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Transitions of Care in Small Rural Hospitals

ASHP's Practice Advancement Initiative 2030 Recommendations start off with Patient-Centered Care, with the Practice-focused recommendations pertaining to pharmacy taking an active role in transitions of care.

Definitions:

- ED: emergency department
- H&P: history and physical
- IT: information technology
- MAR: medication administration record
- MHC: medication history coordinators
- PCP: primary care provider
- PDMP: Prescription Drug Monitoring Program
- SRH: small and rural hospitals
- TOC: transitions of care
- VA: Veterans Affairs

PRACTICE ADVANCEMENT INITIATIVE 2030 RECOMMENDATIONS

Patient-Centered Care

Practice-focused:

A1. Pharmacists should collaborate with patients, families, and caregivers to ensure that treatment plans respect patients' beliefs, values, autonomy, and agency.

A2. The pharmacy workforce should lead medication reconciliation processes during care transitions (e.g., emergency department, upon admission and discharge, ambulatory-care setting, community pharmacy, long term care).

A3. The pharmacy workforce should collaborate with patients, caregivers, payers, and healthcare professionals to establish consistent and sustainable models for seamless transitions of care.

A4. Pharmacist documentation related to patient care must be available to all members of the healthcare team, including patients, in all care settings.

A5. The pharmacy workforce should partner with patients and the inter-professional care team to identify, assess, and resolve barriers to medication access, adherence, and health literacy.

A6. Patients must have access to a pharmacist in all settings of care.

Having a Transitions of Care (TOC) pharmacy position(s) is critical for patient safety and improved outcomes. This can be challenging in small and rural hospitals/health systems.

Where do we begin? How do we get finance and C-suite on board? Why is this important?

TOC pharmacy team members are not revenue generating positions. They are cost-savings positions which can be difficult to assign hard dollar amounts saved.

Provider champion – head hospitalist, medical director, ED medical provider – someone that upper management will listen to and will advocate for the program. This is key. Ask the provider what they would like to see as far as medication reconciliation and discharge. Share with them what the possibilities are with pharmacy involvement with transitions of care.

For management, quality, and finance, show the value of TOC pharmacy, as they may not be aware of what can be accomplished.

- Reducing in-patient length of stay by reducing adverse drug events in the hospital:
  - Omission
  - Dosage error
  - Prescribing medications patient no longer takes
  - Allergies
  - Inaccurate frequencies
  - Contraindications
  - Duplication of therapies
- Preventing readmissions and improving health and well-being of our patients:
  - Same as above
  - Patient/caregiver education, including demonstrations
  - Verifying insurance coverage
  - Verifying availability of needed medication
  - Prescriptions sent to correct pharmacy
  - Patient assistance programs
  - Correct med list for outpatient providers
  - Improved patient adherence
  - Streamlined medications
  - Decreased side effects
- Bundled payment/star rating/Leap Frog scores/patient satisfaction scores

Barriers to TOC pharmacy team:

- Funding $$$ - new positions with limited budget
  - What department needs to budget for these positions?
    - Pharmacy, Nursing, Quality, or Medical staff
- Resources
  - Computer, phone, fax/printer, cell phone

- Staffing – can be challenging in small and rural hospitals to find/recruit pharmacists and experienced pharmacy technicians
- Space – desk/office
    - Where should the TOC team be located?
        - Nursing units, hospitalists' office, secluded space, pharmacy department
- Nursing – may have the belief that the discharge process will be slowed down
    - Nurses pressured to free up bed
    - Patient/family/ride eager to leave

Many hospitals begin the TOC journey by placing a pharmacist in the Emergency Department to perform home medication lists. Compiling home medication lists can be very time-consuming when aiming for the highest level of accuracy. Contacting multiple sources as well as speaking with the patient and/or caregiver is something the nursing department does not have time to do well. Utilizing a pharmacist increases accuracy of the home medication list, but this is an expensive resource.

Start with Medication History Coordinators (Med Rec Tech)

Medication history coordinators (MHC) are pharmacy technicians whose role is to establish the most accurate and up to date home medication list. **MHC's do not reconcile medications as it is out of their scope of practice.**

Who makes a good MHC and what skills should they have?

- Retail technicians (preferably nationally certified) are a good choice for this position as they have experience speaking with patients; retail medications are often different than inpatient medications, so more familiarity with home medication names, doses, and frequencies.
- Attention to detail
- Interpersonal and communication skills
- Ability to work independently as well as with others
- Computer skills – able to obtain home medication histories from outside entities and enter information into medical charts appropriately
- Basic medical knowledge

MHC's job duties:

- Identify patients needing home medication list review
- Interview patients and caregivers regarding home medications, how/when taken, discrepancies, compliance, and about allergies and reactions
- Contact retail and mail-order pharmacies for fill history for the last 12 months
- Contact primary care, specialists, VA, etc. for progress notes and medication lists
- If MHC is registered as an agent for specific providers, they may access the PDMP database per state guidelines.
- Based on information gathered, compile an accurate and up to date home medication list and enter it in patient's chart

- Inform nurse that is caring for the patient and the provider when medication list is completed and any discrepancies found – by phone call, secure chat, direct communication
- Involve hospital inpatient pharmacist to assist with any clarifications or assistance needed if no TOC pharmacist at site
- Once they have compiled the list, they indicate if the list is: fully accurate, partially verified, or this list may not be complete.
- IT IS THE PROVIDER'S RESPONSIBILITY TO THEN RECONCILE THE HOME MEDICATIONS WITH INPATIENT MEDICATIONS.
- At the end of their shift, email the list of names/DOB of the patients whose home medication lists were completed, to inpatient/TOC pharmacists for review.

Certification programs specifically for MHC:

- ASHP's Medication History-Taking Certificate: https://elearning.ashp.org/products/10521/medication-history-taking-certificate

  The online curriculum includes the following topics:

  - The impact of incomplete and inaccurate medication histories on patient safety
  - a review of the most commonly prescribed medications and immunizations, and the diseases they treat/prevent
  - sources of information for medication histories
  - interviewing patients to gather "best possible" medication histories
  - recommendations for avoiding common errors and omissions when obtaining medication histories
  - medication adherence assessment and improvement strategies
  - legal considerations related to medication history-taking
  - customizing and implementing a medication history-taking service

Other Resources:

- https://www.ptcb.org/guidebook/ptcb-medication-history-assessment-based-certificate-program
- https://www.pharmacytechnician.org/npta/Medication_History.asp

Transitions of Care Clinical Pharmacist's duties

- Admission med rec review – assist MHC's with questions, secondary reconciliation, clarify discrepancies between Primary Care Provider (PCP), retail med list, patient
  - Any discrepancies are then discussed with provider and resolved
  - Documentation of actions taken
- Chart review – labs, vitals, H&P/progress notes/discharge summary
- Discharge medication reconciliation

    - Identifying which patients should be the primary focus
        - Disease state specific – (e.g., congestive heart failure, chronic obstructive pulmonary disease, etc.)
        - High risk of readmission – IT report, quality/case managers may have the data
        - Specific nursing unit – general medical, surgical, observation
        - Bundled payment patients
        - New blood thinner or high-risk medication
        - Non-compliant patients
    - Identifying if the discharge medication list is correct
        - Best practice guidelines for all disease states
        - Appropriateness for: age, weight, renal or hepatic function, current vital signs, potential interactions of other medications, medications requiring dose/frequency adjustments
        - Duplications – therapeutic interchanges
        - Omissions
        - New medications not on the discharge med list
        - Supplies needed left off list
        - Microbiology not addressed
- Patient's concerns: potential side effects, cultural considerations, likelihood of compliance, complicated scheduling/timing of medications taken into consideration
- Confirming if new prescriptions were sent to correct pharmacy
    - Mail order versus local pharmacy
        - Need to change from regular pharmacy to one close to hospital
- Ability to obtain medication orders or corrections from provider and update discharge medication list and transmit orders to retail pharmacies
- Documentation of actions taken by TOC pharmacist
- Prior authorizations – Does TOC pharmacist or the case managers take responsibility?
    - TOC pharmacists are more likely to know which prior authorizations are urgent and why that particular medication is necessary
    - TOC pharmacists are able to suggest an appropriate alternative if available
- Patient assistance/co-pay costs
    - Call retail pharmacy to verify coverage, co-pay, cost
        - Can the patient afford it?
        - Is there a coupon available? – Work with manufacturers to have coupons on hand or do quick internet search
        - Patient assistance program through manufacturer – direct patient to assistance programs and help where possible.
        - Pharmacy discount card
        - Will the hospital cover the co-pay? Petty cash?
        - Preferred formulary alternative – obtain order from provider to change and send to pharmacy
- Availability

  - Local pharmacies are now using a "central fill" pharmacy, which delays patients' medications, sometimes over 24 hours. Call local pharmacies to have them filled at the local store if medications are needed on the same day.
  - Availability of new or medications not used frequently, or medications that may not be stocked and hard to find
- Patient/caregiver education
  - Motivational interviewing (e.g., open-ended questions, goals, concerns)
  - New/discontinued/changes
  - Disease state education/monitoring – diabetic education including self-monitoring, anticoagulation teaching
  - Device demonstration – inhalers, insulin pens, glucose monitoring supplies
    - Does the patient have the supplies needed at home and are they willing to use them?
      - Nebulizer for breathing treatments
      - Glucose monitor, test strips, lancets, glucose tablets, alcohol pads, sharps container, pen needle tips for insulin pens
  - Scheduling medications – try to have as few dose times as possible, encourage use of pill boxes
  - Medication reminders and assistance - alarms on watch or phone to remind them to take their medications, pill boxes - some pill boxes have alarms, friend/family member to call or to go to patient's home to check if medications have been taken, some retail pharmacies offer Pill Packs
  - Special diets/lifestyle modifications – tyramine free diet, reading food labels, counting carbohydrates, low sodium
  - Clinical pharmacist's phone number
  - Pharmacists' note in chart viewable by patient and other health care providers
- Collaborative care team/rounds
- Integrate into hospitalist department or nursing units – demonstrate your skill set and knowledge and they will advocate for you
- Document interventions/catches
- Hand off to primary care provider – communicate concerns and changes
- Follow-up phone calls to patients
  - Check with nursing so patient does not receive multiple calls
  - Prioritize patients who need calls

Who benefits from a Transitions of Care pharmacy team?

- Patients – discharged on correct medications/treatments, improves quality of life, decreased costs, decreased pill burdens, better understanding of disease states and medications leading to improved compliance and decreased visits to hospitals, urgent care or emergency room
- Caregivers – better understanding of medications and how to care for patient
- Pharmacists – practicing at top of license, proactive role, job satisfaction, instant gratification of making a difference

- The hospital – decreased readmissions, decreased length of stay, improved patient satisfaction scores
- Medical providers – confidence in home medication list, another layer of security on discharge, able to be more efficient
- Nursing – not medication experts, more confident in medication list, takes med teaching off their plate to focus on "nursing"

How do you measure success?

- Patient satisfaction scores
- Readmission rates
- Decreased length of stay
- Documented interventions
- Employee engagement

Things to determine prior to starting a TOC program:

- Do you need a TOC written policy?
- How many and which sources (minimum) should you use when compiling home medication lists to ensure the most accuracy?
    - Retail pharmacy fill history
    - Mail order pharmacy fill history
    - External medication history if available (e.g., EHR, external databases, etc.)
    - VA
    - Medication bottles
    - PDMP
    - Primary care provider – last visit and med list
    - Specialty provider – cardiologist
    - Recent hospitalizations – within 1,3,6 months
    - Nursing home or care facility MAR
    - Patient if able
    - Caregiver or family member
- How do you clarify discrepancies between how a home medication is prescribed and how the patient actually takes it or is not taking?
    - Prescribed and filled at pharmacy, but patient not taking or taking differently
        - Attempt to determine why there is a discrepancy
            - Adverse reaction, rationing due to cost, forget to take, side effects leading to patient reducing dose or frequency, did not understand what medication was for or its importance, does not believe they have the condition for which it was prescribed, etc.
- Whose responsibility is it to check the MHC's work or answer their questions?
- Do MHC's have the ability to remove medications from the home medication list or make changes?
- How to communicate the accuracy of the home medication list

    - Color coded: red – not able to verify with patient/care giver; yellow – mostly accurate; or green – completely verified and accurate
- What is the timeframe goal for completing the home medication list?
- Should the TOC pharmacist concentrate on admission or discharge?
- Should the TOC pharmacist send corrections/new prescriptions to retail pharmacy or does the provider need to do it?
- Integrating with the care teams – be included in rounding or anytime discharges or discharge processes are being discussed
- How are the MHC's alerted to new admissions and ones that have not had home a medication list verified?
- Who verifies home medications when MHCs are not here? (weekends, nights/evenings)
- How are TOC pharmacists notified of discharges? Providers, nurses, ward clerks, status boards
- How do you prioritize discharges when multiple discharges are happening at the same time?
- Who covers when TOC pharmacist is not available?
- Are TOC pharmacists covering in-patient pharmacy holes or weekends thereby creating holes in the TOC coverage?
- After hours patient calls/messages – time frame to answer
- When do you have to do a medication event (error report)
- Documentation on teaching required to satisfy accreditation bodies (e.g., TJC, DNV)
- Correcting admission medication list (home med list) if discharge has already been done by provider - requiring additional changes or reconciliation.
- Who is responsible for prior authorizations
- Alert local pharmacies of the new TOC program and that they will be receiving calls requesting medication histories. Give local pharmacies the phone number for the TOC pharmacist to assist in clarifying prescriptions they receive from hospitalists.

Utilizing pharmacy students and residents in TOC rotation

- Would your hospital provide housing for students? This can attract more students to your rotation.

Example Rotation Description:

- Schedule: Monday – Friday, 8am to 4:30pm
- Patients transitioning into and out of hospitals are at a heightened risk of having medication errors. Pharmacists have the medication knowledge and patient counseling skills to help prevent errors and improve the quality of life of our patients. The Transitions of Care pharmacists are an important part of the collaborative care team and work out on the nursing units and hospitalists' office, assisting in medication reconciliation and addressing discrepancies. This Transitions of Care rotation will cover pre-hospital home medications, in-patient medications, and discharge medications with patient/care-giver education.

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Goals and Objectives:

- Admission medication lists
- Reconciling medication lists
- Identify and resolve medication discrepancies
- Communicate appropriately with medical providers, nurses, case managers, and patients/care givers
- Communicate with external pharmacists and technicians
- Identify barriers to medication therapy outside of the hospital
- Appropriateness of medications
- Disease state and lab review
- Patients' role and responsibility of their care
- Retrieve pertinent information from EHR
- Document interventions/trending
- Review/reconcile MHC med lists
- Motivational interviewing listening/empathy skills
- Develop patient goals
- Demonstrate use of insulin pens and inhalers
- Home health agencies
- Post-discharge follow-up

Activities:

- During this rotation students will be expected to perform daily activities and others as assigned by the preceptor such as, but not limited to, the following:
    1. Check-in with nursing units and providers to gather anticipated discharges at 8 am and throughout the day to ensure we are completing as many discharges as possible.
    2. Answer questions and communicate with nursing, case managers, social workers, and providers throughout the day.
    3. Shadow Medication History Coordinators and observe how to complete an accurate and up-to-date home medication list.
    4. Review home medications with hospital medications and be able to resolve discrepancies by reviewing EHR, speaking with nurses, or in discussion with providers.
    5. Review and resolve discrepancies with discharge medication list, in-hospital medications, and pre-hospital medications, supplements, and alternative therapies. Ensure medications are following current best practices and have appropriate pharmacotherapeutic recommendations to discuss with providers if they are different than currently prescribed.
    6. Complete medication discharge list by indicating last dose given date and time, and any important administration information (e.g., empty stomach, with food, rinse mouth, start tomorrow, etc.).
    7. Discuss discharge medications with a pharmacist prior to speaking with the caregiver/patient.
    8. Communicate discharge medications with patient/family/caregiver and identify any barriers to compliance with medications.

9. Demonstrate device usage for new prescriptions – insulin pens, inhalers, diabetic testing supplies.
10. Develop action plans and monitoring for patients after discharge.
11. Contact community pharmacies to ensure transmission of prescription, insurance coverage, co-pay, and availability of medication(s) to be picked up.
12. Document significant discrepancies and interventions appropriately.
13. Complete post-discharge follow-up phone calls within 72 hours of discharge for patients returning home and actions necessary from call.
14. Attend committee meetings for: Discharge Process, Medication Reconciliation Data, Nursing/Pharmacy Committee, and any others required by preceptor.
15. Topic discussions with preceptor:
    a. Motivational interviewing
    b. Barriers to medication adherence
16. Current best practices for:
    a. Diabetes
    b. CHF
    c. Anti-coagulation
    d. Infectious Diseases – pneumonia, cellulitis, osteomyelitis, c-diff
    e. COPD
    f. Post-op joint replacement
    g. Acute vs Chronic Pain
    h. Other disease states that pertain to current patients
17. Weekly presentation on a patient; including current best-practice and literature review.

Expectations:

- Students are expected to be on time and stay as late as necessary to complete their work.
- Professional dress and an ID badge are required; white coat is optional. (Ties or scarves are not to be worn due to infection prevention policies).
- Professional, courteous, and respectful communication is required.
- If you have a question, please ask. Never guess - it is okay if you don't have the answer and have to get back to someone.
- Daily communication with the preceptor is required and feedback will be given at a minimum weekly.
- Cell phone use is not to be done in patient care areas or in front of patients/caregivers.
- Do not take patient information home with you, keep it secured when not in your possession.
- This rotation requires communication skills and levels of communication. You have to be able to take what you've learned and communicate it in ways that patients will understand. It is understood that this may be the first time you are doing this, and you will improve in this area as the rotation progresses.

ASHP's Transitions of Care Student Rotation available at:

https://www.ashp.org/-/media/assets/pharmacy-practice/resource-centers/preceptor-toolkit/sample-transitions-care-appe-student-rotation.pdf

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