FR23- Reducing Re-Hospitalizations Through Pharmacist-Physician Collaboration (ASCP/AMDA Joint Session)

Friday, March 23
3:30 PM- 5:00 PM

Session Description

Safe medication management in the vulnerable senior population and the avoidance of preventable medication errors during care transitions are building blocks of value-based care. Consultant pharmacists and medical directors are vital players in improving medication safety practices during these transitions to improve quality, reduce adverse drug events, prevent re-hospitalizations, and increase patient satisfaction. Join ASCP and AMDA leadership as they discuss how recent regulatory and legislative efforts affect transitions of care, how medications contribute to rehospitalizations, and how a collaborative effort between the medical director, consultant pharmacist, and facility staff can avoid readmissions.

Learning Objectives

- Explain how the Impact Act and Mega-Rule affect transitions of care.
- Describe potential financial penalties for skilled nursing facilities.
- Describe how medications contribute to the frequency of re-hospitalizations.
- Discuss how pharmacists, physicians, and other facility team members can collaborate to reduce hospital re-admissions.

Presenter(s): Cari Levy, MD, PhD, CMD; Chad Worz, PharmD; Marylee Grosso, RPH; Lori Aronson, NHA, MBA

Presenter(s) Disclosures: Chad Worz, PharmD: Has a financial disclosure: RXConcile: Stock Shareholder; All other speakers have reported they have no relevant financial relationships to disclose.
Reducing Rehospitalizations Through Inter-Professional Collaborations (ASCP/AMDA Joint Session)

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Speaker Disclosures
• Chad Worz, PharmD - RXConcile: Stock Shareholder
• Cari Levy, MD, Marylee Grosso, BSPharm, PD, FASCP, and Lori Aronson, NHA have no financial relationship(s).

Learning Objectives
By the end of the session, participants will be able to:
• Explain how the Impact Act and Mega-Rule affect transitions of care
• Describe potential financial penalties for skilled nursing facilities
• Describe how medications contribute to the frequency of rehospitalizations
• Discuss how pharmacists, physicians, and other facility team members can collaborate to reduce hospital readmissions

Acronyms used in this presentation
ACO Accountable care organization
ALF Assisted living facility
BPCI Bundled payment for care improvement
CMS Centers for Medicare and Medicaid
HHA Home health agency
IRF In-patient rehabilitation facility
LOS Length of stay
LTCF Long-term care hospital
NOI Net operating income
PAC Post-acute care
PAMA Protecting Access to Medicare Act of 2014
PPS Prospective payment system
QA Quality assurance
SNF Skilled nursing facility
SNFRM Skilled nursing facility readmission measure
SNFPPR Skilled nursing facility 30-day potentially preventable readmission measure
SNF VBP Skilled nursing facility value-based purchasing program

Unprecedented Change
• Changing characteristics of the resident
  • Older and with greater care needs
  • Shorter LOS
  • More discharges to home
• Competition
  • People staying home longer before entering a nursing facility
  • Bundled Payment Program encourages “by-passing” skilled nursing facilities SNFs
  • Home- and community-based programs
  • ALFs
  • Taking residents that historically went to SNFs
• Reimbursement models
  • Bundled Payment for Care Improvement (BPCI) Initiative

How did we arrive here?
• The Baby Boomer generation has always been associated with “the best.” “bigger is better.” “changing the world through consumption”
• Patients are becoming consumers looking for services & information
  • Health services
  • Wellness
  • Convenience
• By 2021 consumers will spend 24% of household income on health care
  1. Source: Brian Owens, Vice-President, Kantar Retail IQ, May 2016
Discharges to the community

- One clear area where quality and finance intersect is hospitalizations, particularly preventable hospitalization.
- One clear area where interventions may successfully reduce preventable hospitalization is a focus on the population of "recently hospitalized".
- SNF Admissions & Discharges 2016 Q2:
  - 1.8 million admissions from hospitals
  - 1.2 million discharges to community
  - 66% go back to community
  - 34% go to skilled nursing centers

Source: CMS MDS Data. Prepared by AHCA: The Discharge to Community Measure determines the percentage of all new admissions from a hospital who are discharged back to the community and remain out of any skilled nursing center for the next 30 days. The measure is based on MDS 3.0 data. This document describes how the Discharge to Community measure is calculated and how to interpret your results.

What about long-term care? SNFs?

23.5% of SNF stays resulted in a rehospitalization within 30 days of the initial hospital discharge. 78% of those were deemed potentially avoidable.


What about long-term care? SNFs?

13% of SNF patients who transition home require ED visit or hospitalization within 30 days at a cost of $24 billion per year. 75% are considered preventable.


How rehospitalizations happen

BIGGEST reason for rehospitalizations

66% of Hospital Rehospitalizations are due to Issues with Medications:
  - Non-adherence
  - Adverse drug reactions


2010 - Affordable Care Act

Based on performance based payment models:

- Value Based Purchasing (ACO)
  - CMS makes deals with hospitals or physician groups
  - Voluntary and savings can be shared

- Bundled Payment for Care Improvement (BPCI)
  - CMS makes deals with hospitals, physician groups
  - New CMS models do not allow SNFs to initiate a BPCI episode
  - Voluntary and savings can be shared
What is SNF value-based purchasing?

- Protecting Access to Medicare Act of 2014 (PAMA) required CMS to implement SNF VBP, a value-based program that through hospital readmission measures aims to:
  - Link financial outcomes to quality performance
  - Institute uniform policies for acute hospitals, SNFs, HHAs, IRFs and LTCHs
  - Encourage coordination across the acute-post-acute continuum of care

How does the program work?

- Establishes a 2% withhold to SNF Part A payments that can be earned back based on a SNF’s rehospitalization rate and level of improvement
- Uses the SNFRM hospital readmission measure
- Catches all rehospitalizations within 30 days of admission to the SNF
- That is, rehospitalizations both directly from the SNF and after discharge.

- Holds hospitals, SNFs and the HHAs accountable for the readmissions in the VBP programs

How does the program work?

- Beginning in FY 2019, Medicare A rates will be reduced by 2% to fund SNF VBP “incentive” payments
- Your SNF-PPS payments from 10/1/2018 - 9/30/2019 will be adjusted based on:
  - Your readmission performance for stays in 1/1/2017 - 12/31/2017
  - And if you’re in around the worst 25% in the nation:
    - Improvement from CY2015 to CY2017 can also help

The performance scoring equation

- The SNF VBP scoring methodology uses both an achievement and an improvement score, defined by CMS as:
  - Achievement score: Points awarded by comparing the facility’s rate during the performance period (CY 2017) with the performance of all facilities nationally during the baseline period (CY 2015).
  - Improvement score: Points awarded by comparing the facility’s rate during the performance period (CY 2017) with its previous performance during the baseline period (CY 2015).

Performance scores are the larger of achievement score and improvement score

The performance scoring equation

- Between 50-70% of the 2%, in aggregate, that was withheld must be returned to SNFs
- Worst 40% must receive less back than best 60%
- SNFRM measure used initially is an all-cause readmission measure and will eventually be replaced with a new measure that is based on potentially-preventable readmissions (SNFPPR-Skilled nursing facility 30-day potentially preventable readmission measure)
Case Study

Gregory, 79

- Aspirin 81 mg daily
- Metformin 500 mg twice daily
- Tamsulosin 0.4 mg daily
- Citalopram 20 mg once daily
- Brimonidine tartrate/timolol maleate ophthalmic solution 0.2%/0.5% (Combigan) 1 drop in left eye twice daily
- Amitriptyline 10 mg daily for neuropathic pain
- Insulin Glargine 10 units once daily
- Furosemide 40 mg once daily
- Potassium 10 mEq once daily

Strategies for improving your rates

SNF rehospitalization rate

- We need to employ effective readmission reduction strategies to avoid financial threats further down the road...

The IMPACT Act (2014)

Improving Medicare Post-Acute Care Transformation Act
- Designed to standardize patient care, outcomes and transitions across all PAC settings
- Medication reconciliation upon admission is one of the quality measures developed pursuant to the IMPACT Act
- Multiple studies show the positive impact of pharmacist-led medication reconciliation and care transitions programs

Look what happens when a pharmacist is involved

Pharmacist led medication reconciliation associated with reduction in adverse drug related hospital revisits by 67%

Pharmacist intervention in a care transitions program for complex patients led to cost savings of nearly $300 per MRP

Look what happens when a pharmacist is involved

A new CVS Health research study shows a lower risk of rehospitalization as a result of pharmacist intervention through an insurer-initiated medication reconciliation program
Post-acute strategies for reducing rehospitalizations

**During the SNF stay…**
- Implement the INTERACT program to reduce 30-day rehospitalization
  - Follows principles of QA
  - Identify early and evaluate changes in condition before they become severe
  - Manage common changes in condition
  - Improve advance care planning and use of hospice care when appropriate
  - Improve communication and documentation – both within the facility between the facility and families, and between the facility and the hospital and home health agency

**Are efforts to reduce rehospitalizations worth the investment?**

**YES they are!**
- A reduction of 2% in Medicare rates equals a reduction of 0.6% in net operating income (NOI) margins at an average skilled nursing facility
  - Or $450/day X 2% = $9/day X 21 days = $189/discharge lost
  - $189/discharge x 500 discharges/year = $94,500
- Greater threat… loss of referring hospitals
  - You need post-acute referrals to survive
  - Low Medicaid reimbursement rates
  - Shrinking private paying patients
  - Better care and great patient/family satisfaction

**Post-acute strategies for reducing rehospitalizations**

**During the SNF stay…**
- Implement advanced care planning
  - Identify anticipated service needs immediately upon admission (Home Health, Meals on Wheels, etc)
  - Schedule 72-hour post-admission meeting with patient family and home health nurse liaison to set clear discharge and post discharge expectations

**Post-acute strategies for reducing rehospitalizations**

**During the SNF stay…**
- Invest in nursing education to enhance critical thinking
- Look at which of your MDs are sending patients back to the hospital (often concerned about malpractice)
  - Identify them
  - Counsel them about your SNF's services and competencies
- Develop clinical protocols for managing high rehospitalizations
  - COPD and CHF are a good start
- Enhance discharge planning processes
- Complete medication reconciliation and education with each patient
  - Consider pharmacist-led medication reconciliation upon admission and at discharge

**Are efforts to reduce rehospitalizations worth the investment?**

- RIGHT thing to do
- Reimbursement
- Regulatory
- Referrals