Reducing Hospital Readmissions: The Importance of Medication Management

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Objectives of Presentation:
At the conclusion of this presentation, participants will see the potential the healthcare community has to continue to reduce the number of readmissions when focusing on medication management and utilizing community resources.

Education Points
- Targeted readmission diagnoses
- Systems to assist in reducing readmissions
- Contributing factors to readmissions
- Medication Management at a higher level

The Hospital Readmission Reduction Program
- The Hospital Readmission Reduction Program was created by the Patient Protection and Affordable Care Act. The HRRP is a reimbursement penalty approach for general acute care hospitals that have readmissions deemed "excess" by CMS.
- Fiscal year 2013 marked the starting point of potential penalizations for general acute care hospitals
  - 2013: Up to 1% of all Medicare Revenue
    (Dx: Heart Attack, Heart Failure, Pneumonia)
  - 2014: Up to 2% of all Medicare Revenue
    (Dx: Heart Attack, Heart Failure, Pneumonia)
  - 2015: Up to 3% of all Medicare Revenue
    (Dx: Heart Attack, Heart Failure, Pneumonia AND Chronic Obstructive Pulmonary Disease, Total Hips and Total Knees)

Number of Hospitals Receiving Penalizations

- Fiscal 2013 (1%): 2217
- Fiscal 2014 (2%): 2255
- Fiscal 2015 (3%): 2610

http://www.modernhealthcare.com/article/20141002/NEWS/310029947

Transitioning to a Patient-Centered Model

System Initiatives That Assist in Reducing Readmissions

- Social Worker/Case Manager establish PCP follow up appointment
- Physicians can bill for Transitional Care Billing and Chronic Care Management
- Integrated Transitional Care Strategy when discharging from SNF/Hospital
- Utilization of Home Care Services
Establishing PCP follow up appointment

- Among Medicare beneficiaries requiring readmission within 30 days of discharge, only 50% had seen a clinician for a follow up visit.

- In a study of 225 hospitals, it was found that rates of readmission within 30 days were lower when their Medicare patients followed up with their PCP within 7 days of discharge.

New billing codes for physician offices

- Transitional Care Management
- Chronic Care Management

Transitional Care Management

- In 2013, the Centers for Medicare and Medicaid Services (CMS) estimated that two-thirds of all hospital discharges would be eligible for Transitional Care Management (TCM) services.

- Additionally, CMS estimated that TCM reimbursements would generate:
  - 4% increase in payments to family practice physicians
  - 3% each for internal medicine and pediatrics
  - 2% each for gerontologists, nurse practitioners and physician assistants.


TCM codes 99495 and 99496 are used to report physician or qualified non-physician practitioner care management services for a patient following the patient's discharge from:
- Inpatient hospital
- Observation status in a hospital
- SNF
- Community mental health center

- Home
- Independent Living
- Assisted living
- Long-term Care

Proper billing for TCM services using the 99495 code must include:
- Communication (direct contact, phone, or electronic) with the patient and/or caregiver within 2 business days of discharge;
- Face-to-face visit within 14 calendar days of discharge; and medical decision-making of at least moderate complexity during the service period.

Proper billing for TCM services using the 99496 code must include:
- Communication (direct contact, telephone, or electronic) with the patient and/or caregiver within 2 business days of discharge;
- Face-to-face visit within 7 calendar days of discharge; and medical decision-making of at least high complexity during the service period.

Billing Codes for Transitional Care Services

CCM requires at least 20 minutes of time per calendar month by clinical staff in order to bill for CPT code 99490.

Who qualifies as clinical staff?
- Physician
- Physician assistant
- Nurse practitioner
- Clinical nurse specialist
- Certified nurse midwife


https://www.cms.gov/Medicare/Medicare-Fee-for-Service/Payment/ChronicCareManagement/downloads/Chronic-Care-Management-FAQ.pdf
Qualifications for CCM

- Multiple (two or more) chronic conditions expected to last at least 12 months, or until the death of the patient,
- Chronic conditions place the patient at significant risk of death, acute exacerbation/decopensation, or functional decline,
- Comprehensive care plan established, implemented, revised, or monitored.


No Shortage of People….

- Alzheimer’s disease and related dementia
- Arthritis (osteoarthritis and rheumatoid)
- Asthma
- Atrial fibrillation
- Autism spectrum disorders
- Cancer

Chronic Conditions
(included but not limited to)

- Chronic Obstructive Pulmonary Disease
- Depression
- Diabetes
- Heart failure
- Hypertension
- Ischemic heart disease
- Osteoporosis

CCM Scope of Service Elements - Highlights

- Structured recording of patient health information
- Electronic care plan addressing all health issues
- Access to care management services
- Managing care transitions
- Coordinating and sharing patient information with practitioners and providers outside the practice.


Benefits of utilizing TCM and CCM

Increased communication among healthcare providers will lead to pre-acute services being utilized at a higher level. This will decrease the number of ER visits and hospitalizations while providing a higher quality of life for each patient.

Integrated Transitional Care Strategy

Offering a higher standard of care by structuring a continuous flow of communication between providers, which will enhance patient satisfaction and outcomes.
Identify Resources for Patients Discharging to Community

- Medication Management
- Home Health
- Hospice
- Private Duty Nursing
- In-Home Services & Consumer Directed Services (Medicaid Eligible Patients)
- Outpatient Therapy

Studies show that persons who live alone have a 50% greater chance of readmission compared to those living with others.

Risk factors that increase the opportunity for a readmission

- Clinical risk factors
- Demographic and logistical risk factors

Clinical Risk Factors for Readmissions

- Medication
  - Polypharmacy (5+ medications)
  - Poor communication upon transition from one healthcare setting to another
  - Use of high risk medication
    - Antibiotics
    - Glucocorticoids
    - Anticoagulants
    - Narcotics
    - Antiepileptic medications
    - Antipsychotics
    - Antidepressants
    - Hypoglycemic agents

- More than 6 chronic conditions
- Specific clinical conditions
  - COPD
  - Diabetes
  - Heart failure
  - Stroke
  - Cancer
  - Weight loss and Depression

http://www.upToDate.com/contents/hospital-discharge-and-readmission
Demographic and Logistical Risk Factors For Readmissions

• Location of Hospital
  
  A study in Health Services Research included data collected from 4,073 hospitals in 2,254 counties. Analysis showed that 58% of variation was at the county level. When demographic information was analyzed, having more general practitioners and more nursing homes per capita in a county resulted in a lower readmission rate.

• Socioeconomic Factors
  
  Associates with the Center for Health Policy and Health Services Research at Henry Ford Health System, in Detroit, Michigan conducted a study concerning more than 7800 hospitalizations among Medicare fee-for-service (year 2010) patients ages 65+ and determined that patients living in high poverty neighborhoods were 24% more likely to have a readmission.

http://www.cfah.org/hbns/2014/community-demographics-linked-to-hospital-readmissions

Did you know?

Medication Management
A component that is often overlooked or only given oversight for a limited amount of time is medication management.

40% of adults (65+) take 5-9 medications
18% take 10+ medications

Adverse Drug Effects

Each year, there are nearly 100,000 emergency hospitalizations for adverse drug events in U.S. adults aged 65 years or older.

Almost half (48.1%) of these hospitalizations occur among adults aged 80 years or older.

Two-thirds (65.7%) of the hospitalizations were due to overdoses, or to situations in which patients may have taken the prescribed amount of medication but the drug had more than the intended effect on the patient’s body.

Four Types of Medication Accounted For 2/3 of These Hospitalizations

1. **Warfarin**: An anticoagulant medication used to treat blood clots—33%
2. **Insulin**: Insulin injections are used to control blood sugar in people who have diabetes—14%
3. **Antiplatelet drugs**: such as aspirin or clopidogrel: prevent platelets or pieces of blood cells from clumping together to start a clot—13%
4. **Oral hypoglycemic agents**: diabetes medication taken by mouth—11%

Reminder of Diagnoses Targeted For Readmissions

- Chronic Obstructive Pulmonary Disease
- Heart Attack
- Heart Failure
- Pneumonia
- Elective Total Hip Arthroplasty and Total Knee Arthroplasty
Cardiac Medications

- Anticoagulants
- Antiplatelet Agents
- Angiotensin-Converting Enzyme (ACE) Inhibitors
- Angiotensin II Receptor Blockers (or Inhibitors)
- Angiotensin-Receptor Neprilysin Inhibitors (ARNIs)
- Beta Blockers
- Combined alpha and beta-blockers
- Calcium Channel Blockers
- Digitalis Preparations
- Diuretics
- Vasodilators

Common Discharge Medications For Elective Total Hip Arthroplasty and Total Knee Arthroplasty

- NSAIDS, such as Ibuprofen or Naproxen
- Antibiotics
  - Anticoagulants

  Something to consider is that these medications are in addition to the patients current medication regimen.

COPD Facts

- High number of comorbid conditions
- Over 30% take 5-10 prescribed medicines daily.
- Over 25 percent take 11+ medicines daily.
- Compared to people without COPD, people with COPD are more likely to be put in the hospital with angina, heart attacks, fibrillation, heart failure and blood clots.
- More likely to develop diabetes

So even though COPD is not typically treated with the drugs that account for the majority of hospitalizations there is a good chance they have a comorbidity that is, whether that is heart failure or diabetes.

http://www.webmd.com/lung/copd/the-importance-of-comorbidities
Diabetes

- More than 25% of the over 65 population has diabetes.
- Projections suggest that the number of cases of diagnosed diabetes in those aged ≥65 years will increase by 4.5-fold (compared to 3-fold in the total population) between 2005 and 2050.
- Older adults with diabetes have the highest rates of major lower-extremity amputation, myocardial infarction, visual impairment, and end-stage renal disease of any age-group.
- Those aged ≥75 years also have double the rate of emergency department visits for hypoglycemia than the general population with diabetes.
- Delirium is a common complication seen in older adults during and after hospitalization and may require more supervision to avoid errors in dosing. [Link](http://care.diabetesjournals.org/content/35/12/2650.full)

What Does This Mean For The Future of Healthcare?

- As our geriatric population grows, so will the number of potential hospitalizations and readmissions.
- A large percentage of people have one or more of the disease processes that are being targeted for readmissions.
- A significant amount of those people and others are taking medications that put them at an increased risk of hospitalization.
- The number of prescriptions people are taking also put them at risk for hospitalizations:
  - Each new medication added to someone’s regimen, adds more than one additional adverse drug event per year. Taking 6+ medications increases this fourfold. [Link](http://www.aafp.org/afp/2013/0301/p331.html)

What Else Can be done?

What are some resources people can utilize to help avoid a hospitalization?
**Definition**
Facilitation of safe and effective use of prescription and over-the-counter drugs.

**Medication Nonadherence**
- 75% of Americans do not always take prescription medications as prescribed
- 20% of older adults report not filling or delaying filling prescriptions
- 31% of people taking prescriptions skip doses
- 37% do not finish taking all prescription medications as instructed
- 23% of patients report they do not refill their prescriptions as instructed
- $100 billion per year in economic costs are associated with hospital readmissions due to poor medication adherence

**Common Reasons For Nonadherence**
- Number of medications
- Cost of prescriptions
- Inaccurately communicating with physician(s) what medications are being taken (including over the counters)
- Can’t remember to take prescriptions
- Can’t see/read the prescription bottles
- Fears side effects
- Asymptomatic

[Link](http://www.rand.org/pubs/technical_reports/TR765.html)
The Solution?  
A Medication Management Program

Case Study:  
The MedPak Program

The MedPak Program

- The MedPak program is an innovative medication management program that ensures people take the right medication at the right time every time.
- The MedPak was designed with the intent of helping people be successful in their medication management thereby allowing them to remain independent for a longer period of time.
- The MedPak reduces clinic and ER visits and hospital readmissions due to increased compliance.

The MedPak

- Contains a 30-day supply of medications in pre-sorted packets based on the time of day the medications are to be administered.
- Each packet lists:
  - Patient’s name
  - Date
  - Day of the week
  - Time of day
  - How many packets are to be taken at that time of day
  - Name of all medications in each packet.
Program Components

- **Medication Nurse Consultant**
  - A Medication Nurse Consultant conducts a home visit when admitting each client to the pharmacy.
  - Available to assist with medication changes

- **Pharmacy Support Staff**
  - The staff at the pharmacy works with the physicians and insurance companies to synchronize all medications so everything comes due at the same time.
  - Each client is called every month to discuss possible medication changes.
  - The pharmacy manages the refills for clients.
  - The pharmacy utilizes a courier service to deliver medications.

- **Pharmacists**
  - Completes detailed medication review each month.

People who would benefit from The MedPak medication management

- Chronic Care Management patients
- Takes 5+ stabilized medications
- Frequent Flyers
- Has difficulty getting to the pharmacy
- Multiple co-morbidities
- Has limited/no family support
- Struggles with managing medications

How a medication management program helps people become more successful

- Increased adherence with daily oral medications by utilizing the MedPak program.
- Inhalers, PRN medications, and all other medications that are not housed in the MedPak will be delivered at the same time the MedPak is delivered so there is no break in the medication regimen.
- Medication Nurse Consultants are available to complete medication reconciliation after a hospitalization and to assist with changes.
- The MedPak reduces medication errors and increases adherence.
- Medication Nurse Consultants assist in identifying additional needs of clients after completing initial home visit.
What do clients say?

“Finally a medication management system with ME in mind!”
--Francis, Medication Management client

Questions?