	N



Assessment can be completed at entity level to review potential opportunities.

Self Assessment Action Plan[3]

THE ACTION PLAN

Day 0

DISCHARGE | HOW WILL YOU:

- Know if your patients have been discharged
- Obtain the discharge summary
- Gather data from your hospitals, are data sent electronically, by fax, or paper

Day 1-2

INITIAL CONTACT | HOW WILL YOU:

- Contact your patient within two business days
- Contact the patient - what is your documentation process?
- Ensure that scheduling an appointment can be completed while being mindful of the seven or 14 day limits

Day 7-14

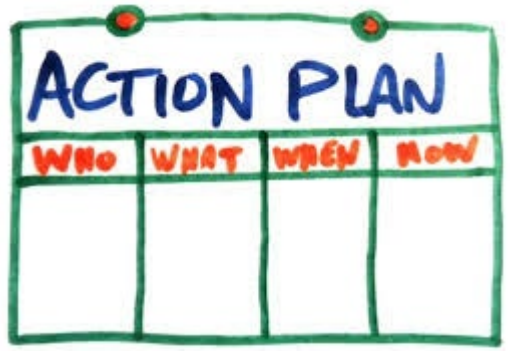
ENCOUNTER | HOW WILL YOU:

- Complete the encounter
  * Provider needs to know this is a transition encounter
- Document the place of the encounter
- Complete the medication reconciliation
  * Pre-encounter vs. Encounter
- Documenting complexity of the patient (moderate vs. high)

Day 30

BILLING | HOW WILL YOU:

- Bill as soon as possible after encounter has occurred.
- How will you remember this? Electronic, Spreadsheet, Tickler File

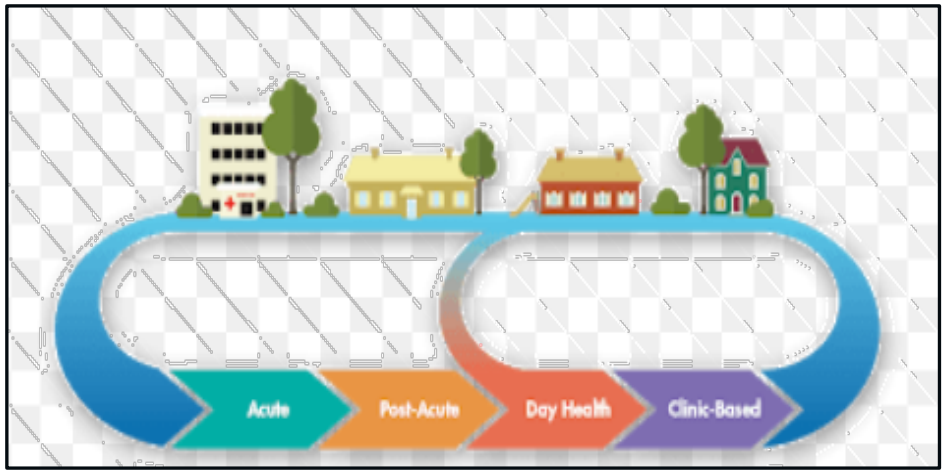


Establishing Objectives

Establishing TOC Objectives

- **TOC** is an opportunity for you and your team, to reach beyond your practice walls to find common goals with facilities and other providers who also provide care to your patients.

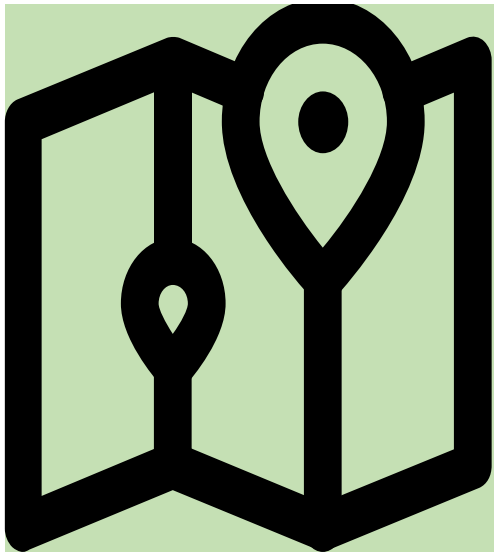
- These efforts are intended to help with the coordination of care, reducing potential duplication of efforts, and readmission.



Establishing TOC Objectives

Benefits of a TOC Visit may include the following:

- Decreased readmission rate
- Increased financial gains in VBR programs
- Increased medication reconciliation / compliance
- Increased patient satisfaction
- Better patient outcomes (as defined by….)



Establishing TOC Objectives[4]

Objectives **will define the actions to take to achieve the goals identified.**

- Ask the following questions:
- **What** are we going to do?
- **Why** is it important for us?
- **Who** is going to be responsible?
- **How** are we going to do this?

Define your objective:

- **Specific**: Concrete, detailed, well defined.
- **Measureable:** Measurement and comparison
- **Realistic:** Consider constraints such as resources, personnel, time frame
- **Time-Bound:** Time frame helps to set boundaries

There will need to be continued measurement and assessment of the objectives to determine if adjustments need to be made.

Plan – Do – Study - Act

Source: CDC Centers for Disease Control and Prevention: CDC 24/7: Savings Lives Protecting People ™; Public Health Professionals Gateway, Public Health Information Network Communities for Practice.

Sample TOC Objectives

TOC Initiative		Responsible Party	Notes / Key Milestones	Date for completion	Status
Education	Assess knowledge of TOC through survey	Care Management Team	Survey in development Unable to obtain approval from all parties	July 30, 2020	
	Provided education based on survey results including; - Current status of readmissions/observation rates - Requirements of a TOC visit. - Best practice examples of a TOC process with positive results.	Care Management Team/ Lead Physician	In jeopardy due to delay in survey deployment	August 15, 2020	
Process Improvement	Establish process for TOC visits. - Identify person(s) to view reports of discharged patients daily - Collaborate with hospital(s) in obtaining discharge reports. - Identify person(s) to outreach to patients within 72hrs of discharge	Office Manager / staff Office Manager Office Manager / Staff	Office manager has met with staff and identified 2 positions that will look at daily discharge reports. Office manager is working with hospital to have discharge reports automatically sent to office. Office manager work with staff to identify the positions that will outreach to patients.	August 15, 2020 August 15, 2020 August 15, 2020	

On Track ; In jeopardy ;

HIGHMARK BCBS HIGHMARK BS

Patient Prioritization, Identification & At-Risk Populations

Prioritization

- Phone call to patient within 24 to 72 hours of hospital discharge to assess needs
  Items for discussion:
  - Medication Review
  - Home services (RN, MSW, PT, etc.)
  - Transportation needs for follow-up visit
  - Schedule/ confirm follow-up visit

What your patient may be feeling after hospital discharge:

Overwhelmed
Lack of understanding of treatment plan
Distrust of providers
Confusion- conflicting treatment plans
Fear of the known and unknown
Depression/ Anger
Lack of support
Denial

Patient Risk Identification[1]

6 components to identify patients at risk for poor outcomes who would benefit from TOC

- **Five or more chronic conditions**
- **A recent fall**
- **Deficits in basic activities of daily living**
- **Diagnosis of dementia or poor performance on cognitive impairment screening tools**
- **History of mental or emotional health problems**
- **Hospitalization within the past 30 days or two or more hospitalizations within the past 6 months**

At Risk Populations[5]

Characteristics of readmitted patients:

- Elderly
- Diagnosis: heart failure, COPD, dementia/ AMS, renal insufficiency, pneumonia, history of noncompliance, respiratory failure
- Taking more than TEN medications
- 3 or more newly prescribed medications
- Those prescribed anticoagulation
- More than one diagnosis identified at first admission
- No primary care follow-up post discharge
- Discharged late in the day, on weekends or holidays

- **Consider higher level of care at discharge**
- **PCP visit within first 7 days of hospital discharge**
- **Improved discharge education**
- **Attention to discharge medications and dosages**
- **Case Management Referral**
- **Frequent contact or office visit with patient**

Guidelines

TOC Guidelines[7]

There are several sources for guidelines for TOC Management and TOC Visit coding.
Below are a few of these resources:

TOC Visit Coding

- **Highmark Provider Resource Center** – Claims, Payment & Reimbursement section, Reimbursement Policy - Reimbursement Policy Bulletin: *RP-043, Care Management. For information on completion of TOC visits via telehealth please reference information on the Provider Resource Center under COVID 19 heading, Telemedicine and Virtual Visits.*

Transitional Care Management Services

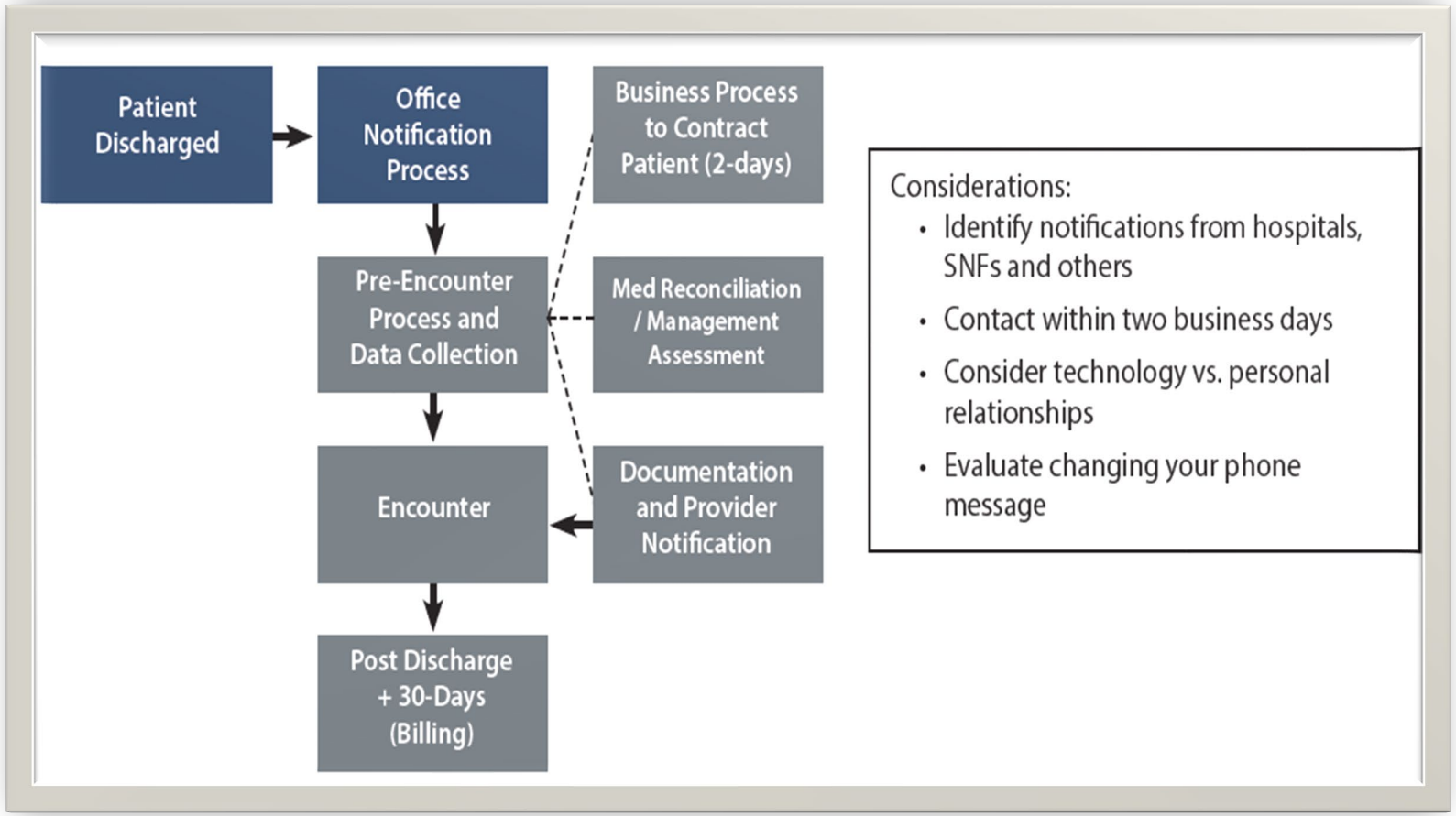
CMS Transitional Care Management Services MLN908628 August 2022:
https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf

Population Health University

Visit the Population Health University page on the Provider Resource Center today to view tools and best practices under Education/Manuals.

Protocol/ Workflow

Workflow Example[3]



Specific workflow processes allows for:

- Seamless path.
- Helps identify obstacles and barriers.
- Identifies accountability
- Clearly defines responsibility

Workflow- Responsibility Chart[3]

Responsible for Performing	Who is Responsible for the Implementation	Implementation Date and who is Responsible for Performing the Actual Tasks for the Process
Overall	Point Person	
Discharges	Medical Records	
Set Appointment	Front Desk	
Visit Performance Elements, Determination for Documentation	Internal services - Annual Wellness Visit (AWV)/ Chronic Care management (CCM)/ Advanced Care Planning (ACP) External Services Specialists External Community – Self Management Services (SM)	
Referral to Additional Services	Clinician and or Medical Assisting Staff	
Bill	Administrator/Biller	

Determine who will be responsible for each task

Workflow- Initial Transitional Care Contact[8]

All patients discharged should be contacted by the clinical staff. The post-discharge follow-up phone call allows the patient's actions, questions and misunderstandings, including discrepancies in the discharge plan, to be identified and addressed, as well as any concerns from caregivers or family members. Callers review each patient's:

- ❑ Health Status
- ❑ Medicines
- ❑ Appointments
- ❑ Home services, and
- ❑ Plan for what to do if a problem arises

Use a script to make initial TOC outreach to patient

Patient Outreach- before, during and after[9]

Prior to Patient Outreach:

- Daily assessment of discharges
- Staff responsible for patient coordination will assess for discharge notifications via:
  - Payer reports
  - Patient self-reporting
  - Post-Acute Facility Notifications
  - Hospital Notifications
- All staff members are aware of TOC process and TOC designated representative. Staff communicates any discharge notifications/summaries or cancellation/rescheduling of TOC appointments to responsible party
- Pre-call prep-review/access documents prior to patient outreach including medical history, medication lists, discharge summary/instructions, home situation/setting, caregiver assistance, recent admissions
- Outbound call includes assessment of patient understanding of discharge instructions, responsible individual intervenes on needs/education
- Discharge Instructions should include the following:
  - Medications
  - Diet/Activity Restrictions
  - Signs/Symptoms
  - Wound Care (if applicable)
  - Follow up appointment(s)

During Patient Outreach:

- Outbound calls are within timeframes and rules per CMS guidelines
- Outbound call includes assessment of patient understanding of discharge instructions, responsible individual intervenes on needs/education.
- Key Components of discharge calls:
  - Patient understanding of admission
  - Current health status
  - Nutritional needs / restrictions
  - Medication Review / Adherence
  - Signs / Symptoms / Emergency Plan
  - Home Care needs
  - Assess for Barriers to compliance / follow up.
- Patient is educated on importance of keeping following up visit and how to reach provider as needed
- Responsible person uses Motivational Interviewing skills to facilitate patient engagement.
- If designated representative is working under the supervision of a physician, additional workflows needed to be incorporated to ensure needs of the patient are met and appropriate action is taken.

After patient outreach:

- Call should be documented in EMR with any interventions
- Send notification to the appropriate office staff via their preferred channel and format (i.e. EMR Flags, Email, phone)

Establishing Policies

Establishing Policies[10]

Establishing TOC Policy may help:

- Identify accountability
- Provide operational efficiency

& Minimize:

- Waste
- Loss of resources

TOC Policy Checklist

- ❑ Define procedures for patient's discharge to home and post-acute facilities (includes responsible individuals, time frames and documentation requirements/ process).
- ❑ Pre-call guidelines to review/access documents prior to patient outreach (includes medical history, medication lists, discharge summary / instructions, home situations / setting, caregiver assistance).
- ❑ Includes directives for utilization of phone scripting to ensure coverage of key post call components.
- ❑ Includes workflow guidelines for incorporating discharge instructions/notification as part of the outpatient record.

Sample TOC Policy[9]

Daily TOC Process and Responsibilities of designated representative

- Monitor Admission / Discharge Notifications
- Assess ADT feeds along with other electronic discharge systems daily to identify patients being admitted and/or discharged
  - Monitor additional electronic discharge information delivered to EMR, via Fax, or direct messaging.
  - All information should be scanned into the medical record for future reference per office protocol.
- Initiates population health/other tracking tool:
  - Patient demographics
  - Discharge date

TOC Process

- Prior to the phone call the designated representative will review:
  - Discharge Instructions
  - Health History
  - Medication List
  - Home situation / care giver support
  - Equipment or Home Health Care

- After reviewing this information, the representative should call the patient to discuss:
  - Review patient's perception of condition that triggered admission
  - Assess for any discharge needs, education, or support
  - Review discharge medications and discrepancies and home medication list.
  - Assess for self management needs / knowledge
  - Ensure that follow-up appointments are made

Key Components

- All Transition of care calls should be made within 2 business days of hospital discharge, regardless of diagnosis.
- All patients discharged from the hospital should be scheduled for an office visit within 7 to 14 calendar days of discharge. Patients with uncontrolled conditions should be seen sooner rather than later.
- Monitor scheduled TOC patients for visit compliance/reschedule no-shows during patient close-out (preferably within 14 days).
- The designated representative should attempt to reach the patient daily for three consecutive days, calling at different times of the day. After three attempts, if the patient has not returned calls, an "Unable to Reach" letter should be mailed to patient.

Sample TOC Policy[9]

Daily TOC Process

- Documentation:
  - The designated representative will document all notes in the EMR.
  - If the patient is readmitted to the hospital from a facility, the designated representative should begin this process again.

Transition of Care Phone Conversation

The designated representative's TOC phone call should cover the following information:

- Diagnosis and Health Status:
  - The care manager should address symptoms that led to hospitalization.
  - Assist the patient in developing a symptom management plan to prevent readmission.
  - Assess for new problems since discharge.
  - Assess for patient's understanding of signs and symptoms to call office or go to emergency department.
- Review medication:
  - Compare Medication lists from EMR, hospital discharge instructions, and any list the patient has to identify and correct potential discrepancies.
  - If the designated representative is not an RN, he/she should address discrepancies by sending a task to the patient's physician at which point the physician will provide classification of medications. The physician will complete the medication reconciliation at the time of the visit.

Follow up Appointments:

- The designated representative should ensure a follow up office appointment is scheduled within the appropriate time frames. Emphasize importance of visit. Assess for barriers to attendance / develop a potential resolution.
- Encourage the patient to remind the specialist to send an update to the Primary Care Physician.
- Encourage patient to have questions prepared and written down for the next office visit, specifically questions relating to medications, symptom management, and plan of care. If caregiver involved, encourage caregiver participation at follow up visit.

Coordination of Post Discharge Home Services:

- The designated representative should ask if any home care agency is following the patient. If no home care involvement, the representative should assess if there are home care needs and obtain an order.
- If home care is ordered, have they contacted the patient? When are they due to visit? It is also important to clarify which company is being used.
- Assess functional status and any need for durable medical equipment.

Post-discharge Follow-up Script Documentation Template

Post-Discharge Follow-up Script & Documentation

- Embed template into EMR for ease of access and continuity among disciplines using the template
- Review current discharge trends and update template as needed
- Ensure timely post-discharge calls (24-72 hours)

- Important Key Items for Post-Discharge Follow-up:
  - Able to adequately care for self at home
    - may need to initiate HHC or SNF admission
  - Medication Reconciliation
  - Discharge education- when to call physician
  - Confirmation of follow-up visit and any barriers to keeping appointment

Post-Discharge Follow-up Checklist[11]

Checklist for Post-Hospital Follow-Up Visits

Prior to the Visit

- ☐ Review discharge summary.
- ☐ Clarify outstanding questions with sending physician.
- ☐ Reminder call to patient or family caregiver to:
  - ☐ Stress importance of the visit and address any barriers.
  - ☐ Remind to bring medication lists and all prescribed and over-the-counter preparations.
  - ☐ Provide instructions for seeking emergency and non-emergency after-hours care.
- ☐ Coordinate care with home health care nurses and case managers if appropriate.

During the Visit

- ☐ Ask the patient to explain:
  - ☐ His/her goals for visit.
  - ☐ What factors contributed to hospital admission or ED visit.
  - ☐ What medications he/she is taking and on what schedule.
- ☐ Perform medication reconciliation with attention to the pre-hospital regimen.
- ☐ Determine the need to:
  - ☐ Adjust medications or dosages;
  - ☐ Follow up on test results;
  - ☐ Do monitoring or testing;
  - ☐ Discuss advance directives;
  - ☐ Discuss specific future treatments (POLST).
- ☐ Instruct patient in self-management; have patient repeat back.
- ☐ Explain warning signs and how to respond; have patient repeat back.
- ☐ Provide instructions for seeking emergency and non-emergency after-hours care.

At the Conclusion of the Visit

- ☐ Print reconciled, dated, medication list and provide a copy to the patient, family caregiver, home health care nurse, and case manager (if appropriate).
- ☐ Communicate revisions to the care plan to family caregivers, health care nurses, and case managers (if appropriate). Consider skilled home health care or other supportive services.
- ☐ Ensure that the next appointment is made, as appropriate.

Post-Discharge Scripts- Diagnosis[8]

Gauge understanding of primary discharge diagnosis

CALLER: Before you left the hospital, [DE name] spoke to you about your main problem during your hospital stay. This is also called your "primary discharge diagnosis." Using your own words, can you explain to me what your main problem or diagnosis is?

If yes, confirm the patient's knowledge of the discharge diagnosis using the "teach-back" method. After the patient describes his or her diagnosis, clarify any misconceptions or misunderstandings using a question and answer format to keep the patient engaged.

If no, use this opportunity to provide patient education about the discharge diagnosis. Then conduct teach-back to confirm the patient understood.

CALLER: What did the medical team at the hospital tell you to watch out for to make sure you're o.k.?

Review specific symptoms to watch out for/things to do for this diagnosis (e.g., weigh self, check blood sugar, check blood pressure, create peak flow chart).

Measure patient's understanding of disease-related symptoms or symptoms of relapse (e.g., review diagnosis pages from AHCP).

CALLER: Do you have any questions for me about your main problem [diagnosis]? Is there anything I can better explain for you?

If yes, explain, using plain language (no jargon or medical terms).

If no, continue.

CALLER: Since you left the hospital, do *you* feel your main problem, [diagnosis], has improved, worsened, or not changed? What does your family or caregiver think?

Any new concerns?

If improved or no change, continue below.

If primary condition has worsened,

CALLER: I'm sorry to hear that. How has it gotten worse? Have you spoken to or seen any doctors or nurses about this since you left the hospital?

If yes, CALLER: Who have you spoken with/seen? And what did they suggest you do? Have you done that?

Using clinical judgment, use this conversation to determine if further recommendations, teaching, or interventions are necessary.

Record any action patient/caregiver has taken and your recommendations on the documentation sheet.

CALLER: Have you spoken to anyone about this problem? Prompt if necessary: Has anyone:

Contacted or seen PCP?

Gone to the ER/urgent care?

Gone to another hospital/provider?

Spoken with visiting nurse?

Other?

How do patients handle new concerns/ problems?

Following the conversation about the current state of the patient's medical condition, consider recommendations to make to the caregiver, such as calling PCP, going to emergency department, etc. Record any actions and recommendations on documentation sheet.

Post-Discharge Scripts- Medications[8]

Can you bring all of your medicines to the phone, please? We will review them during this call. Bring both prescription medicines and over-the-counter medicines, the ones you can buy at a drugstore without a prescription. Also, bring any supplements or traditional medicines, such as herbs, you are taking. Finally, could you also please bring to the phone the care plan that we gave you before you left the hospital?

CALLER: Do you have all of your medicines in front of you now?

CALLER: I'm going to ask you a few questions about each one of your medicines to see if there is anything I can help you with. We will go through your medicines one by one.

First of all, I want to make sure that the medicines you were given were the right ones. Then we'll discuss how often you've been able to take them and any problems or questions you might have about any of them.

Choose one of your medicines to start with.

What is the name of this medicine? The name of it should be on the label. **If the patient is using a generic,** check that he or she understands that the brand and generic names are two names for the same medicine.

At what times during the day do you take this medicine?

How much do you take each time?

If the patient answers in terms of how many pills, lozenges, suppositories, etc. What is the strength of the medicine? It should say a number and a unit such as mg or mcg.

How do you take this medicine? **If there are special instructions** (e.g., take with food), probe as to whether the patient knows the instructions and whether he or she is taking the medicine as instructed.

What do you take this medicine for?

Have you had any concerns or problems taking this medicine? Has anything gotten in the way of your being able to take it? Have you ever missed taking this medicine when you were supposed to? Why?

Do you think you are experiencing any side effects from the medicine?

If yes, Could you please describe these side effects?

Are you taking any other medicines? Repeat list of questions for each medicine.

After patient has described all medicines, ask: Are you taking any additional medicines that you haven't already told me about, including other prescription medicines, over-the-counter medicines, that is, medicines you can get without a prescription, or herbal medicines, vitamins, or supplements?

High Alert Medications!!!

- Anticoagulants – Who is managing?
- Antibiotics
- Antiretrovirals- Review for drug interactions
- Insulin
- Antihypertensives

Post-Discharge Scripts- Medications[8]

If patient has been prescribed medicines that the patient hasn't mentioned, ask whether he or she is taking that medicine.

If yes, go through the list of medicine questions.

If not, probe as to why not. **If patient is unaware of the medicine,** make a note to check with discharge physician as to whether patient is supposed to be taking it, whether a prescription was issued, etc.

CALLER: Have you been using the medicine calendar (in your care plan) that was given to you when you left the hospital?

If yes, provide positive reinforcement of this tool.

If no, suggest using this tool to help remember to take the medicines as directed. **If patient has lost care plan,** offer to send a new copy of AHCP by mail or email.

CALLER: Do you use a pill box?

If yes, provide positive reinforcement of using this tool.

If no, suggest using this tool to help remember to take the medicines as ordered.

CALLER: What questions do you have today regarding your medicines and medicine calendar (if using)?

CALLER: Does your family or caregiver have any questions or concerns about your medicines?

Please note on the documentation sheet any recommendation you made to the patient and followup actions you took.

Sample of medication tracker in After Hospital Care Plan (AHCP)

What time of day do I take this medicine?	Why am I taking this medicine?	Medicine name Amount	How many do I take?	How do I take this medicine?
 Morning				
 Noon				
 Evening				
 Bedtime				

Medications During Transitions of Care

Impact of TOC on Medication Errors[12-18]

Medication error: any preventable event that may cause or lead to medication harm

- Errors of **omission**: lack of action
  - Ex: fail to prescribe enoxaparin for a patient who needs VTE prophylaxis
- Errors of **commission**: wrong action taken
  - Ex: ordering Bactrim for a patient with a sulfa allergy

- Improve post-discharge outcomes (ER visits, rehospitalization, time to readmission)
  - **>40% of medication errors result from inadequate reconciliation during hospital admission, transfer, or discharge with ~20% resulting in harm**
- Patient impact
  - 1.5 million patients harmed each year
  - ~50% of older adults affected at discharge
- Medication Error Costs
  - Morbidity and mortality: $77 billion/year
  - Extra medical costs: $3.5 billion/year

Overview of TOC Best Practices

Medication reconciliation

- Verify reason for medication discontinuation and cancel prescription at pharmacy if appropriate
- Add refills for new prescriptions
- Send new prescriptions for starter pack medications

Identify drug therapy problems

- Verify correct directions (clarify any confusing directions or abbreviations)
- Check for duplicate therapy and polypharmacy

Provider connection

- Communicate with PCP and specialists
- Identify opportunities for care coordination

Patient education

- Assess health literacy
- Discuss reason for hospitalization
- Counseling on medication changes, adverse effects, etc.

Social determinants of health

- Address any adherence concerns
- Identify problems with affordability
- Discuss any barriers to access (e.g. mobility transportation, etc.)

Value of Pharmacists in TOC Process[19-21]

Spiegel B, et al. Cost-Effectiveness of Pharmacist Postdischarge Follow-Up to Prevent Medication-Related Admissions.

- Readmission rates for a TOC pharmacist-run program versus usual care were **16.2% and 21.6%**
- Average cost per patient were **$3,433 and $4,015**

Ni W, et al. Budget Impact Analysis of a Pharmacist-Provided Transition of Care Program.

- Total healthcare costs at 180 days after discharge in pharmacist-provided TOC were **$2,139 lower** than costs in the control group with **savings of ~$1.8 million** for the health plan

Ni W, et al. Reduction of healthcare costs through a transitions-of-care program.

- 50.8% of pharmacist recommendations accepted by physicians resulting in **cost avoidance of ~$293 per drug therapy problem**

What to Do Without a Pharmacist

Identify High Risk Patients

- Understanding that staff and time are limited resource, try to:
  - Target patients with many comorbidities, over 10 medications, and/or multiple hospitalizations within the past year
  - Stratify patients by risk level and prioritize contacting those with high-risk

Medication Review

- Conduct a thorough medication reconciliation
- Identify why medications were discontinued
- Review medication take back programs for discontinued medications

Counseling

- Highlight importance of adherence to the medication
- Review dose, frequency, and route of administration
- Address common adverse medication effects

Follow-Up

- Determine patients' understanding of their disease state and when to ask for help
- Assess any barriers for patients obtaining their medication (e.g. cost, transportation, refills)
- Confirm upcoming doctor appointments

Considering adding a pharmacist to your team? See our **Pharmacist Business Case** resource for a detailed guide

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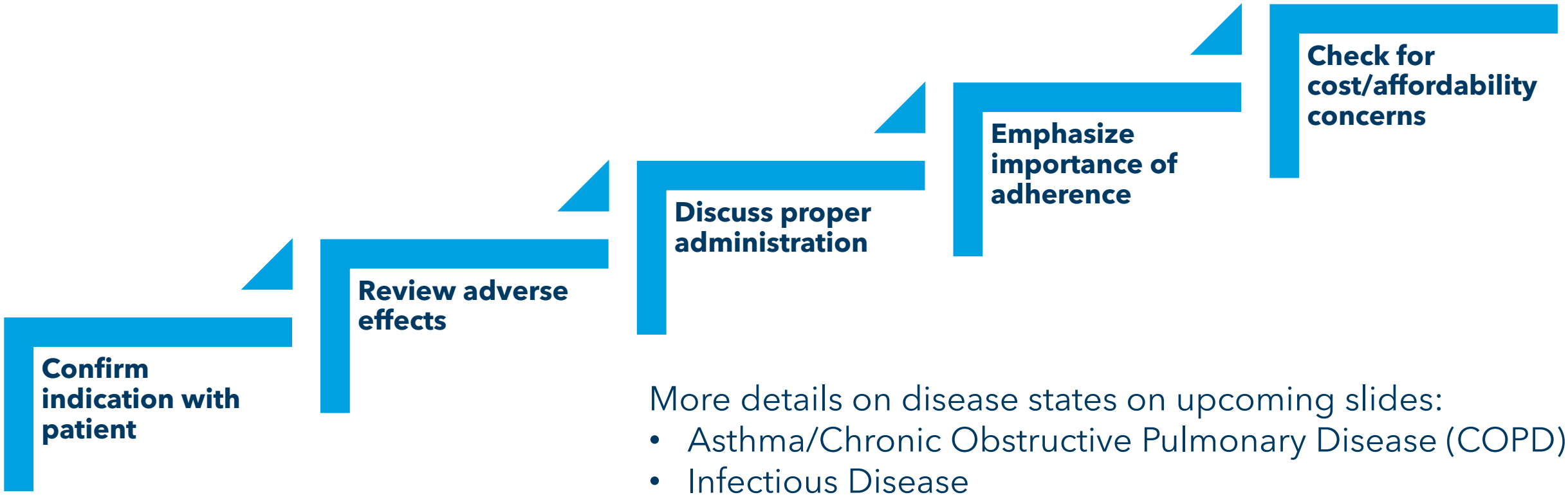
High-Risk Disease States



More details on disease states on upcoming slides:

- Asthma/Chronic Obstructive Pulmonary Disease (COPD)
- Infectious Disease
- Chronic Heart Failure
- Diabetes
- Anticoagulation
- Mental Health

Disease Specific Considerations

Asthma and COPD

Proper Inhaler Use

- Offer spacers for easier administration
- Differentiate between as needed inhalers and scheduled inhalers
- Counsel on inhaler techniques (e.g. dry powder vs. metered-dose inhalers)

Patient Education

- Rinse mouth after using inhaled corticosteroid (ICS) inhalers to prevent thrush
- Avoid allergens, tobacco smoke, dust, and triggers
- Discuss need for a nebulizer machine and send any applicable orders to a durable medical equipment store

Cost

- Identify if patients are eligible for state assistance programs
- Identify combination inhalers to reduce copay
- Explore NeedyMeds, GoodRx, and manufacturer coupons

Chronic Heart Failure (CHF)

Loop Diuretics

- Discuss timing of administration (e.g. take earlier in the day to avoid waking up at night to use the restroom)
- Side effects: dizziness, dehydration, electrolyte imbalance, weight loss

Beta Blockers

- Discuss exercise intolerance and how it improves with time
- Side effects: fatigue, dizziness, slower heart rate

Monitor Signs & Symptoms

- Recommend the patient to contact their provider if they notice a 2-3 pound increase in a 24-hour period or more than 5 pounds in a week
- Side effects: shortness of breath, fatigue, swelling

Infectious Disease

Finish Entire Course

- Prevents antibiotic resistance
- Do not stop despite improvement in or elimination of symptoms

Side Effects

- Common: nausea, diarrhea, abdominal pain, photosensitivity
- Severe: allergic reaction/anaphylaxis (hives, throat swelling, trouble breathing)

Drug Interactions

- Separate tetracyclines and fluoroquinolones by 2 hours from dairy products, antacids, multivitamins

Diabetes

Injectables (insulin & GLP-1 agonists)

- Check the expiration date before each use
- Discuss storage conditions (how long it can be kept at room vs. fridge temperature)
- Review how to set the correct dose and administer the product

Blood Glucose Monitoring

- Discuss the steps of using a blood glucose meter or a continuous glucose monitor
- Review frequency of testing desired by provider (e.g. fasting, post-meal)
- Signs & symptoms of hypoglycemia & how to treat (e.g. glucose tablets, orange juice)

Lifestyle Modifications

- Recommend minimizing intake of refined carbohydrates, added sugars, alcohol, soda, high-fructose fruit juices
- Focus on intake of carbohydrates from vegetables, legumes, fruits, dairy (milk and yogurt), and whole grains
- Recommend moderate intensity aerobic exercise of 50 minutes 3 days/week

Anticoagulation

Warfarin

- Discuss INR goal range
- Explain drug interaction with foods containing Vitamin K

Enoxaparin

- Discuss proper administration technique
- Review steps for bridging to other anticoagulants

DOACs

- Evaluate cost/affordability concerns and refer patient to appropriate resources

General Monitoring

- Discuss dosing regimen and duration of therapy
- Review signs/symptoms of bleeding
- Advise discussion with provider about when to hold prior to procedures and when to resume

Mental Health

Medication Effects

- Antipsychotics
  - Set expectations for metabolic side effects (e.g. weight gain, cholesterol increase, glucose imbalance)
  - Discuss potential for motor side effects (e.g. dystonia, akathisia, tardive dyskinesia)
  - Caution for signs/symptoms of neuroleptic malignant syndrome
- Antidepressants
  - Discuss that seeing the full benefit may take up to 6 weeks
  - If benefits are not seen, encourage patients to avoid discontinuation until speaking with their provider

Follow-up

- Establish which provider will be responsible for the patient's mental health care and prescribing of medications
- Set-up the next appointment
- Obtain accurate contact information from patient

Care Management/ Disease Management

Care Management/ Disease Management

The range of activities intended to improve patient care and reduce the need for medical services by helping patients and caregivers more effectively manage health conditions.

Clinical Care & Wellness: Referral Feature Available in Availity

This feature helps to:

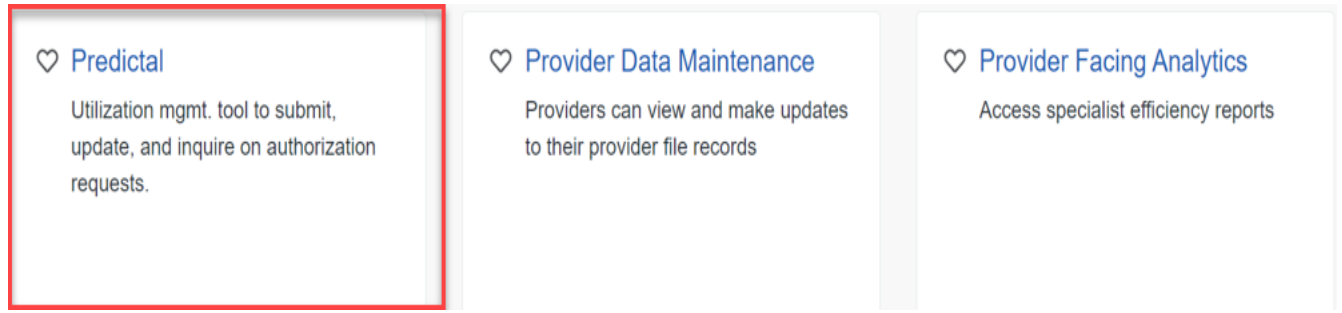
- Ensure that patients with chronic conditions and complex medical needs are connected with the right clinical support for their needs
- Simplify and expedite the overall case management referral process
- Reduce administrative burden

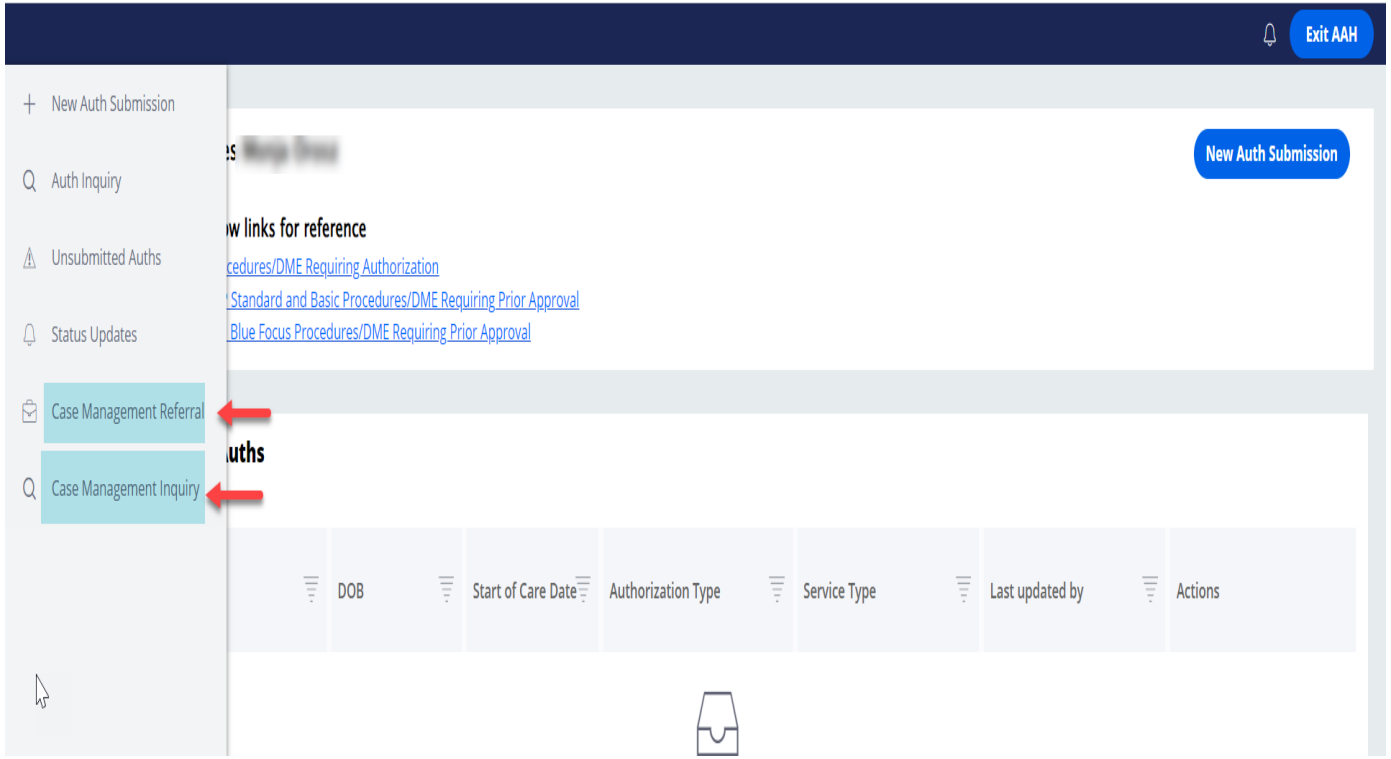
How It Works:

To access this feature:

1. Log into Availity

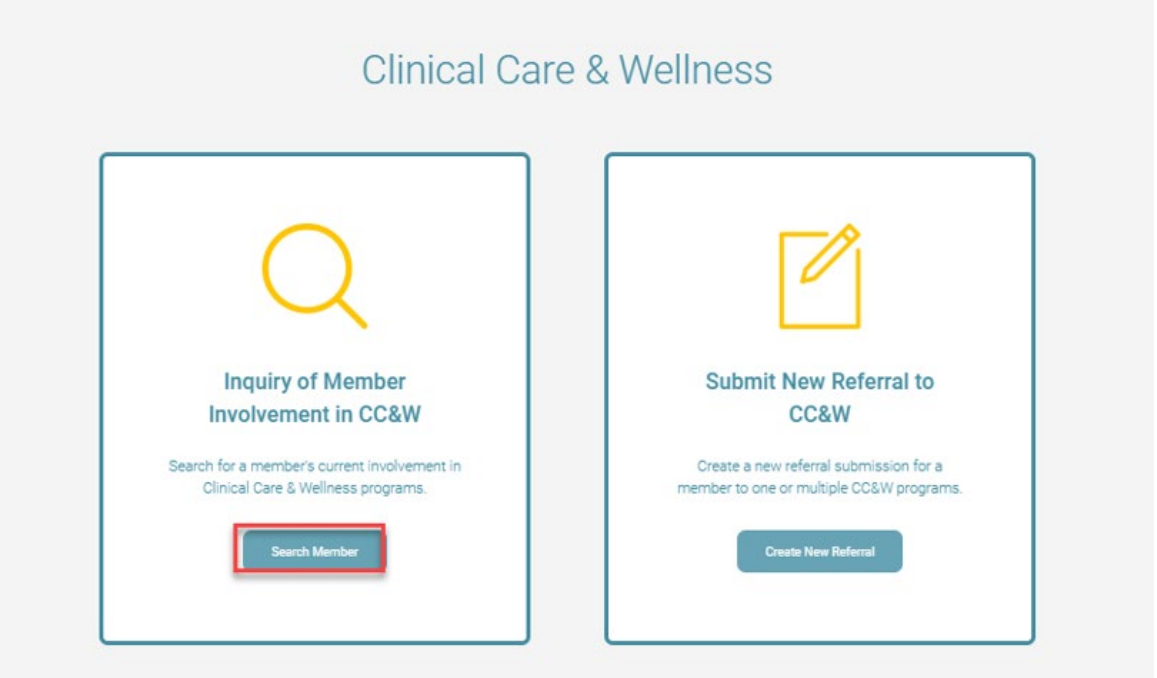
   (For best results, use Chrome)
2. Select the Predictal tab
3. Providers will see two options:
   a. Case Management Referrals
   b. Case Management Inquiry
4. Follow the steps to create a CM/DM referral or complete an inquiry





Inquiry of Member Involvement in CC&W

- Ability to search for information on a member's involvement in CC&W programs.
- This will display all open and closed programs for a member with the exception of programs with sensitive diagnoses.



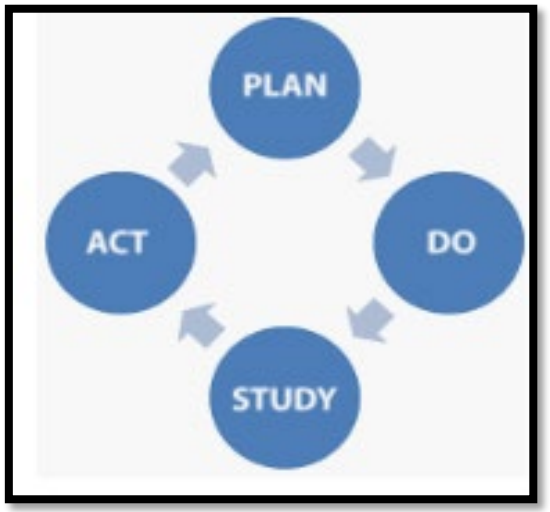
Tracking Outcomes

Monitoring Success

Monitoring and measuring allows you to determine the success of your TOC Process and helps to identify if you are achieving the outcomes you expected.

Monitoring & Measuring allows you to:

- Identify and address challenges and barriers in the implementation process.
- Hold staff accountable for performance goals.



First Steps in Monitoring

When beginning your initiative, you want to identify the following:

- Who will be tasked to improve Care Transitions & monitor progress (could be individual(s) or team).
- Select specific measures to track, make it manageable, but also:
  - ❑ *Meaningful*
  - ❑ *Credible*
  - ❑ *Feasible*
  - ❑ *Timely*
- Determine what to measure and your source of the measure.

Some examples of measures:

- Are patients receiving the post-discharge call in the appropriate time frames.
  - # of patients that received the call.
  - Avg. time frame between discharge and post-discharge follow-up call?

  (Can obtain data from Hospital Discharge reports and patient records)
- Are you:
  - Reducing the number of readmissions?
  - Reducing the number of observations?
  - *(Can obtain data from Hospital Discharge reports and quality measures)*
- Are patients:
  - Increasing their knowledge of self-management?
  - Increasing patient satisfaction?
  - *(Can obtain data from patient satisfaction surveys)*

Health Behavior Impact and SDOH

Social risk, social factors and SDOH[22-23]:

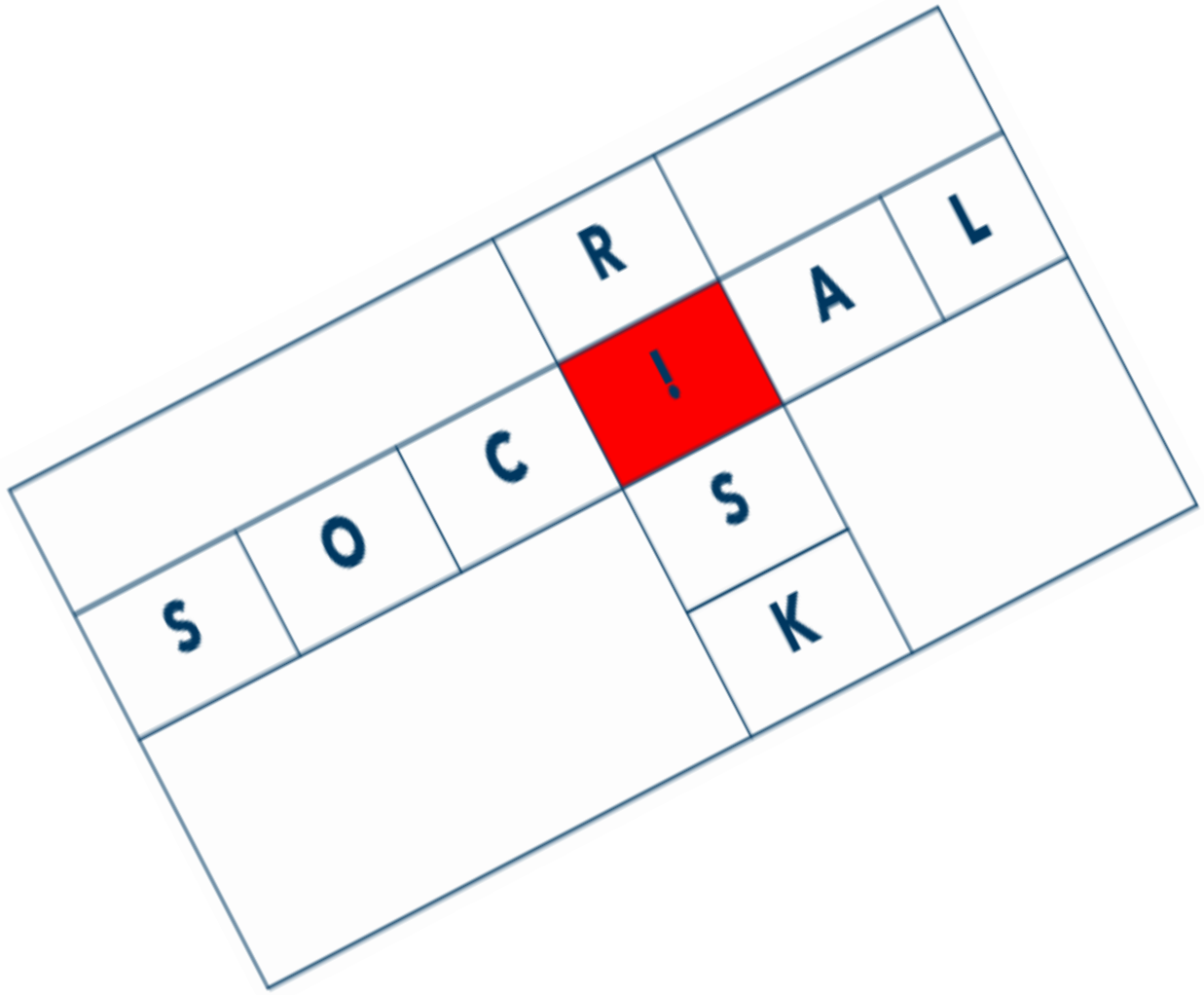
- Social risk factors are important determinants of health outcomes and are disproportionately represented in high-needs populations.

- Identifying and addressing a patient's SDoH through the development of accessible and evidence-based programs will be needed as a complimentary approach to improve health outcomes.

Social risk, Social factors and SDOH[22-23]:

- Social factors may be associated with higher readmission rates due to post-discharge healthcare access issues.

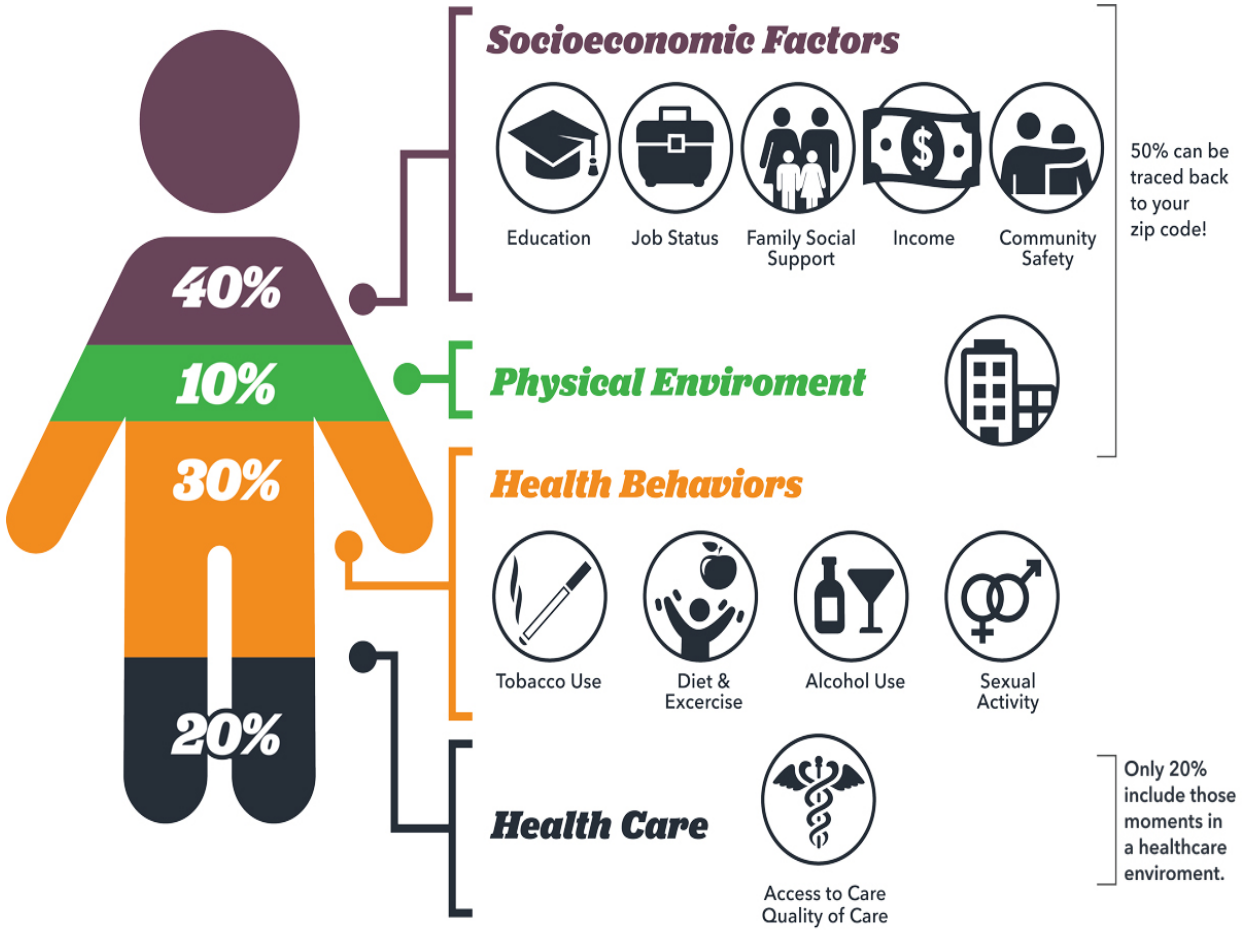
- Individuals with disproportionate social disadvantages may be unable to afford prescriptions, lack adequate transportation for follow-up appointments have poor health literacy, or be unable to follow self-care regimens.



Socioeconomic Status (SES)[24]

- 50% of what makes up someone's health can be traced to their zip code

- Low socioeconomic status has been associated with low health literacy, poor social support, and a higher prevalence of comorbidities such as hypertension, diabetes, and obesity



Source: Institute for Clinical Systems Improvement, Going Beyond Clinical Walls: Solving Complex Problems (October 2014)

Health Behavior:

Includes all those things we do that influence our physical, mental, emotional, psychological and spiritual selves.

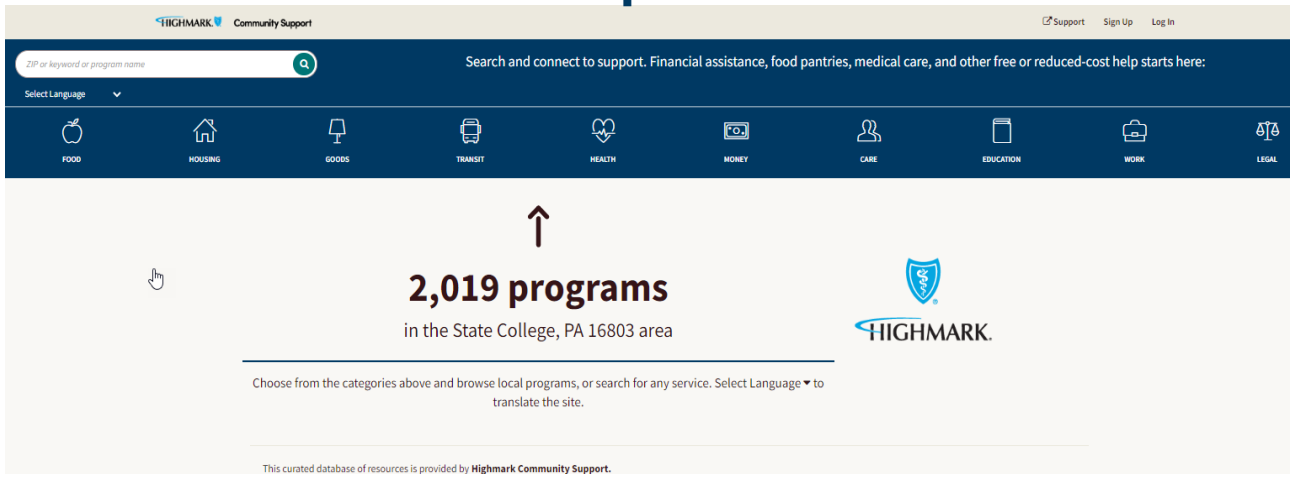
Accounts for approximately 30% of a person's health outcome.

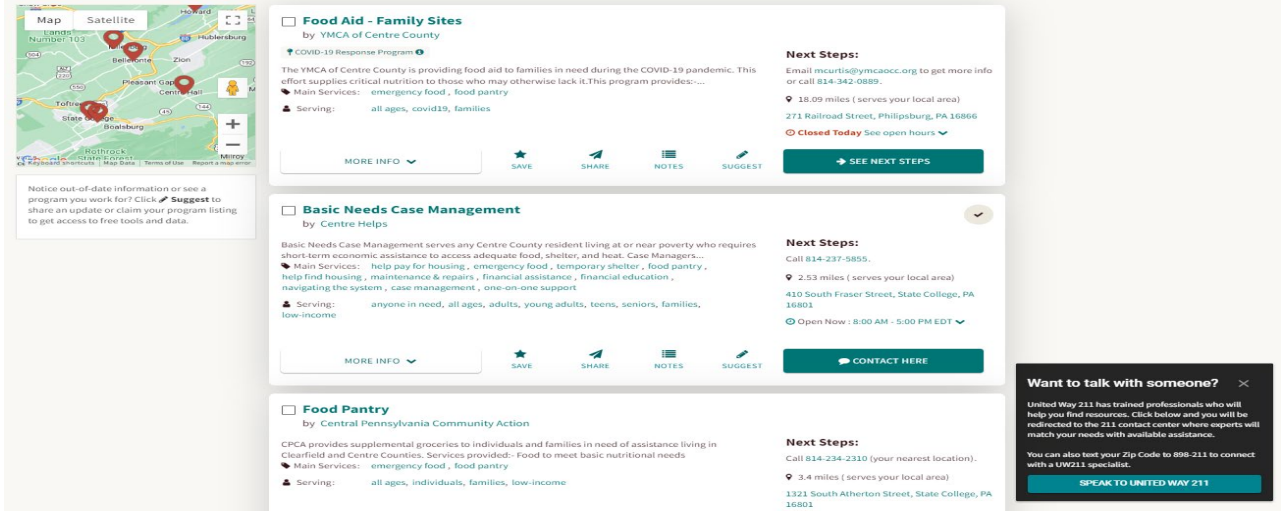
Highmark Find Help

Resource Directory for your patients

- https://highmark.findhelp.com/
- Find Help connects people seeking help and verified social care providers that serve them. At Highmark's Find Help, a social care network was created that connects people and programs – making it easy for people to find social services in their communities.
- The search platform is free and open so people can search for resources with dignity, ease, and without restrictions or gatekeepers.

Example:





Studies Show the Impact of Proper Communication

Communication Focused Dimension[25]

Harvard Business Review: What has the Biggest Impact on Hospital RDM rates

- When the process-of-care quality is high, improving on the communication-focused dimension has a much stronger effect on reducing readmission rates when compared to improving on the response-focused patient-experience dimension.
- Communication-focused dimension corresponds to the caregiver's ability to engage in meaningful conversations with the patient.
- The response-focused dimension corresponds to the caregiver's ability to respond quickly to a patient's explicit needs.
- This approach requires significant training costs, it is a shift in culture from focusing on evidenced-based processes rather than the patient experience.

Agency for Healthcare Research and Quality[26]

Strategy: Training to Advance Physicians' Communication Skills

The Problem:

- The focus on technical aspects of Healthcare are accepted by patients as they are unable to judge competence.
- They **can judge** the clinician's communication, if the clinician explains diagnosis's, test results, treatment options to a patient and they did not understand all that was said, it was not effective.
- Poor communication can have serious impacts on health outcomes
- In a study on communication, it was found physicians thought 89% of patients understood the potential side effects of meds when only 57% said they understood.

The Intervention:

- Training practitioners in the communication skills needed, for more information go to the AHRQ website: ahrq.gov

Additional Resources To Support in Improving Physician Communication[26]:

•American Medical Association. Section II: Resources Emphasizing Communication Skills. In: Cultural Competence Compendium. Chicago, IL; *American Medical Association* 1999: 89-106.

•Carrillo JE, Green AR, Betancourt JR. Cross-cultural primary care: A patient-based approach. *Ann Intern Med* 1999 May 18;130(10):829-34.

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Provider Resources

Highmark Provider Resource Center:

Clinical Programs & Services for Highmark Members Reference Guide available on the Provider Resource Center

- Click EDUCATION/MATERIALS
- Click Reference Guide of Highmark Member Programs
- Click the link for the 2024 Reference Guide of Highmark Member Programs

What is Population Health University?

A platform to provide the tools and resources to assist with Practice Transformation and Population Health Management

In support of Highmark's journey to transform health and be a leader in the industry by focusing on individual needs of each member and provider (referred to as Living Health), Highmark has partnered with the American Journal of Managed Care in the creation of Population Health University.

The Population Health University page has recently been updated with new toolkits, toolkit overviews and the Transition of Care Module. The page now includes the following Quality Guides:

- Chronic Care Management
- ED Utilization
- Palliative Care
- Transitions of Care

Visit the Population Health University page on Provider Resource Center today to view these tools and best practices.

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