Medication Reconciliation in the Home Care Setting
Why is Medication Reconciliation so Important?

- #1 problem in treating illnesses is patients’ failure to take prescribed medications correctly, regardless of age.
- 50-70% of patients do not take medications properly
- 10% of hospital admissions relate to taking meds properly, 23% of all nursing home admissions
Statistics

- 67% of Medicare beneficiaries’ drug lists at discharge had discrepancies
- 44% of Medicare patients have at least one unnecessary drug after discharge
- 33% of frail elderly beneficiaries had one or more adverse drug reaction post discharge
- 60% of frail elderly patients fail to meet their full prescribed medication therapy post discharge
Learning Objectives

- Identify best practices for medication reconciliation in the home care setting
- Describe the use of a pharmacist to improve staff knowledge and competence with medication reconciliation and management
- Discuss how to use medication reconciliation to align with the medical home model
Our Agency

- Established in 1899
- Service 35 Communities in central New Hampshire
- 330 employees
- $24 Million Dollar Operating Budget
Goals for Our Program

• Improve the quality of medication reconciliation upon admission
• Decrease the re-hospitalization rate during the first 30 days
• Improve patient experience
• Improve OBQI medication management scores
• Demonstrate value to hospital partners
Step One Improving Staff Quality

• First step in our process was to improve the quality of the medication reconciliation process for all professional staff including home care/hospice/pediatric nursing and therapy staff
Identified Staff Education Needs

• Formal education of process for performing reconciliation based on best practice guidelines
• Review of health literacy barriers to identify during the reconciliation process
• Practical application of medication reconciliation process in the field setting
Staff Learning Objectives for Education

• Staff would demonstrate how to complete a medication reconciliation based on best practice guidelines

• Staff would verbalize how to resolve medication discrepancies, duplications and or interactions during the reconciliation process

• Staff will verbalize how health literacy problems impact medication compliance
Process used for Education

• Formal interactive presentation developed as a clinical competency for professional staff. Pre and post test included.
  – Presentation included
    • Rationale for why medication reconciliation is important to providing quality care
    • Explained in detail the 3 step process for improving medication reconciliation
    • Discussed barriers patients may have when taking medications and ways to overcome them
Practical application

• All professional staff were required to have a field visit with their director or clinical educator to demonstrate a proper medication reconciliation.
• Field visit was required to be a admission visit
• Supervisors were given a checklist tool to help them validate staff.
Ongoing Education

• Medication reconciliation competency is part of new staff orientation
• Reviewed yearly and as needed with existing staff
• Ongoing medication education given
2 Day Admissions for Patients identified as High Risk for Re-Hospitalization

- Patients identified as a risk for re-hospitalization using screening tool while still in hospital
- Scheduled for a 2 day admission visit
- Goals is to have more time to provide quality medication reconciliation, assessment and teaching with follow up next day
- Process developed for one nurse performing both visits or a different nurse performing each visit
  - Same nurse is the goal
Pharmacy Consultant Pilot Project

• Grant received from NH Charitable Foundation for one year for a 4 hour a week pharmacy consult
• Main goals of project included
  – Reduce avoidable hospitalizations for patients with chronic illness
  – Improve medication reconciliation process
  – Improve patients management of oral medications
  – Increase our patient’s knowledge about how to manage their medications
Pharmacy Project Scope

• Provide advice on medication-related policies and procedures
• Medication information and education for clinical staff
• Medication reviews
• Clinical advise on specific patient issues
Pharmacy Formal Education for Clinical Staff

• Medication Reconciliation and identification of interactions/ duplicate therapy
• High risk medications
• Disease specific medications
  – Example Coumadin management for therapists
  – Heart failure medications
• New medications
Complex Care Patient Review Process

• New process developed for patients with multiple medications or at risk for re-hospitalization
• 8 patients weekly identified by staff, directors or telehealth nurse
• Pharmacist role
  – Review clinical documentation and medication profile prior to team meeting
  – Offer advice on individual patient medication therapy, assist with care planning, clinical monitoring and patient education during meeting.
Complex Care IDT Process

• Case Manager Role
  – Come to meeting prepared using SBAR format
  – Responsible to follow up with MD with recommendations made during IDT
  – Responsible for adjustment to care plan based on recommendations during the IDT meeting
Outcome Measures Tracked as Part of Pharmacy Pilot

- Reduction in acute care hospitalization using home health compare/SHP
- Improvement in our medication reconciliation process (M2000) using home health compare/SHP
- Improvement in management of oral medications (M2020) using home health compare/SHP
- Improvement in patient satisfaction as reported on HHCAHPS survey
Outcome Results to Date

• Re-hospitalizations have been reduced from 27% to 25%,
• Patients' ability to take oral medications correctly has increased from 38% to 49%,
• Patient satisfaction on specific care issues has increased from 81% to 87%.
Step Three: Demonstrate Value to the Medical Home

• Concord Regional VNA joined together in a project with Dartmouth-Hitchcock Concord to reduce acute re-hospitalizations of at risk patients.

• Goal to improve care coordination and care management that will support self-care management, improve care cost-effectiveness and improve patient’s intended outcomes of care.
Target Patient Population

• Patients with risk for re-hospitalization
  – Eligible patients will have 2 or more risk factors including but not limited to poor self-management, multiple chronic illnesses, polypharmacy or recent hospital admission
Program History

• Program started in Feb 2012
• Position developed through the CRVNA for a Home Health Care Coordinator Nurse to work with the Dartmouth primary care practice
• Pilot group identified at physician practice of 1 team (three physicians)
Data to Support The Service Need

Readmissions within 30 days

- 1 - 5 Days: 22
- 6 - 10 Days: 16
- 11 - 15 Days: 9
- 16 - 20 Days: 14
- 21 - 25 Days: 13
- 26 - 30 Days: 246

Total: 246
Program Core Services

• A chart review of hospitalized patients for inclusion in the program
• CRVNA Hospital Liaison will meet with eligible patients and offer the program
• A dedicated Home Health Care Coordination Nurse will be identified for each patient for the duration of service provision.
Core Services Medication Reconciliation

• Initial home visit on the same day as hospital discharge/referral occurring before 1pm; a home visit on the next day as hospital discharge/referral occurring after 1pm

• Initial assessment will include medication reconciliation and identification of any barriers to care
  – If the patient is homecare eligible, this visit is separate from the SOC visit by a homecare nurse
Core Services

• Will ensure a Physician follow-up visit is scheduled for patients post-hospitalization
• Will provide regular communication to the designated Medical Home Care Coordinator. This communication will follow the SBAR method and will occur no less frequently than weekly
Communication

• Means of communication:
  – Ability to access the practice EMR (centricity) and physician portal
  – Centricity flags used for medication reconciliation/updates or questions for DH Team Nurse to manage and update patient records.
  – Face to face meetings- weekly
Core Services

• If patient qualifies for homecare, a follow-up home visit after the medication reconciliation visit will be completed by the home care case manager to complete the OASIS documentation and the plan of care.

• Implement tele-monitoring unless patient opts-out/isn’t qualified. Where possible, tele-monitoring would be introduced to patient’s pre-hospital discharge.

• While patient is enrolled in program all patient status and medication questions/changes will be coordinated thru the HHCC Liaison.
Discharge Criteria from Program

• Discharge criteria from program
  – 30 days if stable
  – For those with hospitalization/ER visits, med changes, symptom management issues or fall discharge after stable 2 weeks post event
Outcome Measures

• Patient satisfaction survey results
• Re-admission rates-actual and those prevented
• Emergency Room visits-actual and those prevented
• Reduction in medication errors during transitions in care
• Improvement in medication management as reported on the Home Care OASIS
Pilot Findings 2/1/12-9/28/12

- Total Patients served = 140
- Total Visits performed= 104
- 80% of medication reconciliation visits identified medication issues
  - Medication issues further defined as patient level issues or system level issues for trending
  - Medication Reconciliation note developed to capture information
Medication Reconciliation Note

Identifiers

Patient Level:

- Adverse drug reaction or side effects
- Difficulty keeping up with multiple medications and complex dosing schedules
- Money/financial barriers
- Taking incorrect dosage
- Outdated medication list
- Sight/dexterity limitation/cognitive impairment
- Intentional non-adherence
- Number of medication errors ______
- Other__________________

System Level

- Prescribed with known allergies/intolerance
- PCP not aware of medications prescribed by other providers
- Conflicting information from different informational sources
- Generic and brand names duplicated on medication profile
- Discharge instructions incomplete/inaccurate/illegible
- Duplicate medication orders
- Incorrect dosage
- Incorrect quantity
- Incorrect label
- No caregiver/need for assistance not recognized
- Sight/dexterity limitations not recognized
- Other__________________
Medication Reconciliation Note

Interventions

Resolution/hospital avoidance:

- Medications reconciled with PCP
- Follow up visit with PCP
- Increase in SN visit frequency
- SN PRN visit
- Adjustments to medications
- Home care episode started
- Referral for MSW
- Medication education
- Mediplanner set up
- Patient provided updated medication list
- Problem resolved with pharmacy within 24 hrs
- Caregiver assuming responsibility for medications identified
- Other

Interventions resulted in resolution of symptoms and hospital avoidance?

- Yes
- No
Comparison Data of our Pilot Physician Group

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Program Expansion

• Program expansion from pilot phase as of 10/1/12.
• Expansion to entire Concord Dartmouth practice as of 11/15/12
• Practice consists of 14 primary care physicians and 5 primary care ARNPs
Video For Robert Wood Johnson Foundation

Conclusion

• Quality medication reconciliation practice will impact outcomes:
  – Decrease the ACH rate during the first 30 days
  – Improve patient satisfaction scores
  – Improve OBQI medication management scores
  – Demonstrate value to physician practices as a collaborative member of medical home