Partnering in Better Healthcare

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EMPLOYERS' FORUM OF INDIANA

Addressing the challenges of the local healthcare marketplace

Transitional Care- Collaborative Program Design

Shared clinical goals and financial incentives

Strong leadership and governance drives partnership development

Designed to complement current efforts and collaborate with care teams

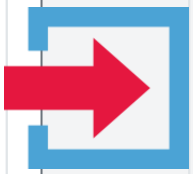
Eligibility determined by clinical criteria regardless of servicing pharmacy

WellTransitions®

Pharmacy-led program designed to reduce preventable readmissions through medication education and adherence

Care Platform and Enabling Technology

Information Sharing with Care Team and PCP



Customizable and Effective Workflow Management

Support of Call Center Pharmacy Team: Expert Resources

Ability to Match Interventions Based upon on Risk

Enhancements

Patient/Caregiver and Provider Portal

Remote-Monitoring Capabilities

Collaborating to determine eligibility criteria

Categories of eligibility criteria

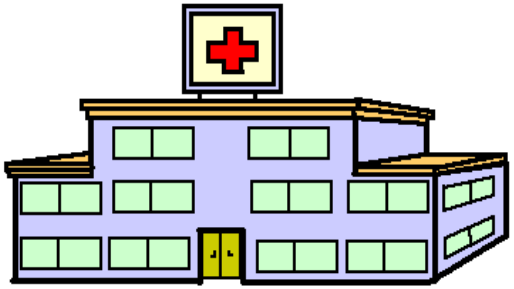
Demographic:
- Inpatient, discharging to home or with home health
- Frequent readmissions, admissions through ED
- Floor or room range
- Age

Clinical:
- Chronic health conditions at admittance or history of (examples: HF, AMI, PN, COPD)
- Complaint keywords at admittance associated with chronic health conditions
- Physician specialty (example: cardiology)

Financial classification/payor:
- Medicare
- Indigent and risk-based
- Commercial
- Other

Program Components- In hospital

- Data extraction- Admissions, Discharge and Transfer (ADT) feed from hospital
- Eligibility criteria entered into technology to filter appropriate patients
- Offer of bedside delivery extended
- Receive a copy of the discharge medication instructions



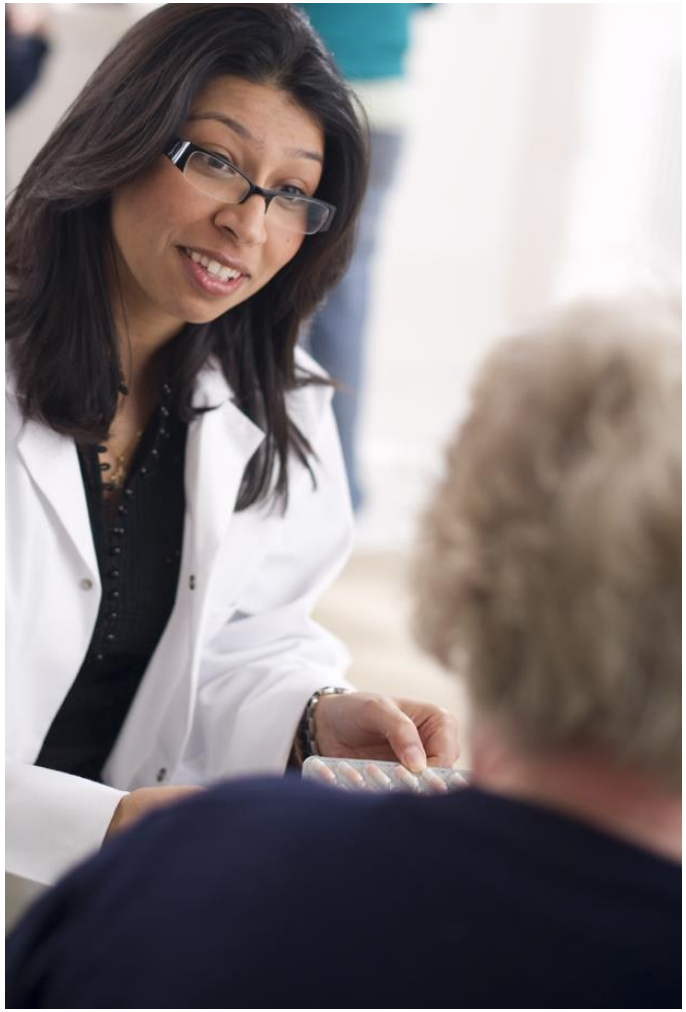
Complete Medication Review Follow-Up Initiated 48-72 Hours After Discharge

- Pharmacist completes medication review via discharge instructions and disease specific questions
- Pharmacy staff encourages medical home by verifying follow up appointment has been scheduled and records date
- Lifestyle questions also included in conversation
- If any issues are identified, escalation occurs and are pushed to the appropriate healthcare provider
- Next phone call scheduled after primary care provider/specialists visit

All calls are recorded for quality purposes

Clinical Therapy Review Approx. 10 Days Post Discharge

- Verify follow up appointment as been completed, if not issue escalated
- Pharmacy staff completes medication review
- Importance of appropriate refills reviewed
- If any issues are identified, escalation occurs
- Next phone call scheduled



Bridge to the Community 25 Days Post Discharge

- Pharmacy staff completes medication review
- If any issues are identified, escalation occurs
- Encourage Rx refill at the pharmacy of choice
- WT summary converted to CDA format and pushed to PCP, HIN or EMR

Impact on readmissions

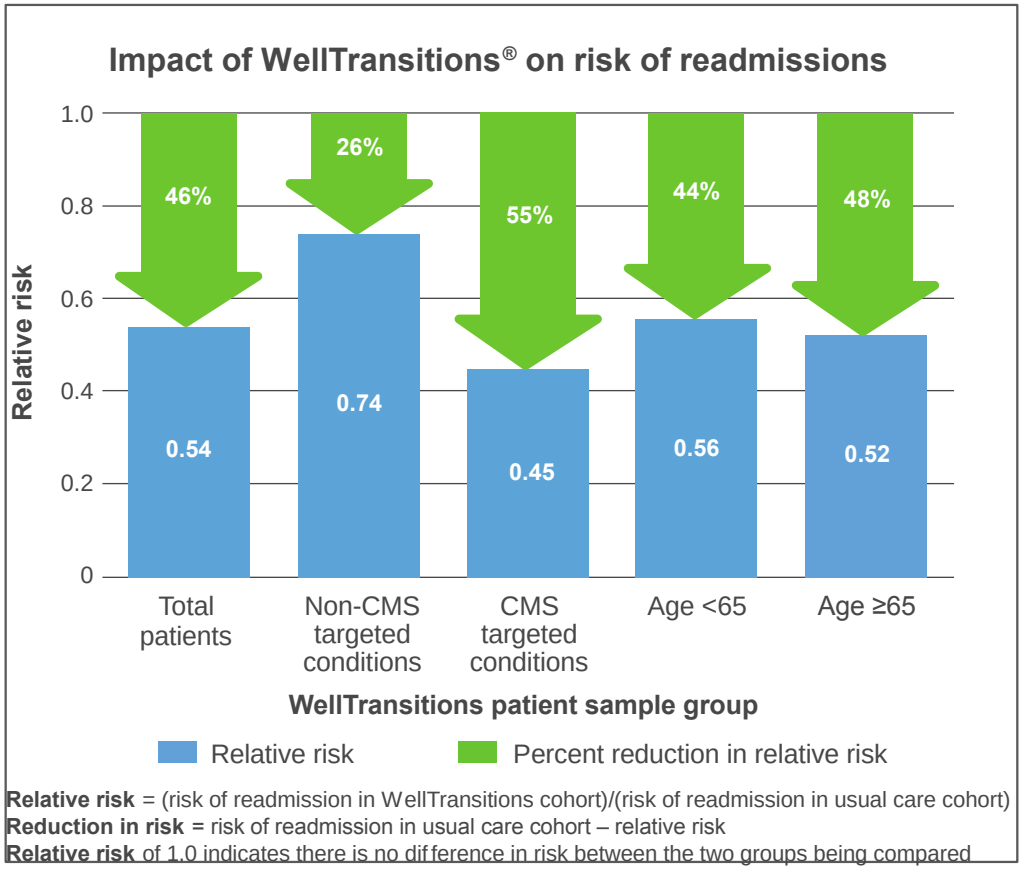
WellTransitions® patients were **46% less likely** to be readmitted unexpectedly within 30 days of hospital discharge.*[1]

Non-CMS targeted conditions:
26% less likely to be readmitted

CMS targeted conditions:
55% less likely to be readmitted

Age <65: 44% less likely to be readmitted

Age ≥65: 48% less likely to be readmitted



*Walgreens study conducted January 2013 through December 2013, with 744 matched pairs selected from four hospitals (744 WellTransitions patients and 744 non-WellTransitions patients).

1. Clark B, Hou J, Cohen E, Kwasigroch D, Singer S. Reducing preventable hospital readmission through a pharmacist-led care transition intervention. Poster presented at: American Pharmacist Association (APhA) Annual Meeting; March 28-31, 2014; Orlando, FL.

Impact on readmissions

Sample	Sample Size (matched pairs)	Case Cohort (readmissions, %)	Comparison Cohort (readmissions, %)	Case-comparison (RR, 95% CI)	P-Value
Total	N=744	45 (6.05%)	79 (10.60%)	0.54 (0.37-0.79)	<.0001
Non-CMS targeted conditions	N=609	33 (5.42%)	44 (7.22%)	0.74 (0.46-1.17)	<.0001
CMS targeted conditions	N=135	12 (8.89%)	24 (17.8%)	0.45 (0.22-0.95)	<.0001
Age <65	N=440	25 (5.68%)	43 (9.77%)	0.56 (0.33-0.93)	<.0001
Age ≥ 65	N=304	20 (6.58%)	36 (11.8%)	0.52 (0.30-0.93)	<.0001

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Value and ROI

- Financial value is measured by the number of averted readmissions
- Value of averted readmission varies by financial risk to health system
- Current results- ROI
  - Seven hospitals analyzed over seven months
  - Over 12,000 eligible patients
  - 286 readmissions averted
  - Approx $2.50-$3.50 saved for each dollar spent
- Pricing Models
  - FFS
  - Pay for performance
  - Blended

Challenges- Learnings

- CMS financial drivers not at tipping point
- Communication throughout health system
- Operational support in field from retail
- Change caller ID to individualize program
- Blended FFS and P4P eases transition
- Transitional care model for Health Plans

Thank You

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