ADVERTORIAL

A Model of Quality Care During Transitions

The Continue Care transitional care management program, created by PharMerica and BrightSpring Health Services, aims to address the gaps in care that exist when an individual is transitioning from a skilled care facility to their own home. Though the program officially launched in May 2022, its development has been underway for much longer, gaining evidence of its impact on the quality of care offered to individuals during critical times of transition.

At its core, Continue Care integrates seamlessly into a facility's discharge planning process to extend care management into the home by offering a dynamic set of services and solutions that promote medication therapy optimization and nurse engagement at all levels of care. These include 44 days of medications provided post-discharge with most providers, including an initial 14-day supply of medications at the time of discharge; weekly check ins from a nurse starting within 48 hours of arriving home; in-home visits from nurse practitioners (NPs) where available; and 24/7 virtual nurse and pharmacist support for residents and families.

Conceptually, the Continue Care transitional care management program has gained support from key industry leaders. To add more demonstrative proof of its impact on quality care, PharMerica partnered with Avamere, a leader in post-acute and senior living, to pilot Continue Care's transitional care management program. Under the leadership of Dr. Elizabeth Burns, Chief Medical Officer at Avamere, the company launched Continue Care's pilot program to support its goal of increasing quality care and the patient experience.

"One of the core missions of Avamere is to pursue innovation, not emulation," said Dr. Burns. "That mission made the decision to join the Continue Care program an easy one."

Like many centers, Avamere was seeking solutions to address key areas of quality care, including reducing hospital readmissions, improving medication adherence at home, preventing emergency hospitalizations, and providing care in the home for those who need a higher level of assistance.

"Our goal is to improve the quality of seniors' lives," said Dr. Burns. "That requires that we set each person in our care up for success whether they are staying at one of our senior living facilities or discharging from our post-acute care centers. The Continue Care program breaks down barriers for safe and effective transitions in the home while improving the well-being and experience of patients and residents."

While the pilot overall has been a success thus far, three specific areas of Continue Care's program are supporting Avamere's goals of setting patients up for long-term success:

Primary Care Hub: Where available, the Primary Care Hub offers NP-led care within the facility itself to partner with staff to develop a proactive care path.

Clinical Nursing Hub: The Clinical Nursing Hub offers care navigation into the home, monitoring, and triage tools designed to address risks and improve outcomes in real time.

Pharmacy Packaging: Continue Care provides convenient multi-dose pillow packaging of prescription medications organized by administration time, synchronized into 30-day cycles with clear instructions to increase adherence and reduce confusion.

'Continue Care integrates seamlessly into a facility's discharge planning process to extend care management into the home.'

Primary Care Hub

Honoring Continue Care's goal of creating a model that positions individuals for the best care possible along all stages of the care continuum, Continue Care integrated aspects of BrightSpring's home-based primary care services into Avamere's trial through the Primary Care Hub. This in-facility service is a patient's initial interaction with a care team, beginning the day of admission and continuing through discharge. From this early interaction, care providers can spend time getting to know the patient, their medical diagnoses, and complications, and better understand what the best proactive care plan should be for that specific individual.

"This partnership between home-based primary care and Continue Care is being developed to offer all care providers a great understanding of a patient," said Dr. Arif Nazir, Chief Medical Officer, Primary Care, at BrightSpring Health Services. "We're focused on proactive care, which relies a lot on communication between care providers as well as taking time and resources to better educate patients about their own medical care."

Based on initial observations, BrightSpring's proactive care models within the Continue Care program can help better identify specific medical issues that need attention before they require reactive care. This is particularly important in the Continue Care program, where patients will have complex co-morbidities. While certain technological components are still being developed, BrightSpring's team-based process requires collaboration between in-facility care teams and the transitional care management teams of Continue Care, as well as educating the patients themselves.

The Primary Care Hub overlay includes:

- A NP-led care program to partner with facility staff.
- A risk-stratified, proactive care path-based model to meet individualized medical and psychiatric needs.
- NPs/physician assistants (PAs) supported by care navigators to assure care path compliance.
- Weekly grand-rounding processes to enhance staff competencies and to promote team learning.
- Integrated, high-quality 24/7 call center to answer staff and family questions and prevent hospitalizations.
- Timely outcomes reporting for all stakeholders.
- Chronic disease management and behavior health integration programs.
- Advance care planning on admission and then periodically.
- Polypharmacy optimization and deprescribing.

Burns

Nazir

"Incorporating home-based primary care is what makes this model incredibly innovative in advancing the care delivery upon discharge, wherever you call home" said Dr. Burns of Avamere. "The Primary Care Hub with Continue Care allows a successful transition to home where patients will get the highest level of care at the right place at the right time along their care journey."

The pilot program at Avamere is still on track, providing critical data points that will help other centers around the nation successfully integrate Continue Care into their facilities. For more information about the Continue Care transitional care management program, visit www.PharMerica.com/ContinueCare. ■

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