

Alternate Site Pharmacies

White Paper

Medicare Initiative to Reduce Hospital Readmissions: Implications for LTC Pharmacy

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Executive Summary

Within the Affordable Care Act (ACA), the Centers for Medicare and Medicaid Services (CMS) created the Hospital Readmissions Reduction Program. The goal of this program is to reduce preventable hospital readmissions within 30 days of discharge. Hospitals with above average readmission rates will have a cut in their Medicare reimbursement. Approximately 40% of Medicare patients are discharged from the hospital and admitted to a skilled nursing or rehabilitation facility, therefore these facilities are critical to reducing hospital readmissions. The long-term care pharmacy (LTC) has an important role in effectively managing the drug therapy of those residents at risk for hospital readmission.

This white paper will provide an overview of the Hospital Readmissions Reduction Program, discuss the effect of this program on skilled nursing facilities (SNFs) and LTC pharmacy, and provide examples and strategies that can help LTC pharmacies meet the needs of their SNFs and referral hospitals.

McKesson convened an alternate site advisory board meeting in October 2013 to discuss the Centers for Medicare and Medicaid Services (CMS) Hospital Readmissions Reduction Program and its impact on nursing facilities and LTC pharmacies. The following advisory board members participated in the meeting:

Samit Banerjee

Chief Executive Officer

Senior Care Pharmacy Services, Garden Grove, CA

Brian Beach

Vice President

Kelley-Ross Long-Term Care Pharmacy, Seattle, WA

Alan Bronfein

Senior Vice President

Remedi SeniorCare, Baltimore, MD

Stephen Carroll

Chief Operating Officer

All Care Pharmacy, Arkadelphia, AR

Sherri Cherman, PharmD

President and Chief Operating Officer

Modern HC Pharmacy, Monrovia, CA

Jim Dunham

General Manager and Chief Operating Officer

Americare Pharmacy Services, LLC, Cookeville, TN

Jim Mathews

Chief Operating Officer

Hometown Pharmacy, New Era, MI

Tom Noesen

Chief Financial Officer

Symbria, Inc.

Symbria Rx Services, LLC, Chicago, IL

This white paper summarizes the advisory board discussions on the effect of the Hospital Readmissions Reduction Program and presents the results of research conducted with key LTC thought leaders on the program's impact to nursing facilities and LTC pharmacies.

The objectives of this white paper are to:

- Provide an overview of the CMS Hospital Readmissions Reduction Program
- Discuss how this program affects nursing facilities and LTC pharmacies
- Identify resources that may assist nursing facilities and LTC pharmacies in reducing avoidable hospital readmissions
- Highlight strategies and services that nursing facilities and LTC pharmacies are using to reduce avoidable hospital readmissions
- Define action steps that nursing facilities and LTC pharmacies should consider when implementing a program to reduce avoidable hospital readmissions

Hospital Readmissions Reduction Program Overview

In 2006, Medicare costs associated with rehospitalization were approximately \$4.3 billion. Today, these costs have skyrocketed to nearly \$25 billion annually.¹ As a result of these rapidly rising costs, CMS included the Hospital Readmissions Reduction Program in the 2010 Affordable Care Act (ACA).²

In fiscal year 2012, Section 3025 of the ACA required CMS to reduce Medicare payments to hospitals with excessive readmissions within 30 days of discharge. Three specific conditions were initially targeted for review with respect to hospital readmissions:²

- Acute myocardial infarction (AMI)
- Heart failure (HF)
- Pneumonia

Hospitals with a readmission rate higher than the national average for any one of these conditions are penalized with a reduction in hospital Medicare reimbursement for all Medicare patients, not just those with targeted conditions. Three additional conditions — chronic obstructive pulmonary disease (COPD), elective total hip arthroplasty (THA), and elective total knee arthroplasty (TKA) — will be added in fiscal year 2015. The reduction in reimbursement is noted in Table 1.³

As of October 2013, a total of 2,225 hospitals in 49 states had Medicare payments reduced by \$227 million because of readmission penalties. As a result, hospitals are focused on strategies to reduce avoidable hospital readmissions.⁴

Clinical studies have found that one component of the discharge process that influences hospital readmissions is medication management and reconciliation, particularly during transitions in care:

- Studies have revealed a 30% to 70% variance in the medications a patient took prior to hospital admission compared to the admission orders.⁵
- A medication reconciliation errors study found a 36% medication error rate at the time of hospital admission. This primarily occurred during the medication history gathering phase.⁵
- A study at Yale New Haven Hospital looked at 377 older patients who went to the hospital with heart failure, acute coronary syndrome or pneumonia. Most of those patients (81%) encountered medication issues after discharge. One quarter (24%) of those issues involved a hospital error relating to new prescriptions that the patients received at discharge. But nearly two-thirds of medication issues (60%) may be due to patients' lack of understanding of how their ongoing medication regimens had changed while they were in the hospital.⁶

The high percentage of readmissions has prompted hospitals to examine their protocols for discharge and transition to post-acute care settings. Approximately 40% of Medicare hospitalizations end in discharge to a skilled nursing facility or rehabilitation facility, and roughly 20% of those discharges result in readmission to the hospital.⁷ As a result, SNFs and rehabilitation facilities also have begun to reevaluate the hospital readmission process.

Table 1

FY 2013	-1%	AMI, HF, Pneumonia
FY 2014	-2%	AMI, HF, Pneumonia
FY 2015	-3%	AMI, HF, Pneumonia, COPD, THA, TKA

Impact on Skilled Nursing Facilities

SNFs are targeting certain times, residents and services as critical to reducing hospital readmissions:

- At time of arrival and up to 48 hours after arrival into the SNF
- At time of discharge back into the community for high-risk and short-stay residents
- Additional services usually provided in the hospital are now being administered in the SNF

SNF executives and administrators recognize that hospital readmission rates are critical to future relations with referral hospitals, as those SNFs with higher rates may receive fewer referrals in the future. As one payer notes, “Hospitals, along with payers of nursing facility care, are looking for ‘quality SNF providers’ that can provide services that lower hospitalizations.” Many SNFs have been approached by hospitals to develop and/or implement high-quality programs and services such as intravenous therapy that will keep residents in the facility, avoiding the need for transfer. The connection between SNFs and hospitals is more important than ever, and as a facility administrator stated, “I’m discussing readmissions with hospitals on a daily basis, even more now since the fines have been implemented by Medicare.”

Facilities face significant challenges in reducing hospital readmissions. Keeping a resident that otherwise would have transferred can result in increased healthcare costs and services for the facility. This is especially true with respect to managing resident medication administration. For example, a febrile resident generally requires IV antibiotics. In some facilities this may necessitate transfer to a hospital; however, in an effort to reduce avoidable readmissions, some SNFs have been administering IV antibiotics within the facility. While this may prevent a hospital readmission, it results in increased facility expenses such as nursing staff time, pharmaceutical costs and IV equipment costs. The tradeoff or risk associated with balancing readmissions and costs will present a significant challenge for nursing facilities and require very careful decision-making in the future.

Nursing facility executives noted that the first 48 hours after arrival are critical to preventing hospital readmissions. One SNF administrator stated it is vital that the correct medications be received by the facility during this critical period to ensure the continuity of resident care. Without these medications, some residents will be transferred back to the hospital simply because the medications have not arrived and the resident has not been stabilized. In this case, despite the facility’s best attempts to care for the resident, hospital transfer is the only option. Thus, the transition of care and availability of the correct medications within 48 hours of transfer is essential to success in preventing readmissions.

“The facility wants to ensure that the pharmacy can get the right medication to the newly admitted resident at the right time. Essentially – right drug, right patient, at the right time – to grow their business.”

Alan Bronfein

Senior Vice President
Remedi SeniorCare, Baltimore, MD

Another challenge SNFs have is ensuring that physician orders are written in advance of hospital discharge to allow the SNF and LTC pharmacy time to plan for the resident’s arrival. Nursing facilities and hospitals need to coordinate the transition to improve the timing of discharge orders. The goal is to receive orders far enough in advance that the LTC pharmacy can have the resident’s medications ready upon arrival at the SNF.

Not only is timing of arrival a concern, but so is timing of the resident’s discharge from the SNF. This is especially important to SNFs with a high percentage of Medicare Part A residents, since short-stay Medicare residents may be discharged from the SNF within the 30-day hospital readmission window. One nursing home executive noted that hospitals put increased pressure on SNFs to take responsibility for these short-stay residents during the 30-day window even if they have been discharged and are now in the community.

Due to this heightened focus, SNFs are now evaluating all department roles and responsibilities to reduce avoidable hospital readmissions. This extends to providers in the facility and to physician extenders such as nurse practitioners, physician assistants, and LTC pharmacies.

Impact on LTC Pharmacy

Until recently, the mandate to reduce avoidable hospital readmissions has been considered primarily a “SNF issue.” Increasingly though, LTC pharmacies are being approached by facilities to play a greater role in this transition of care and meeting hospital readmission-reduction goals. Services that LTC pharmacies have provided include:

- Ensuring medications are appropriate and delivered in a timely fashion
- Providing extensive medication management and reviews at time of arrival and discharge
- Dispensing medications at time of discharge for use in the community for up to 30 days

As already noted, LTC pharmacies are being asked to ensure that the appropriate medications are available at the time of admission. For example, a resident admitted to a facility at 10 p.m. on a Sunday will need his or her medications available immediately. This may require LTC pharmacy resources and services that are beyond their current scope, such as longer pharmacy hours, additional consulting and delivery services. Moreover, facilities are expecting that these added services be provided without significantly increased cost.

In addition to providing the appropriate medications promptly, LTC pharmacies will be asked to provide medication reviews that go beyond the scope of traditional medical management reviews. These expanded evaluations might include performing extensive resident chart reviews to ensure appropriate medication selection upon a resident’s arrival at the SNF. For example, a resident with COPD may have been prescribed a metered-dose inhaler, but he or she does not have the inspiratory capabilities for effective use. This should be noted by the nurse or pharmacist, along with suggestions for an appropriate administration method to better manage the condition.

LTC pharmacies are also being asked to assist in medication management at the end of the facility stay at time of discharge. SNFs are requesting that LTC pharmacies dispense and closely monitor residents at time of discharge and for up to 30 days afterward. Monitoring may include medication reconciliation and counseling to improve adherence and minimize complications. This is especially important for high-risk discharged residents such as those receiving multiple medications for multiple chronic conditions.

“LTC pharmacies will need to develop more extensive medication management programs to meet the needs of facilities.”

Brian Beach

Vice President

Kelley-Ross Long-Term Care Pharmacy, Seattle, WA

Moreover, the monitoring effort should focus on all residents at risk for rehospitalization, not just those with the CMS-targeted conditions. As a result, some LTC and community-based pharmacies are contracting with SNFs post-facility discharge to provide medication management services. Such services generally involve in-home medication management for the discharged resident for a defined period.

Dispensing medications at the time of resident discharge may not have legal implications. However, dispensing by the LTC pharmacy once the resident is back in the community may raise class-of-trade issues, depending on how the LTC pharmacy contracts for drugs. It is imperative that LTC pharmacies discuss this with legal counsel prior to dispensing to patients residing in the community.

Discussions with LTC pharmacy decision-makers noted that there is potential to generate revenues by providing additional medication management services to SNFs and high-risk patients. A key is to identify who might be willing to pay and how to charge for these services.

Accountable Care Organizations (ACOs) offer an opportunity for additional services and potential revenue. ACOs have risk-based contracts for revenue, costs and outcomes, and therefore are at economic stake to keep patients out of the hospital. As noted, one way to do this is by improving medication management. Pharmacies can generate revenue through contracting with ACOs to provide additional consulting pharmacy services such as medication reconciliation for high-risk patients. These pharmacies providing medication management services have shown themselves to be cost-effective in managing the patient at risk for complications and helping to reduce hospital readmissions.

The Medicare Community-Based Care Transitions Program (CCTP) — noted in the callout box on page 6 — is another option that may generate additional services and revenue for LTC pharmacies.

Unfortunately, reimbursement for additional medication management services remains a challenge. Most pharmacies are not currently contracted to provide extra dispensing and/or medication management. With SNF margins eroding, there is less likelihood of reimbursement for these additional services.



Medicare Community-Based Care Transitions Program¹

The Affordable Care Act includes several pilot programs that may eventually result in reimbursement for pharmacy services to improve patient management and reduce hospital readmissions. A key program of interest is the Medicare Community-Based Care Transitions Program (CCTP). The Medicare CCTP was initiated in 2011, with the most recent round of new-member organizations announced in March 2013. The goal of CCTP is to improve transitional care for high-risk Medicare beneficiaries. Under CCTP, hospitals with high readmission rates must partner with a community-based healthcare provider organization. As of 2013 a total of 103 sites will deliver care to about 700,000 Medicare beneficiaries. CMS will spend \$300 million over the next three and a half years on this initiative, with contracted organizations called “care transition providers” being required to offer at least one of five care services:

- Care transition services at least 24 hours before discharge
- Post-discharge education
- Assistance to ensure timely patient interactions with post-acute care providers
- Patient self-management support (or caregiver support)
- Medication management review

More information on this program is available at <http://innovation.cms.gov/initiatives/CCTP/>.

Future Trends in the Hospital Readmissions Reduction Program

The growth of ACOs presents an opportunity for LTC pharmacies. Since the goal of ACOs is to improve quality of care and reduce overall healthcare costs, one focus may include improving medication management and reconciliation. Thus ACOs, particularly those with large high-risk populations, may elect to contract with LTC pharmacies to provide these services through a fee-for-service or shared agreement.

Resources to Help LTC Pharmacies Reduce Hospital Readmissions

A number of federally funded and association-driven programs and tools are available to assist SNFs and LTC pharmacies in their efforts to reduce hospital readmissions. Most programs have a medication management or reconciliation component in which the LTC pharmacy can take the lead role.

Most of these programs were developed for hospital use, but can be adapted for SNFs and community settings.

AMDA Clinical Practice Guideline for Transitions of Care⁸

The American Medical Directors Association (AMDA) developed a clinical practice guideline (CPG) in 2010 that provides guidance on managing residents transitioning into and out of a nursing facility. The goal of this CPG is to assist facilities in reducing avoidable care transitions.

The AMDA CPG focuses on medication reconciliation and its importance in the transition of care process. The guideline specifically mentions the pharmacist as the healthcare provider ideally suited to perform the medication reconciliation. AMDA recommends that medication reconciliation be performed and documented each time a resident arrives in the facility and at time of discharge. The guidelines further suggest that, if possible, the SNF or LTC pharmacy should obtain a comprehensive list of all the resident’s medications prior to and during his or her hospital or home stay to ensure that the correct and appropriate medications are initiated at time of arrival into the SNF. This may reduce medication errors during the critical 48 hours of arrival to the facility. The CPG provides a summary table of essential elements that should be included in the medication reconciliation.

INTERACT Program⁹

The Interventions to Reduce Acute Care Transfers (INTERACT) program was created in 2007 with the goal of improving SNF resident care. Originally a toolkit, INTERACT has evolved into a quality-improvement program that can be used by facilities to meet the federal requirement for a Quality Assurance and Performance Improvement (QAPI). The INTERACT program is designed to improve the early identification, evaluation, management, documentation and communication of acute changes in condition of residents in nursing facilities. One of its goals is to reduce the frequency of potentially preventable transfers to the hospital and related complications that may lead to increased healthcare expenditures.

A medication-reconciliation program is one component of the INTERACT program that is applicable to SNFs and LTC pharmacies. The worksheet for “post-hospital care” lists all medications required at time of hospital discharge, but also clarifies why a medication is needed and how the medication-resolution process occurred. LTC pharmacies can use this clinical tool or train facility staff (i.e., nursing staff) on how to use this tool to improve medication reconciliation.

More information and tools are available on the INTERACT website at <http://interact2.net/>.

MATCH Toolkit for Medication Reconciliation⁵

The Medications at Transitions and Clinical Handoffs (MATCH) toolkit was developed for the acute care setting; however, elements are adaptable to the SNF. MATCH provides a step-by-step guide to improving the medication-reconciliation process.

This toolkit is divided into seven components:

- Building the Project Foundation:
Gaining Leadership Support within the Organization
- Building the Project Foundation:
Project Teams and Scope
- Developing Change: Designing the
Medication-Reconciliation Process
- Developing and Pilot Testing Change:
Implementing the Medication-Reconciliation Process
- Education and Training
- Assessment and Process Evaluation
- High-Risk Situations for Medication Reconciliation

Section 1 lays the foundation for this toolkit by providing an argument for medication reconciliation as a clinical and patient-safety issue. The section provides a method to justify the resources required to perform medication reconciliation and explains how to link this process to other facility initiatives such as QAPI and the quality measures. The methods used to justify resources are hospital-based, but the information is adaptable to nursing facilities.

The MATCH toolkit discusses a medication-reconciliation process design that should center on the concept of a single list to document the patient’s current medications (referred to as the “One Source of Truth”). This list should be shared with and utilized by all physicians, nurses, pharmacists and others caring for the patient. It can be kept in the paper resident chart or the electronic medical record. The goal is to have all disciplines caring for the patient working from the same medication list, regardless of the format. The medication list becomes the reference point for ordering decisions and reconciliation, screening medications to be administered during a procedure/episode of care, and determining the patient’s medication regimen upon discharge.

More information and tools for the MATCH program can be found at <http://innovations.ahrq.gov/content.aspx?id=1979>.

Ongoing Initiatives to Reduce Hospital Readmissions

There are several initiatives that have been implemented by SNFs to reduce hospital readmissions:

- A facility contracting with a primary care physician to monitor high-risk residents within the SNF
- LTC pharmacies and community-based pharmacies implementing medication management programs for high-risk residents being discharged from a SNF
- SNFs and LTC pharmacies providing IV therapy to residents that might usually be transferred to a hospital for this care

Some SNFs and LTC pharmacies have begun working proactively with hospitals to reduce hospital readmissions. Several were mentioned by McKesson advisory board members, nursing home chain executives and LTC pharmacies.

A McKesson Advisory Board member noted that a hospital had placed a primary care physician in a SNF with high hospital readmission rates. The physician spends approximately three hours per day, five days a week in the SNF reviewing charts and assessing high-risk residents including those with multiple comorbidities, not just those with acute myocardial infarction, heart failure or pneumonia. The pharmacy assists the physician in managing the medication of these high-risk residents. The program was initiated by the nursing facility and is supported by the hospital, with a goal to improve outcomes. To date, the program has resulted in a reduction in emergency room visits and hospital readmissions, while the pharmacy has shown value in supporting this initiative.

Several LTC pharmacies are involved in providing medication management or reconciliation at time of nursing facility arrival and at time of discharge. The facilities that have contracted for these services are targeting high-risk residents, those with multiple disease states and medications, at greater risk for hospital readmission. When a resident arrives at a nursing facility, a pharmacist performs extensive medication management review. The recommendations generated from this review are intended not only to lower medication cost, but to ensure use of the appropriate medication for the disease state.

Medication reconciliation is also being offered as a service by some LTC pharmacies and community pharmacies at the time a resident is discharged from the SNF. A McKesson advisory board member noted that his pharmacy is working with a state agency to provide medication management and consulting to high-risk residents at time of nursing facility discharge. This program was initiated to improve medication adherence and reduce medication/disease state interactions in high-risk populations. Most pharmacy consulting services are conducted in the patient's home, and most patients receive consulting services only. The pharmacy bills the state agency an hourly rate based on the length of the visit. As the program has evolved, a key component is patient and caregiver education.

As already noted in this paper, another method LTC pharmacies are expanding to reduce hospital readmissions is an in-facility IV therapy program. The ability to provide intravenous or hypodermoclysis rehydration or antibiotic therapy allows the facility to care for residents instead of transferring them back to the hospital. LTC pharmacies and SNFs must weigh the costs associated with providing these services with those of a hospital transfer. One LTC pharmacy executive noted that more of their facilities are providing IV therapies. As one nursing home executive stated, "We need to provide those services that are going to differentiate us from other facilities in the market so that we can be of value to potential referral hospitals."

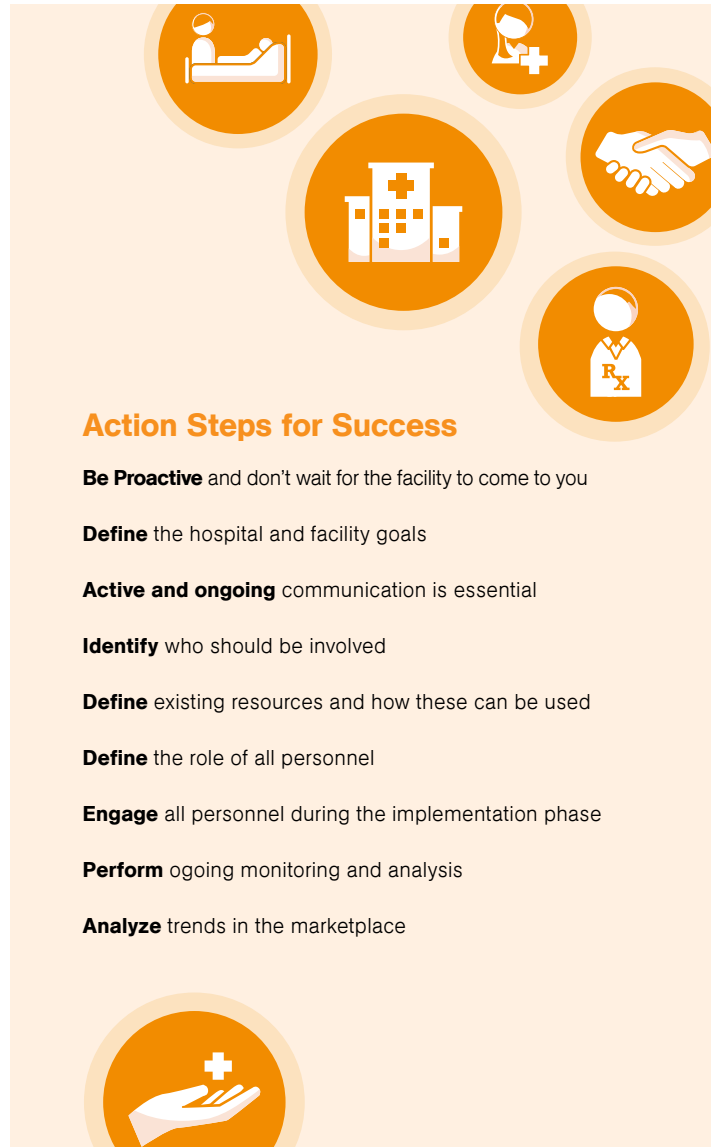
Action Steps for Success

The McKesson advisory board members' recommendation was an emphatic "be proactive!" as a first step. Don't wait for the hospital to approach the SNF or the facility to approach the LTC pharmacy to start making recommendations. The Hospital Readmissions Reduction Program is already in effect and facilities are being approached by hospitals for support. A pharmacy that provides solutions and methods to reduce hospital readmissions will be of great value.

One way for the LTC pharmacy to be proactive is to schedule meetings to define the facility's goals.

- What are the goals of the referral hospital?
How do these compare with the facility's goals?
- Does the facility have policies and procedures in place to reduce hospital readmissions?
- Is the facility looking to make significant changes or minor changes?
- How many preventable hospital readmissions are related to the availability of medications?
- How many preventable hospital readmissions are related to the medication-selection process?
- How can the LTC pharmacy assist the facility in meeting its objectives?

Meetings and communications with the nursing facility can set the tone for all future discussions regarding ways to reduce hospital readmissions. Moreover, these meetings may be the time to discuss current and future pharmacy contracts in order to define the need for additional services and determine methods for reimbursement of these services. The analysis should include identifying any federal, state or local pilots/programs that may assist in supporting these additional pharmacy services.



Action Steps for Success

Be Proactive and don't wait for the facility to come to you

Define the hospital and facility goals

Active and ongoing communication is essential

Identify who should be involved

Define existing resources and how these can be used

Define the role of all personnel

Engage all personnel during the implementation phase

Perform ongoing monitoring and analysis

Analyze trends in the marketplace

To align objectives and meet the desired outcome, LTC pharmacies should also engage with the hospital and the hospital pharmacy. Discussions regarding obtaining the medical and medication history in a timely fashion from the hospital may prevent errors from occurring at the time of transfer.

Once objectives have been set and needs defined, the LTC pharmacy should do a gap analysis to determine how its resources align with the needs of the facility. For example, with respect to the need for medications to be delivered to the facility closer to the time of resident arrival, what processes or resources must the LTC pharmacy implement to meet this requirement? The programs and tools listed in this white paper, such as the INTERACT program, may provide materials necessary for a LTC pharmacy to meet needs. These programs and tools may also be adapted to meet other requirements within the facilities served by the LTC pharmacy.

The next step is to identify the healthcare providers involved with preventing/managing hospital readmissions, define their roles, and determine the processes currently used within the facility. LTC pharmacies should identify where they can assist in this process. There should be an agreement among all decision-makers on the role of these pharmacy services. The facility and LTC pharmacy should implement ongoing monitoring and analysis to determine the value of these services on reducing hospital readmissions. The role or resources provided by LTC pharmacies may change based on the facilities' hospital-readmission goals.

Ongoing analysis of healthcare transformation trends such as implementation of ACOs and other provider group activities will identify marketplace opportunities for pharmaceutical value-add services. A new ACO may increase the need for additional pharmacy services at time of admission to a nursing facility and at time of discharge back into the community. Equally important, there may be financial incentives to provide these services.

LTC pharmacies should identify any state or federal pilots or programs focusing on transitions of care. Organizations that have been contracted to provide services within the Medicare Community-Based Care Transitions Program may provide opportunities for a LTC pharmacy to offer consulting services at time of discharge from a nursing facility and in the community.

LTC pharmacies, just like the facilities they serve, should continually monitor the status of facility-to-hospital readmissions rates. If these rates increase or do not show significant decreases, take a proactive approach to provide solutions to the problem.

"The key is to develop metrics to measure effectiveness of the program."

Tom Noesen
Chief Financial Officer
Symbria, Inc. and Symbria Rx Services, LLC,
Chicago, IL

Summary

The CMS Hospital Readmissions Reduction Program was implemented in FY 2012, affecting hospitals and nursing facilities soon after. It has since become a priority issue among nursing facilities. As facilities aim to reduce their rates of hospital readmission, medication delivery, reconciliation and management have taken on increasing importance. Facilities will be looking to their LTC pharmacies to assist in achieving hospital readmission goals. As medication experts, LTC pharmacies are essential and should be proactive in communicating, analyzing and implementing medication management programs in the SNF and post-discharge.

Resources

CMS Final Rule and Hospital Readmissions Reduction Program

<http://cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Readmissions-Reduction-Program.html/>

INTERACT Program Resources

<http://interact2.net/>

QualityNet Program

<http://www.qualitynet.org/dcs/ContentServer?pagename=QnetPublic%2FPage%2FQnetTier2&cid=1228772412458>

MATCH Program

<http://innovations.ahrq.gov/content.aspx?id=1979>

Project RED (Re-Engage Discharge)

<http://www.bu.edu/fammed/projectred/>

Project BOOST

(Better Outcomes by Optimizing Safe Transitions)

<http://www.hospitalmedicine.org/BOOST>

Partnership for Patients

<http://partnershipforpatients.cms.gov/>

AMDA Clinical Practice Guideline for Transitions of Care

<http://www.amda.com/tools/clinical/toccp.pdf>

STAAR Initiative

(State Action on Avoidable Rehospitalizations)

<http://www.ihl.org/offerings/Initiatives/STAAR/Pages/Approach.aspx>

CMS Community-Based Care Transitions Program (CCTP)

<http://innovation.cms.gov/initiatives/CCTP/>

McKesson Alternate Site Pharmacy™

McKesson Corporation

One Post Street
San Francisco, CA 94104

McKessonAlternateSiteRx.com
alternatesite@mckesson.com

800.571.2889

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