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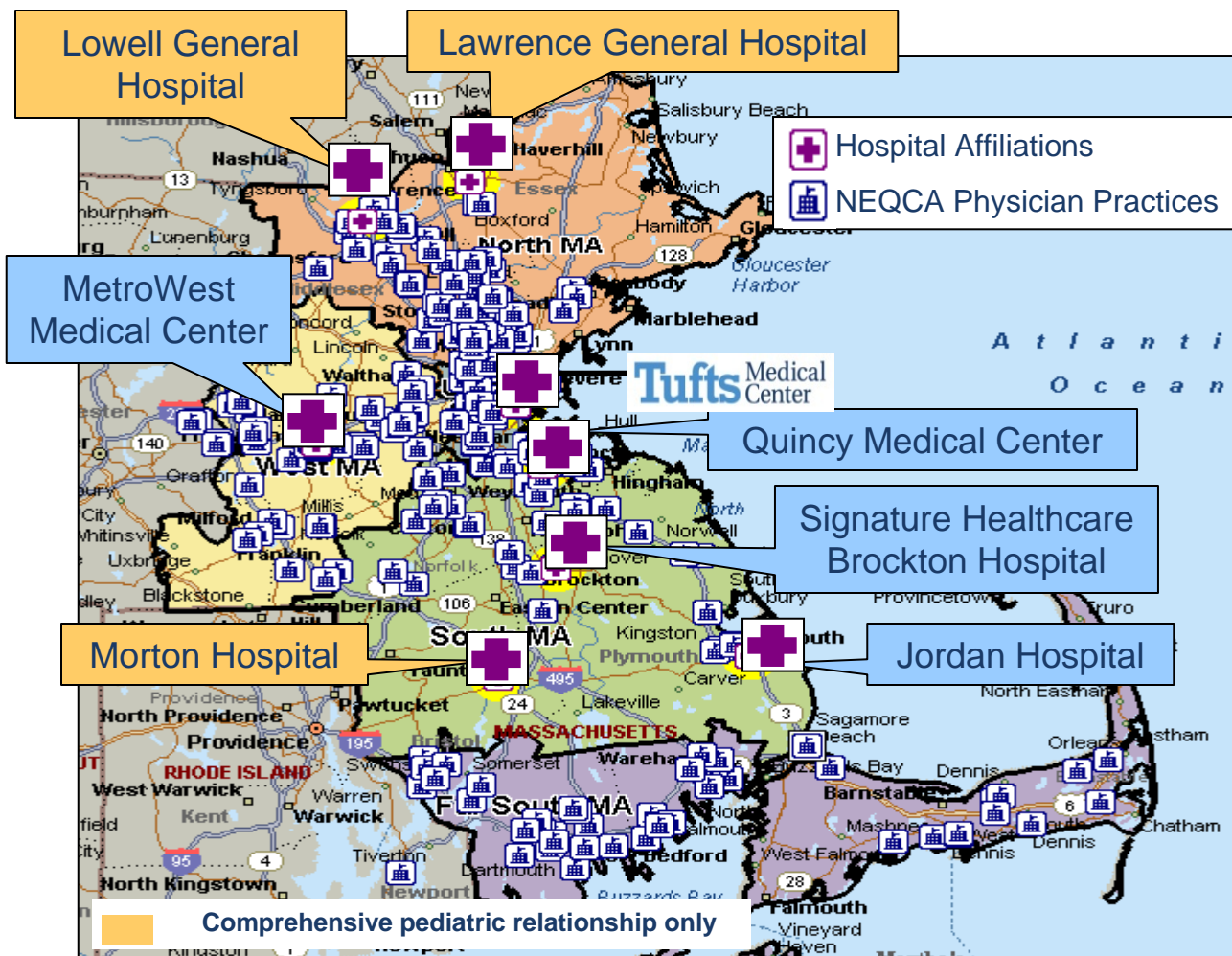


Decreasing Readmissions for High Risk Seniors: The Pharmacist Model

- Headquartered in Needham, MA
- Dovetail focuses on avoiding unnecessary admissions and readmissions in high-risk patients by providing in-home care management.
- Dovetail's programs are collaborative, designed to integrate seamlessly within our partners existing medical management programs.

New England Quality Care Alliance Network

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NEQCA

New England Quality Care Alliance

NEQCA:

- ~1,454 NEQCA MDs
 - 474 PCPs
 - 287 Adult
 - 100 Family Practice
 - 87 Pediatricians
- ~9,000 Medicare Advantage lives
- ~250,000 HMO and PPO members

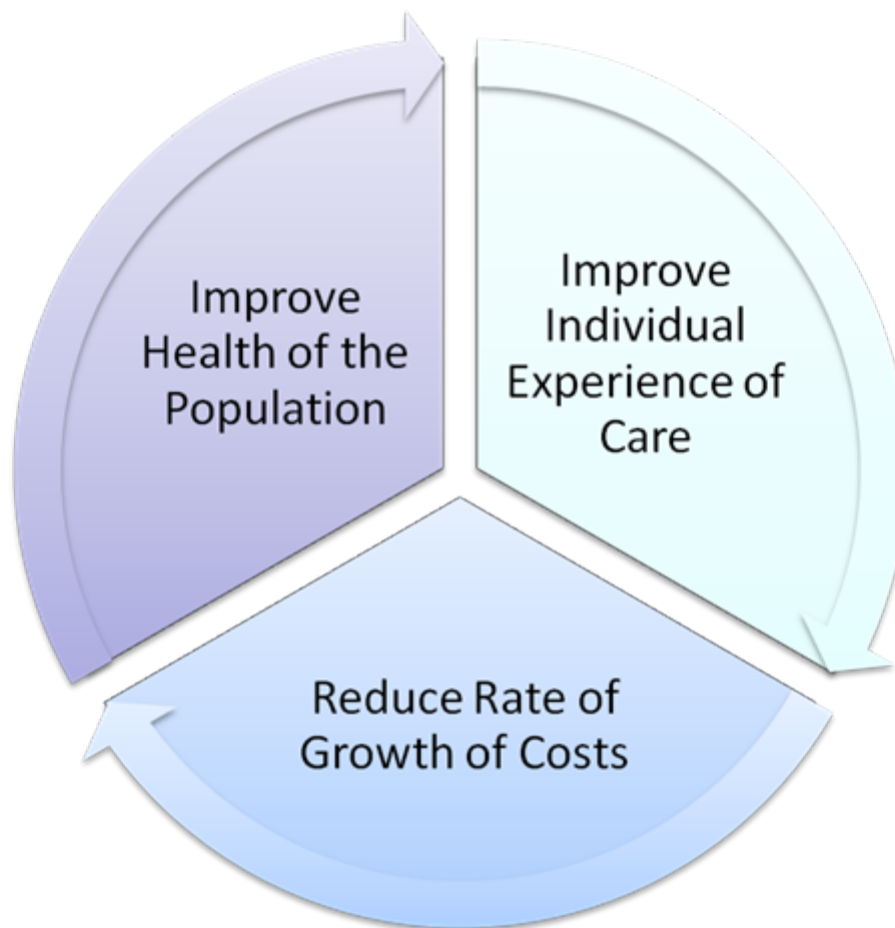
Tufts Medical Center:

- Providers caring for over 500,000 patients

NEQCA's Goal: Accomplish the Triple Aim

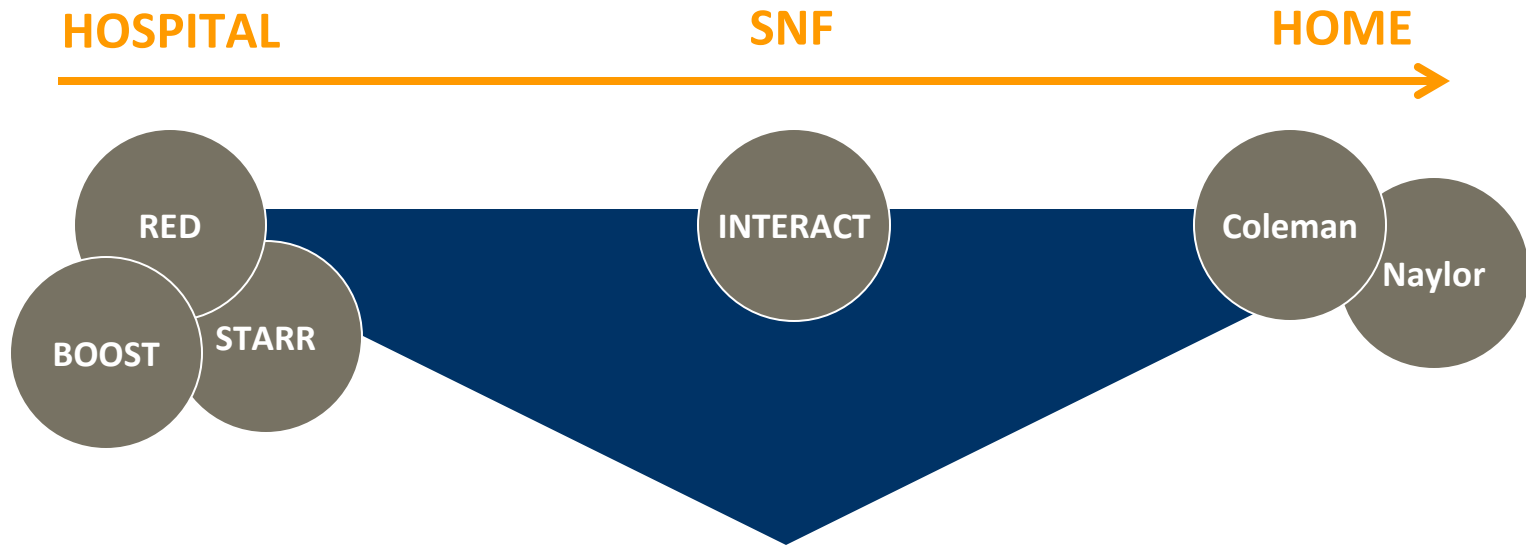
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NEQCA
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Creating a Scalable and Sustainable Transition Program

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There is no "one size fits all" solution to readmissions

What has worked in the "academic world" does not necessarily work in the "real world"

Effective programs must be tailored to meet the unique needs of each patient population

In-Home Transition Management

<i>Program Goal</i>	Prevent readmission and stabilize patient at home post-discharge
<i>Patient Target</i>	High-risk likely to be readmitted (~10% of Annual Discharges)
<i>Program Duration</i>	30 Days
<i>Care Team</i>	PharmD-led with Care Coordinator supporting (RN consult as needed)
<i>Program Focus</i>	<ul style="list-style-type: none">• Medication Adherence: what, how, and why?• Communication and follow-up with PCP• Chronic illness coaching and red flag management• Home safety
<i>Common Patient Characteristics</i>	<ul style="list-style-type: none">- Discharged from hospital or SNF- 1 or more admission in past 4 months- 5 or more prescriptions (60 per year)- Multiple co-morbidities (e.g. CHF, COPD, Diabetes)- Frailty markers

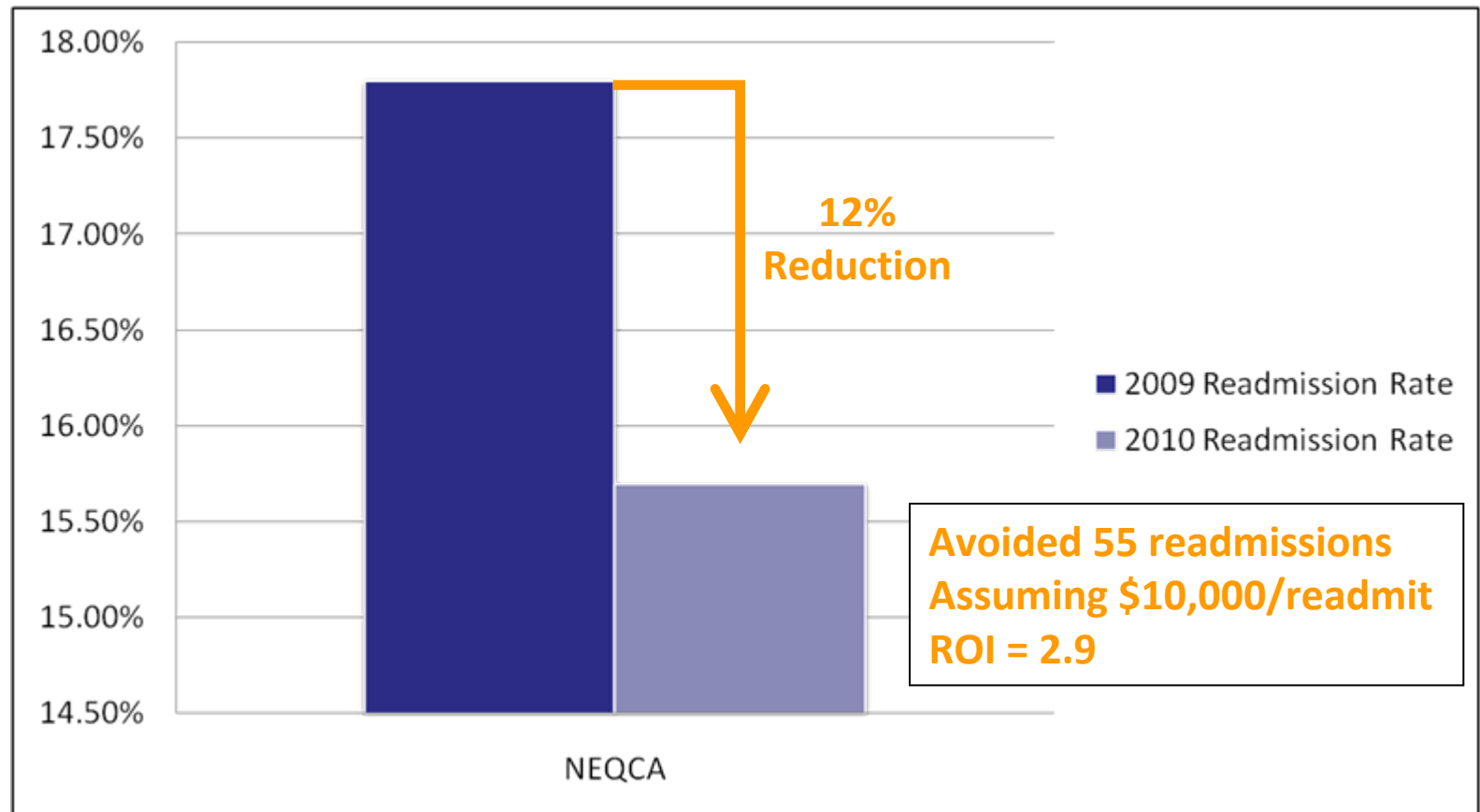
Traditional pharmacist role:

- Review medication regimen per EBM
- Review medical conditions
- Review discharge summaries
- Review labs
- Reconcile medication lists
- Address adherence issues
- Optimize complex regimens
- Collaborate with physicians



In addition to traditional responsibilities, this role includes

- Provide case management, care coordination, including in-home services, social, financial, and “life” issues
- Coach on disease management, self management
- Assess for home safety & environmental concerns
- Assess for falls, caregiver burden, nutritional status, cognition, etc.
- Discuss advance care plans with patient, families, and PCP
- Research community resources
- Utilize managed care knowledge to help navigate the care
- Provide appropriate home-based care
- Be the “eyes and ears” for the interdisciplinary team, collaborate with primary physician, specialists, case managers, and others



- Complete redesign of Medicare Advantage care management model
 - More patients: 20% of population
 - Three levels of care: complex, chronic, telephonic
- Transitions program folded in to complex care model
- Potential continued growth in commercial population and managed Medicare population