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Improving medication information transfer between hospitals, skilled-nursing facilities, and long-term-care pharmacies for hospital discharge transitions of care: A targeted needs assessment using the Intervention Mapping framework

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ABSTRACT

Introduction: Patients transitioning from the hospital to a skilled nursing home (SNF) are susceptible to medication-related errors resulting from fragmented communication between facilities. Through continuous process improvement efforts at the hospital, a targeted needs assessment was performed to understand the extent of medication-related issues when patients transition from the hospital into a SNF, and the gaps between the hospital's discharge process, and the needs of the SNF and long-term care (LTC) pharmacy. We report on the development of a logic model that will be used to explore methods for minimizing patient care medication delays and errors while further improving handoff communication to SNF and LTC pharmacy staff.

Methods: Applying the Intervention Mapping (IM) framework, a targeted needs assessment was performed using quantitative and qualitative methods. Using the hospital discharge medication list as reference, medication discrepancies in the SNF and LTC pharmacy lists were identified. SNF and LTC pharmacy staffs were also interviewed regarding the continuity of medication information post-discharge from the hospital.

Results: At least one medication discrepancy was discovered in 77.6% (n = 45/58) of SNF and 76.0% (n = 19/25) of LTC pharmacy medication lists. A total of 191 medication discrepancies were identified across all SNF and LTC pharmacy records. Of the 69 SNF staff interviewed, 20.3% (n = 14) reported patient care delays due to omitted documents during the hospital-to-SNF transition. During interviews, communication between the SNF/LTC pharmacy and the discharging hospital was described by facility staff as unidirectional with little opportunity for feedback on patient care concerns.

Conclusions: The targeted needs assessment guided by the IM framework has lent to several planned process improvements initiatives to help reduce medication discrepancies during the hospital-to-SNF transition as well as improve communication between healthcare entities. Opening lines of communication along with aligning healthcare entity goals may help prevent medication-related errors.

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1. Introduction

A patient's transition from a hospital to a skilled nursing facility (SNF) introduces the possibility for medication-related problems.^{1–5} Previous research has documented that at least one medication discrepancy, such as medication omissions or inconsistencies, occurs in three-fourths of hospital-to-SNF admissions.⁶ Freestanding SNFs have higher rates of hospital

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readmissions than hospital-based SNFs, demonstrating the importance of proximity to providers for communication during care transitions.⁷ Fragmented inter-setting communication has been found to underlie many of these challenges highlighting the critical need of examining the mechanisms by which SNFs receive medication information when patients are discharged from the hospital.^{2,6} Most SNFs do not supply their own medications and therefore have contracts with long-term care (LTC) pharmacies for their medication needs.⁸ Upon hospital discharge, the necessity of information to flow not only to the SNF but also to the LTC pharmacy further exposes the transition process to errors. Waiting to obtain medications from remote-site LTC pharmacies may further result in delayed patient care, especially for after-hours discharges and prescribed controlled substance medications which often require a signed hard copy prescription for dispensing.^{2,6,9} Despite these documented medication-related issues, there is a paucity of research that includes LTC pharmacies when examining the communication between healthcare settings when patients transition from the hospital to SNF post-discharge.

Hospitals often have no means for freestanding SNF or LTC pharmacy follow-up post-discharge and are unaware to the hardships these facilities face upon patient transfer.² SNF staff have expressed frustration about “blindly” delivering care due to not only unclear medication orders, but also inadequate communication of patients’ psychosocial or functional health status.² Furthermore, variability in skill level and services offered among different facilities result in inconsistent information requirements after an inpatient stay.² There is little guidance for hospitals with what information needs to be communicated to an off-site SNF or LTC pharmacy. In order to safely transition a patient from the hospital back to a SNF, hospital discharge teams must ensure to meet the SNF and LTC pharmacy’s needs.

Through our continuous process improvement efforts, we sought to improve the quality of care for patients transitioning from hospital to SNF post-discharge. We performed a targeted needs assessment at our hospital using quantitative and qualitative methods guided by the Intervention Mapping (IM) framework.¹⁰ The purpose of our needs assessment was to understand the extent of medication-related issues when patients transition from the hospital into a SNF and the gaps between the hospital’s discharge process and the needs of the SNF and LTC pharmacy. Our large academic Midwest hospital is a level one trauma center that annually discharges over 3300 patients to regional SNFs; no SNF is owned by the health system. Communication handoff for patients discharging to SNFs is an interdisciplinary effort between providers, nurses, pharmacists, and social workers/case managers. Case managers communicate with SNFs to obtain acceptance, insurance coverage, and arrange transportation. Providers place discharge medication orders and are required to complete a discharge summary prior to SNF acceptance. Pharmacists reconcile medications and prepare a chart with the medication orders. Inpatient nurses communicate with SNF nurses via telephone as well as sign out and educate patients on discharge. However, healthcare team members have their own expectations for SNF and LTC pharmacy handoff communication, and this process has never been standardized across disciplines. The main product of the needs assessment was a logic model so we may explore methods for minimizing patient care medication delays and errors while further improving handoff communication to SNF and LTC pharmacy providers.

To assist in the development of a needs assessment logic model, the specific aims of this study were to: 1) identify and characterize medication discrepancies that occur between our hospital’s medication discharge list compared to SNF and LTC pharmacy medication lists, and 2) examine barriers and facilitators of medication information communication between our hospital, SNFs, and LTC

pharmacies.

2. Methods

This needs assessment was guided by the IM framework, a widely utilized framework for implementing health programs. IM focuses on pre-implementation research and program evaluation to improve the likelihood of successful implementation.¹⁰ As outlined in the IM framework, a working group was established to perform the needs assessment. The working group members were selected for their expertise in transitional care, medication safety, and familiarity of the hospital discharge process: an inpatient hospital pharmacy manager, a second-year pharmacy resident with a focus on ambulatory care and transitions of care, a PhD-trained pharmacist scientist, and two pharmacy student interns. This work was determined to be Quality Improvement by the hospital’s Institutional Review Board (IRB) Committee.

The logic model was organized by the PRECEDE component of the PRECEDE-PROCEED model,¹¹ a commonly used framework within IM. The PRECEDE-PROCEED model posits that the diagnosis and description of the problem (PRECEDE component) is essential before developing and implementing the intervention (PROCEED component).¹² Further, it is flexible and serves as a structure for applying concepts systematically. As directed by the PRECEDE component, key elements of the logic model included *Patient and Societal Outcomes, Prevalence, and Conditions*. *Patient and Societal Outcomes* were defined as the medication problems and needs of patients who transition from the hospital to a SNF. *Prevalence* referred to the medication-related issues and patient care delays between the hospital, SNFs, and LTC pharmacies. *Conditions* were defined as factors that influence the consistency of medication information between healthcare settings. This study integrated both quantitative and qualitative data collection methods as well as literature reviews and brainstorming sessions to inform key elements as outlined below. Data collection and analyses occurred from January 2016 to July 2016.

2.1. Literature reviews, brainstorming sessions, and maintaining audit trail

The literature review was not intended to provide a foundation for the working group regarding the documented medication communication issues between the hospital, SNF, and LTC pharmacy facilities. Articles were identified through PubMed and Google Scholar using search terms: transition, medication reconciliation, skilled nursing facility, nursing homes, long-term care pharmacies, medication discrepancies, medication continuity, communication, and controlled substance diversion. Relevant articles were placed into a standardized data abstraction forms that were created by the research team.

Throughout the study period, the working group met monthly to discuss findings and barriers with data collection. An audit trail was kept throughout the study duration to document all decisions made with regards to data analyses, study protocol, and logic model creation. Any changes to study protocol were agreed upon by the entire working group, documented, and provided electronically to the team.

2.2. Quantitative approach

Medication discrepancies were quantified by comparing the hospital discharge medication list with the SNF medication administration records and LTC pharmacy profile one day after the patient was discharged from the hospital. All adult patients who were discharged from our hospital to a SNF were identified through

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