PHARMACY VISION 20/20

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Disneyland RESORT

Patient Care Resources to TOC About: A Transitions of Care Toolkit

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DISCLOSURE

NO CONFLICT OF INTEREST TO DISCLOSE

Learning Objectives

Describe best practices to optimize medication therapy during transitions of care

Identify and address barriers to patient access to medications and healthcare services

Improve communication between healthcare providers and patients

Describe best practices for integration of TOC services in various care settings

TRANSITIONS OF CARE[1]

- The Centers for Medicare & Medicaid Services (CMS) defines a transition of care as the movement of a patient from one setting of care to another
- Transition within or across different healthcare settings
  - Change in service or level of care
  - Change in setting
  - Change in provider
- Among Medicare patients, almost 20 percent who are discharged from a hospital are readmitted within 30 days
- Unplanned readmissions, at a cost of USD $17.4 billion, accounted for 17 percent of total hospital payments from Medicare in 2004

CONSEQUENCES OF POOR TRANSITIONS OF CARE[2,3]

INEFFECTIVE OR DUPLICATIVE CARE

MEDICATION ERRORS AND ADVERSE EVENTS

INADEQUATE FOLLOW UP

INCREASED HOSPITAL LENGTH OF STAY

EXCESSIVE ED VISITS AND AVOIDABLE READMISSIONS

INCREASED HEALTH CARE COST

PATIENT DISSATISFACTION

Goals of Transitions of Care[2,3]

TRANSITIONS OF CARE TOOLKIT GOALS[2]

- Transitions of care (TOC) resources are abundant but they are not located in one central location
- Provide an evidence-based summary of resources in one central location for ease of access by individuals involved in TOC
- Improve the education and awareness of the role of pharmacists within TOC.
- Improve the quality of patient-centered care
- Reduce health care costs
- Optimize medication therapy during TOC.

Opportunities for Pharmacist Involvement in Transitions of Care[2,3]

MEDICATION RECONCILIATION

MEDICATION MANAGEMENT

PATIENT AND/OR CAREGIVER EDUCATION

CARE COORDINATION

PRESCRIPTION SERVICES

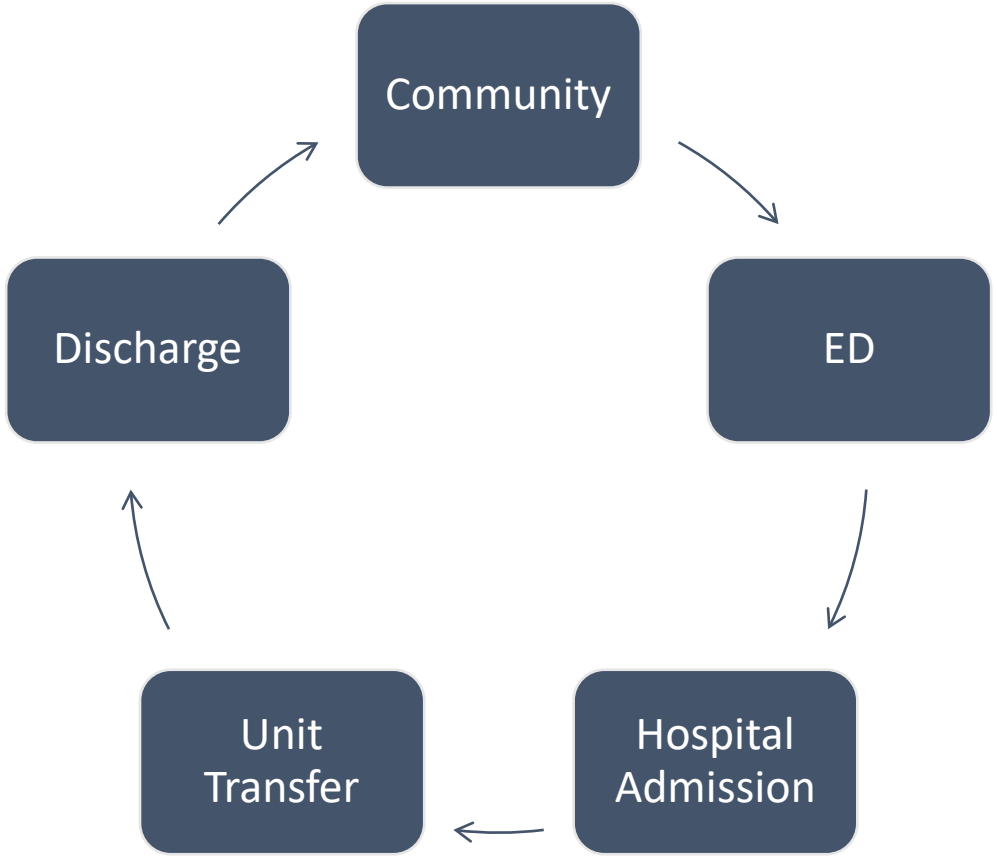
COMPREHENSIVE DISCHARGE PLANNING

Optimizing Medication Therapy

Optimizing Medication Therapy

- Medication reconciliation
- Patient education
- Assessment of adherence and patient barriers
- Follow-up and monitoring

MEDICATION RECONCILIATION[4]



A formal process for ensuring a complete and accurate medication list at each interface of care

Best Possible Medication History (BPMH)[4]

Drug name, dose, route, and frequency	How patient is actually taking vs. how prescribed	Newly prescribed medications	Unchanged medications that are to be continued
Medications held	Adjusted medication	New medications started upon discharge	Adherence

COLLECTING A BPMH[4]

- Patient medication interview where possible
- Verification of medication information with more than one source as appropriate including:
  - family or caregiver
  - community pharmacists and physicians
  - inspection of medication vials
  - patient medication lists
  - medication profile from other facilities
  - previous patient health records
- Other sources should never be a substitute for a thorough patient and/or family medication interview.

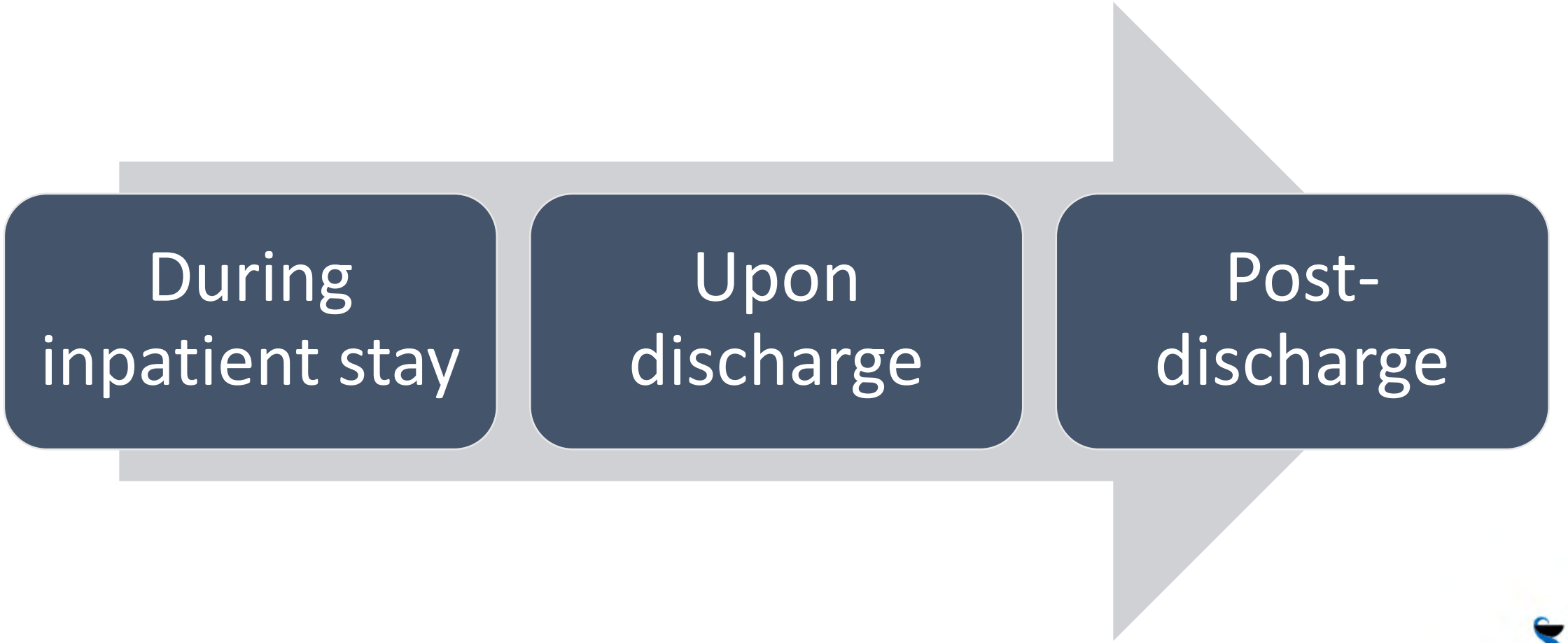
Medication History vs. Reconciliation[2]

Medication History	Medication Reconciliation
• First step of medication reconciliation • Pharmacy technicians, pharmacy students, pharmacists, nurses, physicians • BPMH	• Evaluate and assess patient medications to optimize therapy • Physicians, pharmacists

Tools to Support Medication Reconciliation[4,5]

- Collecting a BPMH
- Identifying and addressing medication discrepancies
- Assessing adherence

Patient Education – When?



Patient Education – Who?

Providing the education

- Nursing
- Medical
- Pharmacy

Receiving the education

- Patient
- Family
- Caregiver

Providing Education: What?

Review best possible medication list

- Dose, frequency, administration technique, storage, disposal, ADRs, monitoring parameters, goals of therapy

Discuss disease state management

Discuss warning signs

- What should the patient do?

Provide written information

Providing Education: How?

- Consider health literacy and language barriers
- Medication management support
- Teach-back method → confirm patient understanding
- Motivational interviewing → self-management

Patient Case

- CD is a 62 year old asthmatic who discharged from the hospital after being treated for an exacerbation. On admission, she was taking albuterol but was not compliant with her Flovent inhaler. She was discharged with a prescription for Advair 100/50 1 puff BID and albuterol inhalation solution for nebulizer. One week later, she is followed up with a post discharge phone call. She admits she went to the pharmacy but did not pick up her Advair because it was too expensive and only albuterol has worked in the past. She complains she still has some shortness of breath.
- **How can you help this patient?**

Patient Case

- Barriers:
  - Compliance issue
  - Cost
  - Educational deficit
  - Patient is still symptomatic
  - May not have a nebulizer
- Solution:
  - Consider co-payment cards to assist with cost
  - Switch to alternative
  - Education: Expectations, benefits vs. risks
  - Counseling: Establish and keep patients trust

Tools to Support Patient Education[6-8]

- Improving communication
- Incorporating Teach-Back
- Assessing health literacy and language barriers
- Respecting belief systems
- Motivational Interviewing

Comprehensive Discharge Planning

- Medication management
- Patient education
- Follow-up and monitoring
- Access and formulary issues
- Discharge disposition

Interdisciplinary Team Care Rounds

- Identify and address medication access issues in advance of hospital discharge
- Consider unique patient needs based on discharge disposition
- Interventions
  - Initiate prior authorizations
  - Ensure medication stock
  - Coordinate medication delivery
  - Schedule appropriate follow-up and monitoring
  - Identify patient specific barriers

Addressing Barriers to Patient Access

THE TOC PHARMACIST AND MEDICATION ACCESS[2,3]

- The pharmacist can play a valuable role in improving patient access to medications by identifying and resolving barriers
- Take into consideration patient specific needs which will affect access to medications and health care services
  - Health and functional status
  - Cultural factors and personal beliefs
  - Health literacy
  - Socioeconomic barriers

PHARMACIST INTERVENTIONS[2,3]

- Securing access to medications
- Instructions for follow-up and monitoring
- Access to durable medical equipment (DME)
- Addressing financial barriers

SECURING MEDICATION ACCESS[2,3]

- Compliance with prescribing requirements
- Securing medication stock
- Coordination with compounding and specialty pharmacies
- Prescription delivery services
- Prior to admission medication refill status

INSTRUCTIONS FOR FOLLOW-UP AND MONITORING[2,3]

HOME HEALTH VISITS

IV INFUSIONS

LABS AND MONITORING

INSULIN SLIDING SCALES

ACCESS TO DURABLE MEDICAL EQUIPMENT (DME)[2,3]

- Nebulizer
- Blood pressure meter
- Mobility aids
- Diabetes supplies
  - Blood glucose meter
  - Test strips
  - Insulin syringes

ADDRESSING FINANCIAL BARRIERS[2,3]

- Identification of formulary restrictions
- Initiation of prior authorizations
- Coordination with case management and social work
- Insurance enrollment
- Payment vouchers
- Co-pay cards
- Manufacturer assistance programs

Patient Case

- GH is a 75 year old female presenting to her local community pharmacy Friday evening with a prescription for warfarin 5 mg daily and Lovenox 60 mg BID. She tells you that she was just discharged from the hospital for a blood clot and her doctor said she has to take both of these medications for at least a week. You notify her that you do not have the Lovenox in stock and that even if you did, it is not covered by her insurance and requires a prior authorization.

Patient Case

- What challenges is this patient encountering?
- How could this patient have been effectively transitioned to avoid these issues?

Patient Case

- What challenges is this patient encountering?
  - Medication is not in stock
  - Medication requires prior authorization
  - Insurance not always available on weekends
  - PA does not always have rapid turnaround
  - PCP not available on weekends
  - Challenge to reach hospital physicians
  - Patient absolutely needs this medication given importance of bridging and new clot
  - Lovenox is expensive medication

Patient Case

- How could this patient have been effectively transitioned to avoid these issues?
  - Sent her prescriptions in advance to confirm coverage
  - Discharge planning to resolve PA in advance
  - Consider alternative medications (NOACs, still check coverage)
  - Check stock of medication prior to discharge
  - Consider bedside delivery

Tools to Support Patient Access[2, 9-12]

- Government Assistance Programs
- Resources for uninsured and underinsured patients
- Medication and healthcare access

IMPROVING HEALTHCARE COMMUNICATION

THE TOC PHARMACIST AND CONTINUITY OF CARE[13-15]

- Readmissions are frequently attributed to medication-related problems and poor communication during TOC
- While 80% of community pharmacists reported receiving discharge mediation lists, only 6% reported offering TOC services
- Need for interprofessional collaboration and improved hand-off communication during healthcare transitions to provide continuity of care

Hand-Off Communication Considerations[2,3,16]

- Mode of communication
- Timing of communication
- Healthcare providers involved in transmitting information
- Healthcare providers receiving information
- Information provided
- Standardized workflow or template

Patient Case

EB is a 56 year old male admitted to the hospital for an acute MI. He is on warfarin for management of his atrial fibrillation but it was held for supra-therapeutic INR. On day 4 of his admission, the following medication list was sent to the skilled nursing facility he was discharging to. He spiked a fever prior to transport and his discharge was delayed. He was started on antibiotics for suspected PNA and was discharged on Day 5 with the intent of completing a 7 day course of levofloxacin. However, no follow up documentation was sent to the SNF. **What are the potential consequences of failure to communicate to the SNF?**

- **Medication List:**
- Aspirin 81 mg daily
- Plavix 75 mg daily
- Metoprolol XL 25 mg daily
- Lisinopril 10 mg daily
- Crestor 40 mg daily

Patient Case

- Consequences of poor communication
  - Omission of warfarin, which is indicated for stroke prevention
  - Labs not ordered for management of warfarin (INR checks)
  - No communication patient is suspected to have infection
  - Omission of levofloxacin
  - No appropriate follow up

Tools to Support Communication[2,16]

- Hand-Off Communication Tools
- Pharmacy Communication Templates
- Discharge Communication Templates

Integrating Transitions of Care Services

Potential Barriers to Integrating TOC Services[2]

Inability to allocate departmental labor and capital to support implementation
Lack of support from key stakeholders
Lack of correspondence between healthcare providers
Lack of interest from medical, pharmacy staff, or patients/caregivers
Prior incomplete implementation of a similar service
Limitations to EMR, issues with access to EMR for individuals, and continuity of care documentation

Addressing Potential Barriers[2]

- Approach will be unique based on needs of the individual institution
- Obtain buy-in from institutional administration and personnel
- Provide education on the new service and the value to the institution
- Obtain and incorporate feedback from key stakeholders to promote engagement
- Provide training to all personnel involved with or impacted by workflow
- Define metrics to track success of TOC services
- Incorporate quality improvement processes to adjust TOC services as needed

WHICH PATIENT CARE OUTCOMES CAN PHARMACISTS IMPACT?

- Readmission rates
- Medication adherence
- Medication error reduction
- Patient satisfaction
- Core measure compliance

TARGET POPULATIONS[1,17]

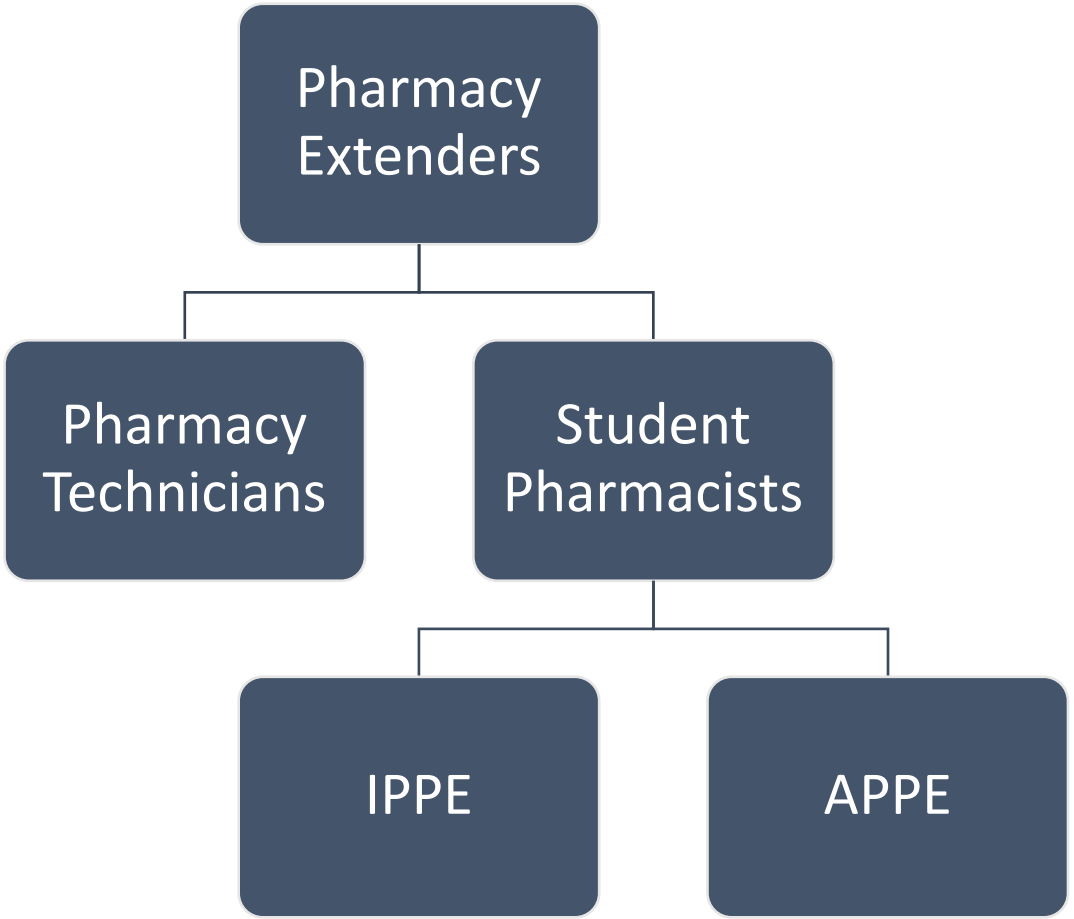
High risk:

- Elderly
- Low health literacy / socioeconomic status
- Special health care needs
- Polypharmacy
- Cognitive impairment
- Complex medical or behavioral health conditions
- Coexisting disabilities
- Homeless or medically underserved

CMS Hospital Readmissions Reduction Progra

- Acute Myocardial Infarction
- Chronic Obstructive Pulmonary Disease
- Heart Failure
- Pneumonia
- Coronary Artery Bypass Graft Surgery
- Elective Primary Total Hip Arthroplasty and/or Total Knee Arthroplasty

Pharmacy Resources



Tools to Support TOC Services[1,17-20]

- Identifying High Risk Patients
- Metrics and patient outcomes
- Quality improvement opportunities
- Billing Resources

CONCLUSION

- Patients must be safety and efficiently transitioned between health care settings
- Transitions of care is an interdisciplinary effort
- Patient needs may vary based on setting and level of care provided
- Medication optimization requires medication reconciliation, patient education, and communication between health care providers
- Every health care provider can contribute to optimizing transitions of care and improving patient outcomes

TEST QUESTIONS

What is the preferred source for collecting a best possible medication history?

a) The patient
b) The primary care physician
c) The community pharmacist
d) The electronic health record

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Answer: A

Test Questions

Which of the following strategies can support optimizing medication therapy?

a) Collecting a best possible medication history
b) Utilizing teach-back when educating patients
c) Identifying and addressing adherence barriers
d) Comprehensive discharge planning
e) All of the above

TEST QUESTIONS

Which of the following strategies can support optimizing medication therapy?

a) Collecting a best possible medication history
b) Utilizing teach-back when educating patients
c) Identifying and addressing adherence barriers
d) Comprehensive discharge planning
e) All of the above

Answer: E

Test Questions

After hospital discharge, which of the following should be communicated to the community pharmacist?

A) Changes to medication list including new medications, discontinued medications, and changes to dosing

B) A comprehensive list of all labs

C) A comprehensive list of all inpatient medications

D) Both A and B

E) All of the above

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D) Both A and B

E) All of the above

Answer: A

Reference List

1. Centers for Medicare and Medicaid Services. Community-based care transitions program. https://innovation.cms.gov/initiatives/CCTP. Accessed July 29, 2020.
2. American Pharmacists Association. Transitions of Care Toolkit. December 2019.
3. American Pharmacists Association. Applying the Pharmacists' Patient Care Process to Care Transitions Services. February 2019.
4. Medication Reconciliation: A Learning Guide – Queen's University Canada. https://meds.queensu.ca/central/assets/modules/mr/. Accessed August 3, 2020.
5. Coleman EA. Medication discrepancy tool (MDT). The Care Transitions. Program, Aurora, CO. https://caretransitions.org/wp-content/uploads/2015/08/MDT.pdf
6. Health Literacy Tool Shed. http://healthliteracy.bu.edu/all. Accessed August 2, 2020.
7. Teach-Back Toolkit. http://www.teachbacktraining.org/using-the-teach-back-toolkit. Accessed August 2, 2020.
8. Pharmacy Hand-Off Communication Resources. https://www.pswi.org/Resources/PSW-Transitions-of-Care-Toolkit/Pharmacy-Hand-off-Communication. Accessed July 31, 2020.
9. Patient Advocate Foundation. https://www.patientadvocate.org/. Accessed July 31, 2020.
10. Needy Meds. https://www.needymeds.org/. Accessed Aug 1, 2020.
11. RX Assist. https://www.rxassist.org/. Accessed Aug 2, 2020.
12. CoverMyMeds. https://www.covermymeds.com/main/. Accessed Aug 2, 2020.

Reference List

13. Bethishou L, Herzik K, Fang N, Abdo C, Tomaszewski DM. The impact of the pharmacist on continuity of care during transitions of care: A systematic review. J Am Pharm Assoc (2003). 2020;60(1):163-177.e2. doi:10.1016/j.japh.2019.06.020
14. Dolan MA., Renfro CP, et al. "Community Pharmacist Preferences in Transition of Care Communications." Journal of pharmacy practice (2018): 0897190018770551.
15. Wooster J, Bethishou L. The power of pharmacist-to-pharmacist handoffs during transitions of care. iForumRX. August 2019. https://iforumrx.org/commentary/power-pharmacist-pharmacist-handoffs-during-transitions-care
16. Bethishou L, Barker S, Bennet M et al. Actionable Patient Safety Solution (APSS) #6: Hand-off Communications. Patient Safety Movement Foundation. January 2019. (https://patientsafetymovement.org/wp-content/uploads/2016/02/APSS-6.pdf).
17. Toolkit to Engage High-Risk Patients In Safe Transitions Across Ambulatory Settings. Content last reviewed December 2017. Agency for Healthcare Research and Quality, Rockville, MD. https://www.ahrq.gov/hai/tools/ambulatory-care/safe-transitions.html
18. Otsuka SH, et al. A practical guide for pharmacists to establish a transitions of care program in an outpatient setting. J Am Pharm Assoc.2015;55:527–33.
19. Chronic care management (CCM): An overview. Developed through collaboration among American Pharmacists Association, Health Quality Innovators and Delmarva Foundation. March 2017. 1–18. https://www.pharmacist.com/sites/default/files/CCM-An-Overview-for-Pharmacists-FINAL.pdf
20. Pharmacy Health Information Technology Collaborative. Guidance for use of transitional care and chronic care management CPT codes. 2019. http://www.pharmacyhit.org/pdfs/workshop-documents/WG1-Post-2019-01.pdf. Accessed September 15, 2020

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