Emphasizing the Care in Transitions

This article is based on information from Let's TOC About Patient Safety During Healthcare Transitions and Transitions of Care—Medication Reconciliation: Then and Now, sessions at the American Society of Consultant Pharmacists' 2025 Annual Meeting.

It is not uncommon for older adults to move between care settings. Managing care transitions and reducing readmissions is a challenge for pharmacists and other practitioners caring for older adults in any setting.

According to data from the Mayo Clinic, nearly one-fifth of Medicare beneficiaries discharged from the hospital are readmitted within 30 days; and nearly 15% of all acute care episodes result in a hospital readmission. The cost to the system is in the billions.

Medications are at the center of many readmissions. During transitions, various changes may be made to the person's medication regimen. Some of these can results in adverse events, interactions, or other problems; and these can lead the person to be readmitted to the hospital. According to one study, 70% of medication-related readmissions are preventable.

TOC: The Basics

The Centers for Medicare & Medicare Services (CMS) defines transition of care as "the movement of a patient from one setting of care (hospital, ambulatory primary care practice, ambulatory care practice, long-term care, home health, rehabilitation facility) to another."

In addition to a change in setting, care transitions also often involve changes in services, level of care, or provider. Challenges to successful care transitions include conflicting recommendations, confusing medication regimens, unclear follow-up instructions and lack of follow-up care, gaps in communication, and lack of understanding about the plan of care by the patient, caregivers, and others.

Consequences of inadequate care transitions include ineffective or duplicative care, medication errors and adverse events, inadequate follow-up, increased hospital lengths of stay, excessive emergency department visits, costs to the health care system and beneficiaries, and patient and family dissatisfaction.

Emphasizing the Care in Transitions, Cont.

Goals of safe and effective care transitions generally involve:

- An interdisciplinary approach to safely and efficiently transitioning the individual through the health care system
- Improved communication and collaboration between providers and settings
- Reduced medication errors and adverse events
- Best possible health outcomes
- Reductions in health care utilization (e.g., shorter hospital lengths of stay)

Medication Reconciliation: Central to Successful Care Transitions

Medication reconciliation, the process in which the individual's medication list is obtained, compared, and clarified across care sites/settings, should occur at each care transition, regardless of the setting. Among tips for effective medication reconciliation:

- It starts with the best possible medication history, as well as a complete and detailed review of all medications the individual is taking.
- Information should be sought from various sources, including the pharmacist and other care team members, family members or caregivers, and (when possible) the patients themselves. It is important to know where the medication list came from, if and how it has been changed, and when it was last updated.
- It is important to avoid focusing only on the acute issue and neglecting medications being used to treat chronic conditions. These can affect individuals' health when they are discharged from or admitted to the hospital. Be cognizant of medication timing and stop dates.
- Look for any changes in medication coverage as the patient moves between settings. No one wants a surprise bill for uncovered medications, particularly when a covered alternative is available.
- Understand who will be managing the person's medications when they leave the hospital. This is important to help identify needs for education or support and changes to the regimen (such as a switch from a three-times-daily dosed medication to a once-a-day alternative) that can help prevent medication-related problems. Particularly if the person will be managing their own medications, it will be essential to address potential barriers to adherence.
- Consider workflow automation that provides real-time notifications for transition of care reviews. This involves a system that assembles all pertinent data—including encounter type—prior to the encounter, drives production of provider- and patient-facing summaries specific for this encounter type, and provides service delivery history archives for all documentation.

The consultant pharmacist plays a key role in reconciliation by making real-time recommendations, improving efficiencies, increasing throughput, identifying and addressing opportunities for deprescribing, and lowering costs.

As more individuals are served by value-based care organizations, medication reconciliation takes on new significance. This, combined with care coordination between patients and their primary care provider, is key to effective transitions that minimize risks and maximize outcomes and cost-effectiveness.

Importance of Care Transitions and the Pharmacist's Role

Medication errors during care transitions are common, with at least some studies suggesting that nearly 50% of individuals, including older adults, experience medication errors after hospital discharge. Add to this that many patients have a medication discrepancy on hospital admission, and the potential for problems is increased.

Emphasizing the Care in Transitions, Cont.

As nursing home residents often take multiple medications, they are at high risk for medication errors and readmissions. There is evidence supporting the benefit of pharmacist involvement in hospital-to-nursing home transitions through systematic medication review and reconciliation. These practitioners can help identify and address inappropriate medication use and reduce readmissions.

The pharmacist's role in care transitions includes:

- Clinical interventions
- Patient and caregiver education
- Assessing and addressing access barriers
- Providing and promoting hand-off communication
- Supporting care continuity
- Medication reconciliation

Education has always been a key role for the pharmacist, and education about medications for residents and caregivers contributes to successful care transitions. This education may include:

- A review of the resident's medication list, including over-the-counter products they are taking, as well as issues related to side effects/potential adverse reactions, adherence, and storage and disposal.
- A discussion of disease state management, adherence and access barriers, and patient or caregiver preferences, concerns, and questions.

As a trusted professional, the pharmacist is positioned to help address barriers such lack of transportation to the pharmacy, language or literacy barriers, or concerns about dosing (e.g., the resident has trouble swallowing pills or doesn't like the taste of a liquid). Specifically, the pharmacist can look at their:

- Health and functional status
- Cultural factors and personal beliefs
- Health care access and quality
- Social and economic barriers

Of course, pharmacists can't function in a vacuum to improve care transitions. They need to be effective communicators and able to promote interprofessional collaboration, proactive care coordination, and current and accurate hand-off communication.

As the population continues to age, there is a growing need to help people age in place and avoid preventable hospitalizations. When seniors and their families partner with providers, including pharmacists, and providers partner with each other, the result can be successful care transitions that keep people safe in their homes and out of the hospital.

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