Effective Medication Reconciliation Practices Reduce Hospital Utilization and Readmissions

Welcome!

- All lines are muted, so please ask your questions in chat
- For technical issues, chat to the 'Technical Support' Panelist
- Please actively participate in the poll that will pop up on the lower righthand side of your screen at the end of the presentation

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ALLIANT QUALITY

We will get started shortly!

Objectives

- Learn Today:
  - Identify the characteristics of an effective medication reconciliation process and when that process should occur in the acute care setting.
  - Understand a multi-disciplinary approach to medication reconciliation at an Inpatient Rehabilitation Facility.
  - Discuss best practices for medication reconciliation in the home setting to an address medication discrepancies and ensure patient safety during care transitions.
- Use Tomorrow:
  - What do you think?

Jennifer Massey, PharmD

TECH ADVISOR, MEDICATION SAFETY

Jennifer is the hospital quality medication safety technical advisor and the North Carolina community coalition coordinator for Alliant Quality. She has over 10 years experience in the acute care hospital setting as a clinical staff pharmacist; including code response, ICU, emergency department, pediatrics and the operating room pharmacy in hospitals across Arkansas, Alabama, and North Carolina. Her background gives her a unique perspective on medication safety and adverse drug events. She earned her PharmD from the University of Arkansas for Medical Sciences in Little Rock, Arkansas. She is a member of the North Carolina Association of Pharmacists and is part of their opioid transformation team.

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Hospital Admission – medication reconciliation/medication review/ BPMH

Hospital Discharge - medication reconciliation, patient education/counseling

Communication with Patient/Family/Home Health/SNF

Medication Review

- Age
- Weight
- Renal function
- Pertinent lab values
- Drug/dose/route/ frequency
- Drug-related side effect
- Actual or potential adverse drug events

Medication Reconciliation

- Complete and accurate list of medications
- Disease state considerations
- Prescribers
- Adherence
- Cost
- Prescribed vs. Reality

Best Possible Medication History (BPMH)

- Patient medication interview where possible
- Verification of medication information with more than one source as appropriate including:
  - family or caregiver
  - community pharmacists and physicians
  - inspection of medication vials
  - patient medication lists
  - medication profile from other facilities
- The BPMH includes drug name, dose, frequency and route of medications a patient is currently taking, even though it may be different from what was actually prescribed.

Medication Administration Record (MAR)

- Medication administration times
- Recently discontinued medications
- Medication refusal
- Medications that are started or stopped frequently

Hospital Specific Medication Issues

- Home meds not brought to the hospital
- Lack of family support/visitation
- Formulary constraints
- Therapeutic substitutions
- Holding or adding medications for procedures/surgery/lab values
- Transfers within the hospital

Discharge Medication Reconciliation

- ‘Resume Home Meds’
- Start early on the discharge med rec process
  - Multi-physician prescribing
  - Communicating with family
  - Coordinating with retail pharmacy
- Outpatient Pharmacy Services in hospital
  - Continuity of Care – is it worth it?
- Retail Pharmacy Considerations
  - Available Stock
  - Operating Hours
  - Location
  - Convenience Packaging

Convenience Packaging

Patient Education

- Review medications vs. counsel on medications
- Review medication discrepancies with patient
- Counsel on all new medications
  - What is it for
  - How often will the patient take it
  - How will it make the patient feel
  - Cost

Patient Education (Micromedex)

Metoprolol Tartrate

Drug Classes: Adrenergic | Adrenergic Blocker | All

Routes: **Intravenous** | **Oral**

Quick Answers | In-Depth Answers | All Results

Dosing/Administration
- Adult Dosing
- Pediatric Dosing
- FDA Uses
- Non-FDA Uses
- Dose Adjustments
- Administration
- Comparative Efficacy
- Place In Therapy

Medication Safety
- Contraindications
- Precautions

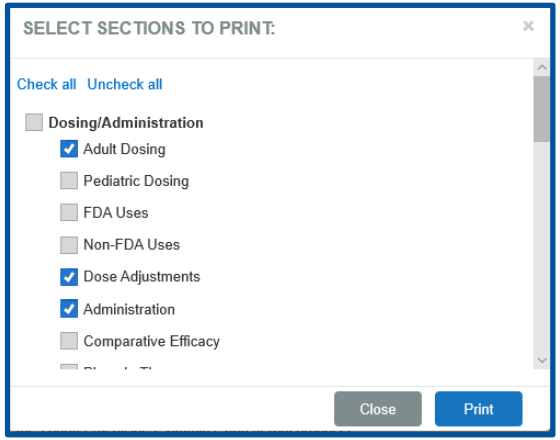
Patient Education

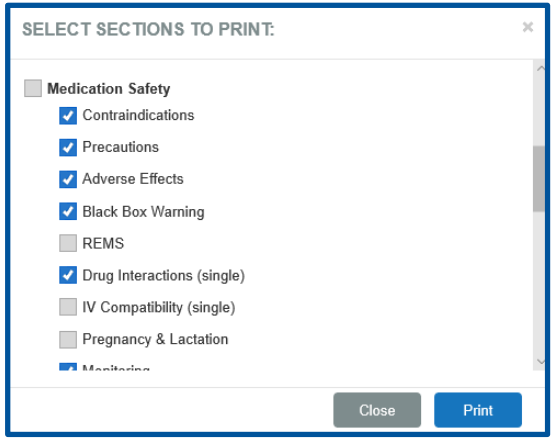
Medication Counseling

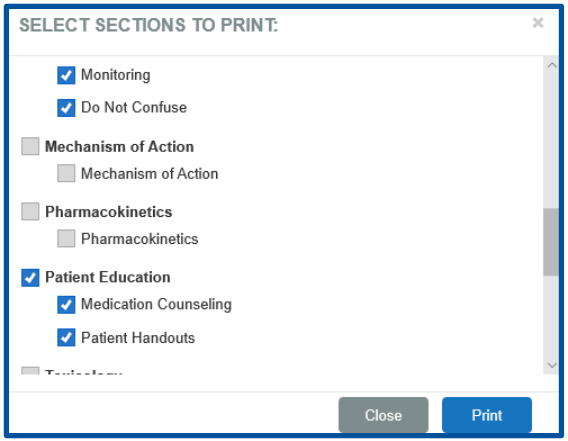
Print

- Patient should avoid activities requiring coordination until drug effects are realized, as drug may cause dizziness.
- This drug may cause diarrhea, depression, or fatigue.
- Advise patient to report signs/symptoms of cardiac failure. This drug may precipitate or exacerbate cardiac failure in CHF patients.
- Tell patient to report signs/symptoms of arrhythmias or hypotension.
- Drug may mask symptoms of hypoglycemia. Advise diabetics to report difficulties with glycemic control.
- Patient should take extended-release tablet with or immediately following meals.
- Advise patient against sudden interruption or discontinuation of drug, as this may exacerbate angina or cause myocardial infarction. Sudden discontinuation by patients with thyrotoxicosis may precipitate thyroid storm.
- Instruct patient to take a missed dose as soon as possible, but if next dose is in less than 4 h, skip the missed dose.

Patient Education (Micromedex) (continued)

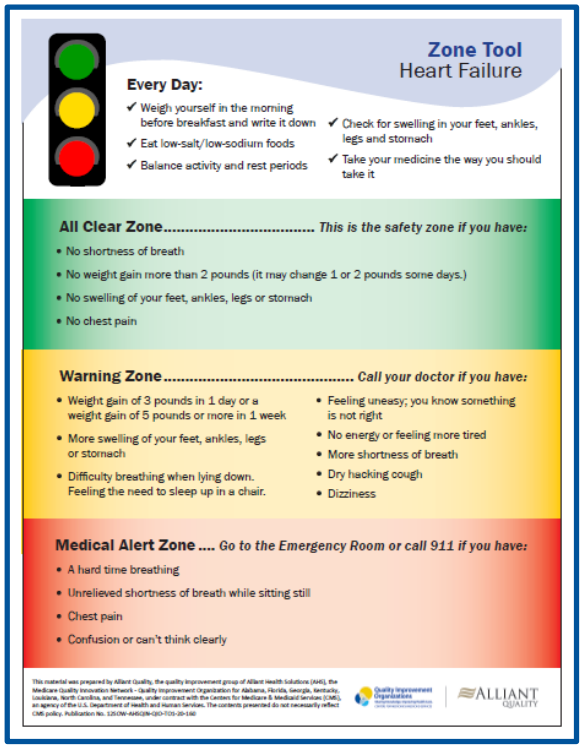






Patient and Family Education

- Zone Tools
  - CHF
  - PNA
  - COPD
  - Diabetes
  - TKR/THR



Zone Tool
Heart Failure

Every Day:

- ✓ Weigh yourself in the morning before breakfast and write it down
- ✓ Eat low-salt/low-sodium foods
- ✓ Balance activity and rest periods
- ✓ Check for swelling in your feet, ankles, legs and stomach
- ✓ Take your medicine the way you should take it

All Clear Zone ..... *This is the safety zone if you have:*

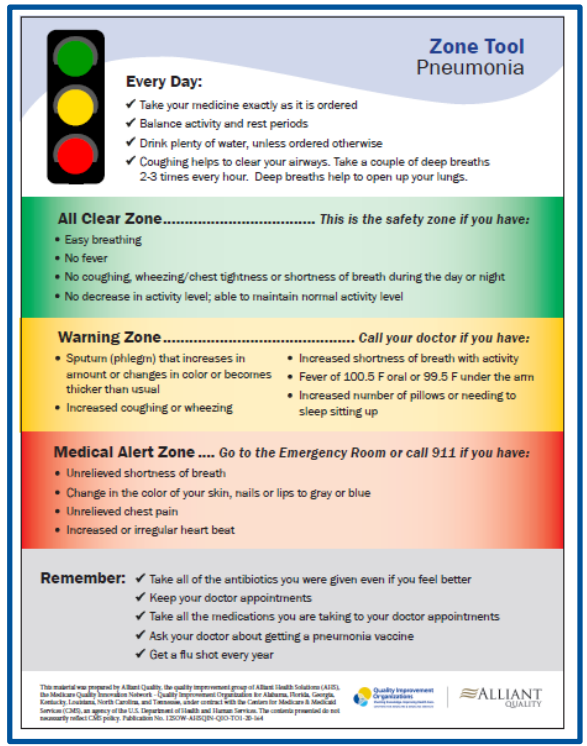
- No shortness of breath
- No weight gain more than 2 pounds (it may change 1 or 2 pounds some days.)
- No swelling of your feet, ankles, legs or stomach
- No chest pain

Warning Zone ..... *Call your doctor if you have:*

- Weight gain of 3 pounds in 1 day or a weight gain of 5 pounds or more in 1 week
- More swelling of your feet, ankles, legs or stomach
- Difficulty breathing when lying down. Feeling the need to sleep up in a chair.
- Feeling uneasy; you know something is not right
- No energy or feeling more tired
- More shortness of breath
- Dry hacking cough
- Dizziness

Medical Alert Zone .... *Go to the Emergency Room or call 911 if you have:*

- A hard time breathing
- Unrelieved shortness of breath while sitting still
- Chest pain
- Confusion or can't think clearly



Zone Tool
Pneumonia

Every Day:

- ✓ Take your medicine exactly as it is ordered
- ✓ Balance activity and rest periods
- ✓ Drink plenty of water, unless ordered otherwise
- ✓ Coughing helps to clear your airways. Take a couple of deep breaths 2-3 times every hour. Deep breaths help to open up your lungs.

All Clear Zone ..... *This is the safety zone if you have:*

- Easy breathing
- No fever
- No coughing, wheezing/chest tightness or shortness of breath during the day or night
- No decrease in activity level; able to maintain normal activity level

Warning Zone ..... *Call your doctor if you have:*

- Sputum (phlegm) that increases in amount or changes in color or becomes thicker than usual
- Increased coughing or wheezing
- Increased shortness of breath with activity
- Fever of 100.5 F oral or 99.5 F under the arm
- Increased number of pillows or needing to sleep sitting up

Medical Alert Zone .... *Go to the Emergency Room or call 911 if you have:*

- Unrelieved shortness of breath
- Change in the color of your skin, nails or lips to gray or blue
- Unrelieved chest pain
- Increased or irregular heart beat

Remember:

- ✓ Take all of the antibiotics you were given even if you feel better
- ✓ Keep your doctor appointments
- ✓ Take all the medications you are taking to your doctor appointments
- ✓ Ask your doctor about getting a pneumonia vaccine
- ✓ Get a flu shot every year

Stephanie Morrell RN-BC, MSN/LM, CRRN

CHIEF NURSING OFFICER

Stephanie is the chief nursing officer (CNO) at Encompass Health, formerly HealthSouth Rehabilitation Hospital of Altamonte Springs. Stephanie has 25 years of experience in healthcare; including an in-depth clinical background in cardiology, orthopedics, med-surg, and pediatrics. She has spent the past 17 years in hospital administration and served as the CNO of Encompass Health Rehabilitation Hospital of Southwest Virginia prior to moving to Florida. Stephanie has a certification in medical surgical nursing through the American Nurses Credentialing Center and is a Certified Registered Rehabilitation Nurse. She received her Bachelor of Science in nursing through East Tennessee State University in Johnson City, Tennessee, and Master of Science in nursing with a management leadership focus from Western Governors University in Salt Lake City, Utah. Her leadership vision is to create a collaborative atmosphere where care is delivered at a high level of professional standards and where employee contributions and job satisfaction are valued. Her mission is to provide safe, quality and compassionate care that promotes maximum independence for people living with illness or disability.

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Matthew Dieter, PHARM.D

DIRECTOR OF PHARMACY

Matthew Dieter is the director of pharmacy for Encompass Health, formerly HealthSouth Altamonte Springs. He has been with HealthSouth since 2006 and has more than 20 years of experience in the hospital pharmacy setting; including inpatient rehabilitation, long-term acute care and small community hospitals in Orlando, Gainesville, and southwest Florida. His professional interests and specialties include the areas of infectious disease, anticoagulation and nutrition. Matt earned his doctorate of pharmacy degree from the University of Florida in Gainesville, Fla. He is a member of FSHP (Florida Society of Health-System Pharmacists). Matt's goal is to provide comprehensive, quality care to the patients he serves.

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How Medication Reconciliation Can Reduce Hospital Utilization and Readmissions: *The MRSG Process*

Stephanie Morrel and Matthew Dieter

Objectives (continued)

- Learn Today:
  - Understanding a multi-disciplinary approach to medication reconciliation at an IRF
  - Understanding the value of involvement of pharmacist in medication reconciliation process
- Use Tomorrow:
  - Improve transition of care and awareness to decrease readmission rates
  - Improve awareness of different types of errors that can arise with the medication reconciliation process

MRSG: Mark, Ready, Set, GO!

- This is a 4-day, multidisciplinary process that is followed with the last 4 days of a patient's inpatient rehabilitation stay. (Typically 10-14 day length of stay).
- Mark Day starts 4 days / 96 hours prior to discharge, followed by Ready (3 days), Set (2 days – the day before), and GO (the day of discharge).
- **Disciplines involved are hospital wide**: Physicians, Case Management, Therapy, Nursing, Respiratory, Pharmacy, Dietary, and Wound Care

MRSG: Medication Reconciliation

Why is medication reconciliation important?

- Errors! Human processes and multiple steps in each process

- Medications doses changed during stay
- Medications stopped / started
- Duplication of medications and therapy
- Hospital therapeutic substitutions not converted back
- Home medications needing to be resumed
- Hospital medications converted to home medications
- Completed therapies continued
- Duration of therapy not stated (antibiotics)
- Inaccurate medication histories
- Lack of physician investment and interest in the process

MRSG: Medication Reconciliation (continued)

What other factors are important to be aware of to decrease readmission?

Transitions of care:

- Converting insulins back to oral diabetes medications
- IV to oral conversion of antibiotics
- Conversion of nebulizers back to inhalers / home inhalers

Patient / Family Education:

- Anticoagulants (Warfarin teaching, INR follow-ups, dietary education)
- Enoxaparin administration (self or via caregiver)
- Insulin (new start) education and demonstration

Medication Access:

- Controlled Substance access and availability can be a challenge
- Medications requiring prior authorization (newer anticoagulants)
- Medications costs / not covered medications (convert prior to discharge)

MRSG: Discharge Med Reconciliation

Medication reconciliation is a physician driven process.

- MRSG has the expectation that the medication reconciliation is completed at least 48 hours prior to discharge.
- Completion in a timely manner allows hospital disciplines to focus on discharge objectives and educate from a finalized list:
- Pharmacy reviews medication reconciliation for errors and omissions
- Nursing and Pharmacy can educate patients and families on medications (both in person and by adding personalization and customization to depart paperwork)
- Pharmacy can help resolve transition of care concerns
- Pharmacy has time to resolve med rec issues with physicians and patients
- Nursing can teach and demonstrate injections like insulin and enoxaparin

MRSG: Discharge Med Reconciliation

What else? What make this process happen efficiently?

- **Physician accountability:** rates of timely completion on scorecard
- **Case management**: updates to discharge calendar (virtual and printed)
- **Pharmacy**: Contact with providers to ensure timely completion
- **Nursing**: reviews and gives prescriptions (new, continued, and stopped), reviews depart education with patient / caregivers, returns home medications upon discharge

Mark Ready Set Go!

Outcomes:

- Hospital completes 77% (6 month trailing of 2020) of discharge medication reconciliations at least 24 hours prior to a discharge, and is a leader in this measure for our company and region.

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Encompass Health

Rehabilitation Hospital of Altamonte Springs

Kellie Newman, BSN, RN, CHPN

NATIONAL PATIENT CARE ADMINISTRATOR

Kellie is a registered nurse and National Patient Care Administrator with VITAS Healthcare. She is a veteran of the United States Air Force and traveled the world before settling in the Chicago suburbs and completing nursing school. She began her nursing career in a community hospital where she met her first nursing love – Wound, Ostomy, and Continence Nursing. An experience with a long-time wound and ostomy patient there would change her life forever. She walked into his hospital room for a visit and discovered he was there with his family and hospice staff, taking his last breaths. The care she witnessed, both for the patient and for his family, would lead her to a career change and to her lasting nursing love – hospice. She has worked for VITAS Healthcare for over 11 years creating policies, procedures, and standards to ensure clinical integrity of each care location. She truly loves mentoring and developing clinical leaders and sharing knowledge and best practices.

Kellie now lives in Tampa with her husband and two huge dogs and enjoys visits with her two beautiful adult daughters.

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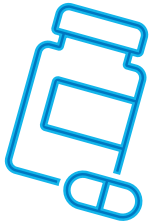
Case Example

- Hospital discharge with new insulin regimen
- Insulin 70/30 at home
- Patient continued both once home

Importance

- Ensure therapeutic benefit of regimen
- Maintain patient at chosen location of care
- Reduce hospital readmissions

Medication Compliance



- 10-70% of patients don't take medications as prescribed
- Adherence to chronic medication regimen is ~50%
- Up to 25% of hospital admission result from improper medication administration

Home Care Challenges

- Multiple comorbidities
- Multiple providers
- Lack of structure and control

When to Reconcile

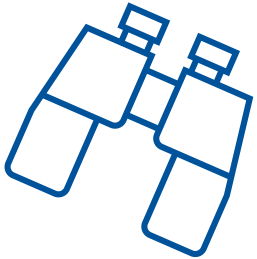
- After each patient visit to healthcare provider
- After each transition of care
- Every visit

Reconciliation Best Practices

- Set expectations
- Pull out all medication bottles
- Review medication bottles

What to Look For

- Duplication of medication
- Dangerous medication
- Medication no longer therapeutic
- Potential interactions



What Can We Do?

- Clear information across care settings
- Engage the patient and caregiver
- Establish standards of practice
- Address discrepancies
- Evaluate effectiveness of practices
- Utilize interprofessional model of care
- Electronic medical record

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- Use Tomorrow:
  - What do you think?

Complete this sentence in Chat: *I will…*

CMS 12th SOW Goals

Behavioral Health Outcomes & Opioid Misuse

- ✓ Promote opioid best practices
- ✓ Decrease high dose opioid prescribing and opioid adverse events in all settings
- ✓ Increase access to behavioral health services

Patient Safety

- ✓ Reduce risky medication combinations
- ✓ Reduce adverse drug events
- ✓ Reduce C. diff in all settings

Chronic Disease Self-Management

- ✓ Increase performance on ABCS clinical quality measures (i.e., aspirin use, blood pressure control, cholesterol management, cardiac rehab)
- ✓ Identify patients at high-risk for developing kidney disease & improve outcomes
- ✓ Identify patients at high risk for diabetes-related complications & improve outcomes

Quality of Care Transitions

- ✓ Convene community coalitions
- ✓ Identify and promote optical care for super utilizers
- ✓ Reduce community-based adverse drug events

Nursing Home Quality

- ✓ Improve the mean total quality score
- ✓ Develop national baselines for healthcare related infections in nursing homes
- ✓ Reduce emergency department visits and readmissions of short stay residents

Making Health Care Better *Together*

Georgia, Kentucky, North Carolina and Tennessee
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Alabama, Florida and Louisiana
Jeana Partington
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Program Directors

Upcoming Events

Nursing Homes
Tuesdays, 2pm ET/1pm CT

Community Coalitions
Thursdays, 12:30 pm ET/11:30am CT

December 15th, 2020: Preventing Healthcare Acquired Infections	December 17th, 2020: Gear up for the New Year! Positioning your Organization to Gather, Track, and Use Data in 2021
January 2021: TBD	January 2021: TBD

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