U.S. Department of Veterans Affairs
Veterans Health Administration
Pharmacy Benefits Management (PBM) Services
Clinical Pharmacy Practice Office (CPPO)

Clinical Pharmacist Practitioner (CPP) Role in Management in Transition of Care and Hospital Readmissions
June 2021

Executive Summary

This Fact Sheet highlights the growing and critical role of the Clinical Pharmacy Practitioner (CPP) in managing disease states post veteran transitions of care within the Department of Veteran Affairs.

Key Takeaways

- The CPP Provider is a critical team member in the primary care setting improving quality of care and access to comprehensive medication management (CMM).
- CPP are highly trained Advanced Practice Providers (APP) who work collaboratively under a global scope of practice (SOP) with prescriptive authority as described in VHA Handbook 1108.11 Clinical Pharmacy Services.
- Readmissions post transitions of care may be preventable with effective and timely primary care. Evidence supports timely intervention by CPP in the primary care setting to prevent readmission for multiple disease states.
    - The 2016 PBM Diffusion of Excellence (DOE) Gold Status Project "Improving Access to Primary Care Utilizing CPP", outlines methods found to be successful.
    - VA facilities have demonstrated the use of CPP to improve Veteran access to primary care and reduce hospital readmissions.
- The VHA Handbook 1108.11 Clinical Pharmacy Services supports the role of CPPs working autonomously in collaboration with providers under a scope of practice (SOP) to provide comprehensive medication management for chronic disease states.
- Population Health Management can be a helpful tool for CPP Providers to identify patients who would benefit from ACSC comprehensive medication management.
- Ensuring a dedicated CPP provider workforce for prevention of readmission can be a highly cost-effective method to improve access to needed care and clinical outcomes.

SEE FOLLOWING SECTIONS FOR FULL NARRATIVE OF THESE POINTS

Background:

Hospitalizations for chronic disease states are in many cases avoidable if primary care is provided in a timely and effective manner. The following conditions are defined disease states evaluated for readmission within the VA: diabetes (short term and long-term complications), perforated appendix, chronic obstructive pulmonary disease (COPD), hypertension, congestive heart failure (CHF), dehydration, bacterial pneumonia, urinary tract infections (UTI), angina without an in-hospital procedure, uncontrolled diabetes, and adult asthma. It has been well established that effective primary care is associated with lower related admissions. Readmissions are one of the measures incorporated into the Strategic Analytics for Improvement and Learning (SAIL) Value Model, a report measuring quality of care in the VA, and are accepted as an indicator of access and quality of primary care.

VA Scope of Practice Authority and the Clinical Pharmacy Practitioner(CPP) Role

VHA Handbook 1108.11 Clinical Pharmacy Services describes the role of the CPP working autonomously in collaboration with other providers under a scope of practice (SOP). The handbook recognizes the benefit of maximizing the comprehensive medication management (CMM) capabilities of the CPP and supports the CPP authority to prescribe medications in practice areas for which the CPP has expertise to order, interpret, and monitor laboratory results, develop patient-centered therapeutic plans, and manage acute and chronic disease states in which medications are part of treatment.

The CPP functions optimally as the medication expert for the VA Primary Care Patient Aligned Care Team (PACT) or primary care team. The PACT model creates an interdisciplinary team-based approach to optimize quality of care and improve transitions of care which is identical to goals of the Patient Centered Medical Home (PCMH) outside of the VA. PACT CPP practice autonomously under the SOP to provide CMM for chronic disease states. This should be a global that allows the CPP to be responsive to the majority of disease states seen in the primary care setting.

Opportunities for PACT CPP Intervention in prevention readmissions within the VA

The PACT CPP is highly trained and well positioned to provide direct patient care with their role in PACT chronic disease management fully established throughout the VA. The VA Clinical Pharmacy Practice Office (CPPO) mission has advocated for the expansion of the PACT CPP role beyond the traditional management of diabetes, hypertension and hyperlipidemia. This has been a facilitated by the creation of disease management competencies that may be used by the PACT CPP and their supervisors to ensure readiness for ACSC disease state management.

PACT CPP Increase Primary Care Access for Management of Comprehensive Medication Management

For a typical panel of 1,200 patients, PACT Primary Care Providers (PCP) only have appointment slots to see a patient 2.5 times per year. The VA has set a goal reduction in PCP re-visit rates, a measure of how often a patient is brought back for a face to face appointment, of 10-20% per year being reasonable with reductions of more than 20% per year being highly commendable. Multiple opportunities exist to decrease return visits which include utilization of non-face to face care modalities and utilization of other members of the healthcare team for coordination of care. PACT CPP have helped contribute to achieving an optimal revisit rate and improved access to care by providing CMM for chronic disease states allowing the PACT PCP time to address other patient care needs. The *Increasing Access to Primary Care using Pharmacist Practitioners: Diffusion of Excellence Gold Status Practice* demonstrated that 27% of PCP return appointments could be averted with CPP integration. Applying this across the entire facility

equated to over 850 new appointments per quarter created for the primary care service. Applying the increase in access VA wide would result **over a quarter of a million newly opened appointments annually**.[1]

Simply put, the advanced role of the CPP improves access and reduces the burden on the primary care provider for ACSC chronic disease follow up by:

- Reducing primary care provider (PCP) revisit rates by providing CMM
- Reducing new patient wait time for Veterans seeking primary care within individual PACT panels
- Increasing same day access to CPP care for Veterans with chronic diseases where hospital admission is a concern

Improving Quality of Care with the CPP

Multiple studies, many of which were conducted in the VHA setting, have been published in peer-reviewed literature and consistently demonstrate positive benefits of pharmacist-directed patient care in the primary care setting.[2-4] Additional evidence reveals reduced hospitalization rates and improved costs with an acute care and outpatient pharmacist providers care coordination model.[5] Specific to chronic disease statement management and prevention of readmission, CPP-led strong practices implemented in three VA facilities have shown benefit in reducing readmission rates and improving patient outcomes. These practices are described below.

The VA Tennessee Valley Healthcare System effectively demonstrated the use of CPP to improve Veteran access to primary care and potentially reduce readmissions through their Pharmacist to Pharmacist Transitions of Care Project. Within this model, patients admitted for COPD, CHF, hypertension, or diabetes related diagnoses are identified by the inpatient medical team Clinical Pharmacist. Prior to discharge the inpatient clinical pharmacist provides standardized discharge education regarding disease state and medications and coordinates follow up with the PACT CPP . Thus far, the Tennessee Valley Healthcare System has exhibited a 14.5-14.9% improvement in reduction of readmission with PACT CPP Provider follow-up.[6]

The William S. Middleton VA Hospital in Madison, WI utilized CPP to develop a post-acute care service for COPD patients within the PACT clinic setting. Veterans with a recent ED or hospital discharge were seen by a CPP three weeks post discharge and were followed up at two months and three months. CPP care included a combined assessment of COPD, medication optimization and education. Compared to non-CPP control group, 30-day readmission rates and ED presentation were statistically significant (p=0.047) at 0% compared to 57.1%.[6]

The South Texas VA Healthcare System in San Antonio, TX utilized CPP for aggressive management of patients discharged with CHF. Patients were seen for intensive discharge follow up by their PACT CPP within 7 days post discharge and then weekly with one supplemental visit by cardiology for four weeks. CPP interventions focused on fluid status evaluation and guideline directed medication management interventions. Readmission rates decreased by 5% from baseline with a total mortality rate reduction of 10%.[6]

The above programs demonstrate that PACT CPP may operate transitions of care or post-discharge follow up clinics, ensuring safe transitions of care between inpatient hospitalizations and follow up with the primary care team. PACT CPP involvement in transitions of care allows for promptly addressing

medication relation questions and documentation of any post-discharge medication issues. Alternately, the PACT CPP may be able to reach out directly to recently discharged patients and assist with their care transitions by ensuring timely follow up within the PACT clinic.

Role of the Acute Care CPP in Transitions of Care

Within the VA's integrated health care system, inpatient acute care CPP play an integral role in the transition of patients from an acute care stay back to their primary care medical home. The acute care CPP is optimally positioned to identify patients with chronic disease state admissions the inpatient care process, as well as coordinate transitions of care at discharge with a PACT CPP. Together, the acute care CPP and the PACT CPP allow for closer follow-up upon patient discharge and increase access to primary care services while focusing on prevention of a readmission.

The acute care CPP has an important role in identifying patients that are at high risk for adverse events and readmission post discharge. To best identify this patient cohort, it is recommended that the acute care CPP perform a structured risk assessment to target those who would benefit most from a PACT CPP intervention post discharge. Patient identification should be initiated as soon as possible upon admission. This practice may include but is not limited to: tailoring of medication reconciliation templates to prompt further evaluation, developing admission order sets to include alerts for pre-specified chronic disease state conditions, and incorporating chronic disease state identification into daily medical rounds. Based on facility specific capacities and workflow design, the patient identification process may initially target select disease states and expand to all conditions as feasible. Selection and addition of conditions should be done in partnership with the PACT CPP to ensure clinic structure can accommodate follow-up care for patients identified. Of note, it is feasible to omit patients with established specialty care follow-up (i.e. diabetes patients seen in endocrine clinic) from the identification process.

Proactive discharge planning, and early identification of chronic disease where the CPP can improve care upon admission, affords time during hospitalization to resolve potential barriers to outpatient care, such as limited clinic availability, weekend discharge, and no established PCP. Standardized methods of transitioning care between the acute care CPP and PACT CPP can effectively span potential gaps in care post-discharge and prevent early readmissions.

To ease the care coordination process for the acute care CPP, creating a local document which maps PACT CPP to their associated PACT teams, may be helpful. Clear referral processes through a Care Coordination Agreement, Standard Operating Procedure, or similar process should be implemented to ensure standardization across all discharges. The best method for coordinating handoffs should be developed in collaboration with PACT and acute care CPP stakeholders to determine the best process prior to implementation.

When planning post-discharge care, the acute care CPP should coordinate a follow-up appointment with the PACT CPP that is convenient for the patient, ideally within 7-14 days of discharge. It is also imperative that a comprehensive description of the purpose of follow-up and the role of the PACT CPP is discussed with the patient. Ensuring the patient recognizes the role of the PACT CPP will help to establish appropriate expectations at the time of discharge. Handoff information to the PACT CPP should be documented in the patient's electronic medical record and may include vital information regarding the patient's hospitalization, medication changes, risk factors, and barriers to remaining out of the hospital.

The acute care CPP should mitigate other preventable risk factors while in the hospital in collaboration with the multidisciplinary team, provide comprehensive medication reconciliation and targeted medication counseling, and provide disease state counseling. Creation of local, standardized disease state

counseling templates or patient education may ensure consistent counseling across all patients. Educational approaches, like the teach back method, should be utilized to ensure patient and caregiver comprehension of imperative aspects of the medication and discharge plan.

Although other health care systems may not have the robust acute care clinical pharmacy programs that the VA provides, coordination of care and communication among members of the healthcare team across the care continuum is critical to ensure appropriate post discharge follow up.

Population Health Management and Identification of Patients for CPP Intervention

Within the VA, population health management tools offer a wealth of information. Selective use of reports that are most relevant for the CPP can optimize the identification of the patients who are hospitalized for a chronic disease state condition to optimize post discharge for care. In addition, VA developed population health tools can also be used for identification of patients who are at high risk for readmission to target efforts to prevent an admission.

The ideal team member to access the population health management reports for identification of high-risk patients will differ based on facility size, staffing distribution and overall work flow. For example, at a complex VA Medical Center with many PACT CPP, it may be useful to have a pharmacy administrator, clinical pharmacy technician or other team member pull reports and distribute them to the CPP. Whereas a smaller facility may prefer to designate one CPP to act as the "champion" for transitions of care and take on this responsibility. Facilities with a Transitions of Care Pharmacist or a PGY-2 Pharmacy Resident(s) in Ambulatory Care may be able to incorporate management of the reports into the designated responsibilities for those positions.

Conclusion

The CPP plays a vital role in management of patients both in the acute care and outpatient settings collaborating to optimize transitions of care within the VA and prevent hospital readmission. Proactive care coordination and identification of at-risk patients is crucial in navigating the patient transitioning from an inpatient stay to their primary care medical home. The VA has utilized coordination between acute care and outpatient CPP when possible to mitigate readmission rates and improve patient outcomes as well as increase the patient care experience. Population health management tools can be used to ensure that high-risk patients are receiving follow up within their PACT team in a timely and effective manner and can be used as a quality check if an active handoff between providers is not feasible to identify patients at discharge.

Ensuring dedicated CPP workforce for transitions of care efforts can be a highly cost-effective method to improve access to needed care and clinical outcomes.

Questions related to this Fact Sheet may be directed to VHAPBM Ask PBM Clinical Pharmacy Practice Office VHAPBMAskPBMCPPO@va.gov**.**

Relevant VHA Directives/Handbooks:

1. VHA Handbook 1108.11, Clinical Pharmacy Services; July 1, 2015. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3120
2. VHA Handbook 1100.10(1), Patient Aligned Care Team (PACT) Handbook; February 5, 2014. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2977
3. VHA Directive 2009-053, Pain Management; October 28, 2009. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=2781

4. VHA Directive 1033, Anticoagulation Therapy Management; July 29, 2015. https://www.va.gov/vhapublications/ViewPublication.asp?pub_ID=3129

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2. Giberson S, Yoder S, Lee MP. Improving Patient and Health System Outcomes through Advanced Pharmacy Practice. A Report to the U.S. Surgeon General. Office of the Chief Pharmacist. U.S. Public Health Service. Dec 2011.
3. PCPCC Medication Management Task Force. Integrating Comprehensive Medication Management to Optimize Patient Outcomes. Washington, D.C.: Patient-Centered Primary Care Collaborative; 2010.
4. Chisholm-Burns MA, Kim Lee J, et al. US pharmacists' effect as team members on patient care: systematic review and meta-analyses. Med Care 2010 Oct;48(10):923-933.
5. Pellegrin KL, Kenk L, Oaks SJ, et al. Reductions in medication-related hospitalizations in older adults with medication management by hospital and community pharmacists: a quasi-experimental study. J Am Geriatr Soc 65:212-219,2017.
6. Department of Veterans Affairs Pharmacy Benefit Management Clinical Pharmacy Practice Office. (November 2018). Internal Data PACT Strong Practices.