Management Case Study:
Implementation and Evaluation of a Pharmacist Driven Skilled Nursing Facility (SNF) Transitions of Care Model

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Learning Objectives

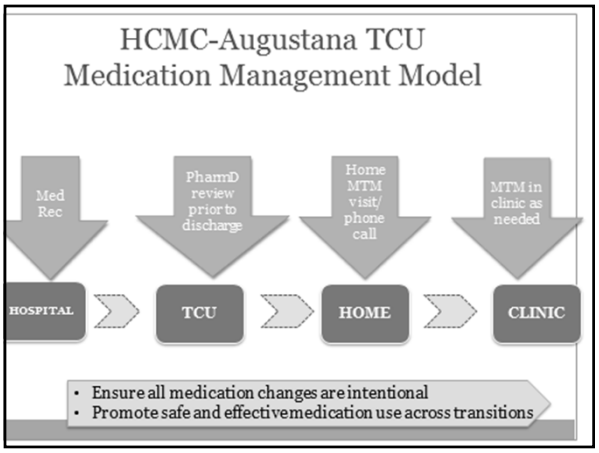
- Describe how a flow diagram may be used as a tool for health systems improvement to ensure safe medication use across transitions of care.
- Outline standard work of a pharmacist managing the transition from SNF to home.
- List electronic health record data challenges faced during quality improvement transitions of care initiatives.

Self-Assessment Questions

- **True or False**: Constructing a flow diagram describing patient care pathways and documentation standards should be one of the initial steps in designing a transitions of care initiative.
- **True or False**: Upon SNF discharge, the pharmacist's highest priority is ensuring the medication list in only the health system EHR is accurate.
- **True or False**: Prior to implementing a transitions of care initiative, a data management plan should be developed that outlines type of data to be collected, data source and frequency of collection.

Overview of the Problem

- Lack of initiatives for SNF Transitional Care Unit (TCU) patients
  - Consultant pharmacists
  - No formal medication reconciliation
- ~70% return home after TCU discharge
  - May have home care services
  - Delayed follow up with PCP post-discharge
  - Inconsistent pharmacist follow up in clinic



TCU Pharmacist Workflow

- Obtain list of discharges from Therapy & Social Work
- Review medication list and chart notes to identify medication changes
- Meet with patient and determine follow up
- Consult with NPs to determine home regimen
- Place discharge med orders in EHR
- Visit patient at their home post-discharge

Evaluation Plan

- **Methods:** Retrospective chart review
- Data collected using EHR from health system & TCU

Primary Outcome	30 Day Post TCU Discharge Hospitalization & Emergency Department Visit Rates
Secondary Outcome	Number & Type of Medication Related Problems Identified Among Intervention Group

Results

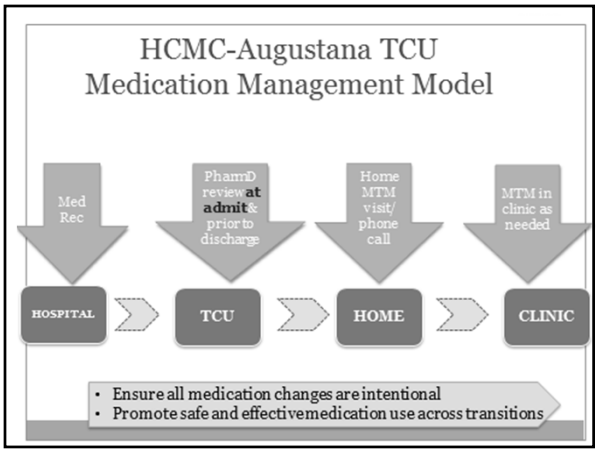
	Comparison (n=189)	Intervention (n=88)	p-value
Ave Age (yrs)	69.7	70.8	0.52
Gender (%male)	40	43	0.64
Ave TCU LOS (days)	35.4	29.1	0.13
Median TCU LOS (days)	24	23	

Results

	Comparison (n=189)	Intervention (n=88)
ED visits (# of events)	64 (33.9%)	21 (23.9%)
ED median LOS (days)	0.40	0.44
Hospitalizations (#of events)	43 (22.8%)	9 (10.2%)
Hospital median LOS (days)	2.9	3

Lessons Learned

- Transition of Care Documentation Problems
- Despite using data from two EHRs, not all outcomes can be tracked
- Adherence to medications not often documented



Self-Assessment Question 1

- **True or False:** Constructing a flow diagram describing patient care pathways and documentation standards should be one of the initial steps in designing a transitions of care initiative.

Answer: True

Self-Assessment Question 2

- **True or False:** Upon SNF discharge, the pharmacist's highest priority is ensuring the medication list in only the health system EHR is accurate

  Answer: False

Self-Assessment Question 3

- **True or False:** Prior to implementing a transitions of care initiative, a data management plan should be developed that outlines type of data to be collected, data source and frequency of collection.

  Answer: True

Key Takeaways

- **Key Takeaway #1**
  - TCU staff and health system staff must collaborate to outline care processes and documentation standards.
- **Key Takeaway #2**
  - Pharmacists must communicate medication changes made to pharmacist & providers across each care transition.
- **Key Takeaway #3**
  - Improvements in delivering accurate clinical data across the transitions of care could help facilitate quality initiatives