INTRODUCTION

PURPOSE: The purpose of the Pharm2Pharm Standard Operating Procedures (SOPs) is:
- To ensure standardized and consistently high quality care is provided to patients enrolled in the Pharm2Pharm service.
- To optimize efficiency and effectiveness of the Pharm2Pharm service.
- To facilitate the training of pharmacists involved in delivering the Pharm2Pharm service.
- To support the roll-out of the Pharm2Pharm service model in other communities.

CONTEXT: This is a new service model for improving care for high risk patients. All of the services described within these SOPs are within scope of practice for licensed pharmacists within the State of Hawai‘i. These SOPs are new and should be viewed as a “Work in Progress”; participating pharmacists are strongly encouraged to continuously give feedback to improve them. While pharmacists are urged to closely adhere to all procedures as described in order to optimize the success of the model, there may be times when strict adherence is neither feasible nor optimal. Deviations from these procedures should be promptly discussed with the Physician Leader, Director of Workforce Development, and/or Project Director (see signature page).

“CONSULTING PHARMACIST”: For consistency, the licensed pharmacists performing the Pharm2Pharm services are referred to as “Consulting Pharmacists”, and at times, more specifically as “Hospital Consulting Pharmacists” (HCPs) or “Community Consulting Pharmacists” (CCPs) based on the specific duties they perform.

BACKGROUND: According to Hawai‘i Health Information Corporation, medication-related hospitalizations in Hawai‘i in 2010 cost over $100,000,000. The elderly and those living in medically underserved areas are at particular risk for medication-related acute care use. This hospital pharmacist-to-community pharmacist collaboration (called “pharmacist-to-pharmacist” or “Pharm2Pharm”) is a care transition and care coordination model designed to address common gaps in care and to reduce medication-related hospitalizations and ED visits, particularly among the elderly and other patients at risk.

The goals of this model include improving health and healthcare, while reducing overall costs of care. In this model, patients are identified by the Hospital Consulting Pharmacist (HCP). The HCP works with the care team to ensure that any medication discrepancies are resolved, begins educating the patient about his/her medications prior to discharge\(^1\), and ensures a smooth transition immediately post-discharge. After discharge, the Community Consulting Pharmacist (CCP) continues to work with the patient and

\(^1\) Hospital pharmacists found unexplained discrepancies between preadmission medication regimens and discharge medication orders in 49% of all general medicine patients in a large teaching hospital: Role of Pharmacist Counseling in Preventing Adverse Drug Events After Hospitalization. Schnipper, et al., 2006, Archives of Internal Medicine, 166: 565-571.
prescribers to identify and resolve drug therapy problems. The figures below highlight the traditional gaps that are addressed by Consulting Pharmacists in the Pharm2Pharm model.

2In California, ambulatory care pharmacist consultations focused on selected high-risk patients resulted in significantly lower non-elective hospitalization and mortality: Effects of Ambulatory-Care Pharmacist Consultation on Mortality and Hospitalization. Yuan, et al., 2003, American Journal of Managed Care, 9(1): 45-56.
The Pharm2Pharm project is funded through a $14.3M Cooperative Agreement between the University of Hawai‘i at Hilo Daniel K. Inouye College of Pharmacy Center for Rural Health Science and the CMS Innovation Center.

**MODEL INNOVATIONS:** While all Pharm2Pharm activities are within the current scope of practice of a licensed pharmacist within the state of Hawai‘i, the model is innovative in the following ways:

- **Pharmacists collaborating across the continuum of care:** Formalizes partnerships between Hospital and Community pharmacists to ensure optimal medication management and safety across the continuum of care, particularly during the high risk transition from hospital to home (currently, none of the leading care transition models include a pharmacist-to-pharmacist collaboration to optimize medication management as patients transition between hospital and community settings; elderly patients are most at risk of medication problems during these transitions).

- **Hospital pharmacist-led medication reconciliation:** Uses the expertise of Hospital Consulting Pharmacists to conduct high level medication reconciliation for high-risk patients prior to discharge, establishing these Consulting Pharmacists as critical members of the discharge planning team (currently this task is typically performed by admission and discharge nurses plus/minus input from attending physicians).

- **Community pharmacist-coordinated medication management:** Leverages untapped expertise and accessibility of community pharmacists by expanding their role in medication management after discharge for patients at risk of readmission or ED visits, establishing these Consulting Pharmacists as critical members of the ambulatory care team. (Currently most medical practices and clinics do not have the resources, revenue, or economies of scale to have an “in house” Consulting Pharmacist on their team).

- **Pharmacist integration into hospital and ambulatory care teams:** Leverages the expertise of hospital and Community Consulting Pharmacists by integrating them into the care teams. (Despite the unique expertise of Consulting Pharmacists in medication management and the substantial evidence documenting the positive impact of Consulting Pharmacists on improving quality and reducing costs, pharmacists currently are not well integrated into care teams due to lack of supporting payment mechanisms.)

- **Payment restructuring for pharmacists:** Establishes a new payment model, based on number of beneficiaries at risk rather than number of prescriptions filled or fee-for-service, that recognizes advanced, coordinated, integrated medication management services as a critical value-added specialty provided by pharmacists across the continuum of care for elderly patients at risk of medication-related hospitalizations and ED visits. (Currently such pharmacist services are not compensated by payers;
pharmacists are paid when prescriptions are filled and fee-for-service for medication therapy management (MTM); payments for MTM visits do not cover the cost of the pharmacist’s time, do not integrate pharmacists into the care team, and do not target high risk care transitions).

**CHANGES TO THE STANDARD OPERATING PROCEDURES:** Changes may be made to these SOPs based on a variety of factors, including provider or patient feedback, assessment of key performance indicators, and CMS requirements. All changes must be approved in writing by the following project leaders: Project Director, Hawaii Community Pharmacist Association officer, Physician Leader, and Director of Workforce Development.

*My signature below indicates that I have reviewed and approve the version of this SOP manual specified in the footer of this page.*

Karen Pellegin, PhD
5/7/14

Hawaii Community Pharmacist Association officer

Ali Bairos, MD
5/8/14

Physician Leader

Lara Gomez, PharmD
5/8/14

Director of Workforce Development

*Signatures on file and available upon request*
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PART 1: Organizational Readiness

*These SOPs are designed to prepare hospitals and community pharmacies for participation in the Pharm2Pharm service. Participating organizations should review and ensure compliance with these SOPs prior to providing the Pharm2Pharm services.*
**SOP 1.1.1: Staffing Models**

**PURPOSE:** To ensure optimum staff coverage while participating in the Pharm2Pharm service model.

**SCOPE:** This SOP applies to all hospitals, pharmacies, and other health care organizations involved in providing Pharm2Pharm services.

**PROCEDURES:** Prior to providing the Pharm2Pharm services, each organization develops a staffing plan for delivering the services as contracted and according to the following parameters:

- To ensure quality, the Consulting Pharmacist is responsible for adherence to these Standard Operating Procedures.
- To ensure cost-effectiveness, use of other types of staff (e.g., pharmacy technicians, administrative staff, etc.), under the supervision of the Consulting Pharmacist and within the scope of the respective staff members’ credentials and competence, is encouraged.
- To facilitate patient engagement and accountability, each patient enrolled is assigned a Consulting Pharmacist who is responsible for overseeing the delivery of the Pharm2Pharm services to that patient while he/she is enrolled. This includes supervising the work of other staff involved in services provided to that patient. In most cases, the Consulting Pharmacist changes as the patient is handed off from the Hospital Consulting Pharmacist (HCP) to the Community Consulting Pharmacist (CCP). Other than this hand-off during the patient transition from hospital to home, it is considered optimal to minimize turnover in the assignment of the Consulting Pharmacist for each patient, unless requested by the patient.
- Those serving as Consulting Pharmacists must attend the Pharm2Pharm training as specified in SOP 1.1.2.

There are several staffing models that may be optimal, depending on available workforce, size of the organization, and patient volume. Examples of staffing models include:

**Dedicated Staff Model:** In this model, some pharmacists (or perhaps just one) serve as Pharm2Pharm Consulting Pharmacists while others are not involved. The benefits of this model include that staff are able to focus their efforts and quickly gain the volume needed to optimize efficiency and quality. In addition, staff are selected based on their interest in and skills needed for optimal care. The primary disadvantage is less flexibility to have other staff cross-cover. In an integrated system where hospital and ambulatory care are part of the same organization (e.g., Accountable Care Organization, closed systems such as Kaiser, the VA, etc.) the Consulting Pharmacist may follow patients across the continuum of care (i.e., rather than hand off the patient from HCP to CCP).

**Distributed Staff Model:** In this model, the workload for delivering Pharm2Pharm services is distributed among all staff. The benefits of this model include the integration of the services into daily operations and enhanced cross-coverage capability. The disadvantages include less opportunity for staff to develop expertise in the model and specialize according to interests and skill sets.
**Patient Volume:** Based on current experience, the information below describes the patient volume expected per Full-Time-Equivalent (FTE) Consulting Pharmacist. These are general guidelines; the ability of a Consulting Pharmacist to achieve this volume depends on experience, available tools, work flow efficiencies, and use of support staff.

- **Hospital Consulting Pharmacist volume:** All adult, non-elective admissions other than deliveries are screened for potential enrollment. Currently, based on experience enrolling from acute care community hospitals, approximately 11-12% of patients screened are enrolled and handed off at discharge. Each HCP FTE should hand off approximately 25 appropriate patients per month on average.

- **Community Consulting Pharmacist volume:** Currently, each CCP FTE should manage approximately 300 active patients.
SOP 1.1.2: Training

**PURPOSE:** To ensure that the Consulting Pharmacists participating in the Pharm2Pharm service have appropriate training to provide the services.

**SCOPE:** This SOP applies to all Consulting Pharmacists and organizations participating in the Pharm2Pharm service model.

**PROCEDURES:** Prior to serving as a Consulting Pharmacist, as described in SOP 1.1.1, the pharmacist must complete and maintain documentation of training in the following areas:

- Goals and objectives of the Pharm2Pharm model
- Specific processes and procedures involved in the model, including these SOPs
- High risk medications, including medications to avoid in the elderly, heart/cardiovascular medications, and diabetes medications
- Continuous quality improvement

The Consulting Pharmacist completes ongoing training as needed in the above or other areas related to efficiency and effectiveness of Pharm2Pharm service delivery.
SOP 1.1.3: Privacy and Security of Patient Information

PURPOSE: To ensure that all communications with and about patients and all other uses of patient information are compliant with federal and local privacy and security regulations.

SCOPE: This SOP applies to all organizations and clinicians participating in the Pharm2Pharm service model.

PROCEDURES: Prior to providing the Pharm2Pharm services, each organization assesses communication systems and procedures to ensure they are adequate for delivering the services and compliant with federal and local laws. The participating hospitals and pharmacies are considered “covered entities” under HIPAA/privacy and security regulations, so related policies and procedures are already in place. These same regulations and procedures apply to communications about patients enrolled in the Pharm2Pharm service.

It is the Consulting Pharmacist’s responsibility to comply with federal and local laws as well as institutional privacy and security policies. This includes use, disclosure, and storage of patient information, regardless of format (e.g., paper or electronic). This also applies to electronic communications and systems (such as email and electronic health information exchange). Only those electronic systems that meet federal privacy and security requirements may be used to communicate patient information. If the Consulting Pharmacist is unsure about the policies and procedures of the hospital or pharmacy where he/she is performing Pharm2Pharm services, he/she should obtain assistance from the organization’s privacy/compliance officer to ensure compliance with all privacy and security requirements for all communications and uses of patient information.

NOTE: The Daniel K. Inouye College of Pharmacy is not a “covered entity”. Therefore, do not send or otherwise disclose protected health information to any Daniel K. Inouye College of Pharmacy faculty/staff, unless the specific faculty/staff member is appropriately authorized by the relevant hospital or pharmacy and the communication method is authorized by that covered entity. Similarly, any Daniel K. Inouye College of Pharmacy faculty/staff (including grant-funded project staff) who are authorized by a participating hospital or pharmacy to use and/or disclose protected health information must comply with all requirements of that covered entity pertaining to patient privacy and security, including using only those communication methods authorized by the respective organization.

The project team periodically conducts patient satisfaction surveys as part of the monitoring and evaluation plan. This survey is distributed to Pharm2Pharm patients by the Community Consulting Pharmacists during their routine visits with enrolled patients as instructed by the project team. The patient satisfaction survey includes instructions NOT to include the patient name or any other identifying information. The anonymous surveys are returned to the Daniel K. Inouye College of Pharmacy for analysis.
SOP 1.1.4: Communication Methods

PURPOSE: To ensure optimal communication among Consulting Pharmacists, patients, and other members of the care team.

SCOPE: This SOP applies to all organizations and clinicians participating in the Pharm2Pharm service model.

PROCEDURES: Prior to providing Pharm2Pharm services, available communication methods are assessed and those most efficient and effective are implemented and utilized. Specifically the following are addressed with regard to communications described in PART 2 of the SOPs on “Patient Care”:

Communication between HCP and CCP leverages optimal available communication methodology via Direct Mail through the Hawai‘i Health Information Exchange (HHIE).

Communication between Consulting Pharmacists and prescribers also leverages optimal available technologies. Many providers rely primarily on fax communication, but actual receipt by the provider is not always assured via this technology. For critical communications, consulting pharmacists must insist on confirmation that the provider has received the information and this is best confirmed by a direct phone call to the provider. Consulting Pharmacists encourage prescribers to adopt available communication technologies offered through the Hawai‘i Health Information Exchange (HHIE). Urgent, critical communications are always via telephone, with written follow up, and confirmation of receipt.

Communication between Consulting Pharmacists and patients is patient-centered. While in-person communications are generally considered optimal, patient preference for phone or email communications is accommodated and supported. Some patients have communication challenges (e.g., hearing impairments, language barriers, etc.) that should be addressed with available services, systems, and technologies (e.g., translation services, etc.). Patients who prefer communicating via non-secure email are accommodated in accordance with the respective organization’s privacy and security policies (see draft “acknowledgement of email communication” form in the toolkit and review with the respective organization’s privacy officer for any needed changes or approvals before patient signs).

NOTE: In all communication, only use generic medication name unless trade/brand name is specified in patient record.
SOP 1.1.5: Provider Engagement

**PURPOSE:** To facilitate building relationships with prescribers (physicians, nurse practitioners and other prescribing providers) in hospital and community settings in a way that enhances the probability of achieving the improvement goals of the Pharm2Pharm model.

**SCOPE:** This SOP applies to all organizations and clinicians participating in the Pharm2Pharm service model.

**PROCEDURES:** Given the shortage of physicians and other prescribers, most clinicians welcome the support by the Consulting Pharmacists providing Pharm2Pharm services. In order to educate these prescribers about the service and strengthen relationships to optimize patient care, these procedures are followed:

- During regularly scheduled hospital meetings, hospitalists, other members of the medical staff, and Emergency Department staff are educated about the service model and related work flow issues in that hospital.

- The community providers expected to have a high volume of enrolled patients are identified and educated about the service model, focusing on the benefits to the patient and the provider.
SOP 1.1.6: Patient-Centered Care

**PURPOSE:** To facilitate building and maintaining trust between patients and Consulting Pharmacists by demonstrating respect for patients’ rights, choices, and preferences.

**SCOPE:** This SOP applies to all organizations and pharmacists participating in the Pharm2Pharm service model.

**PROCEDURES:** According to the Institute of Medicine, delivering patient-centered care is a core competency all healthcare professionals should possess. This competency is defined as the ability to “identify, respect, and care about patients’ differences, values, preferences, and expressed needs; relieve pain and suffering; coordinate continuous care; listen to, clearly inform, communicate with, and educate patients; share decision making and management; and continuously advocate disease prevention, wellness, and promotion of healthy lifestyles, including a focus on population health”\(^4\). This competency is critical for Consulting Pharmacists providing Pharm2Pharm services. Prior to launch, Consulting Pharmacists work with their respective hospital or pharmacy to ensure the organization is committed to a patient-centered approach to delivering Pharm2Pharm services, including the following:

- The patient chooses which Community Consulting Pharmacist (CCP) to work with post-discharge.
- The patient has a right to switch to a different CCP at any time. In such an event, the current CCP ensures a smooth transition to the next CCP.
- The patient has a right to purchase medications from any pharmacy. The patient is never pressured to purchase medications at the CCP’s pharmacy.
- Consulting Pharmacists work to understand and support cultural and language needs and preferences.
- Consulting Pharmacists seek to understand the patient’s personal health goals (i.e., in addition to the clinical goals established by their prescribers) to facilitate achievement.
- Consulting Pharmacists work with the patient and, where authorized by the patient, his/her caregivers and loved ones to facilitate achievement of health-related goals (NOTE: Throughout these SOPs, it is assumed that the Consulting Pharmacists are working not only with patients but also with their authorized caregivers.)

PART 2: Patient Care

These SOPs are designed to specify and standardize the responsibilities of the Consulting Pharmacists involved in the Pharm2Pharm service. All of these duties are within the scope of practice of a licensed pharmacist in the state of Hawai‘i. Therefore, the role of the Consulting Pharmacist is care coordination – that is, supporting the patient in adhering to the care plans and medication decisions made by and between the patient and patient’s prescribers, as well as working with patients and prescribers to identify and resolve drug therapy problems.

Section 1: Pharm2Pharm Processes – SOPs 2.1.1 through 2.1.3 specify the Pharm2Pharm patient care processes from enrollment to care transition to community-based care as shown in the figure below. While primary accountability for a particular standard may belong to the HCP or CCP, all Consulting Pharmacists must be familiar with the entire process to ensure continuity of care.

Section 2: Medication Management – SOPs 2.2.1 through 2.2.2 specify medication reconciliation and management processes to facilitate identification and resolution of drug therapy problems.

Section 3: Special Patient Care Needs – SOPs 2.3.1 through 2.3.5 identify considerations for addressing special issues that may impact medication adherence or achievement of a patient’s personal or clinical goals.
SOP 2.1.1: Patient Enrollment

**PURPOSE:** To ensure the appropriate target population of patients is enrolled in the Pharm2Pharm service.

**SCOPE:** This SOP applies to the Hospital Consulting Pharmacist (HCP).

**PROCEDURES:** The HCP proactively screens all adult, non-elective, non-OB hospital admissions (including observation stays) for enrollment appropriateness according to the criteria described below. Referrals from hospital, Emergency Department, and community-based clinicians are also screened according to these criteria. As time permits, Emergency Department patients are proactively screened (NOTE: Because most ED patients who are appropriate for Pharm2Pharm are admitted to the hospital, proactive ED screening should only be performed when feasible). The following figure is an overview of the enrollment process and patient care prior to hand-off:

**Patient sources:**
- Proactive inpatient screening
- Referrals
- Proactive ED screening (as time permits)

**Inclusion criteria review**:
- Patients who meet criteria are reviewed for exclusions
- Patients who do not meet criteria are excluded

**Exclusion criteria review**:
- Patients with no exclusions are enrolled
- Patients with one or more exclusions are not enrolled

**Enrolled patient care prior to hand-off**:
- Patient engagement
- Medication reconciliation
- Medication management

**In rare cases, these criteria may be over-ridden by HCP judgment in consultation with other clinicians. In such cases, justification for over-riding the criteria must be clearly documented.**
INCLUSION CRITERIA:

Inclusion step 1: Patient is on 15 or more medications*?
   If yes, the patient meets Inclusion criteria. Proceed to Exclusion criteria review.
   If no, go to Inclusion step 2.

Inclusion step 2: Patient is on 10 or more medications* AND at least one of those is high risk (i.e., narrow therapeutic index** and/or commonly implicated in medication-related hospitalizations**)?
   If yes, the patient meets Inclusion criteria. Proceed to Exclusion criteria review.
   If no, go to Inclusion step 3

Inclusion step 3: Current acute care episode is due to a drug therapy problem** (including from over-the-counter medications or supplements)?
   If yes, the patient meets Inclusion criteria. Proceed to Exclusion criteria review.
   If no, go to Inclusion step 4

Inclusion step 4: 2 or more previous acute care visits (ER, hospitalization, or observation stay) for uncontrolled chronic condition** within past 3 months OR any previous hospitalization for uncontrolled chronic condition** within past 12 months?
   If yes, the patient meets Inclusion criteria. Proceed to Exclusion criteria review.
   If no, go to Inclusion step 5

Inclusion step 5: Newly diagnosed Acute Coronary Syndrome, Atrial Fibrillation, Chronic Obstructive Pulmonary Disease, Congestive Heart Failure, and/or Diabetes AND being discharged on a new home medication* regimen for the condition(s)?
   If yes, the patient meets Inclusion criteria. Proceed to Exclusion criteria review.
   If no, go to Inclusion step 6

Inclusion step 6: Age less than 65 with all 5 of the following OR age 65 or older with at least 4 of the following?
   - Use of 1 or more medication with narrow therapeutic index**
   - Use of 1 or more medication* commonly implicated in medication-related hospitalizations**
   - Five or more medications*
   - Three or more chronic conditions**
   - Any ED use or non-elective hospitalization/observation stay within past 12 months

   If yes, the patient meets Inclusion criteria. Proceed to Exclusion criteria review.
   If no, exclude patient unless compelling justification+.

*includes prescription medications, over-the-counter medications, herbals and dietary supplements

**DEFINITIONS:
**Narrow Therapeutic Index (NTI) drugs** are defined as those with less than a 2-fold difference between median lethal dose and median effective dose (http://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/ncd103c1_part3.pdf)


**Drug therapy problems:** *Indication* (i.e., untreated indication or unnecessary medication), *effectiveness* (i.e., dose too low or more effective alternative available), *safety* (i.e., adverse drug reaction or dose too high), *adherence* (i.e., patient non-compliant); from: Pharmaceutical Care Practice – The Patient Centered Approach, Cipolle, Morley, and Strand, 3rd Edition, McGraw Hill, 2012.

**Chronic condition** is defined as a condition that lasts a year or more and requires ongoing medical attention and/or limits activities of daily living. (http://www.hhs.gov/ash/initiatives/mcc/#_edn3)

**EXCLUSION CRITERIA:** Any one of the following criteria excludes a patient.

- Not a full-time county resident
- No reasonable expectation of being discharged to home or short-term rehab (SNF status)
- Severe dementia
- Active psychosis
- Hospitalization related to a suicide or homicide attempt
- Leaves facility against medical advice (AMA)

**NOTE:** In rare cases, inclusion criteria may be over-riden by HCP judgment in consultation with other clinicians. In such cases, justification for over-riding the criteria must be clearly documented.

**ENROLLED PATIENT CARE PRIOR TO HAND-OFF:** “Hand-off” is defined as the transfer of responsibility from HCP to CCP as the patient’s assigned Consulting Pharmacist. Prior to handing off the patient to the CCP, the HCP performs the following patient care procedures:

- **Patient engagement and education:** The HCP meets with each enrolled patient to ensure that the patient understands that he/she is on a complicated medication regimen, is at risk for
medication-related problems and may benefit from Pharm2Pharm services (see script in the toolkit). Prior to hand-off (and prior to discharge for inpatients), the HCP:

- Informs the patient of the importance of taking medications properly.
- Reviews the key medication issues associated with the patient’s condition.
- Identifies the participating pharmacy (based on patient preference) that will assist the patient upon discharge.
- Emphasizes the importance of working with the CCP to reduce risk of medication-related problems.
- Schedules the patient’s first visit with the CCP to occur as soon as possible (and within three days of discharge for inpatients).
- Meets with the patient regularly (every day if possible) while the patient is in the hospital to remind him/her of the above items.

If the patient refuses services prior to hand-off, the HCP attempts to engage the patient according to the following:

- Other members of the hospital care team (especially the physicians) are asked to encourage the patient to receive services.
- The patient’s community-based providers are asked to encourage the patient to receive services.

- **Medication reconciliation** is performed according to SOP# 2.2.1.
- **Drug Therapy Problem Identification and Resolution** is performed according to SOP# 2.2.1 for the following categories of medications:
  - Medications related to the condition for which the patient is currently receiving (or most recently has received) acute care
  - Medications commonly implicated in hospitalizations

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SOP 2.1.2: Care Transition

**PURPOSE:** To ensure timely, smooth patient transition from acute care to home and from Hospital Consulting Pharmacist (HCP) to Community Consulting Pharmacist (CCP).

**SCOPE:** This SOP applies to all Consulting Pharmacists.

**PROCEDURES:** The transition from acute care to home is a high risk time for all patients, but especially for those patients enrolled in Pharm2Pharm (due to their complex medications and disease states). A key goal of the Pharm2Pharm model is to improve care and reduce risk for enrolled patients as they transition to home. The HCP is the responsible Consulting Pharmacist assigned to the patient until the patient has his/her first visit with the CCP. At this first visit, the CCP becomes the responsible Consulting Pharmacist assigned to the patient. The HCP is responsible for confirming the patient attends the first visit with the CCP and, if the patient is a no-show, for attempting to re-engage the patient per SOP# 2.1.3.

The HCP monitors the status of enrolled inpatients and establishes systems to ensure the HCP is notified of discharge plans. The HCP communicates with patients and community-based clinicians as follows:

**HCP COMMUNICATION WITH PATIENTS**

*Pre-discharge communication with patients:* Once the patient’s discharge medications have been determined, the HCP educates the patient about the discharge medications, including:

- The purpose of each medication as it pertains to the clinical goals
- How the patient should monitor himself/herself for each medication
- Potential side effects
- Details regarding how to take the medications properly
- Clarifying whether the patient should re-start pre-admission medications and supplements

In addition, the HCP communicates the following:

- Reminds the patient of his/her first appointment with the CCP.
- Reminds the patient of his/her post-discharge follow up appointment with the provider.
- Informs the patient that the HCP will be contacting the patient within a day of discharge to check on the medications and asks for the best phone number and time to call.

If the patient is discharged before the HCP can complete the above items, the CCP is informed (as shown below) so that extra time is spent covering this information during the CCP’s first visit with the patient.
Immediate post-discharge communication with patients: Within one day post-discharge, the HCP calls the patient to:

1. Determine if the patient picked up all discharge medications and:
   a. If so, from where
   b. if not, identify and assist the patient in resolving the medication access problems
2. Ensure that the patient understands which medications to take and which not to take
3. Reinforce key medication safety issues relevant to the patient’s medications
4. Confirm patient’s follow up appointment with his/her provider
5. Confirm patient’s first visit with the CCP

Unsuccessful Contact: If the patient does not answer the call, the HCP re-checks the contact numbers and continues to try to reach the patient at least once per day (at different times of the day/early evening) through the day before the patient’s first scheduled visit with the CCP. If possible, the HCP leaves a voice message asking the patient to return the call and reminding the patient about his/her first visit with the CCP. If the patient shows for the first CCP visit, no further action is required of the HCP. If the patient does not show for the first CCP visit, the HCP continues to attempt to engage the patient according to SOP# 2.1.3.
HCP COMMUNICATION WITH CLINICIANS

Care transition communication with clinicians: The HCP transmits the following care transition information (shown in Table 1) to the patient’s community-based care providers as soon as possible, but no later than the day before the patient’s first post-discharge appointment with each clinician:

<table>
<thead>
<tr>
<th>Information</th>
<th>CCP</th>
<th>*Relevant providers</th>
</tr>
</thead>
<tbody>
<tr>
<td>Notification of enrollment, including HCP and CCP contact info (see “notification of enrollment” template in toolkit)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Demographics/Face Sheet</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Allergies</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Discharge summary (including care plan, labs, and clinical notes)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Reason for admission/acute care use</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Relevant medical history &amp; clinical goals of drug therapy</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Preadmission medications (NOTE: Only list generic name unless trade/brand name is specified in the patient record)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Discharge medications (NOTE: Only list generic name unless trade/brand name is specified in the patient record)</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Pharmacy(ies) where patient purchases medications</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Reminder of CCP first visit with patient (date, time, location)</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Provider with whom the patient has a follow up visit scheduled, date of that visit, and preferred method of communication from Consulting Pharmacists</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Primary care provider (if different from above) and preferred method of communication from Consulting Pharmacists</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>ADL (Activities of Daily Living) per nursing assessment</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Unresolved medication discrepancies</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Unresolved drug therapy problems</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Potential solutions to resolve drug therapy problems</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Any additional clinical notes from the HCP, which includes the clinical status of the patient related to the patient’s medications</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Any incomplete communications with patient pre-discharge</td>
<td>✓</td>
<td></td>
</tr>
<tr>
<td>Documentation of immediate post-discharge communications with patient</td>
<td>✓</td>
<td></td>
</tr>
</tbody>
</table>

* It is the HCP’s responsibility to confirm and use the preferred method of communication (e.g., fax, hard copy, secure e-mail) for each provider when sending these documents.

PATIENTS DISCHARGED TO SHORT-TERM REHABILITATION: Patients are considered to be short-term rehabilitation patients if they are admitted to a skilled nursing facility with skilled nursing “SNF” status. The HCP ensures that a system is in place for the HCP to know when patients discharged to short-term rehabilitation are being discharged from rehab to home. Any available updates on the patient status at the time of SNF discharge should be included in the above list of information sent from the HCP to the CCP and relevant prescribers.
SOP 2.1.3: Post-Transition Care

**PURPOSE:** To ensure continued optimized medication management to promote the achievement of clinical goals and the patient’s personal health goals throughout the 12 months post-enrollment.

**SCOPE:** This SOP applies to all Consulting Pharmacists.

**PROCEDURES:** Enrolled patients’ medications are managed in the community through the following procedures:

**PATIENT VISITS:** The Community Consulting Pharmacist (CCP) conducts regular visits with his/her patients, on average 12 visits per patient per year with frequency based on patient need in order to reduce risk of medication-related readmission and ED use. Because of the increased risk during care transitions, visits should be scheduled more frequently during the first 30-90 days after discharge and may become less frequent over the course of the 12 months post-enrollment. These visits are conducted in-person (either in the pharmacy, primary care provider’s office, or at the patient’s home). If the patient prefers, the visits are performed via telephone, video teleconferencing, or on-line discussion. In addition, the consulting pharmacist is available regularly, if needed, for unscheduled visits or calls from the patient. The consulting pharmacist completes the following at each patient visit, allowing for extra time during the first visit to build a solid foundation with each patient:

- Ask the patient to self-report functional status using a standardized methodology to ensure reliability (i.e., Dartmouth COOP\(^6\) questions for daily activities and overall health as required in the Excel tool).
- Ask the patient about any urgent care or acute care visits since the previous visit
- Identify and assess progress towards the patient’s personal health goals
- Complete medication reconciliation process per SOP# 2.2.1
- Complete drug therapy problem identification and resolution process per SOP# 2.2.1*
- Complete medication education process per SOP# 2.2.1*
- Contact prescribers as needed to make recommendations to optimize medications
- Track implementation of recommendations and resolution of drug therapy problems from previous visits

*NOTE:* The patient’s clinical status and personal health goals should guide which medication issues are prioritized at each visit.

**PROVIDER CONTACTS:** The CCP updates the patient’s primary care provider (and other prescribers as appropriate) on a routine quarterly basis and on an ongoing basis as needed to provide optimal patient care. This includes telephone consultations, in person meetings, and electronic exchange of patient information.

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\(^6\) [http://www.dartmouthcoopproject.org/coopcharts_overview.html](http://www.dartmouthcoopproject.org/coopcharts_overview.html)
Most patients have multiple clinicians prescribing outpatient medications, some of whom might not communicate changes in prescribed medications. The CCP, as the central point for medication review, has a pivotal role in identifying and communicating changes in the medication regimen. When any one of the prescribers makes a medication change, the CCP sends the updated medication list to all current prescribers. (This is a reminder of the importance of querying the patients and any available technologies at each visit to check regarding prescription changes.) The CCP also helps the patient keep an updated medication list and drug therapy problem list and strongly encourages the patient to bring the lists to every physician visit. (NOTE: Only use generic medication name unless trade/brand name is specified in the patient record.)

A. **Routine quarterly reports:** The CCP updates relevant prescribers about the patient at least quarterly (see “Update to Provider” template in the toolkit). The purpose of these reports is to provide succinct summaries of the CCP’s patient contact including:
   a. Significant changes in the patient’s health or medications
   b. Advice given to the patient
   c. Medication review
   d. Recommendations regarding solutions to drug therapy problems
   e. Resolution of drug therapy problems*
   f. CCP’s contact information

B. **Interim Communications:** While accommodating provider preference, additional interim contact should generally be made via phone. Examples of such communications include:
   1. A significant change in the patient’s health or medications
   2. Resolutions of any clinically significant medication discrepancies
   3. Recommendations regarding solutions to drug therapy problems* (see SOP# 2.2.1 for details)

For any clinically significant issue, the CCP must verify that the prescriber has received the communication (e.g., simply sending a fax or leaving a message is not sufficient).

* Categories and examples of drug therapy problems include:
   a. **Indication/appropriateness:**
      i. Additional drug therapy needed
      ii. Unnecessary drug therapy
   b. **Effectiveness:**
      i. Ineffective drug
      ii. Dosage too low
   c. **Safety:**
      i. Adverse drug reaction
      ii. Dosage too high
   d. **Adherence:** Some patients may benefit from medication changes that make it easier to take them. This would include interventions such as reducing the number of doses per day of a given medication and coordinating the timing of doses with other medications to reduce the complexity.

**TRIAGE:** The Pharm2Pharm service focuses on preventing medication problems and maximizing achievement of therapeutic goals. However, some patients will need urgent, emergent, and/or acute care while they are enrolled in the service. It is essential that the Consulting Pharmacist support the patient in obtaining proper care and never be a barrier to the care. Thus, when the preventive services of the Consulting Pharmacist are unsuccessful, the Consulting Pharmacist should follow the regular protocol or policy of their respective pharmacy with regard to promptly helping the patient get appropriate care, including:

- Referral to the primary care provider
- Referral to an urgent care clinic
- Referral to the ER
- Calling 911

**PATIENT TRANSFER TO ANOTHER CCP:** It is appropriate to transfer the patient from one CCP to another in some circumstances, such as:

- Patient moves to a different neighborhood and prefers a pharmacy closer to home
- The Consulting Pharmacist cannot manage the workload
- The Consulting Pharmacist is no longer working as a CCP
- The patient is dissatisfied with the current Consulting Pharmacist/pharmacy

In all cases of patient transfer, both CCPs (i.e., CCP the patient is transferring from and to) document the transfer of responsibility.

**READMISSIONS:** The HCP reviews, on a daily basis, patient admissions to determine if any enrolled patient has been readmitted.

- For any identified patients, the HCP reviews the medical record and/or interviews the patient to determine if the reason for readmission is medication-related or otherwise potentially preventable by Pharm2Pharm.
- If medication-related or potentially preventable, the HCP discusses with the patient’s CCP and identifies strategies for preventing future readmissions.
- The HCP notifies the relevant providers of the readmission upon admission and/or at discharge (depending on provider preference).
- The HCP follows SOP# 3.1.4 to ensure appropriate peer review of readmissions

**NOTE:** Readmissions do NOT change the patient’s status as a Pharm2Pharm patient. Active enrolled patients who are readmitted remain enrolled. Previously exited patients who are readmitted remain exited upon readmission, but the HCP screens and, if appropriate, enrolls them again per SOP# 2.1.1.

**PATIENT RETENTION:** Patient retention is essential to achieve the goals of the Pharm2Pharm model, so every effort is made to ensure patients complete the year of services, while respecting the patient’s
right to refuse services. The patient status is always accurately documented as “active” or “exited.” The following scenarios describe how to enhance retention and accurately document patient status.

**Early exit:** If the patient does not attend a scheduled visit, and cannot be reached to reschedule the visit, the CCP (or the HCP if the patient doesn’t show for the first visit) does the following:

- Re-verifies contact numbers.
- Makes three phone calls (varying times of the day/early evening) within a one week period.
- If no response and no return phone call, schedules an appointment and notifies the patient of the appointment in writing (see “Appointment Notification Letter”, located in the Pharm2Pharm Toolkit).
- If the patient does not show for this appointment, the HCP makes a final attempt to re-engage the patient, including asking providers to encourage patient participation. If still unsuccessful, the patient status is changed to “exited.”

**Completion:** The CCP formally recognizes the patient for successfully completing a year of services. The Patient Completion letter may be used to recognize this accomplishment (see “Patient Completion Letter” template in toolkit).

**Re-enrollment:** After a patient has exited for any reason, the patient may be enrolled again per SOP# 2.1.1.
**SOP 2.2.1: Medication Processes**

**PURPOSE:** To ensure that Consulting Pharmacists are consistently finding and resolving all relevant medication issues to optimize patient health and reduce acute care use.

**SCOPE:** This SOP applies to all Consulting Pharmacists.

**PROCEDURES:** Patients enrolled in Pharm2Pharm are complex with regard to both their medications and their disease states. Because of this, the processes of medication reconciliation and drug therapy problem identification and resolution must be performed regularly and systematically. The first medication process cycle is performed by the HCP, followed by cycles performed by the CCP at each visit. This cycle is summarized in this figure and described in greater detail below.

- **Medication Reconciliation**
  - Discrepancies Identified and Resolved (see 3-step process, page 29):
    - Medication name
    - Dose
    - Frequency
    - Route
    - Prescribed but not taken
    - Taken but not in patient's record
    - Other conflicting information

- **Review of Medical Conditions**
  - Identified for Each Condition:
    - Patient's current clinical status
    - Clinical goals - where patient should be clinically (per provider and/or clinical guidelines)
    - Patient's personal health goals

- **Drug Therapy Problems**
  - Problems identified and Resolved (see 4-step process, page 31):
    - Indication / Appropriateness
    - Effectiveness
    - Safety / Side Effects
    - Adherence

**Medication Education:** Close gaps in medication knowledge and skill
MEDICATION RECONCILIATION: The goal of medication reconciliation is to obtain a complete and accurate list of current medications (including prescription, over the counter, herbals, supplements, alcohol, tobacco, and illicit/recreational drug use), including frequency, dose, and route. Medication reconciliation is performed according to the following steps:

MED REC Step 1: Query the following sources as available to create a preliminary list of the patient’s current medications:
- Patient (including self-report and/or presented medications)
- Patient’s medical record
- Patient’s caregivers
- Providers and other members of the care team
- Dispensing pharmacies
- Electronic databases

The list should include:
1. Generic medication name, dose, route, and frequency
2. Indication for each medication
3. Patient’s allergies (e.g., drug, food, dyes, etc.)
4. Over-the-counter medications, herbals, and dietary supplements
5. Source of information (e.g., spoke to patient, patient brought in home meds, called patient’s pharmacy, etc.)
6. Discrepancies, defined as any lack of agreement between the medications listed in patient records and the patient’s report of what he/she is actually taking; discrepancies include any incongruity in the following:
   - medication name
   - dose
   - frequency
   - route
   - medications taken, but not in the patient’s records
   - medications in the patient’s records, but not taken
   - any other conflicting information about what the patient is taking

Additional information in the medication list may include:
1. Patient’s community pharmacy and phone number
2. Date and time medication was last taken
3. For a patient with chronic conditions, a history of medications the patient has tried/used in the past 6 months

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7 Adapted from Northwestern Memorial Hospital. http://www.nmh.org/nm/medication-reconciliation-toolkit-education-training
Care transitions: As a patient transitions from one care setting to another (e.g., hospital admission, hospital discharge, ED to home, etc.), medication discrepancies are common and additional effort is needed to identify and resolve discrepancies in the medication list. Therefore, the following additional steps are performed to ensure that a complete and accurate medication list is obtained during care transitions:

- Compare medication orders (e.g., admission orders, discharge orders) against the medication list.
- Compare the medications given in the prior care setting to the new treatment plan.
- Compare the home medications to the current medication list.

MED REC Step 2: The medication list is then reviewed with the patient and/or additional resources contacted above to resolve any discrepancies. NOTES:

- A prescription medication that the patient confirms he/she is not taking is NOT a medication discrepancy, but rather a drug therapy problem that should be properly identified and resolved according to “Drug Therapy Problem Identification and Resolution” steps (beginning next page).
- Discrepancies involving medications considered “high risk” as defined below should be the top priority for resolution:
  - Narrow Therapeutic Index (NTI) drugs
  - Drugs commonly implicated in medication-related hospitalizations:
    - Warfarin
    - Oral antplatelet agents
    - Insulins
    - Oral hypoglycemic agents
    - Digoxin
    - Opioid analgesics

MED REC Step 3: The resolution of any discrepancy is confirmed and documented, and the list is updated accordingly, to produce the current, complete, and accurate list of what the patient is taking and/or prescribed. NOTE: The discrepancy is not considered resolved until confirmation of resolution is received and documented. Simply reporting a discrepancy to a prescriber or other member of the care team is NOT considered resolution.

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**REVIEW OF MEDICAL CONDITIONS:** Once the Consulting Pharmacist has a complete and accurate list of what the patient is currently taking and/or prescribed, the patient’s current medical conditions are reviewed. For each medical condition, the following are identified:

- The patient’s current clinical status (e.g., blood pressure, blood sugars, BMI, etc. based on relevance to clinical status)
- Clinical goals (i.e., where the patient should be clinically per providers and/or clinical guidelines)
- Patient’s personal health goals (e.g., what does the patient want to be able to do, but can’t now?)

**DRUG THERAPY PROBLEM (DTP) IDENTIFICATION AND RESOLUTION:** Correlating the reconciled medication list with the patient’s medical conditions is essential to identifying drug therapy problems. Once the Consulting Pharmacist has a complete and accurate list of what the patient is taking and/or prescribed and understands the goals of treatment (clinical goals as well as patient’s health-related goals), the steps below are followed to identify and resolve drug therapy problems.

NOTE: Patients who are not taking a prescribed medication at all or not taking it as prescribed are generally described as “non-adherent” or “non-compliant” with that prescription. While this is an accurate description of their behavior, these descriptors do not explain why (i.e., the cause of the behavior). In the steps below, “adherence” is a category of drug therapy problem that is only used when problems of indication, effectiveness, and safety have been ruled out as primary causes of prescription medication non-adherence.

**DTP Step 1: Indication/appropriateness problems**

<table>
<thead>
<tr>
<th>Problem Identification Questions</th>
<th>Solution to Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the patient have an untreated condition for which drug therapy is an appropriate treatment? If yes, problem: <strong>patient needs additional drug therapy (for treatment, prevention, or synergistic therapy).</strong> NOTE: This question is typically asked after review of drug therapy problems for all current medications.</td>
<td>Recommend adding drug therapy*</td>
</tr>
<tr>
<td>For each medication (or category of medications), is there an appropriate indication? If not, problem: <strong>unnecessary drug therapy (e.g., duplicate therapy, no current indication, non-drug therapy more appropriate, addiction/recreational use).</strong></td>
<td>Recommend discontinuing drug therapy*</td>
</tr>
</tbody>
</table>

*Consulting Pharmacists should discuss potential changes to prescription medications with the prescriber first and only then, if appropriate, with the patient. **NOTE:** *Only use generic medication name unless trade/brand name is specified in the patient record.*

---

DTP Step 2: **Effectiveness** problems – For each appropriate medication (or category of medications)...  

<table>
<thead>
<tr>
<th>Problem Identification Questions</th>
<th>Solution to Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is it effective in achieving the goals of the drug therapy? If not, problem: <em>ineffective drug</em> or <em>dose too low</em>. (NOTE: If patient stopped taking it due to ineffectiveness, the problem is effectiveness, not adherence) Consider...</td>
<td>Continue to monitor and reevaluate when appropriate</td>
</tr>
<tr>
<td>- Has the patient been on the medication long enough? If not...</td>
<td></td>
</tr>
<tr>
<td>- Has the patient been storing and taking it correctly? If not...</td>
<td>Reinforce patient education, per page 34</td>
</tr>
<tr>
<td>- Is the dose adequate? If not...</td>
<td>Recommend increasing dose and/or frequency*</td>
</tr>
<tr>
<td>- Is there a more effective appropriate drug available? If so...</td>
<td>Recommend switching to more effective drug*</td>
</tr>
</tbody>
</table>

*Consulting Pharmacists should discuss potential changes to prescription medications with the prescriber first and only then, if appropriate, with the patient. **NOTE:** *Only use generic medication name unless trade/brand name is specified in the patient record.*

DTP Step 3: **Safety/side effect** problems – For each appropriate, effective medication (or category of medications)...  

<table>
<thead>
<tr>
<th>Problem Identification Questions</th>
<th>Solution to Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is patient experiencing (or at unnecessary risk of) adverse drug reaction(^{13})/side effects? If so, problem: <em>adverse drug reaction</em> or <em>dose too high</em>. (NOTE: If patient stopped taking it due to ADR/side effects, the problem is safety, not adherence) Consider...</td>
<td></td>
</tr>
<tr>
<td>- Would ADR/side effects (or risk of) be reduced at a lower effective dose? If so...</td>
<td>Recommend decreasing dose*</td>
</tr>
</tbody>
</table>

\(^{13}\) ADR is defined as a response to a drug which is noxious and unintended and which occurs in doses normally used:  
http://www.who.int/medicines/areas/quality_safety/safety_efficacy/trainingcourses/definitions.pdf
**Consulting Pharmacists should discuss potential changes to prescription medications with the prescriber first and only then, if appropriate, with the patient. **NOTE: **Only use generic medication name unless trade/brand name is specified in the patient record.**

---

<table>
<thead>
<tr>
<th>Problem Identification Questions</th>
<th>Solution to Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Has the patient experienced (or is at risk of) an adverse drug reaction, interaction, or side effect when a safer effective drug is available? If so... (NOTE: for all patients 65 and older, see SOP# 2.2.2 for drugs to avoid in the elderly and safer alternatives)</td>
<td>Recommend switching to another drug* and/or treatment* for ADR/side effect</td>
</tr>
</tbody>
</table>

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**DTP Step 4: Adherence problems** – For each appropriate, effective, and safe medication (or category of medications)...

<table>
<thead>
<tr>
<th>Problem Identification Questions</th>
<th>Solution to Consider</th>
</tr>
</thead>
<tbody>
<tr>
<td>Is the patient taking the medication properly? If not, problem: adherence. Consider...</td>
<td></td>
</tr>
<tr>
<td>- Is the patient challenged by complexity of medication regimen? If so...</td>
<td>Recommend appropriate solutions, such as dose simplification*, organizers, and reminders</td>
</tr>
<tr>
<td>- Is the patient challenged by administration issues? If so...</td>
<td>Recommend appropriate solutions, such as smaller pills*, education regarding administration technique, etc.</td>
</tr>
<tr>
<td>- Is the patient challenged by access issues (e.g., cannot afford, transportation, product not available)? If so...</td>
<td>Recommend switching to a less costly alternative*; seek relevant social services for those in need (see SOP# 2.3.4), etc.</td>
</tr>
<tr>
<td>- Does the patient have cultural or personal beliefs that prevent adherence? If so...</td>
<td>Seek to understand the beliefs and seek relevant psycho-social supports</td>
</tr>
<tr>
<td>- Is the patient challenged by communication or health literacy issues? If so...</td>
<td>Seek appropriate translation services and social services (see SOP # 2.3.1)</td>
</tr>
</tbody>
</table>
Documentation and Tracking:

- All drug therapy problems identified are documented and tracked regarding resolution.
- Solutions to address the problems are documented and tracked regarding whether they were implemented.

MEDICATION EDUCATION: Consulting Pharmacists ensure that patients understand the importance of taking each medication and how to take each properly. Gaps in medication-related knowledge and skills are continuously assessed and resolved as described below:

- Patients are proactively given relevant educational materials (e.g., web-based, brochures, etc.).
- Patients are reminded about relevant safety issues, including how to recognize adverse symptoms and side effects and what to do if they occur.
- The Consulting Pharmacist uses the “Teach-back” method to ensure the patients understand and can implement instructions. This involves having the patients explain back to the pharmacist their understanding of the instructions and, where appropriate, demonstrate their ability to implement correctly (e.g., injection of insulin, use of inhaler, etc.). For details on this method, go to the following link and click on “teach back video” under the Training Materials section: http://healthliteracymn.org/resources/presentations-and-training
SOP 2.2.2: High Risk Medications

**PURPOSE:** To ensure special focus on reconciling, identifying and resolving drug therapy problems, and educating patients about those high risk medications.

**SCOPE:** This SOP applies to all Consulting Pharmacists.

**PROCEDURES:** The following medications are prioritized for medication reconciliation, drug therapy problem identification and resolution, and patient education, along with any medication related to the patient’s acute care episode. Resources for additional medication information are on the next page.

**COMMONLY IMPLICATED MEDICATIONS:** As shown in the table below, warfarin, insulins, oral antiplatelet agents, oral hypoglycemic agents, opioid analgesics, and digoxin are most commonly involved medications in emergency admissions among older adults:

- Beers criteria for Potentially Inappropriate Medication Use in Older Adults
- NCQA’s HEDIS list of drugs to be avoided in the elderly

**POTENTIALLY INAPPROPRIATE MEDICATIONS FOR THE ELDERLY:** While the chart above indicates that the Beers criteria medications represent a relatively small number of the medication-related hospitalizations, these are important to identify and resolve when working with an elderly population.

SOP 2.3.1:  Health Literacy and Cognitive Capacity

PURPOSE:  To ensure patients understand their medication instructions.

SCOPE: This SOP applies to all Consulting Pharmacists.

PROCEDURES:  Patients with diminished health literacy and/or limited cognitive capacity may be at increased risk for medication therapy problems. During all patient visits, the Consulting Pharmacist screens the patient for ability to take medications properly. Interventions designed to improve adherence are selected based on results of this screening. The screening is repeated as needed to adapt interventions based on changes in cognitive capacity.

Health Literacy: Studies\textsuperscript{15,16} have shown two simple questions reveal health literacy deficits.

1. "How often do you have someone help you read hospital materials?" (Always, often, sometimes, occasionally, or never), and;
2. "How confident are you filling out medical forms by yourself?" (Extremely, quite a bit, somewhat, a little bit, or not at all).

Additional time and resources may be needed for patients who respond that they require assistance reading (always or often), or filling out medical forms (a little bit or not at all).

Cognitive Capacity:  The Pharm2Pharm toolkit provides several resources that may be helpful in assessing cognitive capacity for medication management.

SOP 2.3.2: Language and Cultural Needs

PURPOSE: To ensure patients receive culturally competent care.

SCOPE: This SOP applies to all Consulting Pharmacists.

PROCEDURES: During all patient visits, the Consulting Pharmacist identifies any language or cultural barriers to medication adherence. The Consulting Pharmacist utilizes translation and other support services as needed to minimize the impact of such barriers on patient outcomes.
SOP 2.3.3: Patient Fall Risk

**PURPOSE:** To minimize the risk of patient falls due to medication issues.

**SCOPE:** This SOP applies to all Consulting Pharmacists.

**PROCEDURES:** During all patient visits, the Consulting Pharmacist assesses medication-related fall risk and takes appropriate steps to minimize risk. (See SOP# 2.2.2 regarding potentially inappropriate medications for the elderly)
SOP 2.3.4: Homelessness and Other Psychosocial Needs

**PURPOSE:** To minimize the impact of social barriers on optimal medication management to achieve clinical goals of therapy.

**SCOPE:** This SOP applies to all Consulting Pharmacists.

**PROCEDURES:** Contact community resources (See County Resource Lists in the Pharm2Pharm toolkit). If assistance is needed, the hospital case managers can be contacted (for CCPs, this contact occurs via the HCP) for guidance.
SOP 2.3.5: Modifying Care in Advanced Illness

PURPOSE: To ensure that the plan for medication management reflects the patient’s situation and the preferences and priorities of the patient and family, in the period when the patient is coming toward the last part of life.

SCOPE: This SOP applies to all Consulting Pharmacists.

PROCEDURES: While patients who are clearly near death are not newly enrolled in the Pharm2Pharm service model, some enrollees experience illness progression and decline, and priorities and goals ordinarily need to be modified during that part of life. One useful definition is that the person is ill enough that it would be no surprise for the person to die in the coming year. Some patients in this category live for years, but the goals of care shift throughout. The Consulting Pharmacist may be among those who first notice the appropriateness of the shift of goals and the willingness of the patient and/or family to modify their goals. Sometimes, the changing goals come to the Consulting Pharmacist from the provider, Hospital Consulting Pharmacist, family, or patient. Often, the Consulting Pharmacist may help by suggesting modified goals, adapting the medication plans, and encouraging use of appropriate services.

The Consulting Pharmacist follows these procedures for all patients living with fragile health and coming to the end of life:

- Be open to patients and families voicing their expectations that decline and/or death is becoming a part of the prognosis. Be willing to explore the person’s situation and inform the key provider of insights.

- Coordinate with other providers to determine if a POLST has been executed. If so, obtain a copy. If not, refer the issue to the appropriate care provider.

  http://kokuamau.org/sites/default/files/uploads/Hawaii_POLST_Form.pdf The consumer advisory may be helpful -

  http://kokuamau.org/sites/default/files/uploads/POLST_information_Consumer_KM_Hawaii.pdf The POLST is not official until signed by a physician (it IS a physician order, recognized throughout the state of Hawaii).

- Some patients may have a CCO-DNR bracelet (Comfort Care Only- Do Not Resuscitate), and those are also acceptable to avoid resuscitation by the emergency technicians in Hawai’i.

  http://kokuamau.org/resources/cco-dnr-bracelet

- Patients facing decline and death should generally name a surrogate and explain their preferences in a more complete advance directive. While counseling and documenting this is not the responsibility of a Consulting Pharmacist, it is helpful to document the person a patient names to speak for the patient if a time comes when the patient is unable to communicate, and
it is also helpful to encourage the patient to talk with his/her doctor, lawyer, minister, or social worker about documenting these needs more fully.

- Most people who are quite ill or frail need modified goals of medication treatment. For example, most ordinary prevention services become less important (e.g., controlling blood pressure, continuing tight control of diabetes). On the other hand, preventing disability, delirium and falls ordinarily become much more important. As the Consulting Pharmacist notes that goals of treatment probably should be changing, the Consulting Pharmacist should be communicating with the primary provider to be sure that the team is staying abreast of appropriate patient support.

- Many people coming to the end of life have serious symptoms, and medication management of symptoms becomes critically important. Continuity of opioid medications across transitions is often especially important and challenging to arrange. Pharm2Pharm processes should work to limit the possibility of failure of maintenance doses at any time, both by anticipation of the issue by the Hospital Consulting Pharmacist and anticipation of need and delivery by the Community Consulting Pharmacist. Sometimes, doses of opioid medications reach surprisingly large levels in order to deal with symptoms of fatal illness. Consulting Pharmacists need to be ready to work with the dispensing pharmacy and other members of the care team.
PART 3: Continuous Quality Improvement

These SOPs are designed to ensure that the Pharm2Pharm service is continuously improved through review of individual cases and key performance indicators and that there is adequate documentation of service delivery to substantiate invoicing for payment.
SOP 3.1.1: Documentation

**PURPOSE:** To ensure proper documentation of Consulting Pharmacist services to support quality improvement and invoicing.

**SCOPE:** This SOP applies to all Consulting Pharmacists.

**PROCEDURES:** Each Consulting Pharmacist uses the approved version of the standardized Excel tool designed by the Pharm2Pharm project team to record required patient information for each enrolled patient. Additional patient files (electronic and/or paper) are kept as needed to ensure a record of the following:

- Discharge information sent from the Hospital Consulting Pharmacist
- Current medication list
- Drug therapy problems identified, including whether resolved
- Solutions to drug therapy problems, including whether implemented
- Other information needed to comply with these SOPs

REMINDER: During the Pharm2Pharm project, CCPs are paid for their services as specified in the service agreement only and are **prohibited from billing any other entity for these or related services provided to enrolled Pharm2Pharm patients.**

Each participating pharmacy reports the required aggregate information monthly according to instructions from the project team so that information may be aggregated for quality improvement efforts and to support invoicing and payment. **Only aggregate information is submitted to the project team. (Reminder - Only pages with green tabs may be sent to the project team).**

Each Consulting Pharmacist backs up his/her file daily to prevent loss of information.
SOP 3.1.2: Key Performance Indicators

PURPOSE: To ensure measurement and continuous improvement of the Pharm2Pharm model.

SCOPE: This SOP applies to all Consulting Pharmacists.

PROCEDURES: Key performance indicators (KPI) are identified, measured, and monitored by the project team. These include a variety of process and outcome measures to allow continuous improvement of the Pharm2Pharm service model. These indicators are not intended to be a reflection on any single individual or organization, but as indicators of how the model is functioning.
SOP 3.1.3: External Review

**PURPOSE:** To ensure access to documents for review by personnel authorized.

**SCOPE:** This SOP applies to all Consulting Pharmacists.

**PROCEDURES:** Participating pharmacies keep project and patient records updated daily and accessible for review, with or without advance notice, by those authorized. Prior to allowing external access to records, the pharmacy obtains documentation of the external entity’s authority to access records, in alignment with HIPAA and other relevant federal and state regulations, and the organization’s relevant policies and procedures.
SOP 3.1.4: Peer Review

**PURPOSE:** To ensure clinician leaders review events that may impact the success of the model.

**SCOPE:** This SOP applies to all Consulting Pharmacists.

**PROCEDURES:** Peer review is performed by the project team, under the direction of the Physician Leader, in alignment with HIPAA and other relevant federal and state regulations, and the organization’s relevant policies and procedures. The Consulting Pharmacist is responsible for reporting events appropriate for peer-review, including:

- Any patient enrolled or excluded from enrollment based on HCP judgment
- Any patient that exits the Pharm2Pharm service early (i.e., prior to completing one year)
- Any enrolled patient that is subsequently hospitalized; the peer review process determines if the hospitalization was medication-related or potentially preventable by Pharm2Pharm services (specifically, the HCP provides weekly updates on readmissions to the Physician Leader as requested)
- Any patient that is transferred to another CCP
- Any recommendation to a provider regarding a solution to a drug therapy problem that was not implemented
SOP 3.1.5: Inter-Organizational Collaborative Learning

**PURPOSE:** To ensure the Pharm2Pharm model is continuously improved through collaboration across participating organizations.

**SCOPE:** This SOP applies to all participating organizations.

**PROCEDURES:** Quarterly meetings are held to identify opportunities for improvement and implement changes designed to improve performance. Peer reviewed cases, aggregated measures, and feedback from patients, pharmacists, and prescribers are reviewed for consideration of model changes to improve efficiency and effectiveness of the service. Additional meetings and consultations are scheduled as needed to ensure improvements are made on a timely basis.
Appendix A: Toolkit Documents and SOP References

Based on experience to date, tools to support SOP compliance and best practice have been developed and collected and are continuously refined to improve the efficiency and effectiveness of the Pharm2Pharm model. These documents are located in the Pharm2Pharm “Toolkit” located at the following web site: https://sites.google.com/a/hawaii.edu/p2p/. Contact the project team for assistance obtaining access to this site and to recommend adding to or improving these tools. Below is a list of the current tools, along with their references in the SOPs.

- **SOP# 1.1.4**: DRAFT Patient Email Communication form (should be reviewed/adapted by your organization prior to use)
- **SOP# 2.1.1**: Initial Introduction script, Hospital
- **SOP# 2.1.2**: HCP Provider Notification form
- **SOP# 2.1.3**: Appointment Notification letter
- **SOP# 2.1.3**: CCP Provider Update form
- **SOP# 2.3.1**: Medi-Cog Cognitive Assessment
- **SOP# 2.3.4**: County Resource lists

Tools not referenced in the SOPs:
- HCP Excel tool (required)
- CCP Excel tool (required)
- CCP Visit form (allows CCP to print and record required information to facilitate documentation and data entry into the Excel tool when real-time data entry is not feasible)
- HCP post-discharge call form
- Patient Completion letter
- Medication Resources