



Pharmacists Can Help Reduce Acute Myocardial Infarction Readmission Rates

by Mary Rothermal, PharmD

BACKGROUND

As stipulated by the Affordable Care Act, hospital reimbursement is now a reflection of a facility's 30-day readmission rates of specific disease states, including acute myocardial infarction (AMI). Rising health care costs and suboptimal patient outcomes resulted in an overhaul of the Medicare reimbursement model. According to data from the Centers for Medicare & Medicaid Services (CMS), AMI is both one of the most expensive conditions to treat and associated with one of the highest readmission rates. The Agency for Healthcare Research and Quality (AHRQ) defines this readmission measure as an unplanned readmission, of any cause, to an acute care hospital within a 30-day window of time following discharge for AMI. In 2005, the Medicare Payment Advisory Commission (MedPAC) reported that 13.4 percent of AMI patients are readmitted within 15 days of

discharge; this figure equates to an astonishing \$136 million of hospital care. A number of these readmissions were due to avoidable causes such as failure to receive necessary medications, miscommunication between the provider and patient, lack of support at home, or poor access to follow-up care. Shared responsibility and fluid communication among all health care practitioners is necessary to assure complete continuity of care. Ensuring this continuation of care will directly improve the overall health of patients, especially those who recently suffered an AMI. The need for outpatient involvement in patient care has never been greater; pharmacists in the community setting can and will directly impact the readmission rates of nearby hospitals and, more importantly, will positively impact their patients' health.

HOW CAN PHARMACISTS HELP?

After a review of available literature, the Joint Commission identified and summarized the effective approaches to transitions of care. This compilation includes a number of processes that can be effectively

performed by a pharmacist, such as identification of those at risk for readmission, medication reconciliation, and improved education to both patient and family. Given the known high readmission rate, any patient discharged after AMI will require extra attention for a successful transition. Upon discharge, AMI patients face a number of challenges, including a new diagnosis to accept, initiation of new medications, access to medications, adherence to their medications, and medication-related adverse effects. Pharmacists, especially community pharmacists, are in a unique position to assess the patient's situation, identify any gaps in care or communication, and then provide individualized care and ameliorate any medication-related issues to ensure a smoother transition post-discharge. Whether it is the standard of care for the pharmacy or part of a formal collaborative transition of care effort with the discharging facility, a pair of phone calls, one within 72 hours and the other at the two-week mark, can go a long way toward identifying medication issues that could lead to a readmission. A technician can ask three questions

Editor's Note: For information on references used in this article, contact Chris Linville at chris.linville@ncpanet.org.

and either get the pharmacist's attention immediately or record patient responses for pharmacist review.

SAMPLE QUESTIONS A TECHNICIAN MIGHT ASK

- How do you feel today?
- How is your mood/sleep/appetite/energy/motivation today? (depression screening)
- How do your (new) medications make you feel?
- How often are you going to cardiac rehab?
- How does cardiac rehab make you feel?
- When is your next doctor appointment? Do you need help getting there?

WHAT SHOULD PHARMACISTS FOCUS ON?

Adherence

The American College of Cardiology (ACC) reports that 31-58 percent of patients taking medications for cardiovascular disease are non-adherent to their medications. To illustrate the significant impact of that nonadherence, the ACC also reports that 33-69 percent of medication-related hospital readmissions are due to suboptimal adherence. Patients who recently suffered an AMI are likely to leave the hospital with a number of new medications, and adherence to those medications must be encouraged and their side effects monitored. Studies show that adherence is more difficult to achieve as the number of medications increases. From a number of sources, pharmacists can identify their patients who would benefit from an adherence check; sources include medication therapy management (MTM) platforms, pharmacy management software that calculates adherence rates, or from face-to-face conversations with their patients. Equipped with this information, community pharmacists can make interventions with their non-adherent patients and educate their patients

beginning on new medications about the importance of being adherent. A useful tool available to community pharmacists is called the Drug Adherence Work-up Tool, commonly known as the "DRAW" tool, available through the Million Hearts "Team Up. Pressure Down." initiative (http://millionhearts.hhs.gov/docs/tupd/draw_tool.pdf). This worksheet can help guide the pharmacist-led adherence intervention through the use of patient-directed, open-ended questions. The initial field test of the DRAW tool found that 77.3 percent of patients reported more than one reason for nonadherence. As a pharmacist, don't always accept, "I don't need any help with my medications" as a response, especially from your AMI patients. Even the most competent patients may benefit from post-discharge medication counseling and an adherence check. Future hospitalizations can be directly avoided if adherence to necessary cardiovascular medications is optimized.

MEDICATION THERAPY MANAGEMENT ENCOUNTERS

Without question, medication therapy management is one of the most valuable services offered by the community pharmacist. These services can take place in the comfort of the patient's pharmacy and by his/her pharmacist. During an MTM encounter, the pharmacist is able to optimize medication regimens, promote preventative and nonpharmacologic measures, identify and correct barriers to access or adherence, provide education, and use motivational interviewing skills. The significant impact pharmacists can have on readmission rates was illustrated in a

study conducted at Group Health Cooperative in the state of Washington. Patients who received a medication reconciliation and assessment post discharge had decreased 30-day readmission rates as compared to those patients who did not have a pharmacist intervention.

MTM encounters can also provide a safe place for the patient to disclose gaps in their understanding of medications or their disease state(s). A study done by Attebring et al. revealed a large portion of AMI patients were confused about the cause of their AMI and the role of medication in their care. During an MTM appointment, pharmacists have the opportunity to identify and dissolve any misconceptions that may surround a patient's medications. Overall, MTM is the ultimate framework for pharmacists to educate AMI patients, counsel individually on their complete medication list, optimize medication regimens, and bill for pharmacy services.

CONCLUSION

Due to the complex medication regimens and probable medication-related adverse effects associated with post-AMI treatment, pharmacists are invaluable members of the interdisciplinary team caring for this patient population. The community pharmacist is key in promoting medication adherence, optimizing medication regimens, and patient education—all of which are imperative in preventing hospital readmission following an AMI. ■

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***Editor's Note:** This is the first of a series of six articles that will be published in America's Pharmacist covering various health issues surrounding transitions of care when patients are discharged from hospitals, and how community pharmacists can help ease the transition and play a key role in avoiding costly readmissions to hospitals. Access NCPA's Transitions of Care toolkit at www.ncpanet.org/toc.*