ADVERTORIAL

Closing the Care Gap with Continue Care

The time immediately following a patient's discharge from an inpatient or post-acute care facility back to home is one of the most tenuous and critical times in a patient's journey. Managing this period of time, known as transitional care management, can be a startling reality for many individuals and families and have a profound impact on a center's rehospitalization rates.

There appears to be, in many cases, a significant gap in care, especially for individuals who are at high risk for rehospitalization due to multiple chronic conditions and complex medication management protocols. Without home-based health care, individuals are at a higher risk for missing doses, failing to refill prescriptions on time, and letting health issues persist due to lack of access to primary care.

PharMerica, part of the BrightSpring Health Services family of brands, created Continue Care to better care for individuals who fall into this transitional care gap. Continue Care combines PharMerica's pharmacy services with BrightSpring's home-based services to offer person-centered, hands-on interventions that help prevent costly rehospitalization of medically complex patients transitioning home.

"About 40% of rehospitalizations can be attributed to medication errors and medication non-adherence," said Jennifer Yowler, President, PharMerica. "If we can take that away with our in-home clinical and pharmacy expertise, we're really able to reduce one of the leading causes of readmission."

Residents who participate in Continue Care receive a 14-day supply of all medications prescribed by their physician in easy-to-use, multi-dose packaging before they leave the skilled nursing care center. This ensures that for the following two weeks, individuals have specific, clear instructions for when and how to take each of their medications, which have been sorted into correct dosages with easy-to-understand instructions.

"A great example of an ideal Continue Care patient is an individual who has six or more chronic conditions, as they are typically on 10 or more medications," said Dr. Bill Mills, Senior Vice President of Medical Affairs, BrightSpring. "We know well that the more medications people are on, the higher risk of having potential adverse drug interactions, emergency department stays, and hospitalizations related to the medications themselves."

According to Dr. Mills, the Continue Care program combats two significant issues that impact both individuals' health outcomes and long-term care facilities' readmission rates: polypharmacy and medication adherence.

The Continue Care solution offers a streamlined process for delivering quality in-home care. Any individual who is being discharged from a skilled nursing facility to return home qualifies for Continue Care's services, but those who seem to benefit most are patients with 8-12 medications, complex co-morbidities and addressable chronic conditions, and high-spend or high-hospitalization-risk individuals. Upon discharge from the center, the patient receives their 14-day medication supply and a call from the Care Manager within the first 48 hours.

As part of the Continue Care program, a nurse practitioner will call to follow up with the patient within their first week at home as well as schedule an in-home appointment within the first 14 days post-discharge. In-home care enables a provider to see the individual, talk with them about how things are going, assess their surroundings for any medically based issues, and determine if a proper prescription protocol is in place and working for the individual. This is also when any medication refills are placed so the patient has everything needed to continue beyond their first two weeks at home.

This at-home attention and focus on medication are essential to helping maintain the health of the individual, which, in turn, leads to lower rehospitalization rates. According to Continue Care, home-based primary care is associated with a 50% reduction in hospital readmissions and a 20% reduction in emergency room visits.

Colvin

Mills

Yowler

Those statistics add up to significant benefits for skilled nursing care centers, but there are more impacts than those on readmissions alone. Improved medication adherence and fewer hospitalizations created two streams of cost savings for centers. First, there is a lower cost of care overall. Continue Care found that program participation in the medication care management model was associated with a $2,400 per member per year reduction in total cost of care, representing a 5% reduction in average costs while improving medication adherence. Second, Continue Care noted improved plan ratings for participating centers, which led to increased Quality Bonus Payments through the Medicare program.

"In today's world, where skilled nursing center operators are becoming more and more financially challenged, many companies that had post-discharge programs are scaling those programs back," said Jeremy Colvin, Senior Vice President, Growth and Market Development, PharMerica. "This program is more longitudinal than anything that has been out there. We are working to make this seamless for the patient and seamless for the center, so that everyone benefits."

Continue Care's initial pilot program also includes an ongoing care support program that extends beyond medication management to include condition monitoring, virtual nurse check-ins, 24/7 triage support, and medication reminders. The outcomes have been 100% medication adherence in participating individuals, hospitalization preventions, and ER diversions.

These outcomes are just the beginning for Continue Care, which is expanding its services via its pilot program in an effort to serve as many individuals as possible. The combined expertise of PharMerica and BrightSpring Health Services positions Continue Care to have the capacity to serve 350,000+ patients daily across 50 states, incorporating 10,000+ clinical providers and pharmacists serving 3,100+ facilities.

To learn more about implementing Continue Care as part of your center's discharge planning, visit pharmerica.com/ContinueCare or contact 1-800-821-4038.

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