A year and a half ago, Inova Alexandria Hospital did something it had never done before: The hospital stationed a full-time, certified pharmacy technician in the busy emergency department (ED) of the suburban Virginia hospital. The initiative was the brainchild of Michelle Le, PharmD, pharmacy director. In a study that she conducted, she found that the hospital medication-reconciliation process was not optimal and that the time it took to perform a good reconciliation was about 20 minutes. She also realized that nurses—ED nurses in particular—had little time to allocate to this time-consuming process. As a result, the medication lists that nurses assembled for incoming patients were typically only 30% to 60% accurate. That impeded the ability of physicians to provide optimal diagnosis and treatment.

That is when Dr. Le decided to strategically place a full-time pharmacy technician in the ED.

“Last year our technician touched 5,000 patients, spending 15 to 20 minutes with each; as a result, the medication lists were 97% accurate,” she said.

Moreover, in April of this year, the hospital went one step further. Thanks to a $150,000 grant from the Northern Virginia Regional Health Information Organization (NoVaRHIO), the pharmacy technician and ED staff members now have access to additional patient prescription information. This software package lists prescriptions that patients have filled within the last four months.

She noted, “From April to September this year, we were able to access over 9,000 medication histories for incoming patients who have used retail and mail-order pharmacies. Prior to this, it was zero! When we query the system, we get the drug name; the strength; and, generally, the last time filled. So, it is not everything, but it’s a very good starting point for a complete medication history.”

This process improved not only patient care and flow but also physician and nursing satisfaction in the ED.

Dr. Le added, “Our pharmacy technician, Mark Levitz, was awarded the hospital employee of the month for what he does.”

Dr. Le has all sorts of other ideas for expanding the pharmacy department’s contributions at the hospital, whether it’s preventing medication errors or reducing hospital readmissions. She is constantly looking for new funding sources that can inject a shot of capital at a time when the budget at Inova Alexandria, and at every other hospital in the U.S., has come under increasing financial pressure. Advised to consider submitting a grant application to Partnership for Patients: Better Care, Lower Costs, sponsored by the Department of Health and Human Services (DHHS), she seemed puzzled, then asked, “What is that?”

Many hospital pharmacists might be asking the same question. The Partnership is a $1 billion, public–private program announced last April by Kathleen Sebelius, DHHS Secretary in a speech to the American Hospital Association. It fuses two separate provisions in the Patient Protection and Affordable Care Act (PPACA), the health care reform bill passed by Congress in 2010. Among the numerous provisions in that landmark bill were one authorizing a program at the Centers for Medicare and Medicaid Services (CMS) to reduce hospital readmissions and another to issue a national quality standard, published by the CMS in March 2011.

One of the quality standard’s six priorities was to improve hospital safety. Out of that came one of the Partnership’s two branches, the Hospital Engagement Contractors (HEC) program, in which hospitals will be teaching other hospitals how to improve patient safety. Preventing medical errors has been a back-burner cause célèbre since 1999, when the National Academy of Sciences published To Err is Human: Building a Safer Health System, a report that detailed the financial cost to the nation—including federal health programs such as Medicare and Medicaid, not to mention private insurers—of preventable medical errors in hospitals.

The effort to reduce hospital readmissions stems from the PPACA provision establishing the second provision, the Medicare Community-Based Care Transitions Program (CCTP).

The two upcoming programs are scheduled to offer $1 billion in grants over a period of five years to hospitals and community partners—that is, if those funds are still available. The deficit reduction proposal President Obama issued in September anticipates considerable funding cuts for Medicare, the source of the future $1 billion.

“While many applications have been made to the Community-Based Care Transitions Program, I do not know of any funds being released, which is somewhat concerning,” notes Mark V. Williams, MD, Professor and Chief, Division of Hospital Medicine at Northwestern University Feinberg School of Medicine. He is also Editor-in-Chief of Journal of Hospital Medicine, published by the Society of Hospital Medicine. The society has initiated its own program to reduce hospital readmissions, called Project Boost.

The dark cloud of imminent and substantial Medicare spending cuts was not hanging over Mrs. Sebelius’ head when she went to the American Hospital Association in April to announce Partnership for Patients.

She said, “First, we will reduce preventable injuries that
happen in hospitals by 40%, preventing 1.8 million injuries and saving 60,000 lives. Second, we will cut preventable hospital readmissions by 20%, saving more than 1.6 million patients from complications that force them to return to the hospital.”

She added that by reaching these targets, the U.S. health care system would save up to $35 billion, including up to $10 billion for Medicare. Over a period of 10 years, the reduction in Medicare costs could be almost $50 billion.

Thomas B. Valuck, MD, JD, Senior Vice President of Strategic Partnerships at the National Quality Forum, worked at the CMS for four years in high-level advisory positions.

“The HHS did nice a job of packaging high priority opportunities into the Partnership for Patients,” he said.

Partnership for Patients has actually contracted with the Forum’s National Priorities Partnership, formed three years ago, to do some of the outreach, including producing webinars. One webinar that took place last July 19 addressed preventing adverse drug reactions, an underlying theme of both the Hospital Engagement Contractors and the Care Transitions program.

Steven Meisel, PharmD, Director of Patient Safety at Fairview Health Services, a large health system based in Minneapolis, participated in that July 19 webinar. He says that pharmacists will have significant opportunities to make contributions to the two Partnership for Patients programs.

“It is trite but true, but pharmacists can make a big difference in reducing medication errors and readmission rates,” Dr. Meisel said.

He notes, however, that pharmacists in the future will have to rethink their day-to-day tasks and shift toward the kind of counseling required by medication therapy management (MTM). Fairview Health Services stations 20 pharmacists in offices with physicians at 40 of its outpatient clinics in the Minneapolis area. Those pharmacists do nothing but MTM, shoulder-to-shoulder with physicians. Asked whether the provision of MTM services is inhibited by the sometimes reluctance of payers to reimburse for those services, Dr. Meisel answers:

“We wouldn’t be spending $2 million on those 20 pharmacists if we weren’t getting reimbursed for their services from insurance companies or reducing costs in other ways.”

Dr. Valuck concedes that less than optimal progress has been made in reducing medical errors in hospitals since the publication of To Err Is Human.

He said, “I think most everyone agrees, and I certainly do, that we haven’t made the progress we would have liked to have seen in improving health care quality and safety. There is a huge opportunity here to avoid things that injure patients and make them sicker, an opportunity to avoid the kinds of complications that shouldn’t be part of the delivery of health care, and huge potential cost savings.”

In July, Mrs. Sebelius announced that 4,500 organizations—including more than 2,000 hospitals—had pledged their support for the Partnership for Patients program. Asked what that pledge required hospitals to do, Kathryn Ceja, spokeswoman for the CMS, said,

“The pledge is not only a tool to help raise public awareness about the need to improve patient safety, but it also has actionable goals.”

Health care providers, including hospitals and pharmacists, agree to “do their part,” according to Ms. Ceja, to meet the 40% and 20% goals set by Mrs. Sebelius in April.

“CMS is circling back to understand what they are doing to get closer to the goals we set,” added Ms. Ceja.

“It is easy to sign the pledge now,” explained Dr. Meisel, whose health system has inked its name on the dotted line. “You don’t have to do anything.”

However, he said that as the $1 billion starts to dribble out of the CMS, various professional medical and health organizations will begin to focus on various elements of Partnership for Patients.

“The stuff is always in your face, through e-mails, conferences you attend, and when the local hospital association starts talking about it,” he explains. “So it becomes a part of your agenda.”

As for reducing hospital readmissions (the aim of the Community-Based Care Transitions Program), Medicare has already nibbled around the edge of that challenge through an initial phasing in of changes to hospital in-patient payment based on a value-based purchasing concept. The Transitions program will offer grants to hospitals that partner with community-based organizations, typically agencies funded by the Administration on Aging. The grants will be determined on a per-eligible discharge basis for Medicare beneficiaries who are at a high risk for readmission, including those with multiple chronic conditions, depression, or cognitive impairments.

Applicants to the program must identify the root cause of the readmissions; define their target population; list their strategies for identifying high-risk patients; and specify interventions for care transitions, including approaches for improving health care provider communications and improving patient activation. Hospitals in the top quartile of the industry (those with high readmission rates) are eligible to apply for a grant without partnering with an agency on aging. The program will run for 5 years. Participants will be awarded 2-year agreements that could be extended on an annual basis for the remaining 3 years, depending on performance.

The Transitions program is based on a limited demonstration program that the CMS started funding in the mid-2000s involving 14 Quality Improvement Organizations (QIOs) around the country. It tested the development and implementation of models to improve patient transitions and reduce hospital readmissions.

Jeremy Milarksy, a spokesman for Primaris Health Care Solutions, which serves as the QIO in the state of Missouri, says that the most recent contract it signed with the CMS on August 1, 2011, for the first time designates care transitions as an official, discrete task in the contract.

“We intend to help hospitals in Missouri find out where their loose connections are internally and externally and help them fix those loose connections so transitions happen more smoothly,” he said.

As part of its efforts, Primaris is partnering with the Missouri Hospital Association to produce webinars for hospitals as a means of ramping up support and applications for the Community-Based Care Transitions Program.

However, the CMS has not yet awarded any Care Transitions grants. In fact, applications might not exactly be pouring into...
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Medicare. The first batch of applications was due on June 20, 2011, and was to be reviewed in July. One limitation is that local agencies on aging (county or city) are essentially responsible for forming a partnership with a hospital in the community. However, those agencies are typically short-staffed and in many instances simply don’t have the wherewithal to develop a potential program and bring in the requisite partners, according to Sharon Burnett, Vice President of Licensure, Regulation, and Accreditation at the Missouri Hospital Association.

Neither has the CMS awarded funds to the Hospital Engagement Contractors program. About $500 million will be available for that program too. The Contractors program expects to create and conduct various types of training events and sessions for hospitals. The training is designed to help hospitals achieve reductions in 10 core areas:

- adverse drug events
- catheter-associated urinary tract infections
- central line–associated bloodstream infections
- injuries from falls and immobility
- obstetrical adverse events
- pressure ulcers
- surgical-site infections
- venous thromboembolism
- ventilator-associated pneumonia
- preventable readmissions

The Contractors program looks much like the 100,000 Lives Campaign, which was launched by the Institute of Healthcare Improvement (IHI) in 2005. Not coincidentally, Donald Berwick, MD, MPP, CMS Administrator, headed the IHI when the 100,000 Lives Campaign got under way.

“The fact that the PFP looks and feels like the IHI campaign is not a surprise,” states Dr. Meisel. The idea there was for hospitals to adopt six safety “planks,” thereby reducing preventable hospital deaths by 100,000 lives. The IHI claimed that 122,000 avoidable deaths were prevented. However, statistics released later by the HHS Agency for Healthcare Research and Quality on hospital-preventable deaths between 2004 and 2006 counted 23,600 lives saved, casting some doubt on the 122,000 claim. The IHI then sponsored a follow-on 5 Million Lives Campaign, which focused on adverse health events as well as mortality rates. The success of that campaign has not been measured to date.

The success of the Partnership for Patients program has yet to be measured; in fact, it hasn’t really gotten off the ground, given that no grants for either community care transitions or hospital engagement have been awarded—nor are there any indications that they will be awarded soon.

There is no question that pharmacists like Michelle Le at Inova Alexandria could put those federal funds to good use. No one knows that better than hospital physicians such as Dr. Mark Williams at Northwestern.

He commented, “I believe pharmacists can have a huge helpful role. Numerous publications document their effectiveness, and they truly help patients with education about their medications and reconciliation.”