Section 2: Medication Safety During Transitions of Care: Clinical Implications

A collection of tools for use by pharmacists in any care setting. These tools are intended to assist in identifying and focusing on key medication classes and disease states to optimize medication safety during transitions of care.
Section 2.6: Tools to Improve Transitions of Care Processes
Section 2.6: Tools to Improve Transitions of Care Processes

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Part 2.6.1: Care Transitions Tools
National Transitions of Care Coalition (NTCC)

- Describes negative impact of poor transitions on care delivery
- Created tools to improve care transitions including:
  - Patient medication list
  - Bill of Rights during transitions of care
  - Transitions of care checklist
  - Importance of health information technology
  - Medication reconciliation essential elements
  - Policy paper

Link to downloadable NTCC tools:
http://ntocc.org/WhoWeServe/HealthCareProfessionals.aspx
Interventions to Reduce Acute Care Transfers (INTERACT®)

- Currently available for Nursing Homes, Assisted Living, and Home Health Care
  - Coming soon: for ACOs Health Systems and Bundled Payment
- Site-specific clinical and education tools include:
  - Quality improvement tools
  - Communication tools
  - Decision-support tools for change in condition
  - Advance care planning tools

Link to INTERACT tools:
http://www.pathway-interact.com/interact-tools/
Atlantic Quality Improvement Network (AQIN) Care Coordination Initiative

- Helpful tools for patients and caregivers include:
  - Personal Health Record (also available in Spanish)
  - Medication Management Golden Rules
  - Ask Me 3
  - Hospital Discharge Planning Golden Rules
  - Managing Your Congestive Heart Failure

Link to AQIN Care Coordination Initiative patient tools:
http://atlanticquality.org/initiatives/care-coordination/care-coordination-ny/
IHI STate Action on Avoidable Rehospitalizations (STAAR) Initiative

• Goal: to improve transitions of care and reduce avoidable rehospitalizations
• Helpful tools include:
  • STAAR overview documents
  • How-to guides customized for hospital to community settings, hospital to SNF, hospital to home health care, and hospital to clinical office practice
  • Diagnostic worksheets
  • State policy maker checklist
  • Issue briefs, webinars, presentations, and videos

Link to IHI STAAR Initiative tools:
Re-Engineered Discharge (RED) Toolkit

- By Boston University Medical Center and AHRQ
- Goal: to improve transitions of care and reduce avoidable rehospitalizations and emergency department visits
- Includes exhaustive how-to guides:
  - 11 steps for hospitals to implement RED
  - The After Hospital Care Plan
  - Delivering RED for diverse populations
  - Post-discharge follow-up
  - Monitoring implementation and outcome measures
  - Enhance the role of family caregivers

Link to the AHRQ RED tools:
Part 2.6.2: Medication Reconciliation Tools
Institute for Healthcare Improvement (IHI) Medication Reconciliation Content

- IHI collected many tools intended to improve medication reconciliation:
  - At all transitions (i.e. into hospital, between care units, and back to community)
  - In outpatient settings and hospital-based clinics
- Each page has links to featured content including:
  - Medication reconciliation toolkits and flowsheets
  - Medication lists for patients and families

Link to the IHI “Reconcile Medications at All Transition Points” page:
http://www.ihi.org/resources/Pages/Changes/ReconcileMedicationsatAllTransitionPoints.aspx

Link to the IHI “Reconcile Medications in Outpatient Settings” page:
http://www.ihi.org/resources/Pages/Changes/ReconcileMedicationsinOutpatientSettings.aspx
HealthIT.gov Medication Reconciliation EHR Meaningful Use Measure

• HealthIT.gov sets meaningful use measures to help providers implement electronic health records (EHRs)
• Collected resources and tools to help perform medication reconciliation at care transitions
  • From CMS and the National Learning Consortium
• To help healthcare professionals meet the Medication Reconciliation meaningful use measure

Link to HealthIT.gov medication reconciliation meaningful use resources:
https://www.healthit.gov/providers-professionals/achieve-meaningful-use/menu-measures/medication-reconciliation
North Carolina Center for Hospital Quality and Patient Safety Medication Safety Reconciliation Tool Kit

- Included as a resource on both the IHI and HealthIT.gov references above
- Includes introduction detailing scope of problem
- Outlines process steps to establish and implement a medication reconciliation process
- Includes sample process maps, algorithms, and forms which can be used to develop performance improvement model
- Cite references, websites, and example processes

Link to Medication Safety Reconciliation Tool Kit:
Part 2.6.3: Medication Management Tools
American Medical Association (AMA) Medication Adherence Module

• Outlines 8 steps to improve medication adherence
• Tips to involve staff and patients in identifying nonadherence and changing behaviors
• Online module and downloadable tools

Citation for STEPS forward Medication Adherence module:
https://www.stepsforward.org/modules/medication-adherence
Healthcare Compliance Packaging Council (HCPC)

• Promotes benefits of unit dose packaging with compliance-prompting features to help people take their medications properly
• Wrote a White Paper on Improving Medication Adherence Through Packaging
  • Shares results of 9 studies

Citation for HCPC White Paper:

Guide for Identifying and Resolving Discharge Medication Accessibility Problems in New York State

• Outlines potential problems and guidance for resolution to help identify potential drug therapy and community pharmacy problems

• Prepared by the Atlantic Quality Improvement Network (AQIN) Quality Improvement Organization (QIN) for New York State, South Carolina, and the District of Columbia

Link for AQIN medication accessibility problems guide:
Optimizing Discharge Medication Lists

• Needs assessment performed by care transitions pharmacist identified opportunities to optimize discharge medication lists

• Goal: to increase patient safety, reduce medication errors, and prevent medication-related hospital readmissions

Citation for pilot study:

Table 1. Ideal Components of a Skilled Nursing Facility Discharge Medication List

- Generate an electronic medication list to minimize human error.
- List both brand and generic medication names.
- Avoid using sig codes and medical abbreviations.
- Include indications for all medications.
- Provide indications in layperson terms.
- Ensure appropriate medication indications.
- Determine if holding parameters are appropriate and assess if patient and/or caregiver is able to understand parameters.
- Eliminate unnecessary protocol medications such as bowel regimens.
- Only specify times of administration if relevant to the patient’s lifestyle.
- Maximize readability by considering the font size and layout of medication list.
- Remove irrelevant information.
Part 2.6.4: Deprescribing Tools
Canadian Deprescribing Network (CaDeN) Deprescribing Tools

• Deprescribing guidelines for reducing or stopping potentially unnecessary or harmful medications:
  • Antipsychotics
  • Benzodiazepines and Z-drugs
  • Proton pump inhibitors
  • Antihyperglycemics

Link to CaDeN deprescribing guides:
http://deprescribing.org/resources/
MedStopper

- Input medications and treated conditions onto this interactive website to generate a list of potentially inappropriate medications to deprescribe (RED highest priority, GREEN lowest priority)

- Recommendations for drugs to stop consider:
  - Frail elderly scale
  - Potential for improving symptoms or reducing risk for future illness or causing harm
  - Whether on Beers or STOPP criteria
  - Whether tapering is suggested

Link to interactive MedStopper website:

http://medstopper.com/
Good Palliative-Geriatric Practice Algorithm

• Series of 5 questions determine whether drugs should be continued at the same dose, switch to another drug, stopped, or dose reduced:
  • Indication is valid and relevant
  • Possible adverse reactions outweigh possible benefits
  • Drug causing adverse signs or symptoms
  • Another drug is superior
  • Dose can be reduced without significant risk

Citation for the Good Palliative-Geriatric Practice Algorithm:
Prioritization & Stopping Medications

• Outlines opportunities for prioritization or discontinuation of medications based on degree of uncertainty (none or minimal, moderate, high)

• Reasons for action include:
  • To correct a medical error, to simplify regimen, benefit is unlikely, when safe for as-needed use, benefit has been achieved, behavioral intervention can be substituted, benefit is unlikely to be realized

Citation for prioritization and stopping medications article:
Medication Appropriateness for Patients Late in Life

- Proposed model for appropriate prescribing for patients late in life considers:
  - Remaining life expectancy
  - Time until benefit will be achieved
  - Goals of care
  - Treatment targets
- Goal: guide discontinuation or withholding of treatments otherwise indicated, appropriate, and recommended according to current guidelines

Citation for medication appropriateness late in life article:
Part 2.6.5: Risk Screening Tools
The LACE Index

• Scoring tool that identifies patients at high risk for readmission or death within 30 days of discharge from hospital

• “L” = length of stay; “A” = acuity of admission; “C” = co-morbidities; “E” = Emergency Department visits within the last 6 months

• Can help pharmacists target and prioritize patients who would benefit most from medication reconciliation and education on transition

Link to LACE index:
http://www.besler.com/lace-risk-score/