Pharmacist to Pharmacist Handoff Letters: A Transition of Care Tool

by Shelby Tjugum, 2017 PharmD Candidate, Thuy-Vu Do, 2017 PharmD Candidate, and David Hager, PharmD, BCPS

***Editors Note:** This article was invited to discuss innovative workflows and technologies within healthcare institutions to promote patient care*

Transitioning between different healthcare settings can lead to adverse drug events as a result of poor communication.[1] Community pharmacies often are not aware their patient was recently admitted to the hospital and sometimes lack the necessary information to safely aid in this transition of care.[2] Through WPQC and others, payment for community pharmacies may be available for services provided to these patients. At UW Health, it has been a goal to improve two-way communication between inpatient and community pharmacists to improve patient care. A component of the solution was the development of a transition of care tool to strengthen post-discharge communication and coordination of medication plans between inpatient and outpatient settings.

Process

Beginning on September 1, 2016, UW Health implemented the faxed Pharmacist to Pharmacist Hand-Off letter to improve communication between hospital and community pharmacists. Decentral inpatient pharmacists are responsible for the creation and electronic faxing of a pharmacist discharge summary to the patients' primary community pharmacy. The patients' primary pharmacy is obtained during the admission history process. For any particular discharge, the filling pharmacy could differ from the patients' primary pharmacy based on convenience, and the Pharmacist to Pharmacist Hand-Off letter could be sent to both pharmacies. TThe main contents of the letter was based on feedback solicited by a PSW workgroup of community, long-term care, and hospital pharmacists in 2013." "The letter includes an updated discharge medication list, patient weight, phone number to contact discharging hospital pharmacist, last dose of medications taken, any adherence issues identified, allergies (including reactions), immunizations, and other transitions of care data (Figure 1).

Since the implementation of the Pharmacist to Pharmacist Hand-Off letter at UW Health over 4,200 pharmacist discharge summary letters have been faxed to community pharmacies across the nation. In phone surveys of nearly 100 community pharmacies across the Midwest, a majority (76%) of pharmacists reported value from this hand-off through ability to complete medication reconciliation and facilitation of tailored patient counseling. Respondents recommended multiple tips for facilitating use in the community setting. First, involve technicians to reconcile the patients' list of drug allergies and immunizations, identify where discharge prescriptions were sent to, and confirm if prior authorization work was completed prior to discharge. Second, utilize the discharge medication list to identify medication changes and update the patient's profile. Finally, check last doses given and provide the patient with more specific directions during counseling.

Overall, the Pharmacist to Pharmacist Hand-Off letter has opened a new line of communication between inpatient and community pharmacists and offered new opportunities for pharmacists' involvement in transitions of care. Within the coming months, pharmacy leaders within UW Health plan to evaluate the necessity of each content area and further refine the letter in order to better meet the requests of our community partners.

Shelby Tjugum and Thuy-Vu Do are 4th Year Doctor of Pharmacy Candidates at the University of Wisconsin-Madison School of Pharmacy, Madison, WI. David Hager is a Clinical Coordinator and Pharmacy Manager at UW Health, Madison, WI.

References

1. Institute for Healthcare Improvement. 5 million lives: preventing adverse drug events (medication reconciliation): how-to guide. http://www.ihi.org/resources/Pages/Tools/HowtoGuidePreventAdverseDrugEvents.aspx. Updated December, 2011. Accessed January 4, 2017.
2. Steeb D, Webster L. Improving care transitions: optimizing medication reconciliation. American Pharmacists Association and American Society of Health-System Pharmacists. https://www.pharmacist.com/sites/default/files/files/2012_improving_care_transitions.pdf. Updated March 2012. Accessed January 4, 2017.

F6/6

UWHealth

600 Highland Av

Madison WI 53792

608-263-8151

November 20, 2016

RE: Bruce Christmas **DOB:** 12/25/1942

Dear Colleague:

The purpose of this communication is to aid in pharmacist to pharmacist hand-off when patients transition from the hospital to an outpatient care setting. This fax is to improve the safety of the transition out of the hospital by providing clinical data on our mutual patient and to allow for medication reconciliation against your profile. This fax does NOT represent legal prescription(s) and does not imply prescriptions are necessarily forthcoming; for patients utilizing long-term care pharmacies, the discharge packet provided to the patient contains an electronically signed medication list to serve as initial prescriptions.

For questions about the hospitalization and discharge medication plan within 2 days of the discharge date, please call the discharging unit at 608-263-8151 and request to speak to the unit pharmacist. If it is greater than 2 days post-discharge, please contact the patient's primary care provider.

Admission Date: 11/29/2016
Discharge Date: 11/29/16
Primary Care Physician: Joel R Buchanan, MD
Primary Care Physician #: 608-265-7550
Discharge Physician: Peter D Newcomer, MD
Location: F6/6
Service: GENERAL MEDICINE 1A
Patient's Preferred Language: English

RPh to Pharmacy DC Handoff by Frank Ruby, RPH at 11/29/16 1533

Summary of Stay:
Hip fracture

Medication Discharge Planning:
11/09/2016 Insurance
Wisconsin Medical Assistance

11/19/2016 Test Claim
Wisconsin Medical Assistance
Oxycontin 20mg #14 tabs = PA Required
Oxycodone 20mg ER #14 tabs = PA Required
Morphine ER 30mg #14 tabs = $0.00

Discharge Medication Coordination:
The following medication prescriptions were given to the patient
-Morphine 30 mg ER tabs

Note: This fax does NOT represent legal prescription(s).

Medicine Plan

START taking these medicines

morphine 30 MG ER tab
Also known as: MS CONTIN
Take 1 tab by mouth 2 times daily.

CHANGE how you take these medicines

albuterol HFA 108 (90 BASE) MCG/ACT inhaler
Inhale 2 puffs every 4-6 hours as needed.
What changed: **Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here.**

budesonide AQ 32 MCG/ACT nasal spray
Also known as: RHINOCORT AQUA
2 sprays in each nostril one time daily.
What changed: **Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here.**

doxycycline hyclate 100 MG cap
Take 1 cap by mouth 2 times daily. For acne
What changed: **Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here.**

famotidine 20 MG tab
Also known as: PEPCID
Take 20 mg by mouth 2 times daily.
What changed: **Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here.**

loratadine 10 MG tab
Also known as: CLARITIN
Take 10 mg by mouth one time daily.
What changed: **Another medication with the same name was removed. Continue taking this medication, and follow the directions you see here.**

KEEP taking these medicines

aprepitant 80 MG cap
Also known as: EMEND
Take 1 cap by mouth one time daily. Take for 2 days following chemotherapy.

Blood Glucose Monitoring Suppl SUPPLIES Misc
2 times daily.

dexamethasone 4 MG tab
Also known as: DECADRON
Take 2 tabs by mouth one time daily. Take for 3 days following chemotherapy.

levothyroxine 100 MCG tab
Also known as: SYNTHROID
Take 1 tablet daily

losartan 50 MG tab
Also known as: COZAAR
Take 1 tablet by mouth daily

prochlorperazine 10 MG tab
Also known as: COMPAZINE
Take 1 tab by mouth every 6 hours as needed for nausea/vomiting.

simvastatin 40 MG tab
Also known as: ZOCOR
Take one tablet daily with evening meal

sumatriptan 100 MG tab
Also known as: IMITREX
1 TABLET 1 TIME ONLY

**STOP taking these medicines

albuterol 90 MCG/ACT inhaler

filgrastim 300 MCG/0.5ML injection
Also known as: NEUPOGEN

losartan-hydrochlorothiazide 50-12.5 MG per tab
Also known as: HYZAAR

ondansetron 8 MG tab
Also known as: ZOFRAN

ranitidine 150 MG tab
Also known as: ZANTAC

Height/Weight:

	11/29/16 1500
Weight:	65.8 kg (145 lb)
Height:	1.854 m (6' 1")

Allergies

Allergen	Reactions
• Sulfa Drugs	WHEEZING
• Penicillins	HIVES
• Sulfa Drugs	WHEEZING
• Sulfa Drugs	RASH

Immunizations Administered for This Admission
No immunizations given during this hospitalization.

*Incomplete immunization = ordered but not yet administered. Patient may have refused vaccine prior to discharge. Confirm status with vaccine registry.

Facility Administered Medications from 11/28/2016 1534 to 11/29/2016 1534

Date/Time	Order	Dose	Route	Action
11/29/2016 1551	**abatacept (ORENCIA) in dextrose 5 % 100 mL bag**		Intravenous	Given

Lab Results
No results found for this or any previous visit (from the past 24 hour(s)).

Tobacco History
History
Smoking Status

• Current Every Day Smoker	
• Packs/day:	1.00
• Years:	35.00
• Types:	Cigarettes

Smokeless Tobacco
• Not on file
Comment: Patient has been trying to stop smoking with minimal success

UW Health Appointments and Labs (if applicable):
Outpatient Follow-Up

Date & Time	Appointment	Department (Center)
Dec 02, 2016 3:00 PM CST	Office Visit with Mark A Ritter, MD	UWH CARBONE CANCER CENTER RADIATION ONCOLOGY (MADISON, 600 HIGHLAND AVE)

Sincerely
RUBY, FRANK, RPH

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