NCPA
NATIONAL COMMUNITY PHARMACISTS ASSOCIATION

2015 Annual Convention

Date:	Tuesday, October 13, 2015
Time:	9:45 am – 11:15 am
Location:	Gaylord National Harbor Resort and Convention Center, National Harbor 3
Title:	Exploring the Expanding Opportunities in Transitions of Care **Sponsored by Merck** ACPE # 207-000-15-129-L04-P · 0.15 CEUs ACPE # 207-000-15-129-L04-T
Activity Type:	Application-based
Speaker:	Doug Josephson, RPh, FASCP, Hometown Pharmacy Jennifer Shannon, PharmD, BCPS, Lily's Pharmacy Richard Logan, Jr., PharmD, L&S Discount Pharmacy

Pharmacist and Pharmacy Technician Learning Objectives:
Upon completion of this activity, participants will be able to:

1. Discuss changes in the hospital, long term care and physician payment structure that make transitions of care programs more attractive to health systems.
2. Outline the business model for an existing transitions of care program, and discuss how it can be adapted to your pharmacy setting.
3. Discuss the appropriate target within a hospital, or facility for a proposal and how to pitch your pharmacy services.
4. Describe the IMPACT Act of 2014 (Improving Medicare Post-Acute Care Transformation) and identify opportunities for your practice.
5. Outline specific ways that you can target patients discharging from long-term care facilities.

Disclosures:
Doug Josephson declares no conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

Jennifer Shannon declares no conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

Richard Logan, Jr. declares no conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

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Exploring the Expanding Opportunities in Transitions of Care

Sponsored by Merck

Jennifer Shannon, PharmD, BCPS
Douglas C. Josephson, RPh FASCP
Richard Logan, Jr., PharmD

Transitions of Care 101

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Disclosure

- I have the following relationships to disclose
  - Consultant for AstraZeneca
- I have no financial relationships to disclose
- The conflict of interest was resolved by peer review of the slide content.

Learning Objectives

1. Discuss literature review on post-hospital medication discrepancies that result in adverse outcomes.
2. Describe readmission penalties and the potential financial impact on hospitals.
3. Discuss changes in the hospital, long term care and physician payment structure that make transitions of care programs more attractive to health systems.
4. Outline the business model for an existing transitions of care program, and discuss how it can be adapted to your pharmacy setting.
5. Discuss the appropriate target within a hospital, or facility for a proposal and how to pitch your pharmacy services.
6. Describe the IMPACT Act of 2014 (Improving Medicare Post-Acute Care Transformation) and identify opportunities for your practice.
7. Outline specific ways that you can target patients discharging from long-term care facilities.

Transition of Care

The movement patients make between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness

Coleman EA, Boult CE. Improving the Quality of Transitional Care for Persons with Complex Care Needs. J of the Amer Ger Society. 2003; 52(4): 556-557

Alarming Statistics Demonstrated in the Literature

- 60% of all medication errors in the hospital occur at admission, intra-hospital transfer, or discharge
- Approximately 20% of patients discharged from hospital to home will experience an adverse event during transition
  - 65% to 70% of these events are associated with medications
  - 77% of these patients receive inadequate medication instructions
- Anticoagulants, antiplatelet agents, insulin, and oral hypoglycemic agents account for the majority of medication-related hospitalizations

Institute of Medicine. Washington DC: National Academies Press; 2000
Butterfield S, et al. www.psqh.com/mayjune-2011/838-understanding care transitions. Accessed 17 Jan 2014
Forster AJ, et al. Ann Intern Med. 2003; 138(3): 161-7
Gray et al. Ann Pharmacother 1999;33:1147 – 1153

Readmission Rates Among Medicare Beneficiaries

On average, 1 in 5 Medicare beneficiaries discharged from the hospital is readmitted in 30 days costing the health system $15 billion annually

76% of hospital readmissions are preventable

Jencks, Stephen F., Mark V. Williams, and Eric A. Coleman. "Rehospitalizations among Patients in the Medicare Fee-for-Service Program." NEJM 2009; 360:1418-28

Regulatory and Financial Impact

Centers for Medicare and Medicaid

- Initiated penalization for hospital readmissions beginning FY 2013
- CMS estimates approximately 2/3 of US hospitals did receive penalties of up to 1% of their reimbursement from Medicare during the 2013 fiscal year
- CMS will increase penalties to 3% in FY 2015 for COPD and cardiovascular disease
- Incremental increase in penalties will continue to occur after FY 2015
- CMS expected to recoup $280 million from the 2,217 hospitals who care for patients with Medicare coverage with high readmission rates

The Joint Commission

- National Patient Safety Goal 03.06.01
  - Maintain and communicate accurate patient medication information
- Core Measures
  - Stroke
  - VTE
  - Heart failure
  - AMI
  - Pneumonia
  - Tobacco treatment

Joynt KE, Jha AK. NEJM.2013;368 (13): 1175-7.
Jencks SF, Williams MV, Coleman EA. NEJM.2009; 360(14):1418-28.
http://www.jointcommission.org/core_measure_sets.aspx
http://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html

Barriers to Successful Care Transitions

- Number of providers involved in patient's care
- Inaccurate documentation during hospital stay
- Prescribing errors
- Inaccurate medication profile at discharge
- Polypharmacy
- Inadequate patient education on discharge medications
- Failure to provide patient follow-up
- Patient resistance

Where Do Pharmacists Play a Role?

- We are uniquely positioned to provide enhanced patient care services and access to care
- Provider collaboration
- Patient education and communication
- Medication reconciliation
- Revenue opportunity through Medicare billing codes if medical director is available
  - 99495- Patient contact within 2 days of discharge and face to face follow-up within 14 days
  - 99496- Patient contact within 2 days of discharge and face to face follow-up within 7 days

Literature Review

Postdischarge pharmacist medication reconciliation: Impact on Readmission Rates and Financial Savings, Kilcup M, et al. J Am Pharm Assoc. 2013;53:78-84

Study Overview

- Ad hoc retrospective comparison and quality improvement analysis from September 2009-February 2010 on 494 patients (243 in med review group and 251 in comparison group)
- Evaluated patients discharged who were at higher risk for readmission at 7 days, 14 days, and 30 days readmission
- Patients with the following factors were considered high risk:
  - Current hospitalization was a readmission
  - Patients with complex care plans
  - Primary diagnosis of chronic disease
  - Major medication changes during hospital stay
  - Concern for patients ability to self manage

Kilcup M, et al. J Am Pharm Assoc. 2013;53:78-84

Study Methods

- Clinical pharmacists contacted patients 72 hours post discharge
- Comprehensive medication reviews were performed
  - Pharmacist reviewed unexplained discrepancies
  - Discussed changes with the patient
  - Pharmacists documented encounter and was sent to patient's primary care provider
    - Also documented medication omissions, therapeutic duplicates, dose changes, discontinued medications, and drug-drug interactions

Kilcup M, et al. J Am Pharm Assoc. 2013;53:78-84

Primary Outcomes

- Rate of hospital readmission and health system financial savings
- Rate of medication discrepancies for patients who receive clinical pharmacist medication reconciliation

Cost-Savings Calculations:

- Estimated cost of readmission for medical admits: $10,000
- Estimated cost for clinical pharmacist labor required for assessment: $73.33/hour (including benefits)
- Estimated time required of clinical pharmacist: 37 minutes

Kilcup M, et al. J Am Pharm Assoc. 2013;53:78-84

Readmission Rates

- At 7 days postdischarge, 2 patients in the med review group and 11 patients in the comparison group were readmitted (p = 0.01)
- At 14 days postdischarge, 11 patients in the med review group and 22 patients in the comparison group were readmitted (P=0.04)
- At 30 days postdischarge, 28 patients in the medication review group and 34 patients in the comparison group were readmitted (P=0.29)
- 80% of patients had at least one medication discrepancy after discharge, with many patients having multiple discrepancies

Kilcup M, et al. J Am Pharm Assoc. 2013;53:78-84

Health System Cost Savings

- NNT of 25 corresponds to 4 admissions prevented for every 100 patients
- With cost of readmission estimated at $10,000, this results in a gross savings of $40,000 per 100 medication reconciliation services
- 82 patients were receiving medication reconciliation per week (4280 patients per year)
- **Annual net cost savings of approximately $1,518,600 as a results of preventing readmissions**

Kilcup M, et al. J Am Pharm Assoc. 2013;53:78-84

Additional Studies

Author/Journal	Title	Pharmacist Intervention	Primary outcome	Results
Jack BM, et al. Annals of Internal Medicine	A Reengineered hospital discharge program to decrease hospitalization (Project RED)	Clinical Pharmacist at 2-4 days following discharge	Rate of rehospitalization in 30 days in 749 patients.	Decreased 30 day discharge by 30% in intervention group Avg cost savings per discharge:$412
Wong, et al. Annals of Pharmacotherapy	Medication Reconciliation at Hospital Discharge: Evaluating Discrepancies	Clinical pharmacists performed at discharge	Rate of medication discrepancy at discharge and clinical impact on patients	106 of 170 pts had medication discrepancy at discharge
Schnippner JL, et al. Archives of Internal Medicine	Role of pharmacist counseling in preventing adverse drug events after hospitalization	Clinical pharmacists performed at discharge, then 3-5 days later	Rate of preventable ADEs within 30 days of discharge	At 30 days, 1 patient in intervention group had a preventable ADE vs 8 patients in the control group

The Core of Transition of Care Programs

Establish the Relationship

- Establish point of contact responsible for quality improvement for the hospital
- Discuss a potential meeting about value-added services
- Develop a transition of care team in conjunction with the hospital

Transition of Care Program Goals

- Provide enhanced patient care services
- Provide a continuum of care from the hospital to home through community pharmacy care
- Reduce readmission and adverse events
- Reduce cost to the health system and patients
- Ensure regulatory compliance

Interventions Performed by Pharmacists during Care Transitions

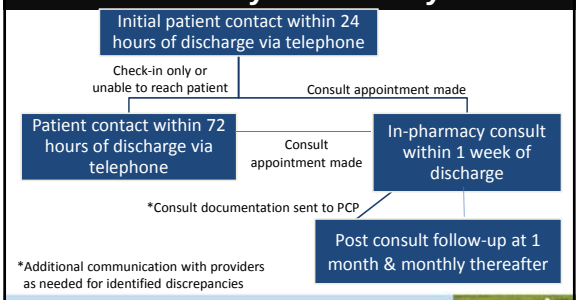
- Pharmacist to perform identification of discharged patients initially admitted with a primary diagnosis of AMI, heart failure, PNA, VTE, stroke, diabetes, asthma, COPD
- Contact patient within 24 hours of hospital discharge to establish follow-up consult
- Detailed review and reconciliation of drug orders between hospital and PCP
- Analysis of prescription, OTC, vitamins, supplements, herbal remedies
- Comparison of patient's preadmission and discharge medication lists
  - Omissions, discontinued medications, dose changes, therapeutic duplicates, drug-drug interactions
  - Discussion of unintended medication discrepancies with providers for resolution

Agency for Healthcare Research and Quality. Toolkit for Medication Reconciliation.www.ahrq.gov/qual/match/match.pdf. Accessed August 18, 2015

Medication Reconciliation During Consult

- Perform comprehensive medication history
- Verify patient's current medication list
- Provide updated medication list to patient
- Provide patient/caregiver medication education
  - Indications for use and importance of adherence to therapy
  - Proper administration (self-injection technique, inhaler technique, etc)
  - Goals of therapy (A1C, BG, BP, Cholesterol, INR, etc)
  - Disease state monitoring
  - Potential adverse effects
- Provide interpretive tools to assist patients with barriers to taking medication
- Ensure patient access to medications

Consult timeline & follow-up example from Lily's Pharmacy



Performance Improvement Indicators

Data Analysis & Performance Feedback to be provided to Community Hospital:

Closing Thoughts

- Determine a hospital to develop a transition of care relationship
- Schedule meeting to demonstrate the result of pharmacist intervention
- Enhance your credentials and certifications to perform direct patient care in your pharmacy setting
- Collect performance improvement data (errors, omissions, etc.)
- Implementation of a program is worth the community relationship!

A Long-Term Care Perspective

Douglas C. Josephson, RPh FASCP
Director of Alternate Site Pharmacy
HomeTown Pharmacy

Disclosure

I have no relevant financial relationships with any commercial interest to disclose.

Care Transitions from LTC Perspective

HISTORICAL – IT DIDN'T MATTER

Patients came into facilities for LONG TERM CARE

(i.e. NURSING HOMES)

and didn't really plan on going home

Care Transitions from LTC Perspective

HISTORICAL – IT DIDN'T MATTER

In the unlikely event that a patient discharged home…if they readmitted – it was OK!

Care Transitions from LTC Perspective

CURRENT– IT'S STARTING TO MATTER

- Assisted Living has taken over! Assisted living patients are the NURSING HOME patients of 20 years ago.
- Nursing homes have become REHAB CENTERS.

Care Transitions from LTC Perspective

FUTURE:

IT MATTERS. A LOT.

IMPACT

The Improving Medicare Post-Acute Care Transformation Act of 2014

H.R. 4994 (113th): IMPACT Act of 2014

Introduced: Jun 26, 2014
113th Congress, 2013–2015

Status: Enacted — Signed by the President on Oct 6, 2014
This bill was enacted after being signed by the President on October 6, 2014.

Law: Pub.L. 113-185

Sponsor: 
Dave Camp
Representative for Michigan's 4th congressional district
Republican

Text: 
Read Text »
Last Updated: Sep 23, 2014
Length: 19 pages

The Impact of IMPACT

- Improve quality of health care for millions of Americans
- Provide information regarding outcomes and costs
- Standardize assessments for critical care issues across post-acute care providers
- Build a bridge to ensure that patient care is delivered based on what the patient needs
- Eliminate the silo approach to quality measurement and resource utilization

https://www.cms.gov

The Impact of IMPACT

SUPPORT THE "TRIPLE AIM"

The Impact of IMPACT

SO WHAT DOES ALL OF THIS MEAN?

The Impact of IMPACT

SO WHAT DOES ALL OF THIS REALLY MEAN?

- There will be better integration between care providers
- Facilities will have to provide better care transitions or face reimbursement cuts

The Impact of IMPACT

SO WHAT DOES ALL OF THIS REALLY MEAN?

- One of the measures will have to do with medication reconciliation at transition
- Another measure will have to do with readmission rates

The Impact of IMPACT

WHO ARE "POST-ACUTE CARE" PROVIDERS?

- Skilled Nursing Facilities
- Home Health Agencies
- Inpatient Rehabilitation Facilities
- Long-Term Care Hospitals

*Hospitals were included in the initial drafts of the bill, but were subsequently deleted.

How will IMPACT be Implemented?

PHASE 1: DATA REPORTING
Quality Measures

Quality Measures	HHAs	SNFs	IRFs	LTCHs
Functional Status	1/1/2019	10/1/2016	10/1/2016	10/1/2018
Skin Integrity	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Medication Reconciliation	1/1/2017	10/1/2018	10/1/2018	10/1/2018
Major Falls	1/1/2019	10/1/2016	10/1/2016	10/1/2016
Patient Health Information and Preference	1/1/2019	10/1/2018	10/1/2018	10/1/2018

http://www.reedsmith.com/files/Publication/a0c30fb6-81bd-4739-9be5-169e20aad8ae/Presentation/PublicationAttachment/1841b086-dd16-4a9c-a0fa-2cc2081dadb6/Analysis%20and%20Impact%20of%20the%20Improving%20Medicare%20Post-Acute%20Care%20Transformation%20Act%20of.pdf

How will IMPACT be Implemented?

PHASE 1: DATA REPORTING
Resource Measures

Resource Use Measures	HHAs	SNFs	IRFs	LTCHs
Resource Use Measures	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Discharge to Community	1/1/2017	10/1/2016	10/1/2016	10/1/2016
Readmission Rates	1/1/2017	10/1/2016	10/1/2016	10/1/2016

http://www.reedsmith.com/files/Publication/a0c30fb6-81bd-4739-9be5-169e20aad8ae/Presentation/PublicationAttachment/1841b086-dd16-4a9c-a0fa-2cc2081dadb6/Analysis%20and%20Impact%20of%20the%20Improving%20Medicare%20Post-Acute%20Care%20Transformation%20Act%20of.pdf

How will IMPACT be Implemented?

PHASE 2: PENALTIES

- Nursing Home Readmission Penalty Task Force met on July 25th, 2015.
- Some penalties MAY begin to roll out with some of the 10/1/16 reporting, but it is not clear.

How will IMPACT be Implemented?

PHASE 2: PENALTIES

- There WILL be readmission penalties for nursing homes.

$=?

BACK TO THE FUTURE

DOES THIS SOUND FAMILIAR?

Under the Medicare Hospital Readmissions Reduction Program – HRRP – (part of the Affordable Care Act), beginning in October 2012 hospitals were penalized for certain readmissions within 30 days.

Why are they DOING this to us?

NURSING HOMES NEED TO IMPROVE THEIR DISCHARGE PROCESSES!

- Confusion on discharge
- Patients' lack of resources after discharge
- Medication IRRECONCILIATION

Why are they DOING this to us?

After discharge from SNF to home, 22.1% of older adults had an episode of acute care use within 30 days, including 7.2% with an ED visit without hospitalization and 14.8% with a rehospitalization.

37.5% of older adults had their first acute care use within 90 days.

Journal of the American Geriatrics Society
January 2, 2014

HOW DO WE GET READY?

"CLOSED DOOR" LONG-TERM CARE PHARMACIES

- Get ready for new changes! Educate yourself! There will be new abbreviations, new survey measures, new requests from your customers.
- Educate your customers. Help them prepare for the new rules. BE the expert that they need.

HOW DO WE GET READY?

"CLOSED DOOR" LONG-TERM CARE PHARMACIES

- Follow the implementation process of the new act
- Get involved with the implementation process
- Offer suggestions and public comment
- Serve on a CMS Technical Expert Panel

HOW DO WE GET READY?

"CLOSED DOOR" LONG-TERM CARE PHARMACIES

- LEARN ABOUT MEDICATION RECONCILIATION. Be able to DO it and TEACH it to your customers.
- Pharmacy should lead the charge in medication reconciliation.

WHY MEDICATION RECONCILIATION?

70% of patients have at least one actual or potential unintentional medication discrepancy upon discharge[7]

Elderly patients who experience at least 1 medication discrepancy post-discharge are **2X as likely to be readmitted within 30-days**[8]

CMS estimates **11% of readmissions** are due to medication non-adherence[9,10]

Research has shown that **20% of readmissions within 1 year** are due to an adverse drug event[11]

7. The Joint Commission: Sentinel Event Alert January 25, 2006, Issue 35
8. Wong JD et al. Medication reconciliation at hospital discharge: evaluating discrepancies. Ann Pharmacother. 2008;42:1373-9.
9. Coleman E.A., Smith J.D., Raha D, Min S. Posthospital medication discrepancies. Arch Intern Med. 2005;165:1842-1847.
10. Hubbard T., McNeil N. Improving medication adherence and reducing readmissions. New England Healthcare Institute. October 2012.
11. Osterberg L, Blaschke M.D. Adherence to medication. N Engl J Med. 2005;353:487-97.

HOW DO WE GET READY?

INTEGRATED RETAIL / LTC PHARMACIES
"COMBO SHOPS"

HOW DO WE GET READY?

INTEGRATED RETAIL / LTC PHARMACIES
"COMBO SHOPS"

- Communicate with each other
  (LTC pharmacy → Retail pharmacy → LTC pharmacy)
- Strategize NOW on how you will work together.
- Prepare your own Care Transitions Program.

HOW DO WE GET READY?

INTEGRATED RETAIL / LTC PHARMACIES
"COMBO SHOPS"

NEVER FORGET: YOU HAVE A VERY UNIQUE ADVANTAGE IN YOUR MARKET! USE IT! YOUR PATIENTS AND YOUR FACILITIES NEED YOU!

- You know the patient's entire relevant medication history
- You know everything that happened clinically in the LTC facility
- You know the patient's financial status

HOW DO WE GET READY?

INTEGRATED RETAIL / LTC PHARMACIES
"COMBO SHOPS"

HOW DO WE GET READY?

RETAIL PHARMACIES
ALIGN YOURSELF WITH LTC FACILITIES

- Get to know your local nursing homes & other facilities / agencies affected by IMPACT.
- Find out if their pharmacy provider has a discharge program available.
- They will love your help – especially if you understand the impact of IMPACT.

HOW DO WE GET READY?

RETAIL PHARMACIES
ALIGN YOURSELF WITH LTC PHARMACIES

- Talk to local LTC pharmacies in your community that don't have a retail component.
- They NEED someone to work with themselves and their facilities in the discharge process.
- How can you partner with them? Can you be their preferred discharging pharmacy?

MY PERSPECTIVE

HOMETOWN PHARMACY

- 36 Retail Pharmacies
- 4 Closed Door LTC Pharmacies
- 2 DME Locations
- 4 Compounding Pharmacies
- Specialty Pharmacy Network
- ApotheCare™ PBM

MY PERSPECTIVE

MY PERSPECTIVE

Care Transitions Program

- Launched summer of 2013
- Marginally successful
- Challenges
- Biggest successes:
  - Built Care Transitions Program structure
  - Started the conversation

TOC Opportunities for Community Pharmacy

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Disclosure

Richard Logan, Jr. declares no conflicts of interest or financial interest in any product or service mentioned in this program, including grants, employment, gifts, stock holdings, and honoraria.

BECAUSE

One in five patients discharged from hospitals suffers an adverse event*

72% of which are related to medications*

Improving Care Transitions: Optimizing Medication Reconciliation, March 2012, APHA, ASHP: Steeb, et al

BECAUSE

76% of Medicare re-hospitalizations in 2007 were potentially preventable, suggesting that:

$13 billion of the $15 billion in readmissions costs may be unnecessary and preventable.*

Improving Care Transitions: Optimizing Medication Reconciliation, March 2012, APHA, ASHP: Steeb, et al.

BECAUSE

Medicare Penalties:

2012 Inpatient Prospective Payment System (IPPS) payments DECREASED up to 3% for ALL MEDICARE PAYMENTS

BECAUSE

- About a third of Hospitals and Health Systems Fined
- Current fines about $428 Million

Health Systems are Searching for Answers

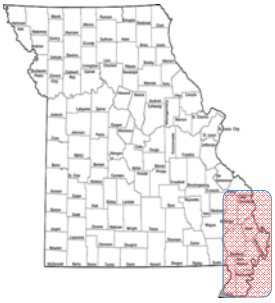
Enter Community Pharmacy

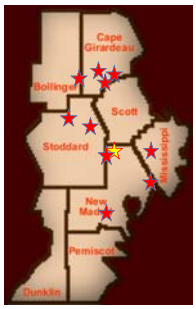
- Local
- Our patients their hospital
- Patient relationship
- Able to perform Med Rec, CMR, Patient Communication
- Ability to impact early readmits

So, What Does This Look Like?

- Transition of Care Pilot Project
- Missouri Delta Medical Center-Sikeston, Missouri

Ten Pharmacies, One Health System





As Independent Community Pharmacists

- What could we do, what could we say that would impact the hospital enough to want to participate in a Transition of Care Project with local pharmacies?

We Have What You Need

- Help with early readmissions
- Improve patient communication between hospital, patient, and pharmacy
- Help you reduce early readmission penalties
- Improve patient outcomes and satisfaction

What the Pharmacy Staff Does

At Discharge:

- Receive patients
- Reconcile discharge meds with home meds
- Resolve any medication issues ($ or clinical)
- Make sure all prescribers are informed
- Reinforce hospital discharge info
- Report progress back to hospital, PCP, etc.
- Encourage patient to contact original hospital with new issues
- Have contact names and numbers of key hospital personnel to share with patient for continuity of care

What the Pharmacy Staff Does

Ongoing

- Enter patient into adherence program
- Regular chart review
- Contact patients for F/U
- Ensure medication adherence

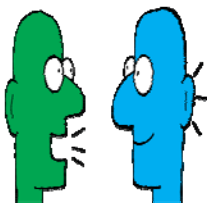
What did We Ask of the Health System?

- We wanted it to be work neutral for the hospital
- All processes needed to fit into the normal workflow of discharge
- It needed to be EASY
- It needed to be WORTHWHILE
- It needed to BENEFIT THE PATIENT

What did We Ask of the Health System?

- Hospital offers/explains program to patient upon discharge
- If patient accepts, discharge notes/new Rxs are sent to pharmacy
- Hospital has a patient ombudsman, liaison, etc. familiar with patient case for pharmacy or patient to contact
- Liaison receives report from pharmacy, assists in transition

- It all boils down to communication
- Hospitals need help
- Pharmacy has resources
- Mutually beneficial relationship



Challenges

- Get your foot in the door.
- Target the right person.
- Know your data.
- Realize hospitals work slowly
- Ask for help

Questions?

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Additional Studies

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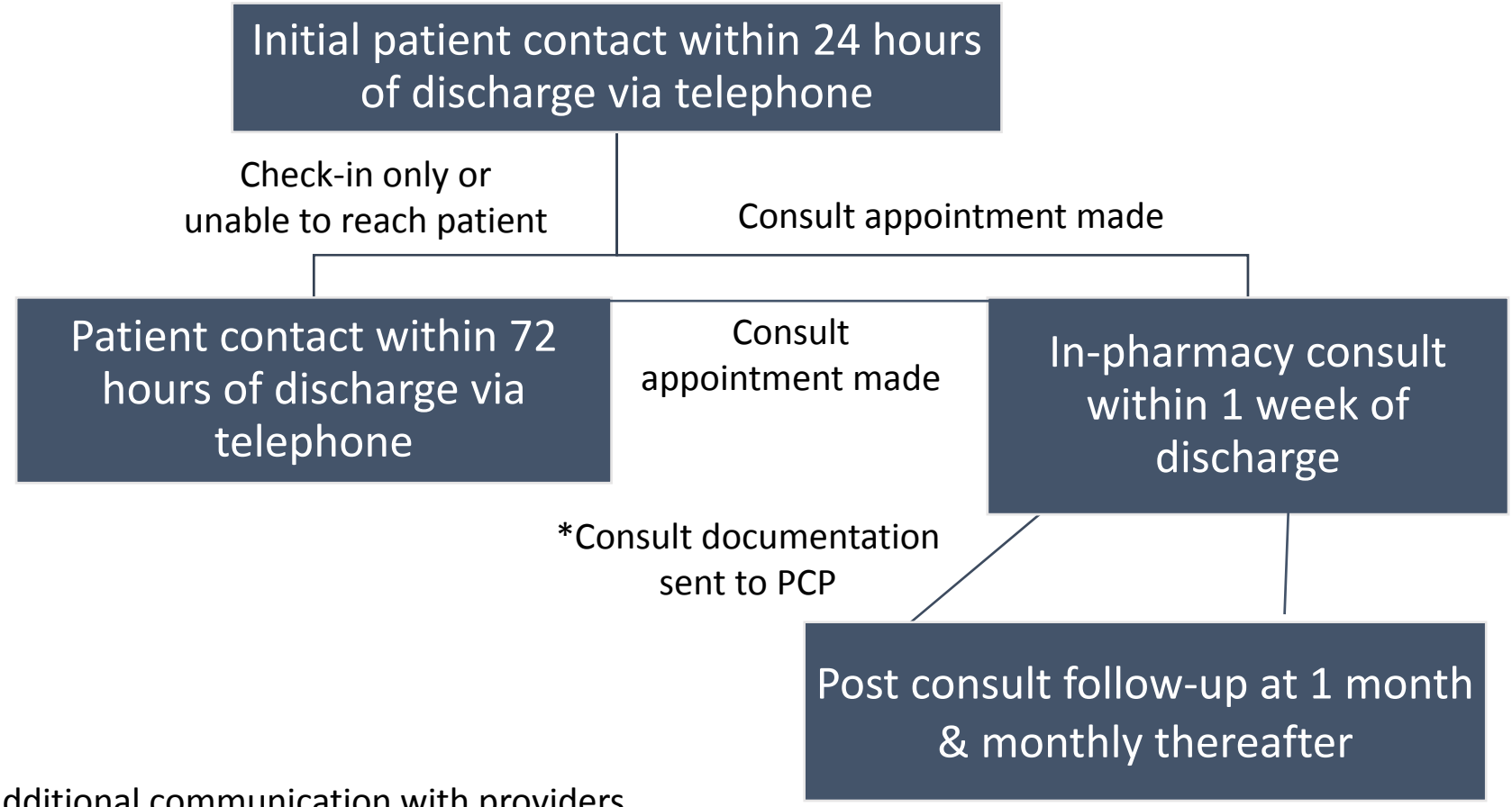
Consult timeline & follow-up example from Lily's Pharmacy



*Additional communication with providers as needed for identified discrepancies

Performance Improvement Indicators

Data Analysis & Performance Feedback to be provided to Community Hospital:

Lily's Pharmacy Transition of Care Monthly Audit Tool																		
FY14		Jan	Feb	March		April	May	June	Q4	July	August	Sept	Q1	Oct	Nov	Dec	Q2	Target
Referrals																		
Opt out																		
7-day readmissions																		
14-day readmissions																		
30-day readmissions																		
Age																		
Gender																		
Discharge diagnosis																		
# prescription medications																		
# OTC medications																		
CMS status																		
Discontinued medications																		
Omissions																		
Dose changes																		
Therapeutic duplications																		
Drug-drug interations																		

Resources

ASHP-APhA Resource Center
http://www.ashp.org/menu/practicepolicy/resourcecenters/transitions-of-care

ASHP-APhA constructed Best Practices Manual
http://media.pharmacist.com/practice/ASHP_APhA_MedicationManagementinCareTransitionsBestPracticesReport2_2013.pdf

AHRQ - Agency for Healthcare Research and Quality
http://www.ahrq.gov/professionals/quality-patient-safety/patient-safety-resources/resources/match/index.html

IHI - Institute for Healthcare Improvement
http://www.ihi.org/resources/Pages/Tools/MATCHMedicationReconciliationToolkit.aspx