



**PHARMACY  
VISION  
20/20**

CSHP SEMINAR 20 • OCTOBER 21-25  
**Disneyland**  
RESORT

# SKILLED NURSING FACILITY TO HOME: ENHANCING TRANSITIONS THROUGH A CENTRALIZED POST-DISCHARGE PROGRAM

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# DISCLOSURE

- Alfonso Becerra and Karen Cham have no conflicts of interest to disclose.

# LEARNING OBJECTIVES

- Discuss current healthcare trends that have shaped transitions of care pharmacy programs
- Explore the role of pharmacists in improving safety and adherence among patients discharged from skilled nursing facilities (SNFs)
- Identify common interventions/recommendations made by pharmacists during transitions of care

# PRE-TEST ASSESSMENT

**The Hospital Readmission Reduction Program and the Skilled Nursing Value-Based Purchasing Program are Medicare programs that tie payment to readmission.**

- A. True
- B. False

# PRE-TEST ASSESSMENT

**Over 90% of discharge summaries reviewed had at least one potential medication related issue.**

- A. True
- B. False

# PRE-TEST ASSESSMENT

**The most common pharmacist intervention in the SNF Discharge Med Rec Program involved age/food/drug interactions.**

- A. True
- B. False



# MEET Ms. DOE

# MEET MS. DOE

An 85 y.o. woman admitted to skilled nursing facility (SNF) for physical and occupational therapy following an Emergency Department visit for orthostatic hypotension and near syncope.

## **PMH:**

Diabetes

Atrial fibrillation

Diastolic heart failure

Hypertension

Osteoporosis

Chronic Back Pain

Patient was discharged home after 2 week stay at the SNF



*Note: Image used for illustrative purpose. Actual patient not depicted*

# Ms. DOE'S SNF DISCHARGE MEDICATION LIST PART 1

	Medication	Sig
1.	Docusate Sodium 250 mg Cap	Take 1 capsule by mouth daily as needed for bowel regularity. Hold for loose stools
2.	Bisacodyl 10 mg Rect Supp	Unwrap and insert 1 suppository rectally daily as needed for constipation
3.	Sennosides 8.6 mg Tab	Take 1 tablet by mouth 2 times a day . Hold if you have loose stools
4.	Polyethylene Glycol 3350 17 gram/dose Oral Powder	Mix 17 Grams in 4 to 8 ounces of water or juice and drink by mouth daily as directed for constipation
5.	Docusate Sodium 100 mg Cap	Take 1 to 2 capsules by mouth at bedtime as needed for constipation
6.	Losartan 25 mg Tab	Take 1/2 tablet by mouth 2 times a day

# Ms. DOE'S SNF DISCHARGE MEDICATION LIST PART 2

	Medication	Sig
7.	Cholecalciferol, Vitamin D3 1,000 unit Oral Tab	Take 1 tablet by mouth daily
8.	Calcium Carbonate-Vit D3 600 mg (1,500mg) - 400 unit Tab	Take 1 tablet two times a day with food
9.	Warfarin 2 mg Tab	Take 2 tablets by mouth daily for 3 days and then as directed by physician or anticoagulation clinic
10.	Amiodarone 200 mg Tab	Take 1 tablet by mouth daily
11.	Insulin Glargine 100 unit/mL SubQ Soln	Inject 8 units subcutaneously daily at 9 AM
12.	Allopurinol 100mg Tab	1 tablet by mouth daily

# Ms. DOE'S SNF DISCHARGE MEDICATION LIST PART 3

	Medication	Sig
13.	Insulin Regular Human 100 unit/mL Inj Soln	If BG <60 & alert give snack, check BG w/in 30 min, hold insulin. Call MD if unresponsive. If BG 60-149 do not give insulin; If BG 150-199 give 2units; 200-249 4units; 250-299 6units; 300-349 8units; 350-399 10units; 400-449 12units; >450 14units & check in 2 hrs & notify MD/NP if glucose still >450
14.	Acetaminophen 325 mg Oral Tab	Take 2 tablets by mouth every 4 hours as needed for mild pain . Do not exceed 10 tablets in 24 hours. Do not exceed 4,000 mg of Acetaminophen per day from all sources
15.	HYDROcodone-Acetaminophen 5-325 mg Oral Tab	Take 1 tablet by mouth every 6 hours as needed for moderate pain

# TRANSITIONS OF CARE



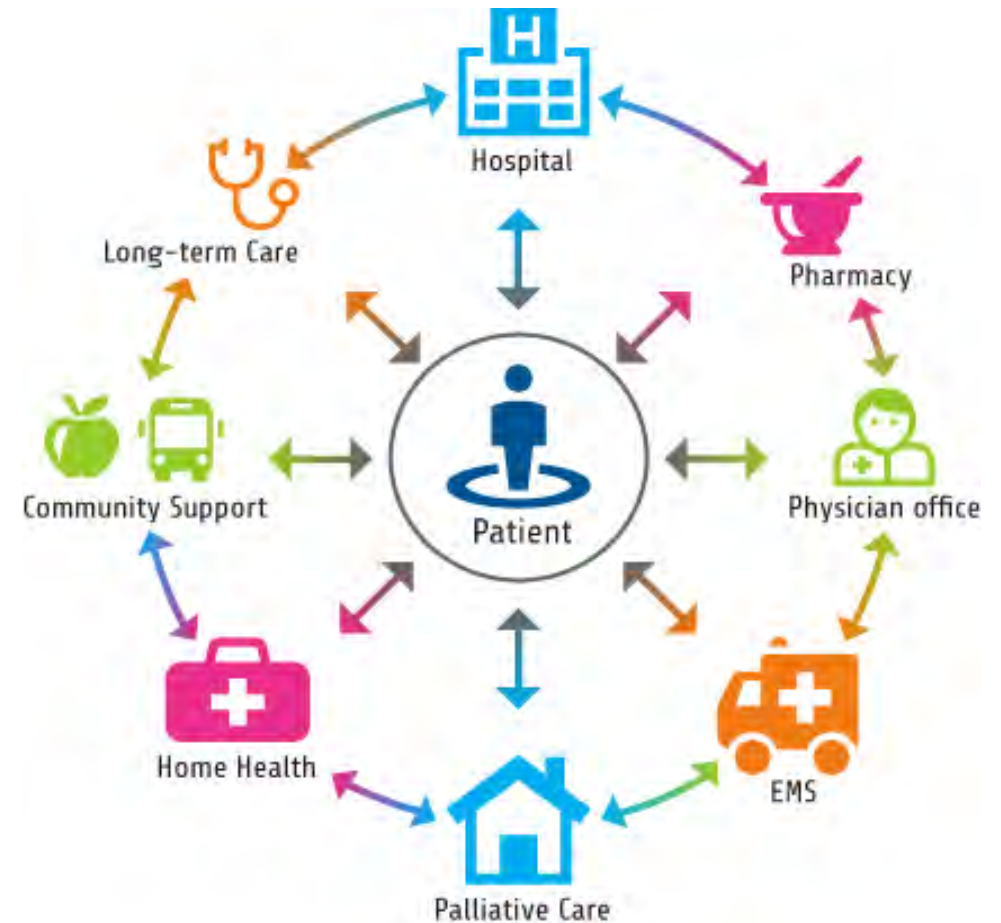
# TRANSITIONS OF CARE ACROSS THE CONTINUUM

## Centers for Medicare and Medicaid Services (CMS)<sup>1</sup>

- “The movement of a patient from one setting of care to another”

## Ineffective transitions increase the risk of adverse events and higher hospital readmission rates and costs

- ~60% of medication errors occur during patient admission<sup>2</sup>
- 14.1% to 32.4% of patients discharged from the hospital has  $\geq 1$  medication error<sup>2</sup>



<sup>1</sup>[https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/8\\_transition\\_of\\_care\\_summary.pdf](https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/8_transition_of_care_summary.pdf)

<sup>2</sup>Kreckman J, Wasey W, Wise S, Stevens T, Millburg L, Jaeger C. Improving medication reconciliation at hospital admission, discharge and ambulatory care through a transition of care team. *BMJ Open Qual.* 2018;7(2):e000281.

# TRANSITIONS OF CARE FROM HOSPITAL



**Hospital**



**Home**

- Hospital Readmission Reduction Program (2012)<sup>11</sup>
  - Medicare value-based purchasing program that reduces payments to hospitals with excess readmission
- National 30-day readmission rate: **15.3%** (CMS)<sup>12</sup>

<sup>3</sup>Centers for Medicare and Medicaid Services. Readmissions Reduction Program. 2012. Available at: <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>.

<sup>4</sup>Data.Medicare.Gov – Hospital Compare. Available at: <https://data.medicare.gov/Hospital-Compare/Unplanned-Hospital-Visits-National/cvcs-xecj>

# TRANSITIONS OF CARE FROM SKILLED NURSING FACILITY (SNF)

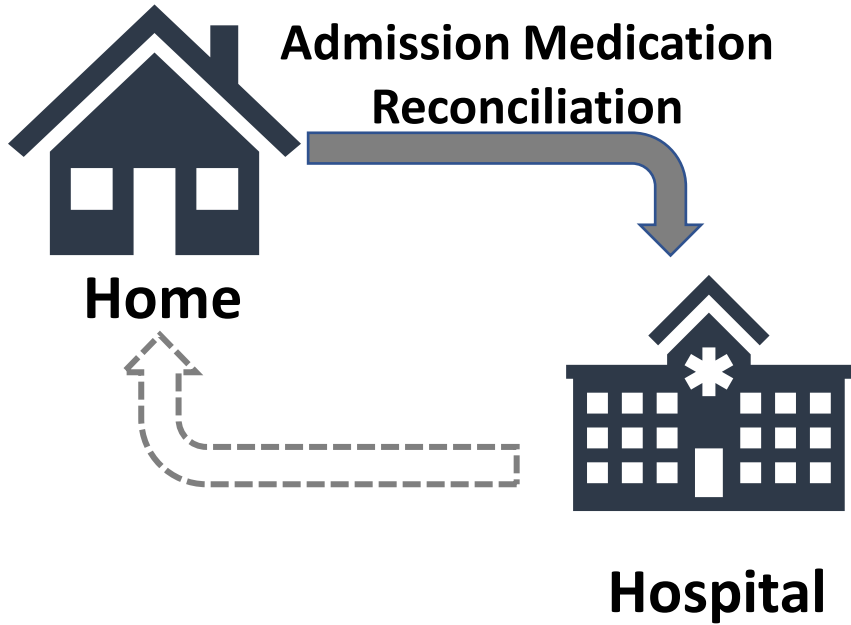


- Skilled Nursing Facility (SNF) Value-Based Purchasing Program (2019)<sup>3</sup>
  - Rewards SNFs with incentive payments for quality of care, in particular reducing hospital readmissions
- **23%** of patients discharged to SNF are readmitted to the hospital within 30 days<sup>4</sup>

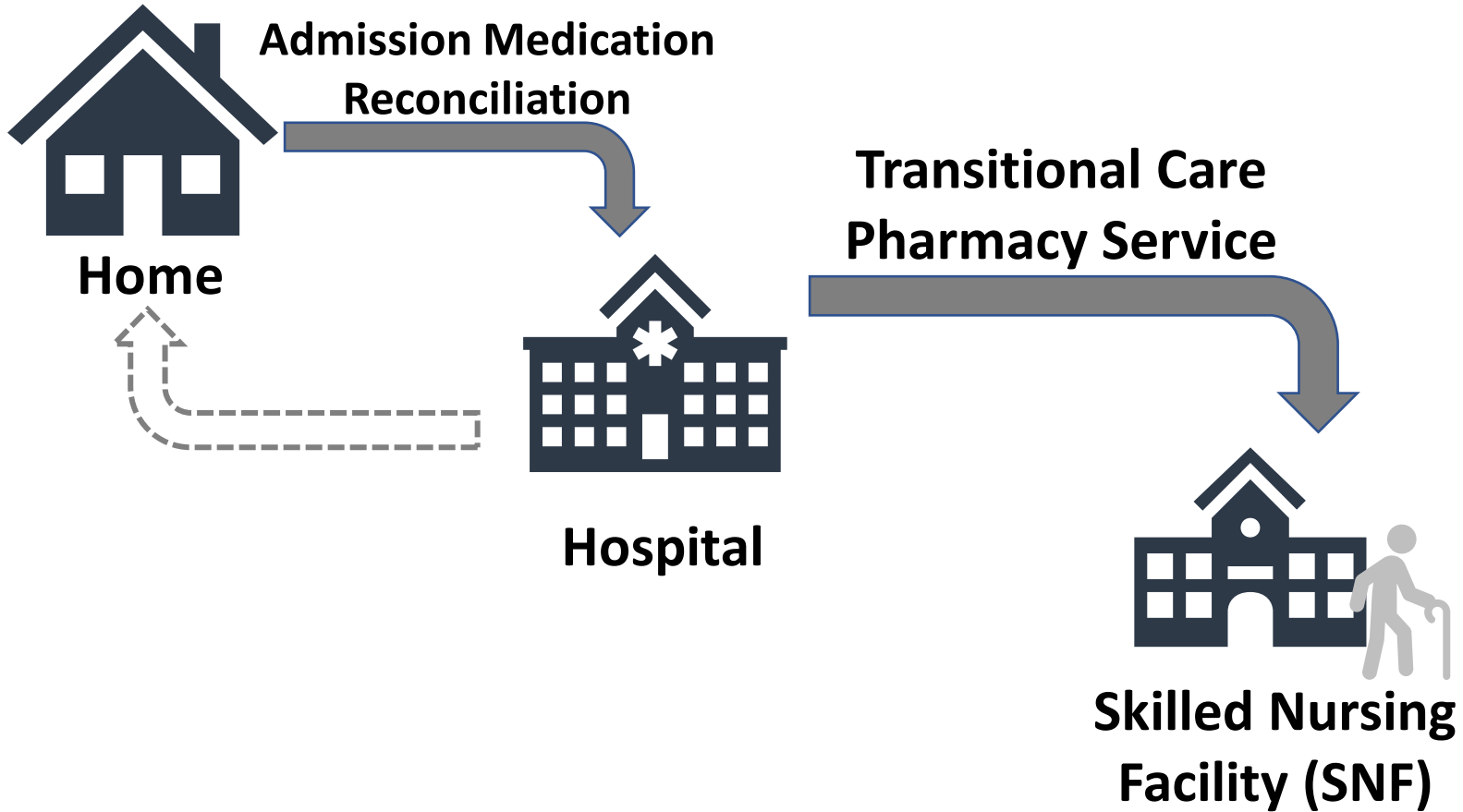
<sup>3</sup> Centers for Medicare and Medicaid Services. Readmissions Reduction Program. Available at: <https://www.cms.gov/medicare/quality-initiatives-patient-assessment-instruments/value-based-programs/other-vbps/snf-vbp.html>

<sup>4</sup> Britton MC, Ouellet GM, Minges KE, Gawel M, Hodshon B, Chaudhry SI. Care Transitions Between Hospitals and Skilled Nursing Facilities: Perspectives of Sending and Receiving Providers. *Jt Comm J Qual Patient Saf.* 2017;43(11):565-572.

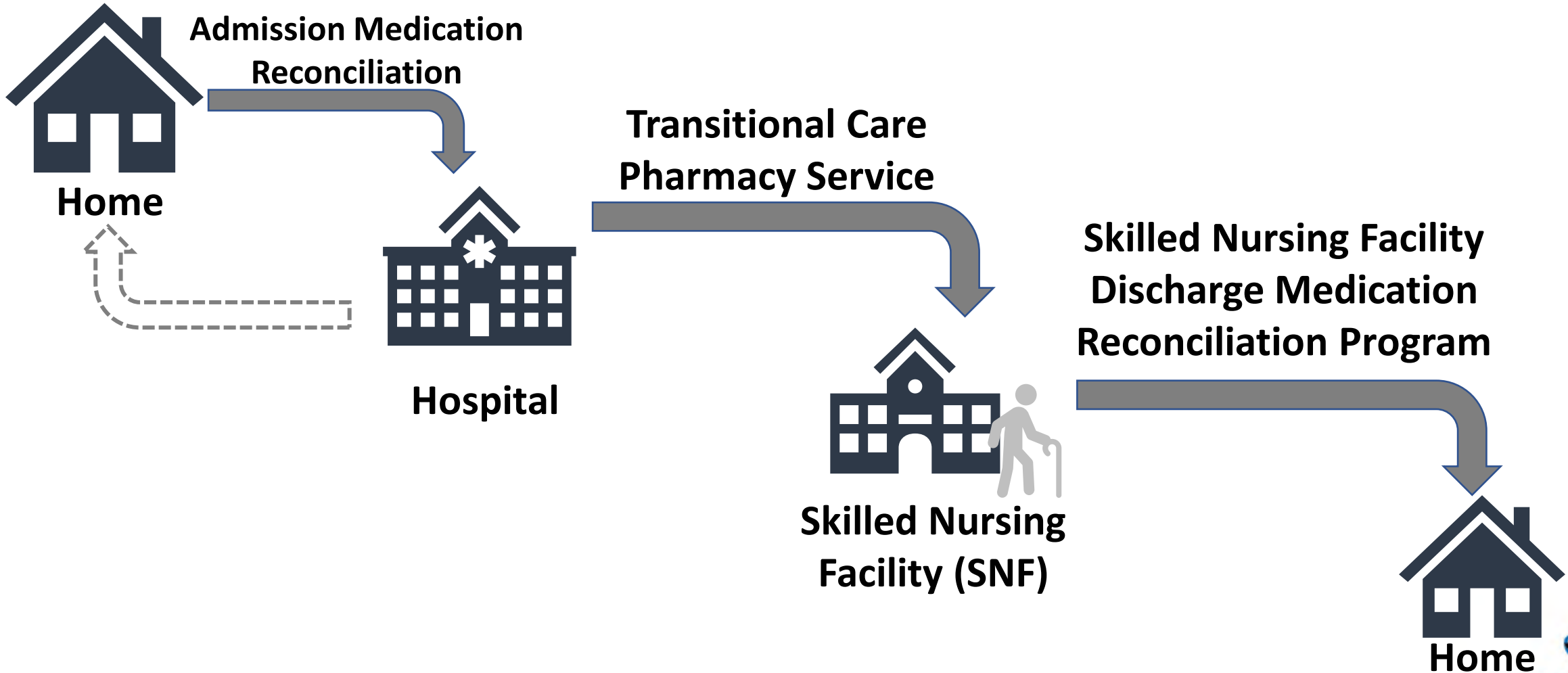
# TRANSITIONS OF CARE ACROSS THE CONTINUUM



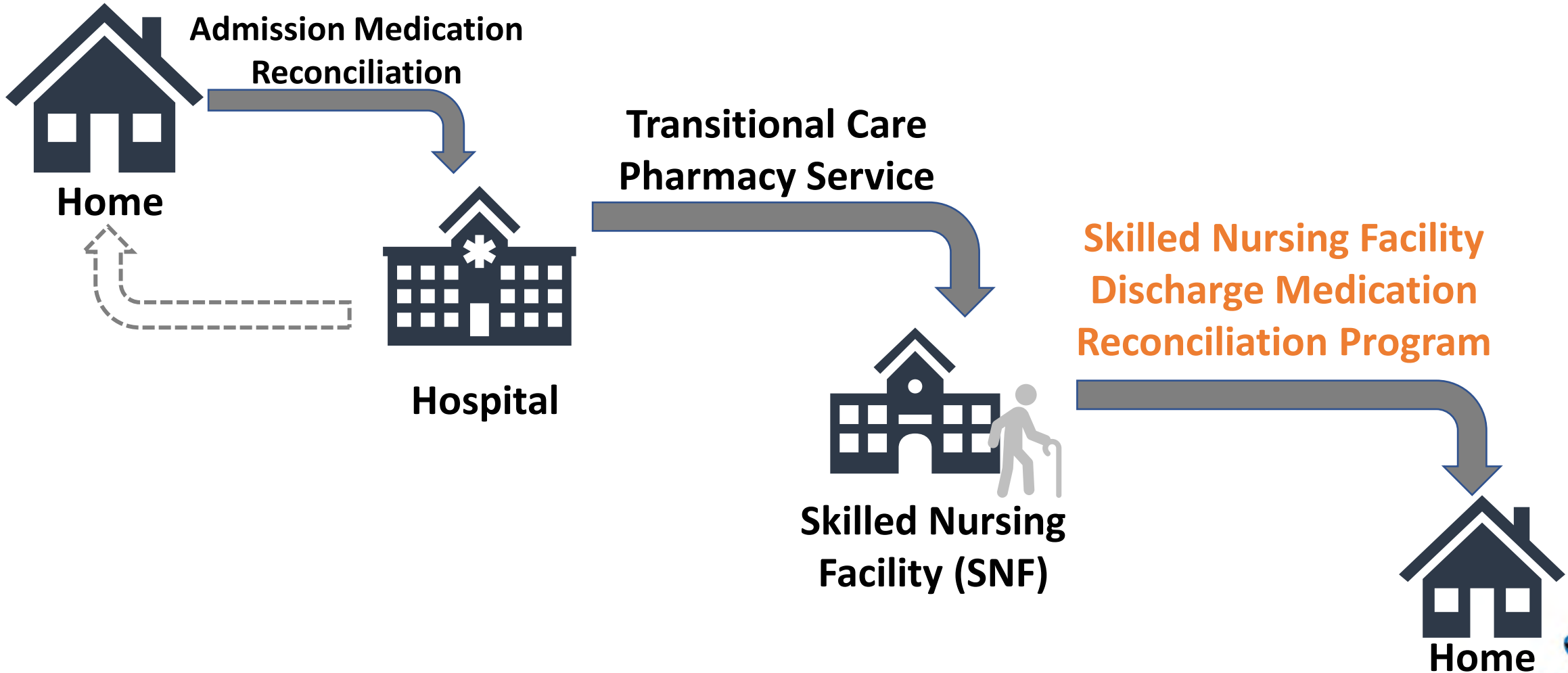
# TRANSITIONS OF CARE ACROSS THE CONTINUUM



# TRANSITIONS OF CARE ACROSS THE CONTINUUM



# TRANSITIONS OF CARE ACROSS THE CONTINUUM



# SKILLED NURSING FACILITY (SNF) DISCHARGE MEDICATION RECONCILIATION (MED REC) PROGRAM



Skilled Nursing Facility



Home

# KAISER PERMANENTE NORTHERN CALIFORNIA REGION

At a  
Glance

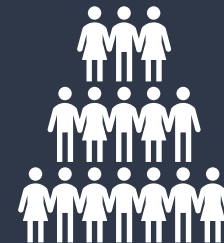
21 Hospitals  
1 Post Acute Care  
Center (KPPACC)  
249 Medical Offices



86  
Contracted  
Skilled Nursing  
Facility  
5 SNF Network  
Partners



4.5 Million  
Members  
*(As of Sept 2019)*



# WHAT ARE WE TRYING TO SOLVE?

- Patients discharging from SNFs are vulnerable population at high risk of readmission due to....
  - Medication discrepancies from multiple transitions
  - Patient misunderstanding of medication regimen
  - Medication not picked up/unavailable after discharge
- **Goal:** Conduct a detailed medication reconciliation upon discharge from skilled nursing facility to mitigate potential drug issues



# WHAT HAS BEEN DONE?

- Kaiser Permanente Colorado established **Home-Based Medication Reconciliation Program** after discharge from SNF<sup>5</sup>

## Clinical Outcomes of a Home-Based Medication Reconciliation Program After Discharge from a Skilled Nursing Facility

Thomas Delate, Ph.D., Elizabeth A. Chester, Pharm.D., Troy W. Stubbings, Pharm.D., and Carol A. Barnes, M.S.

**Study Objective.** To assess the impact of a pilot pharmacist-managed medication reconciliation program on mortality and use of health care services in patients discharged to home from a skilled nursing facility (SNF).

**Design.** Quasi-experimental, controlled trial.

**Setting.** Health maintenance organization (HMO).

**Patients.** Five hundred twenty-one HMO members.

**Intervention.** Patients were assigned to the medication reconciliation program (113 patients) or to the usual care control group (408 patients) after discharge to home from an SNF. Assignment to the medication recon-

- **78%** decrease in mortality 60 days post discharge vs. usual care
- **29%** less likely to need a post discharge Emergency Department visit
- **17%** more likely to follow up with PCP
- **>90%** of all discharge summaries contained at least one potential medication related issue

<sup>7</sup>Delate T, Chester EA, Stubbings TW, Barnes CA. Clinical outcomes of a home-based medication reconciliation program after discharge from a skilled nursing facility. *Pharmacotherapy*. 2008;28(4):444-52.

# KEY CHALLENGES



Limited view of patient's care in the contracted SNF



Notification of discharge from the SNF



Faxed vs. electronic discharge medication orders



Escalation process for medication issues identified

# DESIGN PROCESS

Gather information (literature, colleagues, etc.)

Collaborate with key stakeholders

Design the workflow

Train pharmacists and technicians

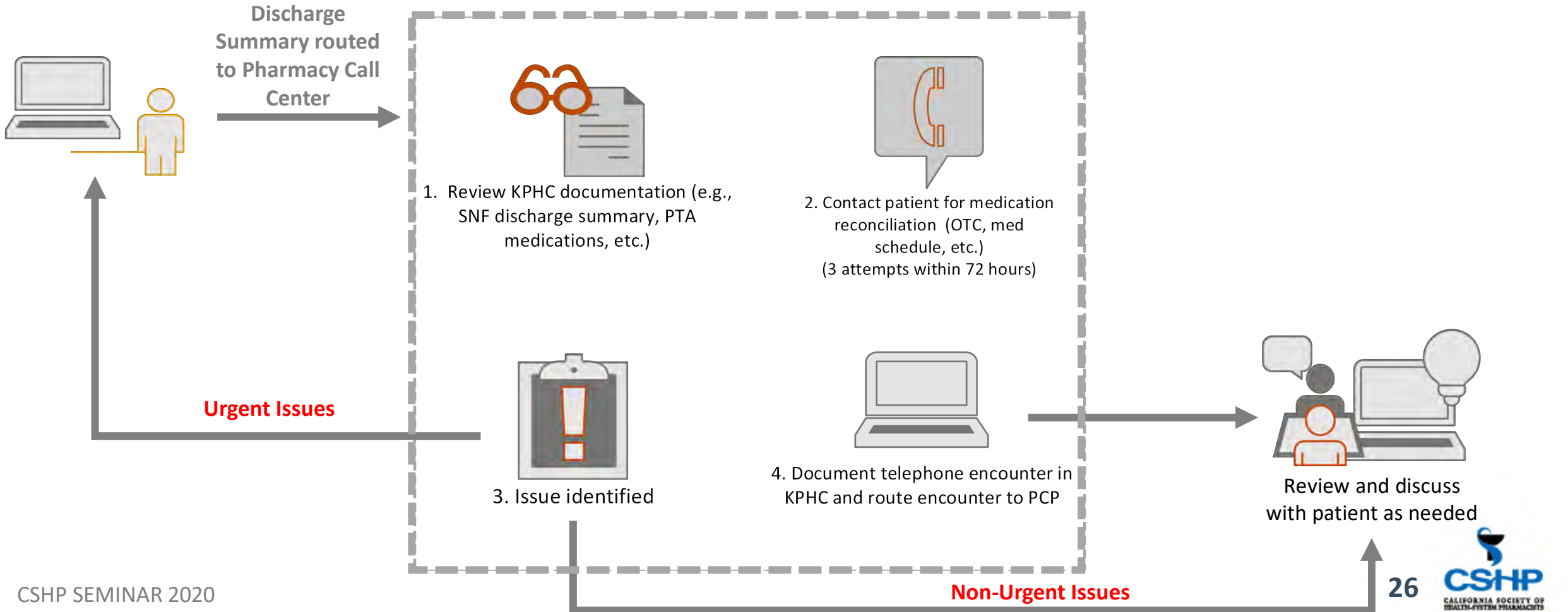
Launch, troubleshoot, and evaluate program

# SNF DISCHARGE MED REC PROGRAM WORKFLOW

*SNF Physician*

*Pharmacy Call Center Pharmacist*

*Primary Care Physician*



# CORE IMPLEMENTATION ELEMENTS

## Support on the Approach

- Centralized model
- Support from:
  - Leadership
  - Continuum Teams

## Training

- Pharmacy Toolkit
- Sharing best practices

## Feedback Loop

- Multidisciplinary meetings
  - Patient cases
  - Workflow challenges
  - Escalation process

## Track and Improve

- Dashboard to track interventions
- Standardized documentation

# **“AH-HA” MOMENTS OF THE SNF DISCHARGE MED REC PROGRAM**

- Learnings about the SNF discharge process
- Common clinical findings for patients discharged from SNF

# **OPERATIONAL LEARNING: DISCHARGE TIME MAY NOT BE THE IDEAL LEARNING TIME!**

# THE REALITY OF WHAT HAPPENS AFTER SNF DISCHARGE

- At discharge, the SNF staff reviews medication with the patient.

## Expectation at Discharge



**Patients know what medications to take**

## Reality in Patient's Home



**Patients have extra medication at home and may be confused!**

**Patients often have MORE medications at home!**

**They may not realize that they are missing specific medications!**

# THE REALITY OF WHAT HAPPENS AFTER SNF DISCHARGE

- At discharge, appointments may be made for patients to follow up with their provider

## Expectation at Discharge



**Patients will follow up with their provider**

## Reality after Discharge



**Appointment may be missed**

**Patients may not follow up with their providers after discharge (i.e. forget appointment, forget to schedule appointment, etc.)**

# KEY OPERATIONAL LEARNINGS ABOUT THE DISCHARGE PROCESS



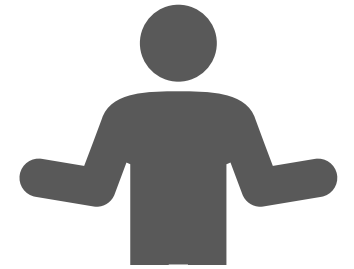
Discharge time  
may not be the  
best time to learn



Patients may not  
follow-up with  
their provider



Patients often  
have more meds  
at home



Patients may not  
realize that they  
need refills or  
need to take OTC

# COMMON CLINICAL FINDING #1: PATIENTS HAVE A LOT OF MEDICATION

# OPPORTUNITY TO EVALUATE AND DEPRESCRIBE

On average, patients have ~15 medications at time of discharge from SNF! <sup>8</sup>



Proton Pump  
Inhibitor



Diabetes regimen  
(e.g. glipizide,  
sliding scale insulin)



Bowel Regimen

- I took it for my GERD a few years ago...just kept on taking it.
- I don't know what it's for. I just take it because I was told to.

- I've been on this combination for years!

- I was on this at the hospital.
- I stopped taking it already.

# TIPS FOR DEPRESCRIBING

- **Acknowledge** that the patient's concern and explain
  - “As you age, your body changes...”
- **Consider** stopping a medication if you need to add another one
- **Evaluate** if the medication is causing symptoms of concern
- Be patient! Deprescribing conversations take time!

# HELPFUL RESOURCES FOR DEPRESCRIBING

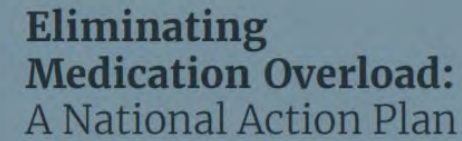
<sup>8</sup>Lown Institute. Eliminating Medication Overload. 2020

<sup>9</sup>Deprescribing.org. Deprescribing Guidelines and Algorithms. 2019

<sup>10</sup>American Diabetes Association. Older Adults: Standards of Medical in Diabetes. 2019

<sup>11</sup>Scottish Government. Polypharmacy Guidance Realistic Prescribing. 34d ed. 2018.

<sup>12</sup>Australia: Primary Health Tasmania. Deprescribing Resources. 2020



Eliminating  
Medication Overload:  
A National Action Plan

JANUARY 2020  deprescribing.org



Deprescribing Guidelines and  
Algorithms

The evidence  
Bruyère Resea  
its collabo



phn  
TASMANIA  
An Australian Government Initiative



primary  
health  
TASMANIA



LOWN  
INSTITUTE



American  
Diabetes  
Association®



CSHP  
CALIFORNIA SOCIETY OF  
HEALTH-SYSTEM PHARMACISTS

**COMMON CLINICAL FINDING #2:  
CONSIDER SAFER ALTERNATIVES ESPECIALLY FOR  
PATIENTS AT HIGH FALL RISK!**

# CONSIDER THE SAFER ALTERNATIVES

Caution for patients at high risk for falls!

## Common Examples



Alpha-blockers  
for hypertension  
(e.g. terazosin)



Z-drugs for  
sleep  
(e.g. zolpidem)



Benzodiazepine  
for anxiety



Opioids for pain  
management

## Considerations

- What is the patient's current condition?
  - Labs
  - Symptoms
  - Environment
- Has the patient trialed safer alternatives for an appropriate duration?
- Does the patient need this?

# SUMMARY OF COMMON CLINICAL FINDINGS FOR SNF PATIENTS

## *Unnecessary Therapy*

On average, patients have **~15 medications** at time of SNF discharge!



Proton Pump Inhibitor



Diabetes regimen (e.g. glipizide, sliding scale insulin)

## *Safer Alternatives Available*

Caution for patients at **high fall risk!**



Avoid alpha-blockers for hypertension (e.g. terazosin)



Avoid opioids for pain management



Avoid Z-drugs for sleep (e.g. zolpidem)

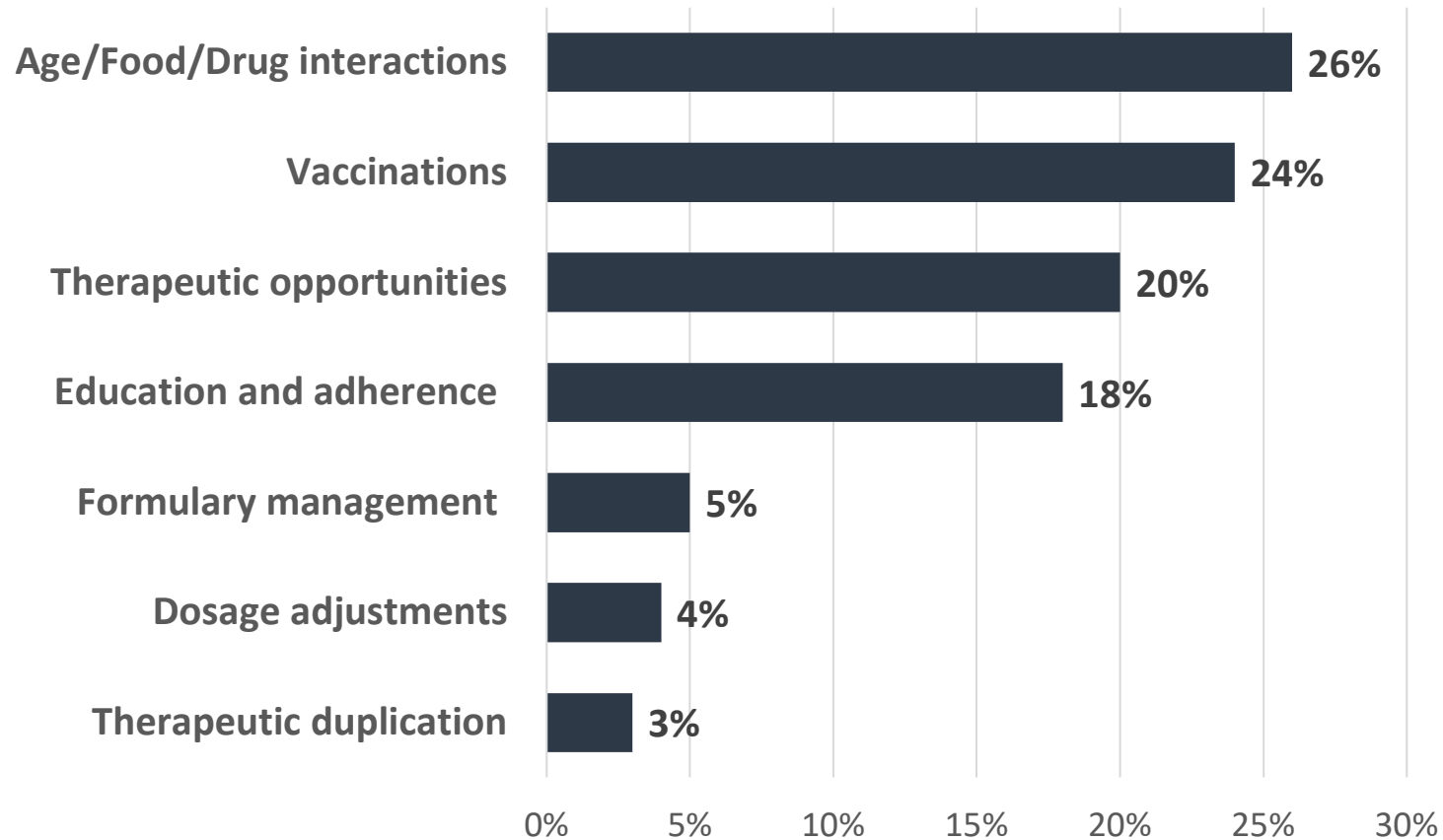


Avoid benzodiazepine for anxiety

# WERE WE EFFECTIVE?

- Pharmacist interventions
- Readmission outcomes

# PHARMACISTS INTERVENTION BY TYPE<sup>13</sup>



Pharmacists averaged  
**4.2**  
interventions per review

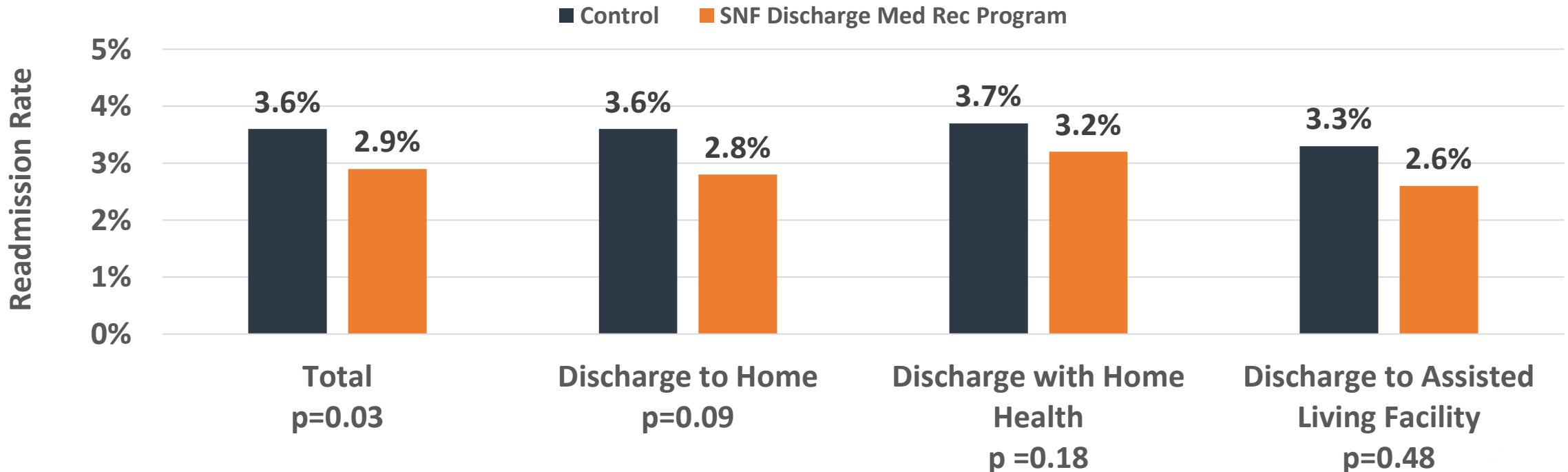
**93%**  
of all discharge summaries  
had at least one potential  
medication-related issue

<sup>13</sup>Kaiser Permanente Northern California internal data

# 30-DAY HOSPITAL READMISSION

## 30-Day Hospital Readmission by Disposition Post SNF Discharge<sup>14,15</sup>

(Study Period: March 1, 2019 thru November 31, 2019)



<sup>14</sup>Kaiser Permanente Northern California internal data

<sup>15</sup>Data based on patients who were readmitted after discharge from the SNF

# SNF DISCHARGE MEDICATION RECONCILIATION PROGRAM SUMMARY



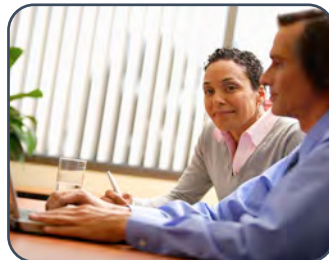
## Observations

- Over **90%** of discharge summaries contain at least 1 medication related issue
- Medication education is important post-discharge



## Key Learnings

- Program identified a need for medication intervention
- Opportunities for deprescribing in the SNF population to prevent adverse events



## Next Steps

- Complete further analysis on impact (e.g. ED utilization, adverse event reporting, etc.)
- Develop deprescribing protocols for SNF population

# BACK TO MS. DOE

# Ms. DOE

An 85 y.o. woman admitted to skilled nursing facility (SNF) for physical and occupational therapy following an ED visit for orthostatic hypotension and near syncope.

## PMH:

Diabetes (A1c = 5.5%)

Atrial fibrillation

Diastolic heart failure

Hypertension

Osteoporosis

Chronic Back Pain

Discharged home after 2 week stay at the SNF

Pharmacist contacted the patient post-discharge to review her medications



*Note: Image used for illustrative purpose. Actual patient not depicted*

# MEDICATION ISSUES IDENTIFIED

## Issue #1: Bowel Regimen

Scheduled	As needed
<ul style="list-style-type: none"><li>• Polyethylene glycol 3350 17gm/dose oral powder</li><li>• Sennoside 8.6mg tab</li></ul>	<ul style="list-style-type: none"><li>• Docusate Sodium 250mg cap</li><li>• Docusate Sodium 100mg cap</li><li>• Bisacodyl 10mg Rec Supp</li></ul>

### Concern:

- 1) Patient has 2 docusate prescriptions
- 2) Multiple as-needed medication. Which bowel medication should patient take?

# MEDICATION ISSUES IDENTIFIED

## Issue #2: Dose Discrepancy

**Medication:** Losartan 25mg – take 1/2 tablet by mouth 2 times per day

### Concerns:

1) Patient reports taking 1 tablet 2 times per day

# MEDICATION ISSUES IDENTIFIED

## Issue #3: Diabetes Regimen

### Medication:

- Insulin Glargine 100 units/mL SubQ Soln
- Insulin Regular Human 100unit/mL Inj Soln – Sliding Scale

### Concerns:

- 1) Missing testing supplies/syringe
- 2) Insulin Glargine is a nonformulary item
- 3) Slide scale insulin is not preferred
- 4) Patient's A1c = 5.5%

# MEDICATION ISSUES IDENTIFIED

## Issue #4: Additional Discrepancy

### Medication:

- Lidocaine 5% Topical Patch
- Ferrous Sulfate 325mg Tab
- Ascorbic Acid 250mg Tab

### Concerns:

- 1) Patient reported taking, but were not listed in the discharge medication list

# MEDICATION ISSUES IDENTIFIED

## Issue #5: Refills Needed

### Medication:

- Warfarin 2mg Tab

### Concerns:

- 1) Patient reports that she ran out

*“Having us pharmacists in the forefront managing conditions, especially during care transitions, is like having a secret weapon to improve patient outcomes.”*

*-Ed Portillo, Pharm.D. Assistant Professor in the University of Wisconsin-Madison School of Pharmacy*

Gerhards, K. A Pharmacist-Driven Intervention to Help Veterans Breathe Easier. University of Wisconsin-Madison School of Pharmacy. <https://pharmacy.wisc.edu/a-pharmacist-driven-intervention-to-help-veterans-breathe-easier/>. Published December 2, 2018. Accessed September 8, 2020

# POST-TEST ASSESSMENT

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# REFERENCE LIST

1. Center for Medicare and Medicaid . EHR Incentive: Eligible Professional Meaningful Use; Menu Set Measures Measure 7-9; State 1 (2014 Definition). [https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/8\\_transition\\_of\\_care\\_summary.pdf](https://www.cms.gov/regulations-and-guidance/legislation/ehrincentiveprograms/downloads/8_transition_of_care_summary.pdf). Updated May 2014. Accessed September 8, 2020
2. Kreckman J, Wasey W, Wise S, Stevens T, Millburg L, Jaeger C. Improving medication reconciliation at hospital admission, discharge and ambulatory care through a transition of care team. *BMJ Open Qual*. 2018;7(2):e000281.
3. Centers for Medicare and Medicaid Services. Readmissions Reduction Program. <https://www.cms.gov/medicare/medicare-fee-for-service-payment/acuteinpatientpps/readmissions-reduction-program.html>. Updated August 24, 2020. Accessed September 8, 2020
4. Centers for Medicare and Medicaid Services. Data.Medicare.Gov – Unplanned Hospital Visits – National (Hospital Compare). Available at: <https://data.medicare.gov/Hospital-Compare/Unplanned-Hospital-Visits-National/cvcs-xecj>. Accessed September 8, 2020.
5. Centers for Medicare and Medicaid Services. The Skilled Nursing Facility Value-Based Purchasing (SNF VBP) Program. <https://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment-Instruments/Value-Based-Programs/SNF-VBP/SNF-VBP-Page>. Updated August 12, 2020. Accessed September 8, 2020.
6. Britton MC, Ouellet GM, Minges KE, Gawel M, Hodshon B, Chaudhry SI. Care Transitions Between Hospitals and Skilled Nursing Facilities: Perspectives of Sending and Receiving Providers. *Jt Comm J Qual Patient Saf*. 2017;43(11):565-572.
7. Delate T, Chester EA, Stubbings TW, Barnes CA. Clinical outcomes of a home-based medication reconciliation program after discharge from a skilled nursing facility. *Pharmacotherapy*. 2008;28(4):444-52.

# REFERENCE LIST

8. Working Group on Medication Overload. Eliminating medication overload: A national action plan. The Lown Institute, 2020.
9. Bruyere Research Institute. Deprescribing Guidelines and Algorithms. Updated 2020. <https://deprescribing.org/resources/deprescribing-guidelines-algorithms/>
10. American Diabetes Association. 12. Older Adults: *Standards of Medical Care in Diabetes-2020*. *Diabetes Care*. 2020;43(Suppl 1):S152-S162. doi:10.2337/dc20-S012
11. Scottish Government Polypharmacy Model of Care Group. Polypharmacy Guidance, Realistic Prescribing 2018, Quick Reference Guide. <https://www.therapeutics.scot.nhs.uk/wp-content/uploads/2017/07/Polypharmacy-Quick-Reference-GuideV3.pdf>. Updated 2018. Accessed September 8, 2020.
12. Australia Primary Health Tasmania. Deprescribing Resources. <https://www.primaryhealthtas.com.au/resources/deprescribing-resources/>. Accessed September 8, 2020. Updated January 31, 2020.
13. Gerhards, K. A Pharmacist-Driven Intervention to Help Veterans Breathe Easier. University of Wisconsin-Madison School of Pharmacy. <https://pharmacy.wisc.edu/a-pharmacist-driven-intervention-to-help-veterans-breathe-easier/>. Published December 2, 2018. Accessed September 8, 2020

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