# A Script for Filling the Gap:
## The Importance of Medication Management and Best Practices in Transitions of Care

# Disclosures

- Faculty for this CE activity have no relevant financial relationship(s) to disclose

# This is Gary

# Objectives

- Describe the background and purpose of Transitions of Care (TOC)
- Discuss differences in medication management in the inpatient and long term care setting
- Investigate possible medication discrepancies during transitions of care process
- Review best practices of transitions of care for the interprofessional healthcare team
- Identify barriers related to care transitions and opportunities for development of transitions of care programs

# Background and Purpose of Transitions of Care (TOC)

# Transitions of Care (TOC)

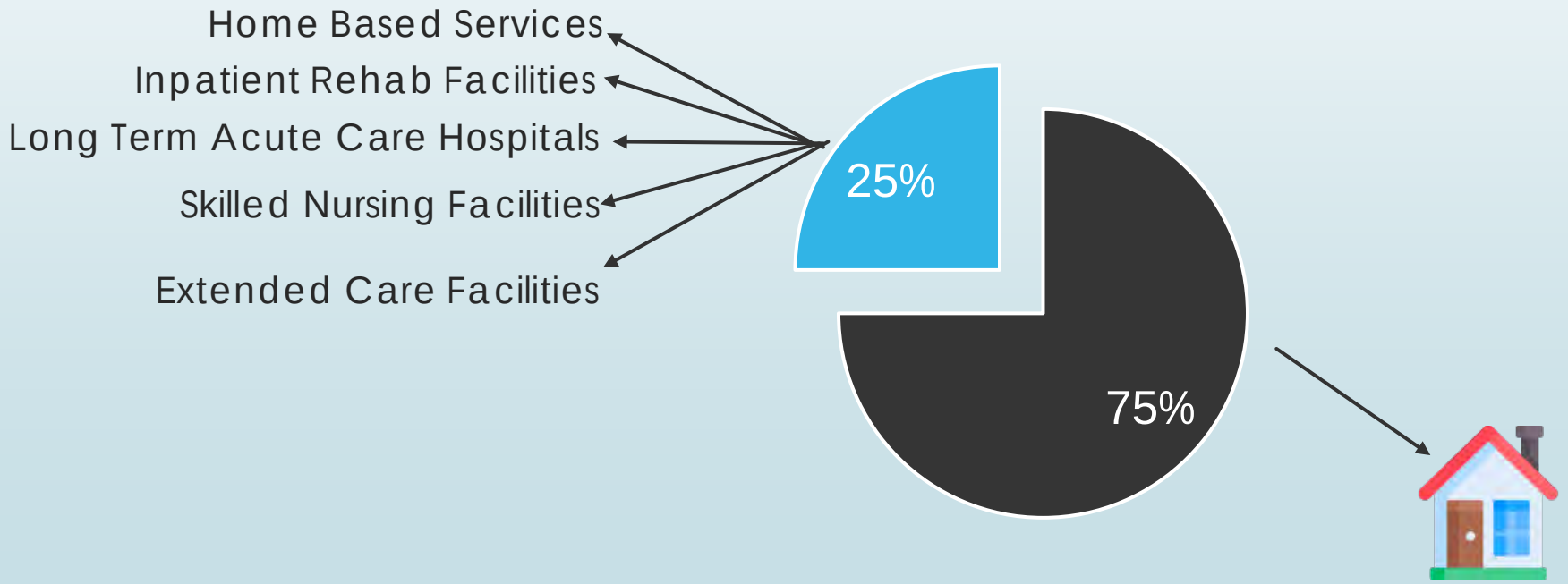
"The movement of patients between healthcare locations, different providers or different levels of care within the same location as their needs change."

- *National Transitions of Care Coalition*


*Consumers — NTOCC*. (n.d.). NTOCC. https://www.ntocc.org/consumers
Image: https://nursesadvocates.com/ensuring-safe-transitions-care/

# TOC involves MANY care settings

- Approximately 75% of hospitalized patients are able to return home following discharge
- 25% go elsewhere




*An All-Payer View of Hospital Discharge to Postacute Care, 2013 #205*. (n.d.). https://hcup-us.ahrq.gov/reports/statbriefs/sb205-Hospital-Discharge-Postacute-Care.jsp

Werner, R. M., & Bressman, E. (2021). Trends in Post-Acute Care Utilization during the COVID-19 Pandemic. *Journal of the American Medical Directors Association*, *22*(12), 2496–2499. https://doi.org/10.1016/j.jamda.2021.09.001

# What's the Problem?

- 20% of Medicare beneficiaries discharged from the hospital are readmitted within 30 days
- $15B of Medicare spending on 30-day hospital readmissions
- 1 in 5 patients discharged from the hospital who experienced an associated adverse event within 3 weeks
- 50% patients who experienced at least 1 medication discrepancy

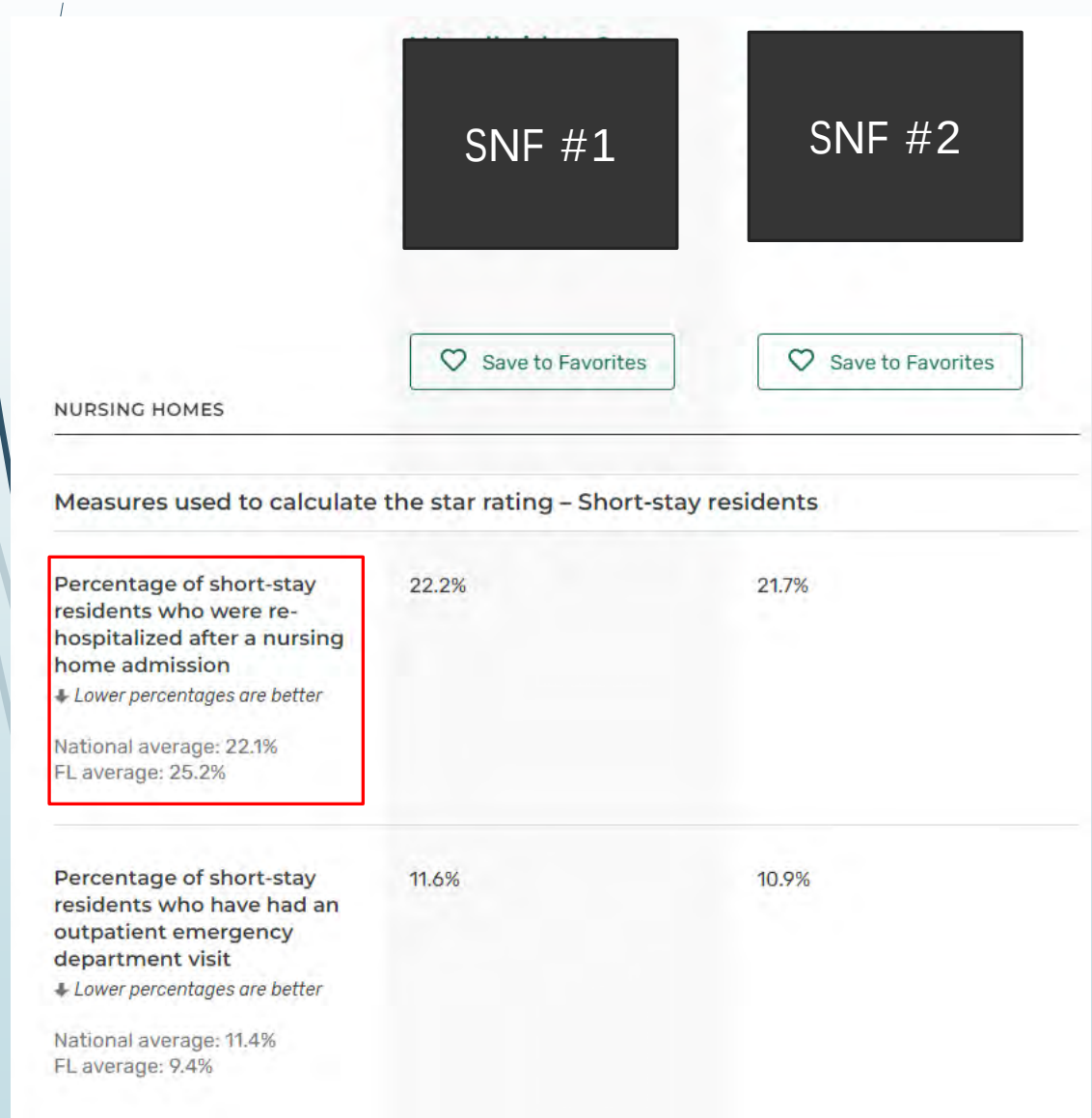
Agency for Healthcare Quality and Research. Patient Safety Network. Readmission and Adverse Events After Discharge. https://psnet.ahrq.gov/primer/readmissions-and-adverse-events-after-discharge. Accessed June 11, 2022.
Phillips M, et al. *J Healthc Qual*. 2022;44(3):152-160.

# Hospital Readmission Reduction Program

- Established in 2012 as part of the Affordable Care Act
- Medicare value-based purchasing program that reduces payment to hospitals with excess 30-day readmissions
- Fiscal penalty up to 3% applied to all Medicare fee-for-service
- Targeted conditions/procedures
  - AMI; CHF; CABG; PNA; COPD; THA/TKA


*Hospital Readmissions Reduction Program (HRRP)* | *CMS*. (n.d.). https://www.cms.gov/medicare/payment/prospective-payment-systems/acute-inpatient-pps/hospital-readmissions-reduction-program-hrrp

# SNF Star Rating




The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 modified the Social Security Act requiring that SNFs be required to submit data for public reporting.

**Quality Measures for SNF Public Reporting**

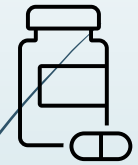
- *Potentially Preventable 30-Days Post-Discharge Readmission Measure (PPR) for SNF*

*Skilled Nursing Facility (SNF) Quality Reporting Program (QRP) Public Reporting | CMS.* (n.d.). https://www.cms.gov/medicare/quality/snf-quality-reporting-program/public-reporting

# Medication Discrepancies in Transitions of Care

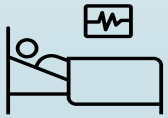
# Contributors to Hospital Readmission

Communication Barriers



Medication Errors

Lack of Follow up



Length of Stay

Patient Education Barriers

Inappropriate Level of Care

Social Factors

# Medication Impact on Hospital Readmissions

- Omissions
- Unnecessary Additions
- Inappropriate Dosing, Directions, Duration
- Adverse Drug Events
- Patient Understanding
- Medications Not Optimized

# Differences in Medication Management Between Settings

# Differences in Medication Management

## Hospital

- **Focus**: Acute Care
- **Formularies**: Restricted Medication Supply + Cost Containment
- **Staffing**: 24h coverage varying levels of RN+ MDs+ PharmDs
  - Pharmacy on-site+ integrated
- **Orders**: Lots of PRN orders, Order changes automatic for RN administration
- **Metrics**: Patient Safety, Abx Stewardship, Renal Dosing

## Facilities

- **Focus**: Recovery/Stabilization + Chronic care for LT residents
- **Formularies**: Cost Containment, possibly wide availability of commercial products
- **Staffing**: Limited
  - Pharmacy offsite/remote usually
- **Orders**: Limit PRN orders, decrease administration burden, order changes not automatic/delayed process
- **Metrics**: Lowering med burden, gradual dose reductions (ie antipyschotics), patient safety

# Gaps with Hospital & Skilled Facility Transitions

## Campbell-Britton et. al. 2017

- *Care Transitions Between Hospitals and Skilled Nursing Facilities: Perspectives of Sending and Receiving Providers*
  - Focus: qualitative interviews assessing patient transfers and experiences with unplanned hospital readmissions
  - Setting: large, northeastern, urban, academic medical center & 2 local SNFs: Suburban for-profit facility and an urban non-profit facility
  - Participants: (*N* = 41) from medicine, nursing, social work, and consult services

# Campbell-Britton et. al. 2017

## Four main themes emerged:

- **1) Increasing patient complexity**
  - multiple co-morbidities; numerous medications; specialized medical equipment
  - psychosocial issues
  - rehabilitation expectations for patients with high illness burden may be unrealistic
- **2) Identifying an optimal care setting**
  - Hospitals: Pressure to optimize Length of Stay
  - SNF: relay on sustained volume but grapple with patient complexity
  - Structural differences in hospital vs SNF for patient care

# Campbell-Britton et. al. 2017

- **3) Rising financial pressure**
  - Hospital: frustrated by patient declinations to SNFs
  - SNF: suggesting that payments drove discharges; have to consider the gain or loss for placement
  - Both Hospital and SNF recognize patient/family unaware or mistaken about their insurance coverage/options
- **4) Barriers to effective communication**
  - SNF: deeply concerned about the quality and consistency of the information sent from the hospital
  - Hospital: recognize concerned about barriers that delayed or disrupted communication efforts from facilities; identify differences in hospital physicians' documentation; high volume discharges as limiting the details put into discharge summaries
  - Lack of knowledge on both sides

# Opportunities

- Enhancing communication between clinicians
  - Direct communication channels
- Promoting provider understanding of post-acute care
  - Tours/visiting rotations through institutions
- Developing strategic opportunities to align facilities
  - Working collaboratively on care plans
  - Creative thinking to manage costs across the continuum of care

# Transitions of Care Barriers and Opportunities

# Case of AO

- AO is a 78 year old male who presents to the ER being increasingly confused and weak. His wife is unable to care for him at home.
- **T:** 97.9 °F (Oral) **HR:** 111 (Pulse) **RR:** 22 **BP:** 134/90 **SpO2:** 97%
- PMH:  CAD, Afib, HFmrEF (EF 45%), HTN, dyslipidemia, BPH, Falls
- DX Mild Cognitive Impairment and set to discharge to rehab
  - **But his BNP went to 1,349.8**

| Hospital Discharge Medication List | |
|---|---|
| Apixaban 5mg 2xdaily | Sacubitril-Valsartan 49-51mg 2xdaily |
| Clopidogrel 75mg daily | Tamsulosin 0.4mg daily |
| Isosorbide Mononitrate ER 30mg 0.5tablet daily | Metoprolol Succinate ER 50mg 2xdaily |
| **Misc Non-Medication (pt states there are more meds, unable to verify with him, family or pharmacy)** | |

# AO Hospital Course

- Hospital Discharge Delayed
  - Treated with IV diuretics; strict ins and outs, daily weight, diuresed very well
  - TOC Pharmacist confirms missing home medications and provides medication recommendations for final discharge
- Pt stabilized for rehab
  - **Rehab does not receive updated medication list**

| Hospital Discharge Medication List | |
|---|---|
| Apixaban 5mg 2xdaily | Sacubitril-Valsartan 49-51mg 2xdaily |
| Clopidogrel 75mg daily | Tamsulosin 0.4mg daily |
| Isosorbide Mononitrate ER 30mg 0.5tablet daily | Metoprolol Succinate ER 50mg 2xdaily |
| *Alirocumab 150mg SQ q2weeks* | *Torsemide 20mg daily* |
| *Multivitamin daily* | *Fish Oil 1000mg 2xdaily* |
| *CoQ10 100mg daily* | |
| **NEW** dapagliflozin 10mg daily | **NEW** Daily weights/Low Salt Diet |

# What barriers occurred for a successful discharge for AO?

# Best Practices for TOC for the Interdisciplinary Team

Best Practices for TOC for the Interdisciplinary Team

# Panelist Discussion

- Mary Lomberk, PharmD, CPh, BCACP
- Michael Samarkos, PharmD, CPh
- Mark Solomon, BS, MA, NHA
- Jacqueline Vance, RNC, BSN, CDONA/LTC, FADONA, IP-BC, CDP, ASCOM, LBBP

# Assessment Question

- What area of opportunity exist to decrease the gap between acute care settings and skilled nursing facilities?
  A. Enhancing communication among clinicians
  B. Promoting provider understanding of post-acute care
  C. Developing strategic opportunities to align facilities
  D. All the above

# Assessment Question

- What area of opportunity exist to decrease the gap between acute care settings and skilled nursing facilities?
  A. Enhancing communication among clinicians
  B. Promoting provider understanding of post-acute care
  C. Developing strategic opportunities to align facilities
  **D. All the above**

# Take Aways

- 30-day readmissions and transitions of care continue to be a focus for quality care in the United States
- Communication is key to working effectively with other teams buliding relationships and ensuring buy-in
- Leveraging pharmacist's knowledge and expertise can create high quality patient care

# Questions?

References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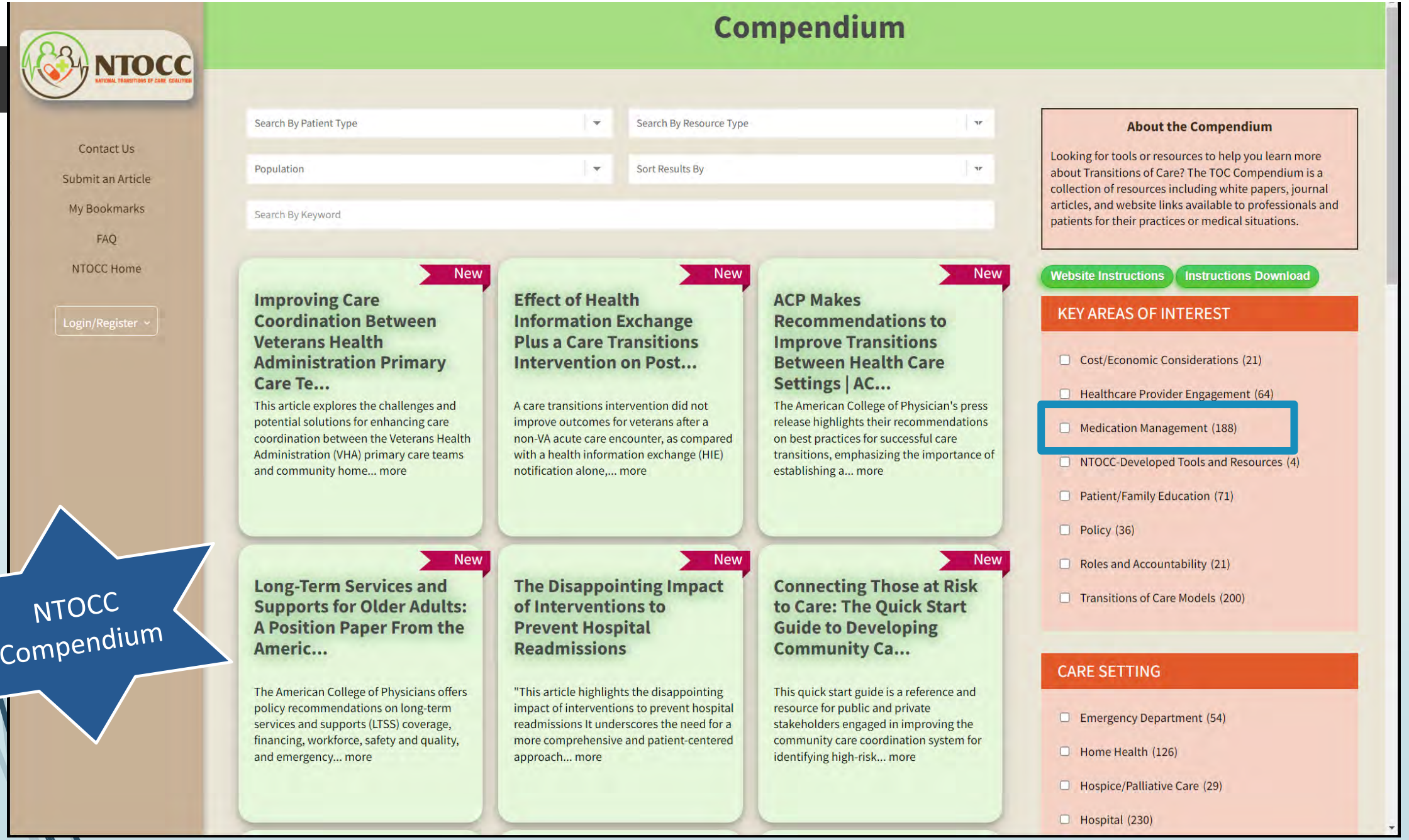



NTOCC Compendium

# EXTRA SLIDES

# Baycare Health Systems Transitions of Care Efforts

## Admissions Med Reconciliation performed by

- ER pharmacy technicians with focused training

## Pharmacists-led Discharge Medication Reconciliation Planning

- Focus on guideline directed medication therapy, optimizing med list and patient safety

## Bedside education

- RN led primarily Pharmacists-led specific units (CABG)

# Baycare Health Systems Transitions of Care Efforts

## Post-Acute Care Team (PACT)

- Additional transitions of care support for preferred SNF network
- Increasing communication, identifying barriers, supporting SNF for successful patient discharge from SNF

## Post-discharge follow up calls

- Supported from pharmacists, RN, SW

# Discharge Medication Reconciliation (DCMR)

**Pre-discharge:**

Discharge medication reconciliation (DCMR)

**Target Population: All Medicare patients ≥ 65yo**

**Prospective:**

Pharmacist plans discharge medications

Physician reviews and signs DCMR prior to patient leaving

**Retrospective:**

Pharmacist reviews discharge medications after provider signs DCMR

Pharmacist contacts provider to recommend medication changes as needed

**Identification of patients**

- Hospital Census Reports

**Planning**

- Goal w/in 24-48hr of discharge
- Prospective vs retrospective

**Communicating with inpatient providers**

- Prospective vs retrospective

# Post Acute Telephonic Follow up

- Calls
  - Targeted medication review
    - Focus on medication changes and disease state understanding
  - All eligible patients receive at least one call
- Communicating with outpatient providers
  - Faxes, calls

**Post-discharge:**

Telephonic follow-up

**0-5 day Post-discharge:**

Pharmacist completes a targeted medication review, clinical assessment, medication counseling, etc.

**14-21 day Post-discharge:**

Pharmacist provides further assessment/counseling if needed

# PTOC Program Data

- Service Capture Rate
  - Goal > 90%

| **Capture Rate: 2021** | |
|---|---|
| Group | All dx Medicare ≥ 65 yo |
| # Eligible for services* | 49,642 |
| # Receiving at least 1 service | 46,118 |
| % Pt receiving services | **92.9%** |

* Services include DCMR and/or post-acute telephonic follow-up

# PTOC Program Data

- 30-day all cause readmission rate
  - O/E < 1 indicates better than expected

| **30-day All Cause Readmissions: 2021** | | |
|---|---|---|
| Group | ≥ 1 Service (DCMR and/or TMR call) | Both Services* (DCMR + TMR call) |
| Observed/Expected Readmissions (O/E) | 0.96 | 0.77 |

* Both Services for TMR eligible patients

# Case of AO

- AO is a 66 year old male who presents to the ER with increased weakness and recurrent falls. He states that he was walking with his walker and felt like his legs were weak and "just gave out from underneath him“; EMS reports BP as low as 74/46.
- PMH: Cirrhosis with grade I esophageal varices + ascites (requiring paracentesis)+ hx hepatic encephalopathy, T2DM, depression; portal HTN, dyslipidemia, BPH
- Social History:
  - Stopped drinking in 2019
  - Manages his own meds
  - Lives with wife
  - Admits to forgetting to take medications sometimes

| Home Mediations Prior to Admission | |
|---|---|
| Insulin aspart 20units BID | Empagliflozin 10mg daily |
| Insulin glargine 10units daily HS | Rifaximin 550mg BID |
| Lisinopril 2.5mg daily | Ezetimibe 10mg daily |
| Nadolol 80mg daily | Gabapentin 300mg TID |
| Eplerenone 50mg BID | Solifenacin 10mg daily |
| Furosemide 80mg daily | Tamsulosin 0.4mg daily |
| Lactulose 30gm TID | Glimepiride 4mg daily |
| | |

# AO Hospital Course

- Relevant Admission Labs/Vitals:
  - CT of head negative; Xrays negative for fractures
  - BP: 85/50; Orthostatic vital signs unremarkable
  - Scr: 1.4 (baseline 0.7); eGFR 47
  - US of ABD shows mild to moderate ascites
  - A1c 6.3%
- 11/1: ACEi and diuretics held on admission for AKI, Rifaximin missing (omission?), Lactulose titrated to QID to increase BMs, IR for paracentesis, which was done on 11/1 and 1800 mL was removed
- 11/2: had an episode of hypoglycemia in the evening (BG 50); PT eval and treat rec rehab; AKI resolved, Scr back to baseline 0.8
- 11/3: Reluctant but agreeable to rehab, Discharged with the following:

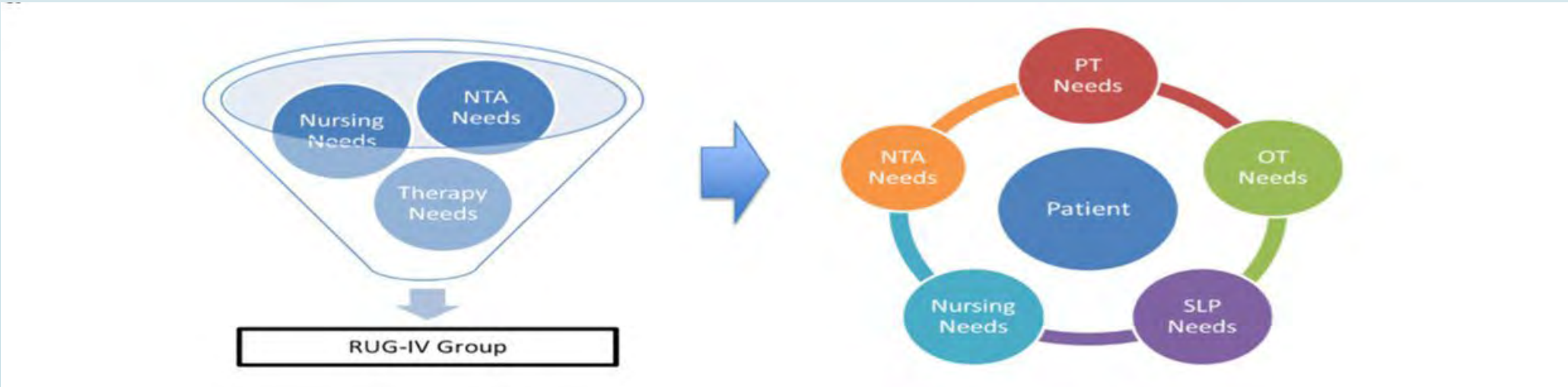
# AO Hospital Course

- DX: Fall, Ascites requiring paracentesis, AKI, Hypoglycemia

| Home Mediations Prior to Admission | |
|---|---|
| **Insulin aspart ~~20units BID~~ 10units BID** | Empagliflozin 10mg daily |
| Insulin glargine 10units daily HS | **~~Rifaximin 550mg BID~~** (missing) |
| **~~Lisinopril 2.5mg daily~~** | Ezetimibe 10mg daily |
| Nadolol 80mg daily | Gabapentin 300mg TID |
| Eplerenone 50mg BID | Solifenacin 10mg daily |
| Furosemide 80mg daily | Tamsulosin 0.4mg daily |
| **Lactulose 30gm ~~TID~~ QID** | **~~Glimepiride 4mg daily~~** |
| **Spironolactone 50mg BID** | **Insulin determir 10units BID** |

# Patient Driven Payment Model (PDPM) Review

- Goal is to improve the accuracy and appropriateness of payment based on the patient's specific needs
  - Replaced the previous RUG-IV (Resource Utilization Group) classification system
- In PDPM, the model considers all its components before a group daily rate is identified.
- The Patient Driven Payment Model (PDPM) provides an opportunity for a facility to maximize the services offered by their provider pharmacy.



# Patient Driven Payment Model (PDPM) Review

- Anticipate an INCREASE :⬆
  - In residents with multiple medical co-morbidities
  - In IV medication therapy orders and potentially requests for TPN therapy
  - Facility Part A medication costs due to more medications prescribed and more expensive medications used, particularly IV medications
  - Also , in reimbursements rates

# AO 5 days later

- At rehab, patient's vitals are stable on admission:
  - BP 123/70, HR 65, O2 95% and FBG ~100s
- Pt participants with PT for first few days
- Consultant pharmacist reviews admission and **DC'd duplicate insulin and MRA order**
  - **Rifaximin still not administered**
- Therapist **notices increased confusion on day 5 and patient falls** during therapy
- Patient is sent back to ER

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# Back to AO

- Evaluating AO's medication regimen
  - Duplicates were identified on SNF admission and corrected
  - On readmission, pharmacist identified that a previous home medication was missing on readmission, Rifaximin
  - Pt was restarted on medication and encephalopathy improved
- Assessment and Root Causes
  - Is this happening to other patients? Where is the error occurring? How can we lessen the risk of error?

# Challenges to TOC programs

## Accountability

- Stakeholder engagement and communication
- Timely follow up for maximized impact
- Patient/Caregiver engagement

## Buy-in

- Identify and enlist champions/leaders
- Identify areas to lessen workload for stakeholders
- Tracking/reporting outcomes or patient stories

## Technology limitations

- Leverage IT team

# Implementation strategies

COLLABORATE CLOSELY WITH KEY STAKEHOLDERS

BRAINSTORM FOR CREATIVE OPPORTUNITIES TO EXPAND TOC SERVICES

LEVERAGE INFORMATION TECHNOLOGY TO EXPAND CLINICAL OPPORTUNITIES

DOCUMENT ALL INTERVENTIONS IN A SYSTEM EASY TO TREND

EVALUATE QUALITY AND PROCESS IMPROVEMENT ROUTINELY