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EGUIDE

4 Components of Successful Transitional Care Management

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Care transitions are high-risk events in which pharmacy and medication management play an essential role. To promote a smoother continuum of care and keep residents from returning to the hospital or emergency room after discharge to the community, here are 4 components of Transitional Care Management (TCM) that drive the best results.

Coordination of discharge with your long-term care pharmacy

This requires a reliable, consistent process that prevents gaps in care and information. For instance, Shauen Howard, DHA, MSN, Vice President of Clinical Practice and Innovation at BrightSpring Health Services, said, "We have created a RN-led nurse hub to use a case management model with 24/7 triage and outbound outreach calls."

However, she stressed that this can't be one-size-fits all. "It is essential to engage with each facility according to its needs, priorities, and goals," she said.

Sometimes that means joining their discharge calls, coordinating medications on discharge, conducting follow-up such as arranging a home-based primary care visit within 7-14 days after discharge, and calling the patient within two days to ensure that they have the medications they need and are taking them as required.

> "It is essential to engage with each facility according to its needs, priorities, and goals"

Reducing rehospitalization rates

It can be overwhelming for residents to go from being in a facility where they have someone overseeing every aspect of their medication management to their home where they may have little or no assistance.

"It can be tremendously helpful if they don't have to go to the pharmacy to fill their prescriptions when they go home. At discharge, we can give patients multidose packaging arranged in time-of-day pouches. These make it very easy to understand how to take multiple medications safely and accurately," Bill Deane, Senior Vice President of Operations and Commercialization at PharMerica, said.

"The goal is to drive medication adherence so the resident's condition continues to improve. And when you package medications in a manner that enables them to take medications accurately, you contribute to adherence at a high level."

> "At discharge, we can give patients multidose packaging arranged in time-of-day pouches."

Making a patient's life easier by helping them stay healthy at home

This requires a bit of detective work. It may mean going into the patient's home and looking for issues or problems that could put them at risk -- the need to add grab bars, remove trip and fall hazards, help arrange for food deliveries, doing a 'brown bag' review of all the medications they have in the house, or other efforts. This type of assessment can make a powerful difference.

Howard said, "If a patient has a functioning, access, or other problem, we want to identify it as early as possible so we can coordinate necessary services and interventions such as physical therapy. The same is true of any deficiency or barrier that can interfere with their recovery." She added, "While medication management and chronic disease management are essential, it is important to look beyond these to other barriers that need to be addressed."

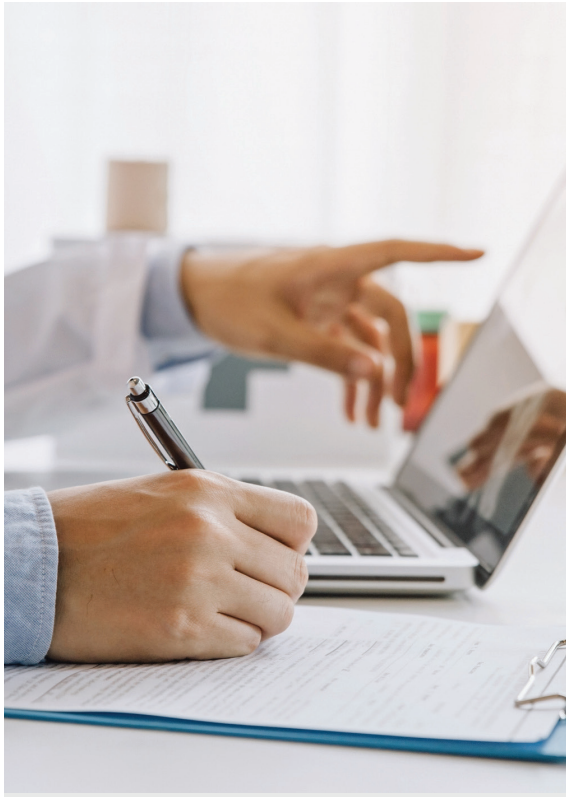
Your pharmacy providing custom reporting for monitoring outcomes.

"This closes the loop," said Deane. "It is important to provide oversight and monitor discharges to determine why a patient went to the hospital and what could be done to prevent this from happening again. Our program is designed to prevent acute care contact for 30-60 days. We want to monitor and report metrics so that facilities and their teams understand the impact of specific services and supports on patients and their ability to stay out of the hospital."

Even under the best of circumstances, there can be gaps in care when a patient transfers to the community. "A good TCM program that meets regulatory requirements and checks all the boxes makes it easier for the facility and more likely that patients will stay home after discharge. The facility actually can get consent for this on admission," said Howard.

The right tools also make a difference. For instance, Howard said, "We created a proprietary documentation depository for patients from each facility. This enables seamless communication between team members and RNs in the nurse hub. It also is used to guide services for that patient in the first six weeks after discharge."

She stressed, "The sooner you get this information, the better equipped you are to have conversations that identify concerns and questions and address challenges." The ability to have open discussions and establish trust with patients, she noted, "really helps change how people function in their homes and our ability to positively impact their lives."



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For a safe return home after a stay in a skilled nursing facility, Continue Care combines pharmacy services with home care services that ensure medication access and increase adherence and extend care planning into the home with 24/7 nurse-led case management. It also provides in-person visits by a Nurse Practitioner, where available, to address patient and family needs, assess social determinants of health, and make relevant referrals. With its person-centered and hands-on interventions, Continue Care keeps people healthy at home for better outcomes, rehospitalization rates, and referral source relationships.

Learn more at PharMerica.com/ContinueCare.

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