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McKnights Long-Term Care News

TRANSITION TROUBLES SOLUTION: CONTINUE CARE

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A lot of focus is often placed on the start of a post-acute patient's stay. But as providers know all too well, the back end of any care visit is becoming more important than ever. Educating the patient, and then equipping that person with access to the right medications, dosages and ongoing services is an extremely challenging caregiving segment.

Roughly half of incoming skilled nursing patients end up staying long term. But for the rest who depart after a relatively short period of rehabilitation, the transition back to home or another location can be fraught with uncertainty. If improperly managed, it can be high risk, which then compounds the trauma of coping with all of the emotions and stress that accompany an injury or brief illness.

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>
> – WILLIAM MILLS, MD, BRIGHTSPRING HEALTH SERVICES

"Every discharge is a complex process and represents a time of significant vulnerability for patients," said William Mills, MD, senior vice president, medical affairs for BrightSpring Health Services. "Safe and effective transfers of responsibility for a patient's medical care really relies on team-based and effective provider communication. Patients really need to comprehend the often complex discharge instructions, which is not always easy."

Mills was a presenter for the recent McKnight's webinar sponsored by PharMerica, "Redefining discharges: A novel blueprint to transitional care."

To address such precarious transitions and ensure optimal outcomes, PharMerica launched Continue Care, a transitional care management (TCM) program that integrates smoothly into a facility's discharge planning process and provides the full spectrum of person-centered, hands-on interventions residents need to live healthier at home.

TCM is a rising movement to redefine the nursing home discharge process by marshaling the power of pharmacy and home-based primary care, where available. It does it in conjunction with nurse-hub outreach services to provide a safer transition home for medically complex residents.

Mills explained the top risks skilled nursing facilities face when residents leave, the types of support residents need to reduce rehospitalizations, steps facilities can take to help affect care after residents leave, and the impact of transitional care management on reimbursements and referrals.

COSTLY CARE GAPS

Gaps in care, for any kind of reason, cause one in five people discharged from an acute-care setting to be readmitted to a hospital within 30 days. That's costing facility operators; in 2019, the most recent year for which data is available, 73% of skilled nursing facilities received a penalty for their readmission rates.

Among the most common causes are:

- Unclear discharge plans and instructions leading to resident noncompliance with their treatment plan
- Lack of engagement on social needs such as food, housing, transportation and loneliness
- Lack of referrals to relevant services
- Problems scheduling follow-up doctor appointments
- Inadequate follow up

One of the most serious issues is the difficulty understanding medication regimens and drug side effects.

"Research shows about two-thirds of short-stay residents transitioning home want more help understanding their medication regimen and drug side effects," said Mills, a board-certified physician who has spent his career providing home-centric care to chronically and seriously ill patients. He has personally made more than 21,000 in-person medical house calls.

According to Mills, ignorance of vital drug information can have devastating consequences, particularly with breathing treatments, antibiotics, diuretics and heart medications. The risks increase exponentially when you factor in high-risk medications such as anticoagulants or blood thinners, glucocorticoids, anti-seizure meds, hypoglycemics and antipsychotics.

The problems only get worse, and the likelihood of an ER visit increases, as a patient moves between sites of care, he added.

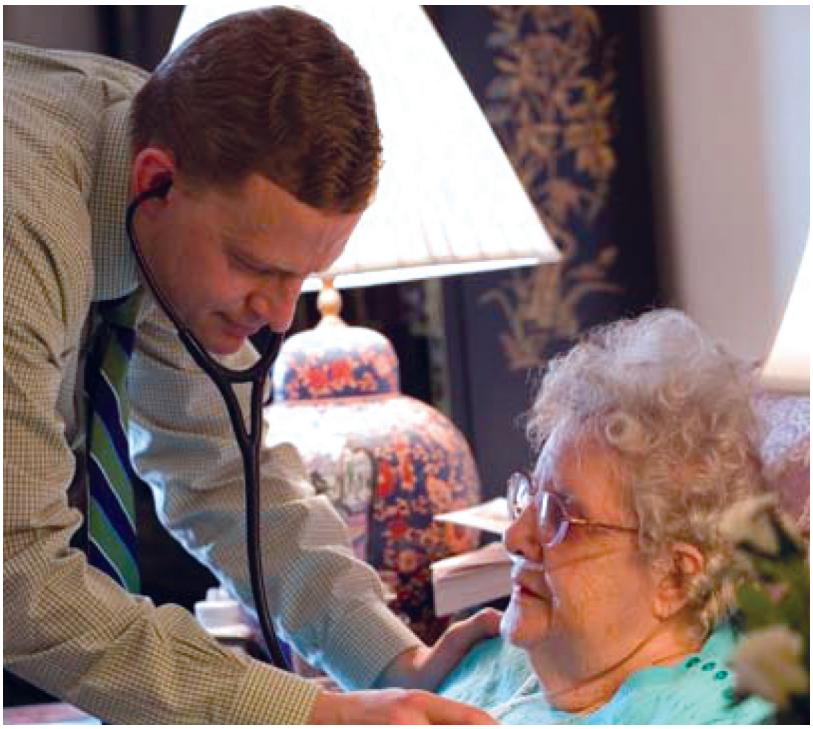

Photo: BrightSpring Health Services

BrightSpring's Dr. William Mills notes that every resident transfer presents a "significant" time of vulnerability.

Too many short-term SNF residents (as many as 40%) don't closely adhere to the instructions on their medication bottles, which leads to high levels of hospitalizations, adverse drug events, severe impairment related to activities of daily living, pressure ulcers and falls.

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"There are also specific clinical conditions that really carry an outsized risk so things like advanced COPD, unstable diabetes, brittle heart failure, stroke, certain cancer diagnoses, weight loss, depression and sepsis," said Mills, who prior to joining BrightSpring founded and led a clinical technology company dedicated to innovations and care management for people with multiple complex medical conditions. "I also know of many nursing home operators that are dealing with an increasingly frail population."

A common problem is ensuring vital information continues to flow as the patient moves from one care setting to another. All too often, that doesn't happen.

"Providers really must be engaged with the overall care plan," he said. "This specific transitional care area is very much a team sport and if one member of that team is not really fully participatory, that patient's ultimate care transition may suffer."

He also cautioned about the need for family education. That includes having watchful eyes around so-called "red flag" symptoms like increasing fever, shortness of breath, bleeding, and somnolence or sleepiness.

"And the education really also needs to be tailored to patients' level of health literacy," he said. One way to facilitate this is called the "teach back method," through which clinicians ask caregivers to explain what they were just taught to look for.

Daily care needs are another gap area given little attention. This includes knowing a patient's needs concerning economic stability, surrounding physical environment, education, food and the local supporting healthcare system. Caregivers also need to be mindful

Photo: BrightSpring Health Services

Continue Care goes into great depth regarding patients' medications and how they should be administered.

of how quickly a patient's surroundings can downgrade from a highly controlled environment or setting such as a hospital to a domicile. For example, one recent study at the University of California-San Diego found definitive links between lack of transportation, an inability to pay for certain types of follow-up care and lack of insurance with high 30-day readmission risk for sepsis.

HOW TRANSITIONAL CARE MANAGEMENT HELPS

Transitional care management is intended to reduce potentially preventable readmissions following discharge from an acute-care setting, Home-based primary care is associated with a 50% reduction in hospital readmissions and a 20% reduction in emergency room visits, Mills pointed out.

Moreover, a study in "Topics in Geriatric Rehabilitation" showed a 51% relative risk reduction in the number of readmissions among patients who had a transitional care management encounter compared to those who did not.

Mills attributes the broad interest in TCM to a 2009 article in the *New England Journal of Medicine* that revealed about 20% of Medicare beneficiaries in the United States were being readmitted within 30 days of discharge. Four years later, the Centers for Medicare & Medicaid Services began reimbursing providers for the "handoff" TCM visits.

"CMS earmarked two different codes that can be billed by physician and non-physician practitioners," said Mills. "One is for kind of a higher complexity encounter that occurs within seven days of discharge and another for a moderately complex face-to-face visit that can be performed within 14 days of discharge."

Other covered activities followed, including medication reconciliation and certain types of follow-up care.

One of the major components of Continue Care is the way medicines are packaged in pouches instead of separate bottles, a method shown to significantly improve adherence and effectively eliminate overdosing.

"Continue Care was designed to combat drug-related problems by introducing a longitudinal solution aimed at those high-risk individuals transitioning from an acute or post-acute setting back to home," said Shauen Howard, DHA, MSN, vice president of clinical practice and innovation for BrightSpring Health Services, who co-presented with Mills. "The program actually allows for multiple entry points, like post-hospitalization, post-skilled facility or through direct physician referrals. The goal here is to use education, care planning and ongoing monitoring to transition the residents back to home."

The major program components include:

- Education, care planning and monitoring
- Engaging prescribers and synchronizing medications
- Consultant pharmacist review and optimization
- Monthly home delivery with convenient multi-dose packaging
- Regular nurse-led medication management check-ins/nurse practitioner (where available).

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Continue Care addresses each of these areas, giving providers more opportunities than ever before to ensure consistent, high-quality care for a longer period span. ■

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