ActualMeds

Pharmacist Led Medication Reconciliation at Transitions of Care

June 11, 2025

VBCExhibitHall.com

Educational Webinar Series

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Today's Agenda

- Who Is ActualMeds?
- The Importance of Medication Reconciliation for Value Based Care
- Transition of Care to Skilled Nursing
- Transition of Care to HOME
- Reducing Readmissions: Results
- Summary and Lessons Learned

Comprehensive Medication Management Solutions

Medication Reconciliation at Admission and Discharge by Setting

Home Health

Outpatient /Community

Skilled Nursing

Assisted Living

Hospice

- STAR / HEDIS Measure Management
- Chronic Disease Population Management
- Transition of Care Services
- Part D Enhanced MTM
- PACE/COA Programs
- Admit/Discharge Medication Reconciliation
- Monthly/Interim Medication Reviews
- Quarterly Business Reviews-SNF
- i-SNP Support

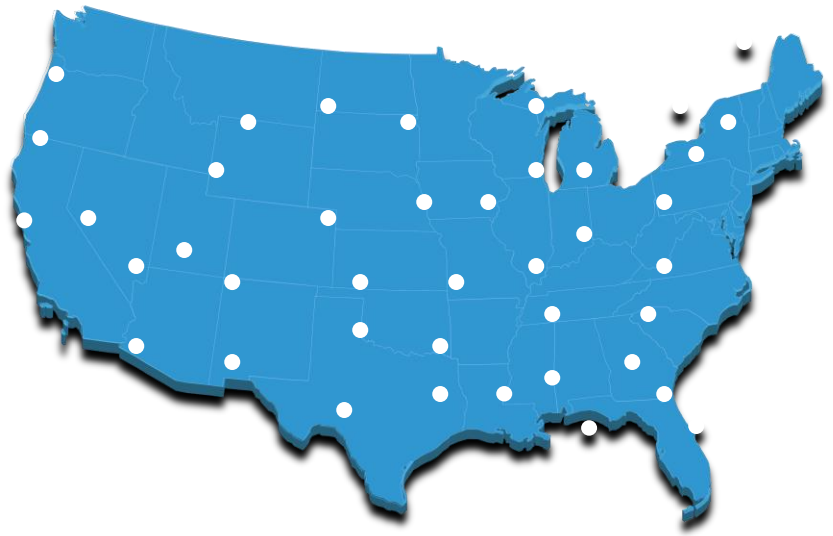
Tech Enabled Service for End to End Medication Management

Powered By Innovative Technology

- Data Interoperability
- AI Driven Risk Assessment
- Robotic Process Automation

Network of 100+ Licensed Pharmacists

- Pharmacist On Demand™



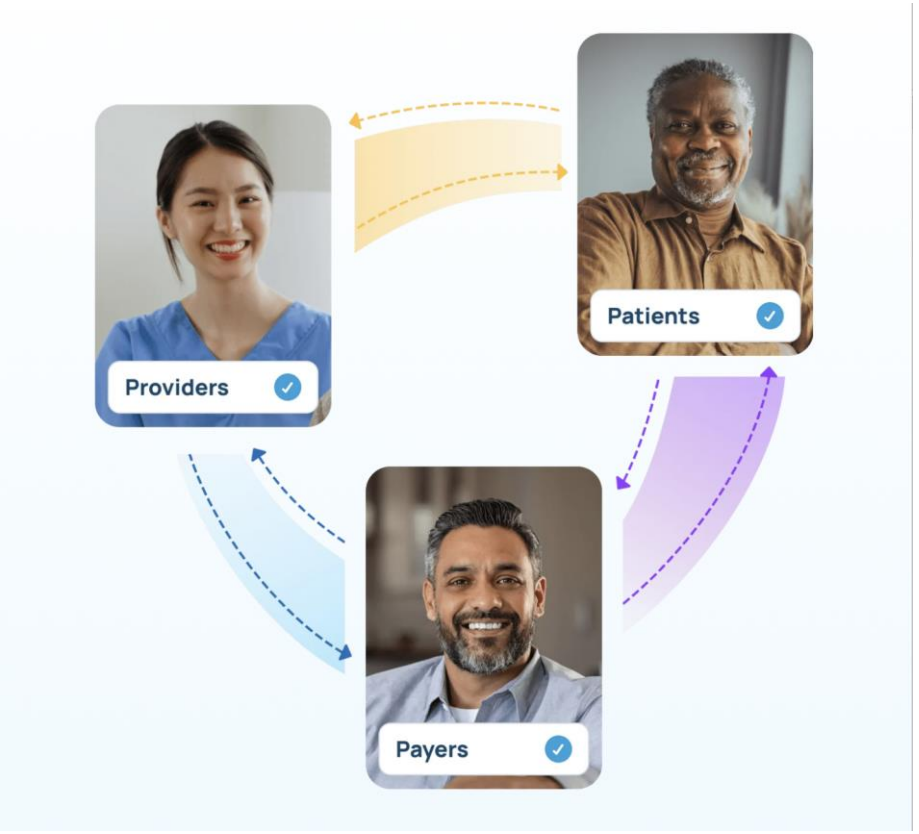
Pharmacist Led Medication Management

Empowering Pharmacists as Key Care Team Members

Optimizing Workflows for Care Coordination

Creating Value for Patients, Providers, and Payers

- Reduced hospitalizations and re-admissions for Patients
- Reduces care coordination burden for care teams
- Best practice medication management that is scalable and cost-effective for Payers



Why Should Value Based Care Organizations Care About Medication Reconciliation at Transitions of Care?

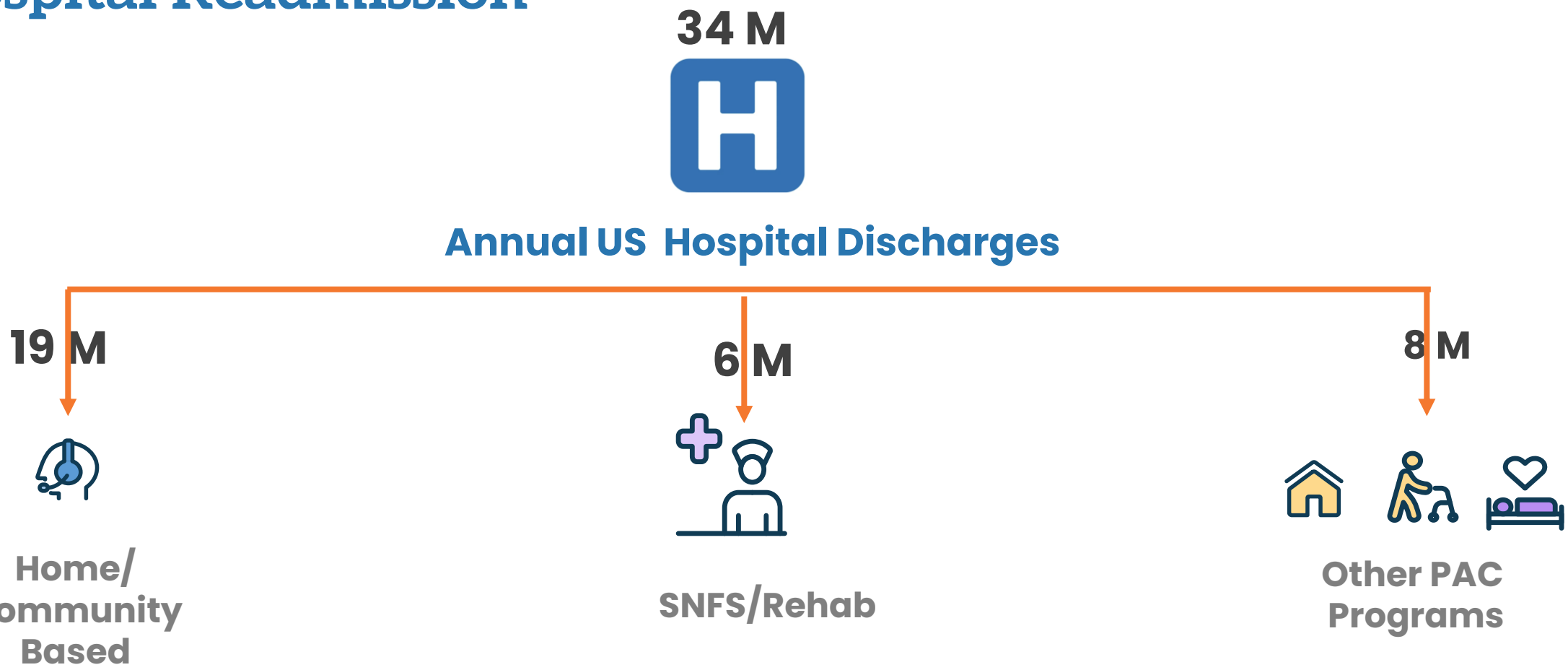
- **Hospitals** are penalized $.5 B in readmission fees over the measurement period for certain key conditions including Heart Failure, COPD, Elective Hip Replacement and Pneumonia

- On Average a re-admission stay costs **Payers** $16,000 vs primary hospitalization at about $10,000

- Best Practice Medication Reconciliation Combined with Care Coordination Between Patient and their Primary Care Provider is Critical to Successful Care Transitions and Reduction of Hospitalizations, ED visits , and Re-admissions*

*Mekonnen et al. (2016)

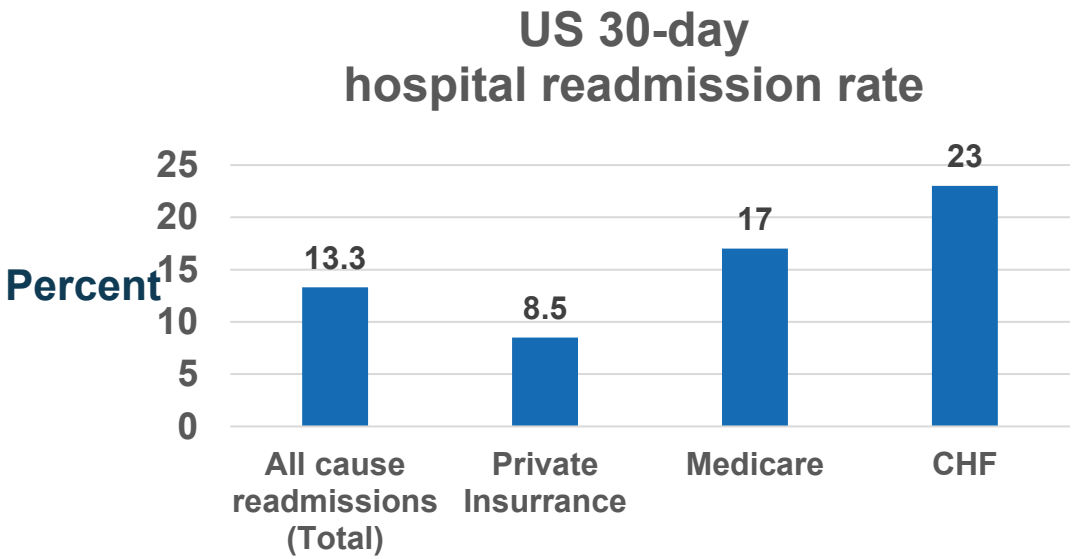
Nearly 15% of All Acute Care Episodes Result in a Hospital Readmission



Jarman B, Aylin P, Bottle A. Discharge destination and length of stay: differences between US and English hospitals for people aged 65 and over. BMJ. 2004 Mar 13;328(7440):605. doi: 10.1136/bmj.328.7440.605. PMID: 15016691; PMCID: PMC381128.

Medication Related Readmissions Cost More Than $15B Annually- 70% of them are Preventable

- 5M Re-admissions

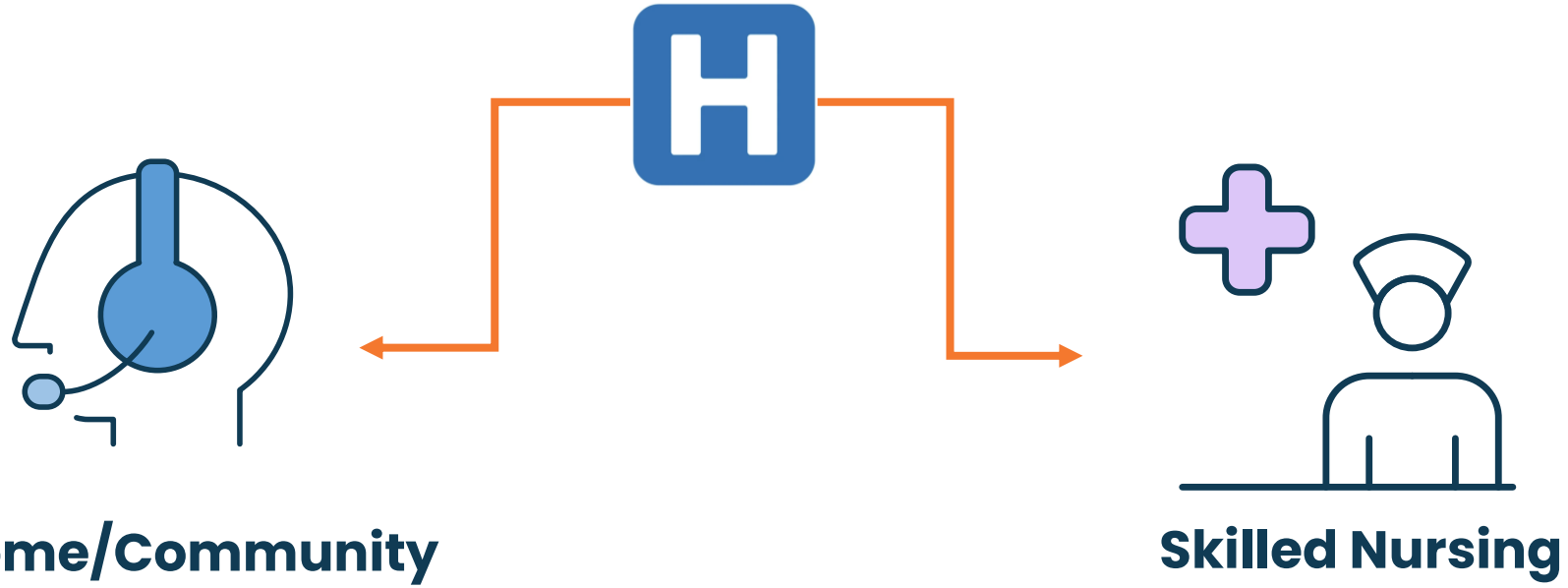


Healthcare Cost and Utilization Project (HCUP) Nationwide Readmissions Database (2022)

- Medication-related problems are responsible for 20% of re-admissions
- Older adults are at increased risk due to co-morbidities, polypharmacy, and social risk factors that contribute to adverse drug events post discharge

El Morabet N, Uitvlugt EB, van den Bemt BJF, van den Bemt P, Janssen MJA, Karapinar-Çarkit F. Prevalence and Preventability of Drug-Related Hospital Readmissions: A Systematic Review. Journal of the American Geriatrics Society. 2018;66(3):602–8. doi: 10.1111/jgs.15244 [DOI] [PubMed] [Google Scholar]

Pharmacist Led Medication Reconciliation at Care Transitions Reduces Re-admissions



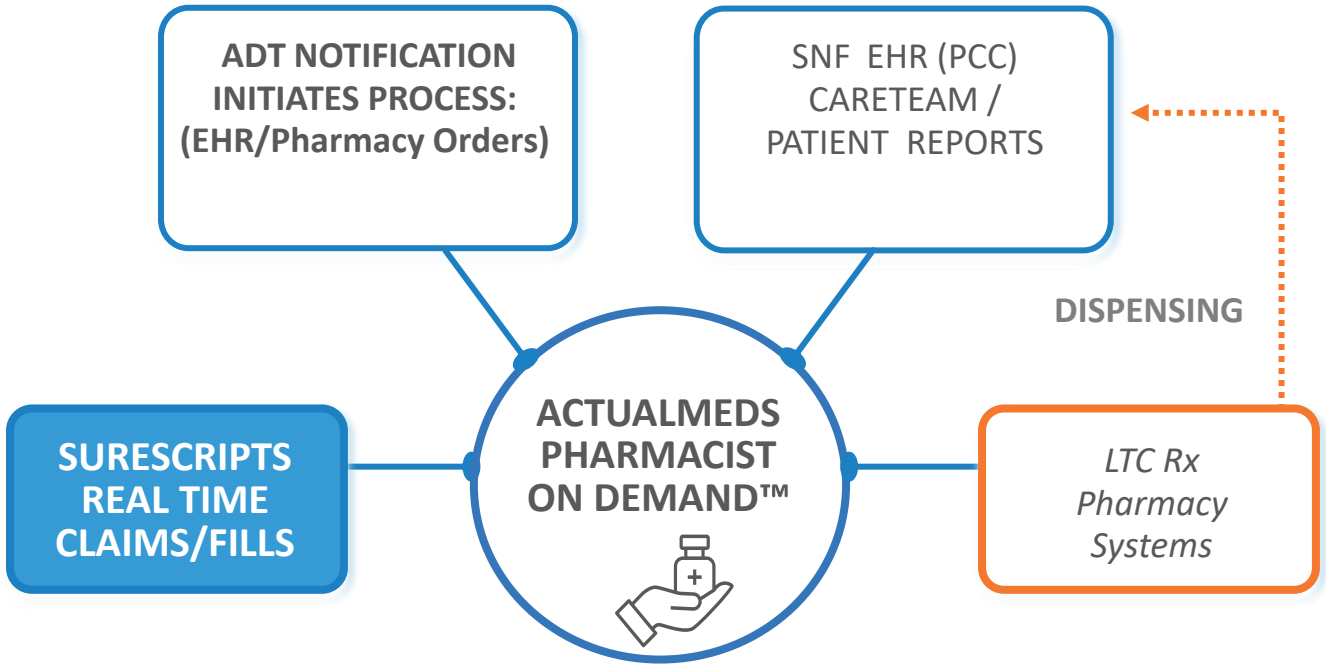
Zemaitis CT, Morris G, Cabie M, Abdelghany O, Lee L. Reducing Readmission at an Academic Medical Center: Results of a Pharmacy-Facilitated Discharge Counseling and Medication Reconciliation Program. Hosp Pharm. 2016 Jun;51(6):468-73. doi: 10.1310/hpj5106-468. PMID: 27354748; PMCID: PMC4911987.

Achilleos M, McEwen J, Hoesly M, DeAngelo M, Jennings T. Pharmacist-led program to improve transitions from acute care to skilled nursing facility care. Am J Health Syst Pharm. 2020 Jun 4;77(12):979-984. doi: 10.1093/ajhp/zxaa090. PMID: 32377682.

Factors That Influence SNF Readmission Rates

- **Staffing levels** (especially RN coverage)
- **Timeliness of post-discharge care**
- **Quality of medication reconciliation**
- **Chronic disease burden and functional status**

Data Driven , Pharmacist Led Medication Reconciliation at Admission of Patients to Skilled Nursing Facilities



AUTOMATED DATA HANDLING AND PROCESSING

ActualMeds Pharmacists:

- Make real-time recommendations
- Improve efficiencies, increased throughput, and lowers costs

Facilities:

- Relieves nursing/staff burden
- Improves quality, reduces regulatory risk
- Reduces Re-admissions for Preferred status with Payers

Admission Reviews Conducted at Discharge to Skilled Nursing Facilities

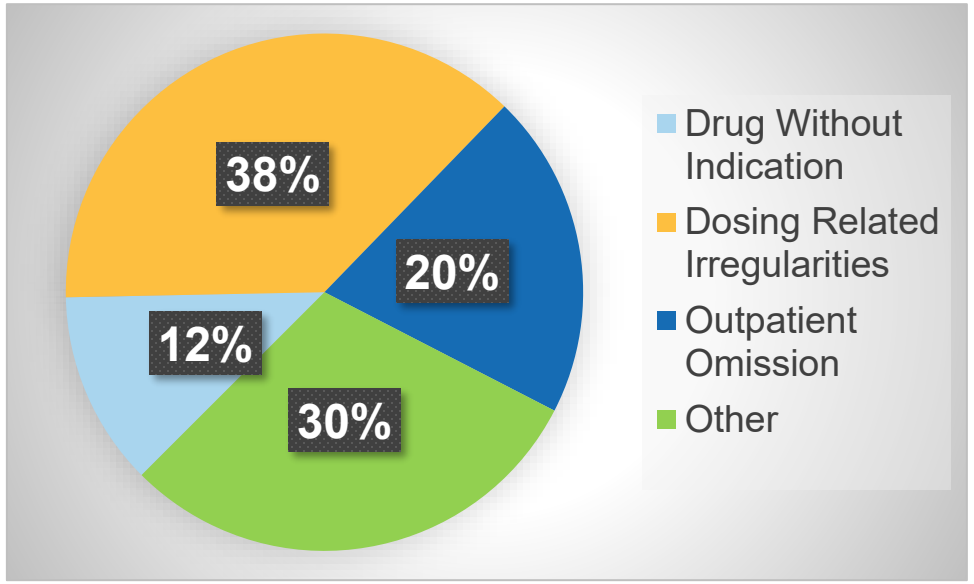
June 2024- May 2025

- 62 Facilities
- 80% of Patients Had Recommendations

Total # Patients	29,029
Patients with Recommendations	23,341
Total Recommendations Made	29,510
Recommendations Per Patient	1.3

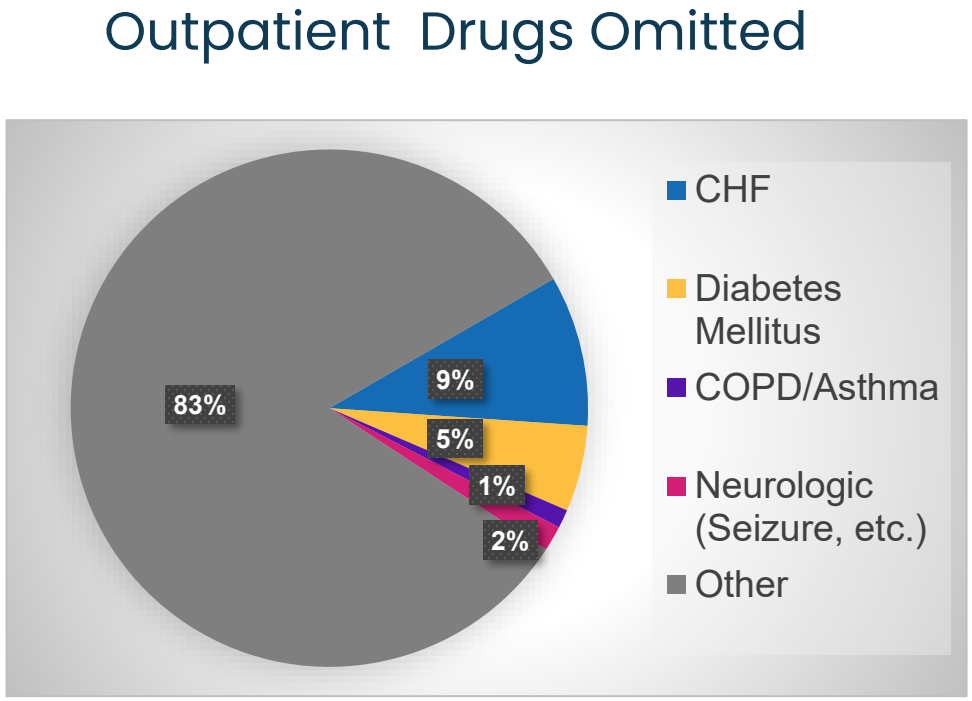
Missing "At Home" Meds Accounted for 20 % of Risks

Medication Reviews Informed by Availability of Patient's Med History in Real Time



- Patient arrives at facility with discharge summary including meds from acute care episode
- No visibility to the "customary" or at home meds prior to hospitalization
- ActualMeds supplies patient's medication history with all current active meds

Medication Reconciliation "Errors of Omission" Are A Significant Risk for Readmission in Skilled Nursing Facilities



Nearly 20% of the 5,900 medications missed at admission were for serious chronic conditions

Med History Available to Pharmacist in Real-time Assists With Corrections to Medications within 24 Hours of Admission

Case 1: Missing Critical Medication

Patient Med History: Stroke, CHF (other)

Pharmacist Recommendation:

> Blood thinner was active med prior to hospitalization. "Please evaluate and consider restoring if appropriate"
>
> .

Follow-Up: Therapy restarted same day as recommendation

Case 2: Missing Dosage

Patient Med History: Diverticulitis, Acute Respiratory Failure, Hypertension (other)

Pharmacist Recommendation:

> Heart Failure/Hypertension med had dose missing from Discharge Summary; Pharmacist was able to reference full med history showing active med with dose

Follow-up: Critical medication continued same day as recommendation.

ActualMeds Rate of Readmission for SNFs is Less Than a Third of the National Average

- Among the nearly 30,000 patients admitted to the SNFs from June 2024 through May 2025, the rate of all cause re-admission in < 30 days was **6%.**

- The rehospitalization rate from SNFs nationally is 22% at an estimated cost of $3B. *

*CMS SNF VBP Program (2024 Performance Data); OIG Report (2019)

Factors Affecting Discharge to Home Readmission Rates

Discharge Procedures to home vary widely among acute care organizations

- Social workers to hospitalists are used to review/reconcile medications
- Delay in updating EHR with discharge summaries that include acute care meds

Patients return to an uncontrolled setting

- Confusion between new and old meds
- Adherence to a revised medication regimen

More than 40% of hospitalizations are for people over 65 years

- More chronic conditions, co-morbidities with polypharmacy
- Elderly who live alone face more social risk factors with barriers to medication adherence

Partnering with a Health Plan to Reduce Re-admissions in their Highest Risk Member Populations

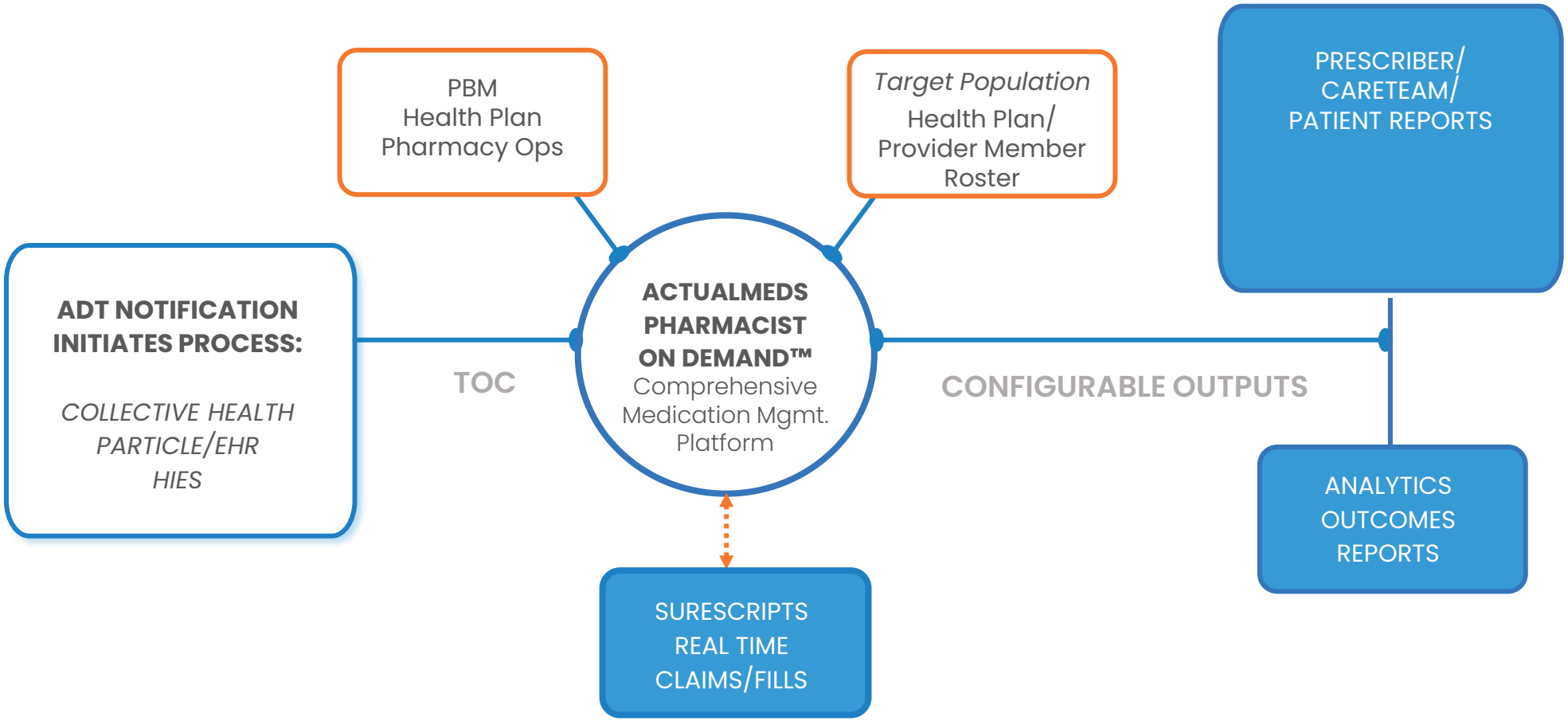
Historical Outcomes With Internal Care Management Programs

Population	Discharges	Re-admits	Rate	Costs ($M)	National Ave Rates
Heart Failure	2,208	640	29%	$ 7.1	20-25%
Diabetes	1,451	305	21%	$ 2..4	22%
COPD	1,248	300	24%	$ 2.4	23%
Total	**4,907**	**1,245**	**25% (ave)**	**$ 11.7**	

Goals of ActualMeds Program:

- Reduce rate of readmissions by 15-20%
- Identify areas for care co-ordination with Plan's internal programs

Data Driven , Pharmacist Led Medication Reconciliation at Discharge of Patients to Home



Care Coordination is Critical to Successful Transitions of Care for Patients Discharged to Home

Goal is to Connect Patients With Their Primary Care Providers Within 7 Days of Discharge

Medication Reconciliation

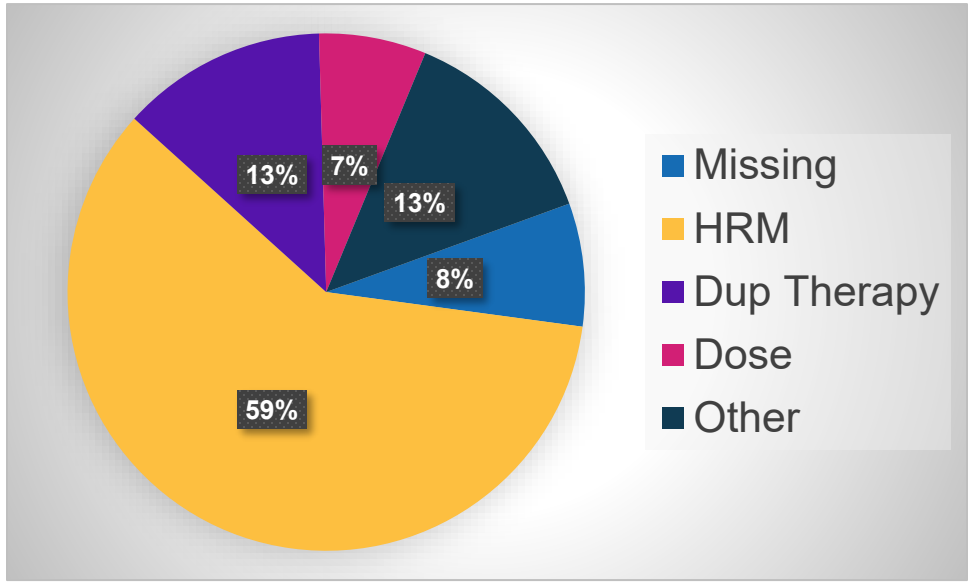
- System generates daily notification of A/D/T and retrieves Discharge Summary and Med History for Patient
- Pharmacist Reviews and Approves Medication Reconciliation With Recommendations

Care Coordination

- System e-faxes to PCP notifying patient has been discharged , along with med rec and recommendations, and reminder to schedule a follow-up visit asap; Receipt of the e-fax is verified.
- Med rec report designed for patient is mailed to address on file , along with reminder to schedule a follow-up visit with PCP. If a mailed report is returned as undeliverable, the med rec process is considered “incomplete” and patient record is updated.

Drug Therapy Problems
Associated With Risk of Readmission with Discharge to Home

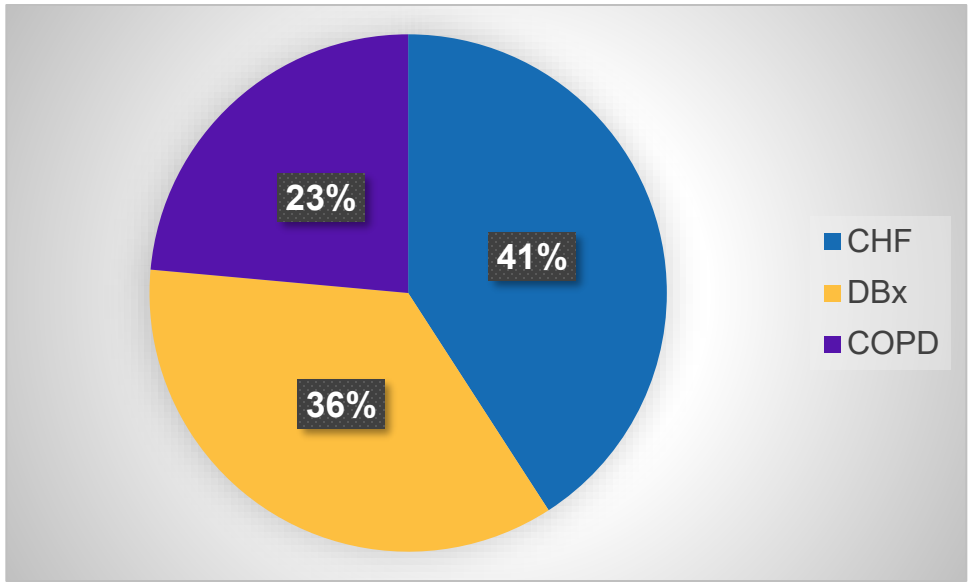
Completed Medication Reconciliation Post-Discharge
910 risks identified



- Approximately 1,457 TOC Cases
  - Risks Identified Per Case = .6

- Risk Categories
  - High Risk Meds, Drug-Drug Interaction
  - Duplicate Therapies
  - Missing Meds
  - Dosing Irregularities

This Process Has Resulted in 14% Re-admission Rate for High Risk Populations



April 1- May 31, 2025

- 1,457 Completed MRPs
- 208 Re-admissions < 30 days
- Overall rate of re-admission = 14%

Summary of Our Findings

Transition of Care	Acute Care to SNF	Acute Care to Home
Patient	Higher acuity patient/less mobile	Lower acuity/ more mobile (* High risk cohorts: CHF, Diabetes, COPD)
Care Setting Environment	• Highly Controlled/ Intense monitoring • Formulary substitutions by facility • Pharmacists doing regular medication management	• Un-Controlled/ Less frequent monitoring • Return to local pharmacy and regular PBM formulary
Greatest risks identified that increase readmission probability	• Missing outpatient meds • Dosing Issues (strength, route of admin etc.) • Drugs without Indication	• High Risk Meds/ Other drug-drug interaction • Duplication of Therapy
Industry Re-admission Rates	SNF 30-Day All-Cause Readmission Measure (SNFRM) (2023-2024) ~21%	~22%
ActualMeds Program	6%	14%

What can we do better?

1. Implement best practice medication reconciliation as a critical part of broader transition of care programs

- Performed by pharmacists or trained professionals
- Combined with patient counseling, written instructions, and post-discharge support
- Integrated into coordinated care transitions especially with follow-up with primary care)

2. For hospitals and health systems aiming to reduce readmissions:

- Implement structured, team-based medication reconciliation processes at discharge.
- Pair it with transitional care strategies such as follow-up calls or home visits.
- Update electronic health records (EHRs) on day of discharge with best possible medication histories

Saving Some Time for….

??? Q&A ???

Thank You For Your Time Today

For More Information please contact us at:

info@actualmeds.com