The Pharmacist’s Role in Improving Transitions of Care in Skilled Nursing Facilities
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BACKGROUND

While hospitals have been diligently working to reduce their 30-day readmission (RA) rates, it is anticipated that the Centers for Medicare & Medicaid Services will implement a similar Value-Based Purchasing program for skilled nursing facilities (SNFs) within the next five years. 1 A Medicare Payment Advisory Commission analysis showed that 23.5% of all patients who were discharged to SNFs were readmitted within 30 days, and 78 percent of these readmissions were potentially avoidable at a cost of $3.39 billion. 2 Toles et al. found that 22.1% of patients had an emergency department (ED) visit or were readmitted within 30 days upon discharge from SNF to home. 3

Patients transitioning from hospital to SNF and from SNF to home often have numerous comorbidities and medications. As the medication experts, pharmacists are uniquely qualified to identify and manage medication-related problems as patient transition from one setting to another. One primary intervention is medication reconciliation, which is defined as the process of bringing together a list of all medications a patient is taking by comparing the medical record to an external list of medications obtained from a patient, hospital, or other provider. 4 At each transition point, inaccurate medication reconciliation increases patients’ risk of hospital RA.

While many hospitals have incorporated pharmacy technicians in the ED workflow to obtain prior-to-admission medication histories and/or decentralized their inpatient pharmacists to counsel patients who discharge from hospital to home, very few hospitals have pharmacist involvement upon patients’ transfer from hospital to SNF and from SNF to home. There is tremendous opportunity as one study identified at least one medication discrepancy in 71.4% of SNF admissions. 5 In addition, Sivani et al. found that 100% of SNF pts were discharged home with more medications than their initial admission to hospital. 6

OBJECTIVES

• Reduce SNF 30-day RA rates
• Conduct a needs assessment in regards to medications as patients transition from hospital to SNF and subsequent SNF to home
• Identify barriers in optimal medication management along the continuum of care and how they can be overcome

METHODS

In January 2014, the Care Transitions (CT) pharmacists at Frederick Memorial Hospital began a pilot project with three local SNFs. Pharmacists identified high-risk patients in the hospital and followed patients as they transitioned from hospital to SNF and subsequently from SNF to home. Pharmacists reconciled medications, recommended medication therapy changes to improve outcomes, identified necessary medication monitoring, and provided medication education along the continuum of care. The primary outcome of this project was the reduction in SNF 30-day RA rates.

RESULTS & DISCUSSION

• The CT pharmacists followed approximately 150 high-risk patients through the care continuum for 6 months.
• For SNF #1, the RA rate decreased from 12.5% to 8.33% during that time period. For SNF #2, the RA decreased from 2.5% to 5.56%. For SNF #3, the RA rate decreased from 22.2% to 12.5%.
• In FY 2011, the FMH SNF RA rate was 24.99%. In FY 2014, the SNF RA rate decreased to 15.33%.
• Due to the success of the pilot, the CT team has expanded the program to include all SNFs in Frederick County.

Despite the success in RA rates, multiple barriers were encountered along the way. The CT team is offering an in-service to SNFs to help improve the discharge process to further reduce RA rates.

Figure 1: Barriers to Optimal Medication Management upon Transfer from SNF to Home

Table 1: Ideal Components of a SNF Discharge Medication List

<table>
<thead>
<tr>
<th>Component</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prescriptions</td>
<td>Medication list for SNF, painter list of all SNF medications, and medication summary</td>
</tr>
<tr>
<td>Medication</td>
<td>Medication lists, medications, and medications in a clear and concise manner</td>
</tr>
<tr>
<td>Instructions</td>
<td>Instructions for medication management, and instructions in a clear and concise manner</td>
</tr>
<tr>
<td>Transitions to Home</td>
<td>Transitions to home, medications to be taken, and medications to take at home</td>
</tr>
<tr>
<td>Home Health</td>
<td>Home health, medications to be taken at home, and medications to take at home</td>
</tr>
</tbody>
</table>

Figure 2: Discharge Medication Lists from Two SNFs in Frederick County

Patients had difficulty deciphering and understanding the SNF medication lists. It is essential to consider patients’ level of health literacy, social support, and ability to teach-back medication names, doses, and frequencies to ensure a safe transition into the community. 7

Table 2: SNF Discharge Medication Checklist

<table>
<thead>
<tr>
<th>Checklist Item</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medication List</td>
<td>List of medications, doses, and instructions</td>
</tr>
<tr>
<td>Medication Summary</td>
<td>Summary of medications, doses, and instructions</td>
</tr>
<tr>
<td>Instructions for Medication Management</td>
<td>Instructions for medication management, and instructions in a clear and concise manner</td>
</tr>
<tr>
<td>Transitions to Home</td>
<td>Transitions to home, medications to be taken, and medications to take at home</td>
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</table>

CONCLUSION

Our needs assessment found multiple opportunities to improve medication management as patients transfer from hospital to SNF and subsequently from SNF to home. Two opportunities include creating a patient-friendly discharge medication list and utilizing a SNF discharge checklist to ensure a safe transition.

REFERENCES


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DISCLOSURES

The authors have nothing to disclose.