



# Implementing Medication Therapy Management Services for Post Discharge Patients

INNOVATION

PARTNERS IN EXCELLENCE



## PROVIDER

Fairview Pharmacy, Medication Therapy Management Department

## CHALLENGE

Patients leaving the hospital often have changes in their medication regimen. This can result in medication errors or medication-related issues. These are both leading causes for readmission, but can often be avoided with the aid of pharmacists. Prior to our project, the Medication Therapy Management (MTM) provider practicing in the patient's primary care clinic did not receive notification of a patient's admission or subsequent referral for MTM services. Since we believe that patients receive better care when it is provided within their medical home, we felt this was a missed opportunity – one that prompted our innovation.

## INNOVATION

We implemented a post-discharge MTM referral process. Our process included risk-stratifying patients to identify those who would benefit most from MTM. We collaborated with other health care systems so patients could be seen in their medical home.

## IMPROVING HEALTH

- Notifying the care team at the time of discharge reduces delay in care.
- It also provides assurance that health care needs are met at time of transition to prevent readmission due to medication related issues.

## ENHANCING PATIENT EXPERIENCE

- Our process connects patients with their care team following discharge. They can then receive a MTM visit, ensuring they are on the correct medications – and possibly preventing a readmission due to medication related issues.
- Additionally, more than 90% of patients agree or strongly agree that their MTM pharmacist helped them understand why they are taking each of their medications, feel more confident in managing their medications and would refer a family member or friend for a MTM visit.

## TAKING AIM AT AFFORDABILITY

- A retrospective cohort study of our work found that hospital readmissions were significantly decreased at 30-days post discharge in the MTM cohort (n=719) compared to the cohort of patients that did not receive a MTM visit (42 vs 70; p=0.0059).



ABBOTT NORTHWEST



## Stroke Rehabilitation Care Coordination – Care at the Right Time

INNOVATION

PARTNERS IN EXCELLENCE

Allina Health

COURAGE KENNY  
REHABILITATION  
INSTITUTE

### PROVIDER

Courage Kenny Rehabilitation Institute, part of Allina Health

### CHALLENGE

Fewer than 15% of individuals returned for outpatient therapy after discharge from acute hospitalization following a stroke. Yet the best chance for taking advantage of neurologic plasticity occurs in the first 12 weeks post stroke. We needed a process for closer follow-up.

### INNOVATION

Beginning in January 2015, we created a case-finding dashboard and implemented an outpatient stroke rehabilitation care coordination program. This enabled us to closely follow patients for one year following a stroke.

Our process connects individuals with a care coordinator for one year following an acute hospitalization for stroke. Care coordination schedules contacts at regular intervals to provide education and coaching, assist with appointment access and remove barriers to receiving timely care.

### IMPROVING HEALTH

- Receiving appropriate therapy in the early weeks following a stroke improves functional outcomes.
- Improving the percent of patients returning for follow-up with physicians after hospital discharge provides better medication management and additional secondary stroke prevention education.

### ENHANCING PATIENT EXPERIENCE

- The health care system can be difficult to navigate. Retention of discharge instructions is challenging after a stroke.
- Of our respondents, 87% found stroke care coordination to be helpful in connecting them with needed services and 78% of caregivers reported they felt supported by care coordination.

### TAKING AIM AT AFFORDABILITY

- When comparing our first year (2015) of care coordinated stroke patients with the previous year's group of non-care coordinated stroke patients, we observed the following:
  - › 22% increase in outpatient therapy services
  - › 43% reduction in ED utilization
  - › 9% increase in primary care follow-up
  - › 15% reduction in inpatient hospitalizations
  - › 56% reduction in mortality per 1000 strokes
- A 2015 total cost of care savings for the program of \$154,000 annually was realized with an average savings of \$2,000 per patient.



## Application of the Triple Aim in Oncology Care

INNOVATION  
PARTNERS IN EXCELLENCE



MINNESOTA ONCOLOGY

*Caring, down to a science.™*

### PROVIDER

Minnesota Oncology

### CHALLENGE

We needed to transform our oncology practice from a fee-for-service, physician-centric organization to one that provides high-value, patient-centered care.

### INNOVATION

We improved adherence to national, Triple Aim-based chemotherapy guidelines and pathways to address chemotherapy treatment plan variations and lower total cost of care. We also implemented a process to reduce chemotherapy-related Emergency Department visits. And, we began a culture change process with measured outcomes of how we discuss end-of-life care with our patients through a structured, comprehensive program.

### IMPROVING HEALTH

- We decreased unexplained clinical variation in chemotherapy prescribing.
- Required critical thinking with published medical evidence to have peer-to-peer discussions of why an off-pathway treatment request is a better option for a specific patient than a pathway option.

### ENHANCING PATIENT EXPERIENCE

- Enhanced process to improve patient education for self-management of chemotherapy side effects.
- Created access to same day urgent provider visits.
- Implemented a Values Assessment questionnaire to address patients' desired goals for end of life care.
- Established direct admission process from the office to avoid the ED when possible.

### TAKING AIM AT AFFORDABILITY

- We reduced the rate of chemotherapy-related ED visits by 31% at our Minneapolis office.
- By improving adherence to chemotherapy pathways, we reduced total cost of drug spend based on previously published data by up to 30%.



# Genetic Testing Utilization Program

INNOVATION  
PARTNERS IN EXCELLENCE

## PROVIDER

Regions Hospital, HealthPartners Medical Group, Park Nicollet Laboratories, & HealthPartners Health Plan

## CHALLENGE

Genetic-based laboratory testing and personalized laboratory medicine is at the cusp of rapid growth. Expenses are projected to reach \$15 to \$25 billion by 2021. The complexity of genetic testing increases risk of testing and interpretation errors. If left unmanaged, it is neither patient- nor practice-centric. And, it will not be sustainable.

- \$300,000 projected annual loss due to order errors stemming from genetic testing
- No review or approval processes existed for genetic tests throughout our system

## INNOVATION

We hired two laboratory-based Genetic Counselors (GC) to review genetic test orders for our medical groups. Our GCs ensure:

- Correct test and testing laboratory are ordered
- Care team and patient are aware of the cost and coverage of the test
- Requirements for patient consent or prior authorization are fulfilled

We also developed an order process so all genetic test orders are centrally tracked and routed to laboratory-based GCs for review prior to testing in-house or at an external reference laboratory. Lastly, in partnership with HealthPartners Health Plan, we developed steering and formulary committees to ensure appropriate testing for patients and members.

## IMPROVING HEALTH

- Patients and providers receive actionable test results due to GC review.
- Leverage health plan evidence-based literature review expertise as needed.

## ENHANCING PATIENT EXPERIENCE

- Routine “hold the draw” orders to ensure all evidence, clinical utility, cost and coverage information is known, and any prior authorization requirements completed before the blood draw.
- Patient participates in shared decision-making, learning test costs prior to presenting in the laboratory.
- After Visit Summary script provides next steps for patient.

## TAKING AIM AT AFFORDABILITY

- 12 month cost savings due to lab GC test review: \$263,000
- 13% of test orders are modified or canceled after laboratory GC review
- Average \$280 per test saved following lab GC pre-review, modification or cancel consultation.





# Asthma Care Management in Highly Mobile Diverse Populations

PREVENTIVE  
PARTNERS IN EXCELLENCE



Hennepin County Medical Center

## PROVIDER

Hennepin County Medical Center

## CHALLENGE

In December 2015, only 28.46% of our adult patients and 47.37% pediatric patients had their asthma under control. Likewise, only 47.15% of adults and 58% of children had an annual Asthma Action Plan on file. Our challenge was to improve care for highly mobile Latino, African American and East African patients with asthma by increasing completion rates of Asthma Action Plans completed within a year and Asthma Control Tests in good control for pediatric and adult populations.

## PROCESS FOR CHANGE

We engaged frontline staff, including medical assistants, nurses and physicians, for quality improvement work. We implemented a Chronic Disease Dashboard operated daily by medical assistants to identify patient needs. We also created an Asthma Champion Workgroup that meets on a monthly basis to problem solve, brainstorm, test and implement workflows that can improve care for patients with asthma.

## RESULTS

- Preliminary data for 167 asthma patients found month after month improvement in asthma control and action plans in place.
- Proactive follow-up with patients to assess their asthma control level and schedule asthma-specific conversations with providers.
- Increased patient and physician satisfaction.

## ADOPTION CONSIDERATIONS

- Involve frontline staff members and don't be afraid to test out their ideas because they know the work best.
- Celebrate successes – no matter how big or small they may be.

## RECOMMENDATIONS FOR SUSTAINING GAINS

- Continue to engage clinic staff to come up with ideas. Seeking input directly from front line staff and conducting small tests of change based on their suggestions help staff members determine whether the process needs to be adopted, adapted or start a whole new process.
- Communicate information in a variety of ways and make sure it is presented in a simple way so staff can see how they are doing collectively in improving patient care.