IMPROVING
DVT/PE TRANSITIONS OF CARE

Helping prescribers, care coordinators, nurses, and other healthcare professionals facilitate the transition of care for patients being discharged from the hospital after a deep vein thrombosis (DVT) or pulmonary embolism (PE) diagnosis.

NTOCC®
NATIONAL TRANSITIONS OF CARE COALITION

janssen | PHARMACEUTICAL COMPANIES OF Johnson & Johnson

INTRODUCTION

In a study of 1897 patients who experienced a VTE event within 3 months of a hospitalization, two-thirds of the patients experienced their VTE within 1 month following discharge.[1] Because transitions of care are an increasingly critical component for improving patient outcomes, leading organizations such as the Joint Commission and the National Quality Forum (NQF) have endorsed various quality performance measures that address the ongoing care coordination needs for patients discharged after a VTE event, either a DVT and/or a PE event.

Improving DVT/PE Transitions of Care is a National Transitions of Care Coalition (NTOCC)-designated transitions of care toolkit for hospital-based healthcare professionals and staff who support improved care coordination for patients discharged after a DVT or PE.

This guide will introduce you to the individual resources and explain how each one **can help healthcare professionals ensure patients diagnosed with DVT or PE are properly transitioned from the hospital**. Various topics addressed include the importance of successful transitions, best practices for providers, patient information, quality measures, and the challenges with warfarin therapy.

TOOLKIT OVERVIEW

TREATMENT PATHWAY RESOURCES

provide important information for choosing the appropriate anticoagulant for each patient.

CONTINUE TO THE TREATMENT PATHWAY

VIEW THE PATHWAY RESOURCES

PROGRAM RESOURCES

are aligned with either the DVT/PE treatment pathway or the patient support pathway.

PATIENT SUPPORT PATHWAY RESOURCES

can help healthcare professionals and staff ensure seamless transitions of care, from intake through discharge.

CONTINUE TO THE PATIENT SUPPORT PATHWAY

VIEW THE PATHWAY RESOURCES

DVT/PE TREATMENT PATHWAY

GUIDANCE FOR HEALTHCARE PROFESSIONALS TO SUPPORT APPROPRIATE ANTICOAGULANT TREATMENT CHOICE

DVT/PE Event With Presentation and Diagnosis at Emergency Room

Low-risk patient

Patient to be discharged from ED[2,3]

Patient diagnosed with DVT/PE

Medium- or high-risk patient

Admitted to hospital; Anticoagulation to begin on IV heparin, SC LMWH, or OAC[4]

Acute Care Hospital Treatment

Continued patient monitoring for progression or improvement of disease[4]

Discharge and Transition to Home or Subacute Facility

Deciding on an oral anticoagulant for DVT/PE for discharge:

- Selection based on ACCP guidelines and is appropriate for patient[4]
- Patient health literacy and social determinants[3]
- Patient comorbidities[3]
- Efficacy vs bleeding risk
- Patient's current medication list[3]
- Potential barriers to adherence/access[3]
- Patient preference[5]

First Year Post Event

Within 1 year, PCP to reassess patient DVT/PE risk vs benefits for continuing anticoagulation therapy[2-3,6]

VIEW THE TREATMENT PATHWAY RESOURCES

ACCP = American College of Chest Physicians; ED = emergency department; IV = intravenous; LMWH = low-molecular-weight heparin; OAC = oral anticoagulant; PCP = primary care physician; SC = subcutaneous.

DVT/PE TREATMENT PATHWAY
RESOURCES

Adherence Rates Consistently Higher for Once-Daily Versus Twice-Daily Dosing

For patients who require anticoagulation, dosing frequency matters. This 4-page resource reviews study results showing medication adherence was inversely related to the number of prescribed doses per day. The data show once-daily dosing may be easier for patients and may result in fewer dosing mistakes or missed doses, which are important considerations for patients with chronic conditions.

Complexities of Warfarin Therapy Lead to Increased Resource Utilization

Balancing the efficacy of anticoagulation with the risk of bleeding is a challenge in warfarin use and can lead to increased resource utilization. This 4-page brochure highlights the drug and food interactions, fluctuations in international normalized ratio (INR) levels, and potential for complications, including hospitalizations, that can lead to increased cost of care for patients associated with warfarin use.

Prescribing Treatment Is Only the First Step—Patient Adherence Drives Outcomes

Getting patients to adhere to their warfarin treatment can be challenging, and nonadherence can be associated with potential unsatisfactory outcomes. This brochure highlights the rates and reasons patients discontinue or are nonadherent with warfarin.

Challenges With Warfarin Therapy in the Elderly Population

Advanced age and comorbidities increase the risk of atrial fibrillation (AF) or stroke and/or DVT/PE in the elderly; and these and other complexities often make treatment decisions more challenging. This 4-page brochure reviews these challenges and presents study data showing a considerable number of patients in nursing homes do not receive adequate treatment for AF or VTE.

Unstable INR Has Implications for Healthcare Resource Use

Maintaining stable INR levels in patients taking warfarin is challenging and time consuming. The graphic-driven trifold brochure highlights the health implications and risks for patients with AF or DVT/PE who fall out of INR range, as well as resource use and associated costs.

DVT/PE PATIENT SUPPORT PATHWAY

GUIDANCE FOR HEALTHCARE PROFESSIONALS AND STAFF TO SUPPORT SEAMLESS TRANSITIONS OF CARE

DVT/PE Event With Presentation and Diagnosis at Emergency Room

Hospital to identify transitions of care practitioner,* begin preparation for transition[7]

Data collection for transitions of care including, but not limited to:

- Current medication list includes prescription and OTC drugs, herbals, vitamins, and supplements[7]
- Allergies to medication[8]
- Current PCP and/or specialty provider contact information[8]
- Preferred pharmacy[8]
- Medical and pharmacy insurance information
- Social determinants including preferred language, home environment, self-care abilities, health literacy assessment, basic socioeconomic status[3,7]
- Assessment of any other needs, as necessary

Upon diagnosis, patient to receive resources on DVT/PE disease state education[9]

Acute Care Hospital Treatment

Continued assessment of patient, patient's family, and patient's caretaker transitions of care needs

Transitions of care practitioner to plan and propose transitions of care plan with all clinical teams, including[7,8]:

- Acute care clinical team
- Home (PCP and other specialty providers)
- Subacute facility/SNF/LTC clinical team

Transitions of care practitioner to schedule appointment for patient follow-up within 2 weeks with PCP[7,8]

Discharge and Transition to Home or Subacute Facility

Implementation of transitions of care plan[7]:

- Patient to receive new medication list with any newly added medications
- Patient to receive counseling for new medications with medication calendars
- Patient to receive printed discharge summary to share with family and HCPs
- Patient to receive direction on follow-up services including pick-up of new medication, follow-up visit, and at home self-care
- Patient, patient family, and caregiver to receive disease-specific resources
- Transitions of care practitioner to facilitate timely transfer of pertinent information to patient's HCPs

First Year Post Event

Within 1 day of discharge, patient to pick up new medications[6]

Within 2 to 3 days of discharge, nurse/case manager to follow up with patient on coordinated discharge plan[7]

Within 2 weeks, patient to follow up with PCP[7]

VIEW THE PATIENT SUPPORT RESOURCES

*Clearly identified practitioner to include Transitional Care Nurse (TCN) or Advance Practice Nurse (APN), case manager, social worker, or practitioner team, depending on setting.

HCP = healthcare professional; LTC = long-term care; OTC = over the counter; SNF = skilled nursing facility.

DVT/PE PATIENT SUPPORT PATHWAY

RESOURCES

Optimizing the Role of the Care Manager

Patients with VTE are at continued risk for recurrence, with the majority of events recurring following discharge from the hospital. This 4-page brochure offers insights into VTE patients and explains the role of the care manager in delivering effective follow-up care for these patients.

What You Need to Know After Deep Vein Thrombosis or Pulmonary Embolism

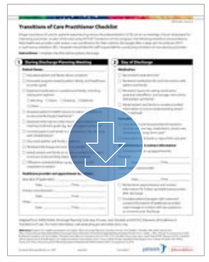
This 8-page brochure is designed to help healthcare professionals create a dialogue with their patients about their condition. This educational resource explains the conditions, causes, and symptoms of DVT/PE and how to treat and potentially prevent a recurrent event. It also provides tips and tools to help patients adhere to their medication and track appointments, refills, and other health issues.

Postdischarge Follow-up

The care manager's role changes once a patient with VTE is discharged from the hospital. This 4-page resource provides guidance from NTOCC and the Agency for Healthcare Research and Quality (AHRQ) on how to prepare for proper patient initial and ongoing follow up, as well as guidelines on how to help ensure patients are adhering to their treatment protocols.

Guidelines and Performance Measures for Venous Thromboembolism (VTE) Treatment and Care Coordination

To help hospital discharge planners prepare for effective transition of care, this 2-sided flashcard presents select performance measures and recommended guidelines for the treatment of VTE and preventing recurrence. This includes evidence-based guidelines from the American College of Chest Physicians (ACCP) and performance measures endorsed by the National Quality Forum (NQF) and the National Committee for Quality Assurance (NCQA), which added Transitions of Care to the 2018 list of Healthcare Effectiveness Data and Information Set (HEDIS®) Quality Measures.



Transitions of Care Practitioner Checklist

Designed to help the healthcare team ensure proper care coordination for their patients upon discharge from the hospital, this 1-page checklist identifies patient/caregiver questions or concerns regarding postdischarge care and encourages care-related discussions with healthcare professionals during the scheduled follow-up appointments.

NTOCC TRANSITIONS OF CARE
PROGRAM SUMMARY

Improving DVT/PE Transitions of Care is a toolkit for hospital-based healthcare professionals and staff that supports improved care coordination for patients discharged after a DVT or PE.

This guide is designed to help you use the **appropriate resources** to support the provision of effective treatment and transitions of care for patients with DVT or PE.

For more information about this guide or the resources listed,
visit CarePathHealthyEngagements.com or contact your Janssen Representative

References: 1. Spencer FA, Lessard D, Emery C, et al. Venous thromboembolism in the outpatient setting. *Arch Intern Med*. 2007;167(14):1471-1475. **2.** Kearon C, Akl EA, Ornelas J, et al. Antithrombotic therapy for VTE disease. CHEST guideline and expert panel report. *CHEST*. 2016;149(2):315-352. **3.** Burnett AE, Mahan CE, Vazquez SR, et al. Guidance for the practical management of the direct oral anticoagulants (DOACs) in VTE treatment. *J Thromb Thrombolysis*. 2016;41(1):206-232. **4.** Lenchus JD. Transitions in the prophylaxis, treatment and care of patients with venous thromboembolism. *Adv Ther*. 2016;33(1):29-45. **5.** Treatment of acute venous thromboembolism. University of Washington website. https://depts.washington.edu/anticoag/home/sites/default/files/VTE%20Treatment%20Pathway%20July%202017_0.pdf. Posted July 2017. Accessed October 31, 2018. **6.** Deep vein thrombosis. Outpatient DVT follow-up protocol. Society for Vascular Medicine website. https://mydeepveinthrombosis.com/wp-content/uploads/2016/06/SVM-DVT-HPCs-OutpatientProtocol.pdf. Accessed October 31, 2018. **7.** Seven essential interventions. National Transitions of Care Coalition website. http://www.ntocc.org/Portals/0/PDF/Compendium/SevenEssentialElements.pdf. Accessed October 31, 2018. **8.** Tool 3: How to deliver the Re-Engineered Discharge at your hospital. Rockville, MD: Agency for Healthcare Research and Quality; March 2013. http://www.ahrq.gov/professionals/systems/hospital/red/toolkit/redtool3.html. Accessed October 31, 2018. **9.** Vinson DR, Berman DA. Outpatient treatment of deep venous thrombosis: a clinical care pathway managed by the emergency department. *Ann Emer Med*. 2001;37(3):251-258.

The **National Transitions of Care Coalition** (NTOCC), a 501(c)(4) organization dedicated to addressing the serious issues and concerns related to transitions of care, to help address the importance of VTE continuum of care for healthcare professionals and their patients.

December 2018

cp-61843v2