Connecting the Dots: Improving Post-Discharge Medication Coordination

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Goals of Today’s Presentation

• Understand why the transition between care settings is a common time for medication errors

• Identify barriers to appropriate medication use after discharge

• Utilize ALL members of the healthcare team to improve medication use post-discharge
Transitions of Care

- The movement of patients between health care practitioners, settings, and home as their condition and care needs change

- Any change in care setting or provider can be an opportunity for errors leading to adverse events
Activity – What Medicines do I Take??

- You’ve just been discharged home from the hospital
- You were given a few new prescriptions when leaving the hospital and a big packet of paper with instructions
- Someone quickly went through the changes with you, but you were so eager to get home that you didn’t ask many questions
- Now you are home – with a big pile of medicine – and don’t know what to do next
Activity – What Medicines do I Take??

• Using only the medication lists you have – figure out what medications you should be taking
Activity – What Medicines do I Take??

• What problems did you identify right away?

• Do you know (from these lists) what medicines you should be taking?

• What adverse events could happen if someone took all of these medications?
Transitions of Care – The Stats

• Patients are most vulnerable for medical errors during transitions of care

• 80% of serious medical errors involve miscommunication during the hand-off between medical providers

• Many errors stem from a lack of effective communication between providers
Transitions of Care – The Stats

• As many of 70% of patients have an unintentional medication discrepancy at discharge

• During the first few weeks after discharge
  – 50% of patients have a clinically important medication error
  – 20% experience an adverse event, most commonly an adverse drug event
Readmission Risk

• If a patient doesn’t know what medications to take after discharge, their risk of readmission can increase

• What patient populations can you think of that are at a high risk of readmission due to medication errors?
  – Patient with heart failure not taking new diuretics
  – Patient with COPD that doesn’t know how to use their inhalers
  – Patient with pneumonia doesn’t realize they need to finish their antibiotics
How Can We Fix This Problem?

• Need to understand all of the areas where problems can arise in the transition from one care setting to another

• Every member of the team can play an important role
Home to Hospital to Home – What’s the Process?

1. Patient taking meds at home
2. Admitted to the hospital
3. Med changes made during admission
4. Discharged home
5. Patient takes meds at home
Activity – The Post-Discharge Visit

• You work in a primary care office as a nurse. A patient comes in to your office before they see their PCP

• It’s a busy day – and this patient was squeezed into the provider’s lunch break because he was just discharged from the hospital

• Patient comes in with a list of medicines from the hospital, and a list of medicines that is dated from before his admission

• He’s not sure what medicines he actually has at home – and didn’t bring in the bottles
Activity – The Post-Discharge Visit

• What problems did you notice immediately?

• What questions do you have for the patient at this point?

• What could have made this process easier?
Transitions of Care: The Reality

• Patients may have multiple transitions before getting to home

• Figuring out what medications the patient should be taking takes a lot of time
So what can we do?

• Improving medication coordination after discharge involves all members of the team

• Each facility/practice site will have unique needs and need to find unique solutions to improve this part of patient care

• There are a few strategies that all facilities can use to improve coordination after discharge
Medication Reconciliation

• The process of creating the most accurate list possible of all medications a patient is taking – including the drug name, dosage, frequency, and route – and comparing that list against all other medication lists with the goal of providing correct medications to the patient
Medication Reconciliation

- “Med rec” is a common part of all visits with healthcare providers

- At the VA – should be completed during every visit with every provider

- Demonstration of what medication reconciliation often looks like in the “real world”
Medication Reconciliation

• What went well in this encounter?

• Did the provider complete a medication reconciliation?
  – An accurate list of medications
  – Includes name, dose, frequency, route
  – Compared to other lists

• What strategies could make this work better?
## Barriers to a Successful Medication Reconciliation

<table>
<thead>
<tr>
<th>Patient factors</th>
<th>Provider Factors</th>
<th>System Factors</th>
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<tbody>
<tr>
<td>• Limited knowledge of medications</td>
<td>• Limited time</td>
<td>• Unclear roles/expectations</td>
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<td>• Low health literacy</td>
<td>• Limited skills/knowledge in taking a medication history</td>
<td>• Insufficient staffing</td>
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<td>• Cognitive impairment</td>
<td>• Lack of buy-in</td>
<td>• IT limitations</td>
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<tr>
<td>• Not keeping updated medication list</td>
<td>• Insufficient knowledge of medications</td>
<td>• Electronic tools not well designed for the process</td>
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<td>• Not bringing medications or lists to health care visits</td>
<td>• Ambiguity regarding “ownership” of outpatient medications</td>
<td>• Increasing number of handoffs</td>
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<td></td>
<td>• Multiple providers/specialists involved in care</td>
<td>• Multiple sources of medication information</td>
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<td>• Competing priorities</td>
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Patient Driven Medication Reconciliation

• Goal of medication reconciliation is to figure out what medications the patient is taking and how they are taking the medications

• Asking the patient to tell you exactly what medicines they take, and how they take each one
  – Includes ALL medications: prescription, over the counter, supplements, etc.

• Takes more preparation and more time
Patient Driven Medication Reconciliation - Activity

- Completing a medication reconciliation in this way takes practice

- More open ended questions = more likelihood that patients will give you an honest representation of how they manage their medications

- Pair up with someone else at the table
  - One person will be the provider, one will be the patient
  - Using the lists provided, try using more open ended questions to complete the medication reconciliation
How to Fix the Problem with Transitions of Care

• Each health system has different unique problems and solutions

• Need to work with the members of your team to figure out the best way to overcome the barriers identified for your system

• Integrate ALL members of the team – everyone can play a role in improving post-discharge medication coordination
VA Maine – Our TOC Journey

• Working on length of stay – trying to optimize how long patients stay in the hospital

• At the same time – if patients are discharged too soon, they may be readmitted

• Concern that medication errors after discharge could increase risk of readmission
VA Maine’s Baseline Process

1. Patient discharged from hospital
2. Post discharge call from RN
3. Med rec attempted by RN – may not be completed
4. Patient comes to PCP visit with unclear med list
5. PCP spends a lot of time on med rec
6. Not enough time to address all concerns
VA Maine’s Process

• Baseline process had room for improvement

• A full medication reconciliation often not completed

• Needed to find a way to use other resources to improve this process
Pharmacists and Transitions of Care

- Pharmacists are becoming involved in post-discharge follow-up nationwide
- Pharmacists can add another point of contact after discharge
- Medication experts – can sort through the discharge summary and medication changes and determine what the patient should be taking
Transitions of Care Consult

- Started as a small, pilot project with a small patient population
- Focused on patients discharged after an admission for heart failure
- Eventually expanded to include any complex patient with any change in care setting
VA Maine’s New Process

Patient discharged from hospital → Post discharge calls: PharmD & RN → PharmD TOC appointment

Med list updated, questions answered → Patient sees PCP who can focus on other concerns → Patient leaves PCP visit knowing what meds to take
The TOC Visit

- Patients were scheduled to see a pharmacist before their post-discharge PCP visit
- Asked to bring in all medications – the actual bottles, pill boxes, vitamins, etc.
- Pharmacist reviews all medications, updates list, optimizes therapy, and provides recommendations
- Provided an accurate medication list to primary care/specialists
The TOC Consult – Results and Next Steps

• Approximately 100 patients have had a review by TOC pharmacists since January 2018
  – Started small with just heart failure
  – Expanding daily to include all complex patients

• Pharmacists prescribe AND de-prescribe medications
  – Targeting polypharmacy at the same time as post-discharge follow up

• Continuing to expand access to patients not seen at our main campus
  – Expanding to use tele-medicine to reach rural patients
What Strategies Work in Your Site?

• Not every practice has a pharmacist

• How can you utilize existing resources to improve follow up?

• On the other side – how can we improve our patients’ understanding of their medications BEFORE an admission?
Conclusions

- Each transition in care setting can increase the risk of medication errors

- Putting the patient at the center of a thorough medication reconciliation can improve their understanding of what medications to take...and improve our understanding of what they’re taking!

- Utilize existing resources and work to integrate more thorough medication reconciliation in all visits
Questions?

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