Transitions of Care Resource Guide

Presented jointly by:

[CSHP logo] [California Pharmacists Association logo]
Introduction

Given that pharmacists are the medication experts with extensive training and education in pharmacotherapy, pharmacists can effectively manage the medication reconciliation process in collaboration with the prescriber. Having access to pertinent medication information such as access to the patient’s medical record and the patient’s dispensing record helps ensure the pharmacist can make the best decision possible regarding the patient’s treatment. It is important for hospitals, health-systems and other places of care to develop and implement processes to facilitate such access.

While there are multiple pathways and models available for reference, CSHP and CPHA have joined forces to provide for its members the following toolkit. A graphical flow chart with an accompanying narrative is included in this tool kit as a model for pharmacy involvement in a patient’s transition of care. Some suggested metrics are provided to help track pharmacy’s value in participation in a patient’s transition of care. Lastly, a compilation of references to commonly cited models and workflows are provided for further reference.

We wish that, with these tools, pharmacists and the pharmacy profession will continue to be at the forefront of cutting-edge patient care, continuing to secure the benefit of a pharmacist’s role in pursuit of exceptional patient care.

Acknowledgements

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Bob LeWinter, RPh
Danielle Colayco, PharmD
Dawn Benton, MBA
Doug O’Brien, PharmD
Grant Lackey, PharmD
Jerry Gonzales, PharmD, Co-Chair
Larry Reis, PharmD

Lee Meyer, PharmD, Co-Chair
Logan Saito, PharmD
Lucy Saldana, PharmD
Noah Fang, PharmD
Parisa Vatanka, PharmD
Patricia Shane, PhD, MPH
Paul LeSage, RPh

Paul Lofholm, PharmD
Rebecca Cupp, PharmD
Robert Schoenhaus, PharmD
Sarah Lorentz, PharmD
Steve Gray, PharmD, JD
Suzanne Shea, PharmD

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Adrian Wong
Clifford Young
Michelle Adia, Student
Veronica Bandy

Vincent Lee, Speaker-Elect
Transitions of Care Overview

Purpose

The CSHP and CPhA Joint Task Force was called upon to help determine the best methods to help support the pharmacy profession in the State of California. With the provisions of the Affordable Care Act coming to fruition, payment models are shifting from traditional fee-for-service to bundle payment for comprehensive services utilizing transitions of care. More providers are moving toward the new transitions of care model, moving a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory specialty care practice, long-term care, home health, rehabilitation facility, etc.) to another. While failures in transitions of care currently burden hospitals and long-term-care facilities with re-admissions, the task force looked at the collaboration among pharmacists from inpatient, community and consultant pharmacists to position pharmacy as an asset in medication management while the patient moves throughout the healthcare system. Transitions of care can be viewed in multiple ways and models. Below is a narrative and flow chart that seeks to illustrate one method of involving pharmacy in a patient’s transition of care. This model focuses on a semi-linear approach, starting from admission to an acute care setting and follows the patient traveling to an outpatient/licensed care facility. An acute care setting is a healthcare facility, often a hospital, where a patient receives treatment for a short-term severe injury, episode of an illness or an urgent medical condition. A licensed care facility is a non-acute care facility that treats patients for chronic, longer-term conditions with less medical staff than an acute care setting, but more oversight than a patient living independently.

Patient Admitted to an Acute Care Setting

Upon admission of a patient to an acute care setting, a designated provider (the practitioner responsible for the patient’s medical care) obtains and documents an accurate medication history. Medication adherence, drug-drug interactions, duplicate therapy, gaps in therapy and accurate/appropriate use of medication should be discussed with the patient/provider when appropriate. This designated provider, in the ideal setting, should be a clinical pharmacist as he or she can most effectively make clinical therapy decisions and recommendations. The task force also recognized the cost-burden of a sole pharmacist performing all such functions; therefore, we believe that pharmacy students/interns, pharmacy technicians and nurses can augment the workflow to better use human resources in this scenario. A clinical pharmacist shall conduct the final review of the medication list for clinical appropriateness.

To obtain an accurate medication history, outside/objective sources in addition to the patient interview should be utilized. This includes family interviews, past medical histories, data from outpatient pharmacy records or centralized databases, etc.

For a complete medication history, over-the-counter medications, herbal supplements and other adjunctive medications in addition to prescriptions must be included. When possible, obtain and
document the last dose administered, dose, form, route, generic name, etc. as part of the medication history.

A pharmacist shall review the ordered medications based on previously gathered information and collaborate with the admitting physician to determine which medications are clinically appropriate to continue and which medications to hold/discontinue. This function is deemed comprehensive medication reconciliation, reviewing a patient’s active medication list to evaluate which medications to continue, hold, discontinue, etc. after obtaining a complete medication history. Considering the expertise of pharmacists regarding medications, performing the above functions should not be substituted by other healthcare providers.

During a patient’s hospital stay, the patient should be assessed for medication adherence and provided education when appropriate. Upon each change in the level of care, medication reconciliation should be completed. This includes another evaluation of which inpatient medications to continue/discontinue and which home medications to resume or continue to hold.

When nearing discharge from the facility, a designated provider should update the medication list to include results of all medication reconciliations and all discharge medications. The electronic medical record should then be updated to include the above actions.

Patient Discharged from an Acute Care Setting

A pharmacist shall provide support during discharge medication reconciliation by at least providing a comprehensive medication review that includes review of therapeutic duplication/omissions, blood draws, drug interactions, drug adherence prior to admission, barriers to adherence such as literacy and cognition, over-the-counter use and herbas, etc. Any recommendations should be discussed with the designated provider. The patient is provided a patient-friendly medication list that includes last time taken, when to take next dose, picture of the prescribed medication, graphical schedule to take medications, purpose/indication, appropriate “as needed” instructions, etc. Medications should be categorized with new medications, changed medications, discontinued medications, etc. This medication list is invaluable and should be up-to-date for patients to reference during follow-up visits to providers and the pharmacy.

During discharge planning, follow-up time should also be discussed and appointments with future providers should be solidified. Additionally, based on a patient’s insurance, medication benefits should be maximized and insurance adjudication should be completed to provide cost-effective therapy. The task force feels that these supportive roles can be completed with the assistance of a pharmacy technician.

When possible, education and medication discharge should be provided at the patient’s bedside. This is the ideal setting for a pharmacist to provide medication consultations, disease state education and education about other outcomes/goals. This is also the setting to re-address and ensure medication adherence. If unable to secure medication delivery at discharge, a designated provider will need to
follow up with a patient after he or she leaves the hospital to ensure the patient was able to receive his or her discharge medication at the pharmacy or whether it was delivered to the home.

**Home Environment**

To ensure better medication adherence, a pharmacist should provide follow-up care post-discharge. This can be a home visit, phone visit, etc. over the first 60 days to assist with adherence and help overcome any barriers in the outpatient arena. Though there is currently no standard in follow-up time, typically the first follow-up is completed within 24-48 hours post-discharge, then another one to two weeks later, then monthly, contingent upon the disease state, up to 60-90 days. It is important to also educate caregivers.

If the pharmacist discovers any barriers or has concerns, the pharmacist shall notify the designated provider or primary care physician. Potential issues include adherence, home environment, clinical conditions, etc. Case managers, nurses, physicians, pharmacists, etc. should work collaboratively to provide the best transitional care possible to help overcome barriers. Through collaboration with the patient’s designated provider, the pharmacist should adjust or discontinue medications as warranted by clinical indications and monitoring. Traditionally community pharmacists are less directly involved, but the task force believes pro-active pharmacist involvement during a patient’s transition of care will be a unique niche to help a patient transition to the outpatient setting upon discharge. Hospital and community providers/pharmacists should provide a pass-off to continue to monitor the patient once discharged until outpatient therapy with the patient’s primary care physician is established.

**Licensed Care Facility**

Upon discharge to a care facility, a comprehensive medication list along with a provider clinical summary that categorizes therapy changes, decisions, goals of care, current medications, etc. needs to be provided to the care facility upon transfer. Ideally pharmacists can become the transitional care patient manager to review medication changes, ensure adherence and monitor for signs of compliance during a patient’s transitional care. This may include ordering follow-up lab tests/monitoring, assessing for side effects and management, ensuring continuation of therapy with accurate timing, etc. The task force recognizes that with the current capacity, consultant pharmacists are not able to be present 24/7 to receive transfer orders, but should prioritize new admissions and provide better transition of care in the initial days of transfer. When interventions are discovered, the pharmacist should work with designated providers to adjust and/or discontinue medication therapies as warranted by clinical indications.

**Conclusion**

Ultimately, with the changing healthcare landscape, comprehensive, collaborative and efficient use of healthcare resources is required. In our complex healthcare system, pharmacists are strategically poised to make a patient’s transition of care more smooth and effective. Pharmacists are the trusted medication manager and should be maximized to ensure optimal patient care possible.
Metrics of Transition of Care in the Community Setting

Transitions of care are becoming increasingly important in a patient’s global care. To prove value of a pharmacist, it is important to look at specific metrics to justify the utility of a pharmacist in transitions of care. Below are specific metrics that can be measured to help with evaluating the benefits of a pharmacist.

**Metrics from Hospital → Community Pharmacy**

**Inpatient Hospital Initial Assessment**

- Medication history
- Initial refill/adherence history of prescriptions taken while an outpatient
- Demographics: Age, financial status, payer, diagnosis, length of stay, disposition
- Appropriate therapy/Interventions after admission based on:
  - Duplication of therapy
  - Omission
  - Drug interactions
  - Change of medications per formulary
  - Core measures
- Number of pharmacies utilized prior to admission

**Discharge from Hospital Measures**

- Number of new medications
- Total number of medications
- Cost of new medications based on insurance carrier
- Receiving method of discharge prescription(s) (e.g. fax, phone, written)
- Length of time between written prescription date of discharge vs. prescription date of fill
- Adherence to medications post-discharge
- Post-discharge follow-up appointments
- Patient education with counseling

**Other Global Metrics**

- Patient satisfaction surveys: for example, HCAHPS
- Immunizations
- Reports of adverse drug events
- Readmission rate
Useful Resources

- American Society of Health-System Pharmacists: Optimizing Medication Reconciliation
- American Society of Health-System Pharmacists: Pharmacy Technicians Assisting in Reducing Readmissions
- American Society of Health-System Pharmacists: PPMI Case Studies
- American Society of Health-System Pharmacists: Webinars
- ARC – Avoid Readmissions through Collaboration
- ASHP-APhA Medication Management in Care Transitions Best Practices
- BOOSTing (Better Outcomes by Optimizing Safe Transitions) Care Transitions
- CMS Readmissions Reduction Program
- Medications at Transitions and Clinical Handoffs (MATCH) Toolkit for Medication Reconciliation
- National Transitions of Care Coalition: Improving Transitions of Care
- No Place Like Home Campaign
- Project RED (Re-Engineered Discharge)
- Root, et al. Implementing a Pharmacist-Led Medication Management Pilot to Improve Care Transitions. *Innovations in Pharmacy* 2012; 3 (2) 75
Admission to Acute Care

- Designated provider obtains and documents medication history in electronic medical record.
- Designated provider documents home medications.
- Designated provider orders medications based on patient’s clinical status and medication list obtained at admission.
- Pharmacist completes comprehensive medication reconciliation and makes necessary adjustments in consultation with patient’s prescriber.
- Physician is consulted regarding any changes made.
- Designated provider updates medication list to include medication reconciliation results and discharge medications.
- Electronic medical record is updated to include results of medication reconciliation and all discharge medications.
- Patient provided with concise, easily understood medication list that considers previous prescriptions, over-the-counter drugs and supplements.
- Pharmacist provides medication consultation to, among other goals, educate the patient.
- Patient’s insurance benefits are maximized and insurance adjudicated.
- Pharmacist ensures patient has received medications upon discharge, picked up medications at pharmacy or had medications delivered to home.

Discharge

Admission to Skilled Nursing Facility

- Comprehensive medication list is sent to care facility.
- Facility nurse reviews discharge orders, enters admission orders into health record, verifies with attending MD and submits Interim Medication Regimen Review to Long-term care or Consultant Pharmacist.
- Pharmacist works with patient to ensure adherence and monitors for signs of complications.
- Pharmacist works with patient’s designated provider to adjust and/or discontinue medication therapy as warranted by clinical indications.
- Long-term care or Consultant Pharmacist reviews admission orders and returns recommendations to facility staff or Director of Nursing Services.
- Interim medication changes made by prescriber, entered into facility system and reviewed by Consultant Pharmacist. Recommendations made as needed.
- Discharge orders received, nursing staff reviews medications and provides them with instructions to resident or caregiver.
- Long-term care or Consultant pharmacist follows up with transfer to community.

Return to Home or Residential Care

- Pharmacist boosts adherence by calling patient at intervals over next 60 days.
- Pharmacist works to educate caregivers as needed.
- Pharmacist notifies patient’s designated provider of any concerns such as home issues, clinical issues, etc.
- Pharmacist works with patient’s designated provider to adjust and/or discontinue medication therapy as warranted by clinical indications.
- Facility staff follow-up with resident or caregiver on discharge instructions and progress at home.
- Community Pharmacist manages medication therapy via pharmacy-directed program.

Discharge