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Transitions of Care

Use this handy checklist at admission, at transfer between units within the same facility, before discharge, and at the patient's first post-admission outpatient visit to help keep patients on track with their meds and out of the hospital. Also see our toolbox, *Reducing Hospital Readmissions*, and our disease-specific checklists, *Post-CABG Pharmacotherapy Checklist* and *HIV Patient Transitions of Care Checklist*, for appropriate patients.

Goal	Suggested Approach
Considerations **upon admission** to an acute care facility.	☐ Get an accurate and complete med list. o Capture all meds patients currently take or use, including prn meds, OTCs and supplements, non-oral meds, non-daily meds (e.g., monthly infusions, meds given at dialysis), etc. o Use multiple resources, including the patient, family, outpatient pharmacy, and primary care provider. In the US, check the prescription drug monitoring program (PDMP) for controlled substances. In Canada, check PharmaNet, where available. o Clarify confusing regimens, such as between immediate- and extended-release dosage forms (e.g., metoprolol 100 mg daily). ☐ Review the home med list with the patient or caregiver before admission orders are entered, if possible.[2]
Considerations **when admission orders are placed** in an acute care facility.	☐ Check for drug interactions, duplicates, omissions, unnecessary meds, etc. o For example, ensure prn home meds are not mistakenly ordered as scheduled meds in the hospital. ☐ Stay alert for issues with anti-infective, cardiovascular, central nervous system, endocrine, and hematologic meds.[1] o The most problematic meds are oral antiplatelets, oral hypoglycemics, insulin, and warfarin.[1] o Accidental overdose is the most common med-related reason for admission.[1] ☐ Look for potential administration problems (e.g., patient now has an enteral tube and cannot take meds by mouth). o If needed, get oral tablets or capsules converted to other dosage forms. o Ensure oral tablets or capsules will not be inappropriately crushed, split, or opened. ☐ Determine how to manage non-formulary meds, such as if there's a therapeutic interchange or other acceptable formulary option; if a non-formulary policy should be followed to order the med; or if home meds can be used.
Considerations for **transfers to different levels of care** in an acute care facility. *Continued…*	☐ Compare current med regimen to transfer orders. ☐ Check for drug interactions, duplications, omissions, unnecessary meds, etc. o For example, assess whether certain meds are still needed, such as PPIs (stress ulcer prophylaxis), antipsychotics (ICU delirium versus other indications), and subcutaneous enoxaparin or heparin (DVT prophylaxis). ☐ Stay alert for problems with anti-infectives, diuretics, hematologic meds, electrolytes, and IV fluids, especially when a patient leaves ICU. o These meds are commonly associated with med errors when transferring out of ICU.[3]

Goal	Suggested Approach
Transfers to different levels of care, continued	☐ Consider incorporating a review of home meds when patients originally admitted to ICU are transferred to a floor, to determine if any meds should be restarted at this point. o Around 75% of home meds are stopped when a patient is admitted to ICU. ☐ Look for location-specific protocols (e.g., ICU or recovery room protocols), meds, drips (e.g., insulin, neuromuscular blocking agents, pressors, sedatives), or infusion rates restricted to use in certain areas. o Ensure inappropriate meds are stopped or changed to align with the appropriate floor-specific protocol, med, or infusion rate. o Check the MAR (not the label) to verify infusion rates, since rates can change after labels are printed. ☐ Ensure doses are adjusted when necessary (e.g., improving or worsening kidney function, certain IV to PO conversions [e.g., levothyroxine, furosemide]). o Consider incorporating a process to reassess doses that were adjusted while a patient was in ICU. ☐ Look for potential administration issues (e.g., patient has an enteral tube, cannot take meds by mouth). o If needed, get oral tablets or capsules converted to other dosage forms. o Ensure oral tablets or capsules will not be inappropriately crushed, split, or opened. o Adjust liquid meds back to home dosage forms if enteral tubes have been removed.
Acute care considerations **when a patient is discharged to home.** *Continued*	☐ Stop inpatient meds that are no longer needed (e.g., PPI, H2-blocker, enoxaparin). ☐ Stop duplicates created due to therapeutic interchanges (e.g., ACEIs, ARBs, statins) ☐ Ensure new meds are continued after discharge (e.g., heart failure meds, antiplatelets post-stent, controller inhaler), if appropriate. ☐ Ensure chronic meds held during hospitalization are restarted (e.g., anticoagulants, diabetes meds), if appropriate. o Verify that these will not result in duplication, drug interactions, or adverse events if restarted/continued.[2,5] ☐ Ensure there are stop dates for meds being given as short courses (e.g., antibiotics, corticosteroids).[4] ☐ Look for opportunities to simplify drug regimens when possible (e.g., consider combination or extended-release products). ☐ Identify expensive or prior authorization meds. o Involve discharge planners to resolve problems before discharge. ☐ Check for other barriers to getting discharge meds (e.g., holiday, evening, or weekend discharge; transportation). o If your facility delivers discharge meds to bedside with education, start the process well in advance of discharge. o If the patient has prescription drug coverage, get this information to minimize out-of-pocket expenses. ☐ Ensure patients/caregivers understand home med regimens. o Educate patients about any new diagnoses. o Make sure patients/caregivers know how to use any prescribed devices (e.g., inhalers) or injections (e.g., insulin, low-molecular weight heparin).

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Patient is discharged to home, continued	○ Use motivational interviewing and teach back to get buy-in and to make sure instructions are understood. ○ Empower patients with customizable action plans. ○ Use appropriate patient education handouts to reinforce discharge counseling. ☐ Check for pending test results. ☐ Make patients/caregivers aware of follow-up appointments and tests. Encourage keeping these. ○ Ensure the patient has a follow-up appointment with their usual primary care provider. ☐ Ensure patients/caregivers know what symptoms should prompt seeking medical attention, and who to contact if these occur. ☐ Check that explanations for any medication changes are in the discharge summary, or in a separate summary. ○ Send the discharge summary to the primary care provider. ○ A patient's med list should be shared with all the patient's providers. We have a template that can be used.
Outpatient/ community pharmacy considerations when a patient is discharged to home.	☐ Check that meds switched during an admission (e.g., due to formulary, therapeutic interchange) are changed back to the patient's pre-admission meds to avoid duplication or omissions. ○ Common formulary switches include ACEIs, ARBs, statins, and PPIs. ○ Liquid or short-acting formulations may need to be switched back to tablet, capsule, or long-acting formulations. ☐ Clarify med instructions that aren't specific (e.g., "as directed" insulin prescriptions, meds that are being tapered or titrated). ☐ Clarify liquid prescriptions written as "teaspoonful" or "tablespoonful"; use only mL. Give instructions for oral syringes or dosing cups. ☐ Help ensure discontinued meds are taken off automatic refill programs. Encourage patients to discard meds they no longer take. ☐ Help patients create an accurate med list and emphasize the importance of keeping it current.
Considerations when a patient is **discharged to a long-term care facility or rehab hospital.** *Continued…*	☐ Ensure accepting facility can meet the patient's needs (e.g., IV antibiotics, unusual or expensive meds). ☐ Ensure meds switched at admission (e.g., due to formulary, therapeutic interchange) are changed back to the patient's pre-admission meds to avoid duplication or omission. ○ Common formulary switches include ACEIs, ARBs, statins, and PPIs. ○ Liquid or short-acting formulations may need to be switched back to tablet, capsule, or long-acting formulations. ☐ Ensure chronic meds held during hospitalization are restarted (e.g., anticoagulants, diabetes meds), if appropriate. ○ Verify that these will not result in duplication, drug interactions, or adverse events if restarted/continued.[2,5] ☐ Ensure inpatient meds started in the acute care facility that are no longer needed (e.g., PPI, H2-blocker, DVT prophylaxis) are stopped.

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Discharged to long-term care or rehab, continued	☐ Ensure new meds started in the acute care facility are continued upon discharge (e.g., heart failure meds, antiplatelets post-stent, controller inhaler), if appropriate. ☐ Clarify med instructions that aren't specific (e.g., "as directed" insulin prescriptions, meds that are being tapered or titrated). ☐ Clarify liquid prescriptions written as "teaspoonful" or "tablespoonful"; use only mL. Give instructions for oral syringes or dosing cups. ☐ Ensure there are stop dates for meds being given as short courses (e.g., antibiotics, corticosteroids).[4] ☐ Check for pending test results. ☐ Make accepting facility aware of follow-up appointments and tests. ☐ Ensure explanations for any medication changes are in the discharge summary, or in a separate summary. ☐ Send the discharge summary to the facility AND the provider who will be following the patient.
Considerations upon **admission/readmission to a long-term care facility.**	☐ Obtain the discharge summary, if applicable. ☐ Identify labs pending at discharge that need follow-up, if applicable. ☐ Get an accurate and complete med list. o Capture all meds patients currently take or use, including prn meds, OTCs and supplements, non-oral meds, non-daily meds (e.g., monthly infusions, meds given at dialysis), etc. o Use multiple resources, including the patient, family, outpatient pharmacy, and primary care provider. Check the prescription drug monitoring program (PDMP) for controlled substances, if possible. In Canada, check PharmaNet, where available. o Clarify confusing regimens, such as between immediate- and extended-release dosage forms (e.g., metoprolol 100 mg daily). ☐ Clarify med instructions that aren't specific (e.g., "as directed" insulin prescriptions, meds that are being tapered or titrated). ☐ Clarify liquid prescriptions written as "teaspoonful" or "tablespoonful"; use only mL. Give instructions for oral syringes or dosing cups. ☐ Ensure there are stop dates for meds being given as short courses (e.g., antibiotics, corticosteroids).[4] ☐ Look for therapeutic duplications (e.g., due to formulary switches), or chronic meds that may have been held but not restarted. ☐ Check for drug interactions, or meds started in the hospital that may cause problems for seniors (e.g., antipsychotics, hypnotics). ☐ Call the inpatient prescriber to clarify pre- and post-admission med list discrepancies that don't make sense.

Goal	Suggested Approach
Considerations at/before **first post-admission primary care visit.**	☐ Follow up with the patient by phone within two business days of discharge to: o ensure discharge instructions are being followed (e.g., antibiotics for pneumonia, prednisone for COPD). o identify symptoms requiring medical attention (e.g., worsening COPD, heart failure, or infection). o remind patients of follow-up appointments. If not scheduled, schedule one within seven to 14 days of discharge. o ask the patient to bring any discharge materials from the hospital to the appointment. ☐ Get info on billing for transitional care management services at https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Transitional-Care-Management-Services-Fact-Sheet-ICN908628.pdf). ☐ Obtain the discharge summary before the patient visit. o Review it for pending labs. o Identify labs pending at discharge that require follow-up. o Order recommended follow-up tests, if needed. ☐ Call the inpatient prescriber to clarify differences between pre-and post-admission med lists that don't make sense. ☐ Look for therapeutic duplications (e.g., due to formulary switches), inpatient meds that are no longer needed (e.g., stress ulcer prophylaxis), chronic meds held during hospitalization but not restarted, and chronic meds that are no longer needed or will result in duplication, drug interactions, or adverse events if restarted/continued.[2] ☐ Ensure patients understand when to stop short-course therapy (e.g., antibiotics, corticosteroids, pain meds).[4] ☐ Ensure patients understand which meds have been changed or stopped and encourage proper disposal. ☐ Use motivational interviewing and teach back to get patient/caregiver buy-in and to make sure instructions are understood. ☐ Create an accurate med list. Give the patient the med list and encourage them to take it to all appointments.

Abbreviations: ACEI = angiotensin converting enzyme inhibitor; ARB = angiotensin receptor blocker; COPD = chronic obstructive pulmonary disease; DVT = deep vein thrombosis; ICU = intensive care unit; IV = intravenous; OTC = over-the-counter; PO = by mouth; PPI = proton pump inhibitor.

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