HealthPartners®

HealthPartners pharmacy home visits reduce avoidable hospital readmissions

CASE STUDY

Annie* was in her mid-70's when she was diagnosed with Alzheimer's disease. She also has chronic kidney disease, congestive heart failure (CHF) and diabetes. Over a two-year period, she had been hospitalized five times. Annie lives alone and does not drive. She struggles to keep her bills and paperwork in order.

To address these barriers to care, Annie's primary care physician referred her to a clinical pharmacist in HealthPartners Medication Therapy Management (MTM) program. The pharmacist visited Annie in her home and helped her with steps such as:

- Changing injections to safer oral diabetes medications
- Creating a plan for Annie to weigh herself daily and take extra diuretic medication if she notices weight gain to reduce swelling and make breathing easier
- Helping Annie enroll in HealthPartners Sync My Meds mail order program which sends refills at the same time each month
- Teaching Annie's brother how to help set up her medication box
- Helping Annie understand why she needed an antibiotic that she had stopped taking for a chronic hip infection

Thanks to these services, Annie is able to live safely and independently. In the four months after she began receiving these MTM services, she had not been to the emergency room or hospital.

*Not her real name

The challenge

More than 17 percent of Medicare patients were readmitted to a hospital within 30 days after a hospital stay in 2013.[1] The Affordable Care Act establishes a program to reduce unnecessary readmission rates. One opportunity is to support patients who have chronic conditions.

The solution

MEDICATION THERAPY MANAGEMENT PROGRAM

HealthPartners implemented a Medication Therapy Management (MTM) program in 2006 as part of Medicare Part D prescription drug benefit. MTM helps prevent adverse drug interactions, improve therapeutic effectiveness and decrease costs from drug-related problems.

MTM is offered at 151 clinics and pharmacies in the HealthPartners network, including 15 HealthPartners and 17 Park Nicollet clinics. The program is available to more than 800,000 HealthPartners members and all HealthPartners Medical Group and Park Nicollet patients.

COMMON MEDICATION PROBLEMS

The most common medication problems identified during the MTM home visits include:

- Medication is no longer needed
- A new medication is needed
- Medication is not being taken as prescribed
- Medication dose is too high

NEW IN 2016

A partnership with the Ramsey County community paramedic program provides MTM home visits with patients who have heart failure. The paramedics can refer patients who do not qualify for home care services for a HealthPartners MTM home visit.

HOME VISITS ADDED FOR HIGH-RISK PATIENTS

In 2014 HealthPartners implemented an MTM home visit program for patients who are at highest-risk for medication-related problems. In addition to having serious, chronic illnesses and taking multiple medications, they are homebound and unable to go to a clinic for regular care.

The home visit program also focuses on reducing unnecessary readmissions to the hospital. Partnering with Integrated Home Care, Regions Hospital, HealthPartners clinics, HealthPartners geriatrics and HealthPartners case and disease management, clinical pharmacists visit homebound patients enrolled in HealthPartners Minnesota Senior Health Options for low-income patients after they leave Regions Hospital.

HOW THE PROGRAM WORKS

Patients voluntarily choose to receive home visits which usually occur within a week after leaving the hospital. There is no charge to patients. The initial visit lasts for about one hour with follow up visits in-person or by phone.

During the visits, pharmacists:

- Review every medication the patient is taking. If there is a problem, the pharmacist works with the care team to adjust medications or dosage, or start/stop medications.
- Ensure that patients understand how to take the medication as prescribed.
- Evaluate the home for any risks that may contribute to readmissions, such as fall risks, or old or discontinued medications.

Results

REDUCED PREVENTABLE READMISSIONS

Among patients who received a home visit in the first year, 6 percent were readmitted to Regions Hospital within 30-days after a hospital stay compared to 16 percent readmission for patients who chose not to receive the MTM home visits.

	PATIENTS READMITTED TO HOSPITAL WITHIN 30 DAYS	
	MTM HOME VISIT	NO MTM HOME VISIT
Number of patients	31	121
Readmitted within 30 days	2	21

Source:
1. Office of Information Products and Data Analytics, CMS