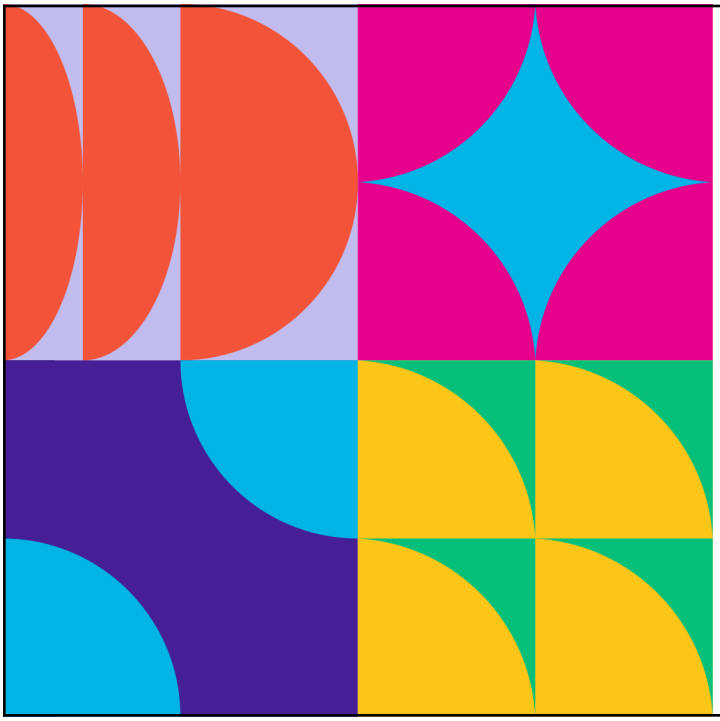

Growing Your Pharmacy Through Long-Term Care (LTC) and Aging-in-Place Services

Leanne Haley-Brown, BS Pharm, RPh

Description

As more older adults receive care across long-term care and aging-in-place settings, pharmacies play a critical role in medication safety and care coordination. Examine how pharmacy services and partnerships can improve adherence and continuity in these environments. Leave with a clearer path to expand LTC and aging-in-place services that improve outcomes and support long-term pharmacy viability.

Meet the Faculty

Leanne Haley-Brown,
BS Pharm, RPh

CEO
Impact Pharmacy Solutions, LLC.

Leanne Haley-Brown

Leanne is a healthcare collaboration leader with more than 35 years of experience in independent pharmacy, specializing in long-term pharmacy care at home and in facilities. She leads CPESN Pharmacy Care at Home and the Remote Care Initiative, helping pharmacies expand patient care through innovative, outcomes-focused programs.

She also serves as Guide Program Liaison and Gameplan ACCESS Program Lead for CPESN and is an ASCP-recognized Age-Friendly Pharmacist. A graduate of the University at Buffalo School of Pharmacy, Leanne is an active leader within NCPA, ASCP, NCPDP, The Alliance for Long-Term Pharmacy at Home, and the NCPA Foundation, where she serves as a mentor, advisor, speaker, and author.

Disclosures

- Leanne Haley-Brown has no relevant financial relationships with ineligible companies to disclose.
- Leanne Haley-Brown discloses that AI tools were utilized to generate content included in this presentation.

Funding for this course was provided by Cencora.

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Learning Objectives

Upon completion of this activity, learners should be able to:

- Recognize medication-related risks and care gaps that create opportunities for LTC and aging-in-place services.
- Identify pharmacy service and partnership opportunities in LTC and home-based care.
- Examine service and care interventions that improve outcomes and support LTC and aging-in-place services.
- Apply two strategies to strengthen coordination between pharmacy teams, caregivers, and care providers.
- Prioritize one opportunity to expand or strengthen an LTC or aging-in-place service aligned with workflow and sustainability.

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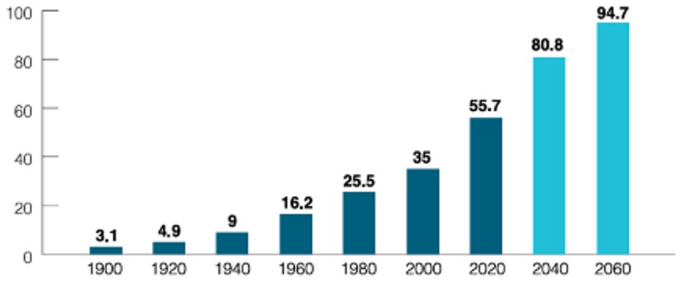
Why This Matters Now

What's Changing With Our Demographics

The 85 and older population is projected to more than double from 6.7 million in 2020 to 14.4 million in 2040 (a 117% increase).

Number of Persons Age 65 and Older, 1900-2060 (numbers in millions)



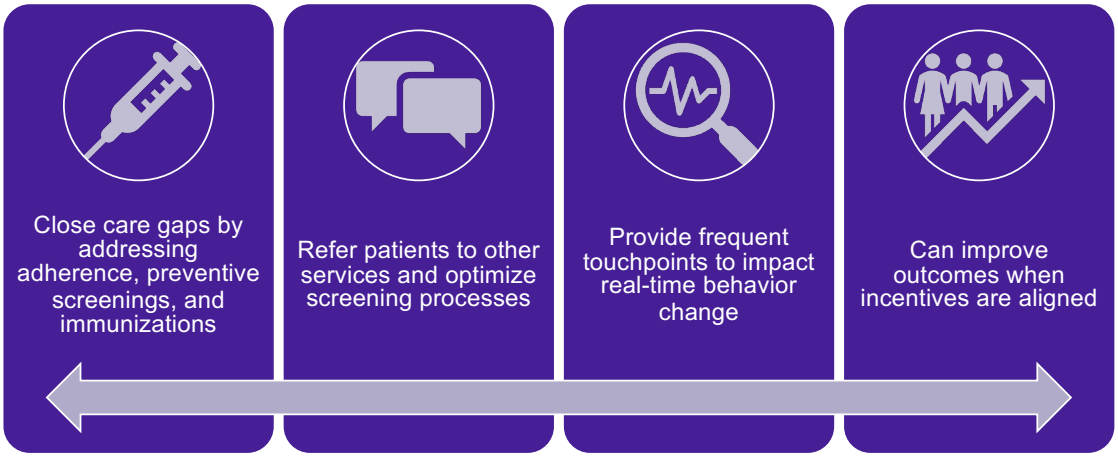
Note: Lighter bars (2040 and 2060) indicate projections.
Source: U.S. Census Bureau, Population Estimates and Projections

www.johnahartford.org/resources/view/acl-2020-profile-of-older-americans

What's Changing With Our Demographics

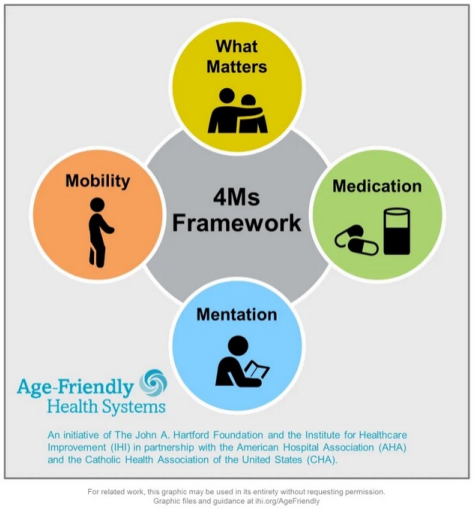
- More people needing Skilled Nursing than we have beds
- Less complex Skilled Nursing patients will need to occupy Assisted Living beds when able
- More people needing Assisted Living than we have beds, due to increase in older adults and use of available beds for moderately complex skilled patients
- Low to moderately complex patients will **need** to remain in their homes as long as possible!

Unique Value of Pharmacies



The 4Ms of Age-Friendly Pharmacy

- Represents core health issues for older adults
- Builds on strong evidence base
- Simplifies and reduces implementation and measurement burden on systems
- Components are synergistic and reinforce one another



Free Age-Friendly Training: https://learning.ascp.com/cw/course-details?entryId=17499442&itemId=717655&subscribed=false
www.ihi.org/AgeFriendly

Why the 4Ms?

- A movement to create Age-Friendly Health Systems is underway in the United States
- The goal is to ensure that every older adult receives the best possible care, is not harmed by care, and is satisfied with the care they receive
- When put into practice, the 4Ms framework is a success because the patient is included in their care plan
- The 4Ms age-friendly movement creates a pathway for older adult care that is standard regardless of where the patient resides

Why the 4Ms?

- **What Matters**
  - What matters to each older adult, their goals and preferences for care, guides the health care team and aligns care to what really matters to them.
- **Medications**
  - Age-related changes can increase the risk of medication side effects. The health team monitors all medications, determines whether they are still necessary, and ensures that older adults' medications do not interfere with **What Matters, Mentation,** or **Mobility**.
- **Mentation (Mind and Mood)**
  - Mental processing, thinking, and memory are important! The health team pays attention to this aspect of care, screening for changes that could be related to dementia, depression, and delirium.
- **Mobility**
  - Staying active and moving daily is how older adults stay strong, maintain function, and do **What Matters**. The health care team ensures safe mobility to help older adults stay active.

www.ihi.org/AgeFriendly
www.agefriendlycare.psu.edu/the-4ms-explained

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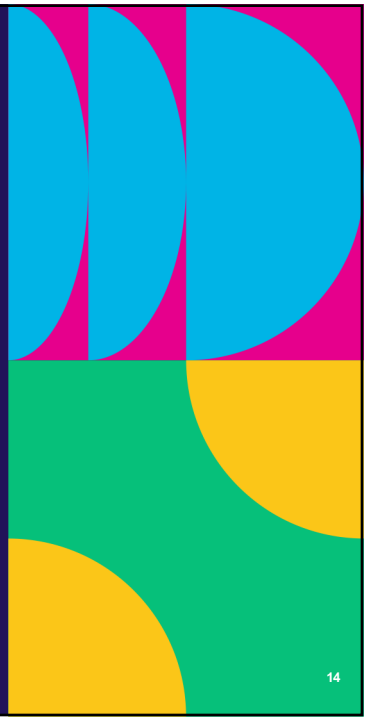
Opportunities to Reduce Medication Risks



Opportunities To Reduce Medication Risks

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Medication-Related Risks & Care Gaps = Service Opportunities

Medication Complexity & Adherence

- Complex regimens increase duplication, interaction, and scheduling risks
- Cognitive, dexterity, and cost barriers hinder correct administration
- Med sync, packaging, delivery, and education reduce adherence friction

Transitions & Monitoring Gaps

- Hospital-to-home transitions are peak-risk for medication discrepancies
- Without proactive follow-up, side effects and duplicates go undetected
- Escalation pathways and social determinants of health (SDOH) integration are core pharmacy values

What It Means for Pharmacy

More complex patients residing in their homes need our medication expertise

- More sites, more handoffs:
  - Older adults receive care across home, assisted living, skilled nursing facilities (SNF), rehab, and clinics
  - More transitions of care = more risk of lost or delayed medication information
- Aging-in-place expands variability:
  - More medication management happens at home with variable routines
  - Caregiver capacity varies; monitoring is less consistent than in facilities
- LTC complexity in the home remains higher-risk:
  - Polypharmacy, frequent regimen changes, and multi-provider coordination
  - High-risk meds (e.g., Beers Criteria, anticholinergic load) elevate error risk

A Universal Pharmacological-Based List of Drugs with Anticholinergic Activity: https://pmc.ncbi.nlm.nih.gov/articles/PMC9863833/
Anticholinergic Burden Calculator: www.acbcalc.com/

American Geriatrics Society (AGS) Beers Criteria®

- Anticholinergics (first-generation antihistamines)
  - Diphenhydramine, hydroxyzine, promethazine
  - Increased risk of confusion, falls, delirium, and dementia
- Benzodiazepines and sedative-hypnotics
  - Diazepam, lorazepam, alprazolam, zolpidem
  - Elevated fall and fracture risk, cognitive impairment, sedation
- Cardiovascular and antithrombotics
  - Aspirin (primary prevention), warfarin, digoxin, amiodarone, nifedipine IR
  - Bleeding risk, orthostatic hypotension
- Nonsteroidal anti-inflammatory drugs (NSAIDs)
  - Ibuprofen, naproxen, indomethacin
  - GI bleeding, renal impairment, increased cardiovascular risk

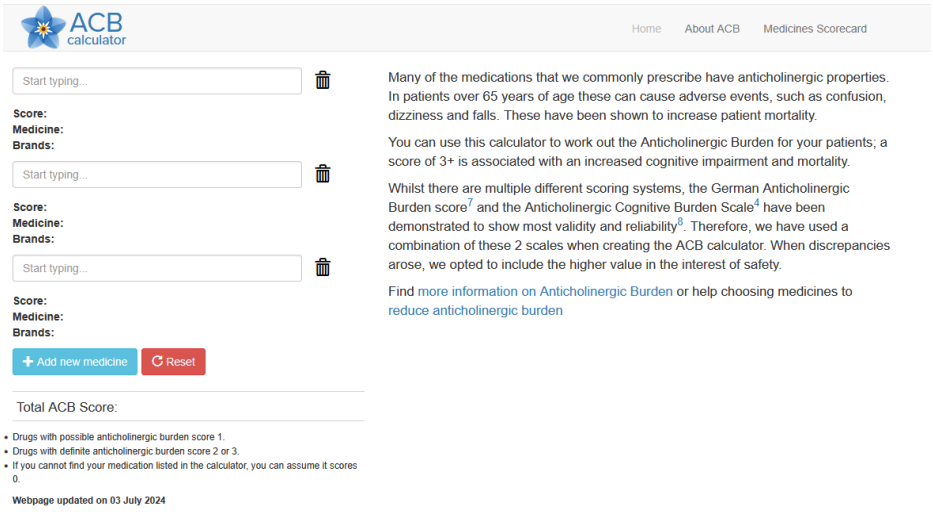
AGS Beers Criteria®. *J Am Geriatr Soc*. 2023;71:2052–2081. doi:10.1111/jgs.18372.
AGS Beers Criteria® Alternatives Panel. *J Am Geriatr Soc*. 2025;73(9):2657–2677. doi:10.1111/jgs.19500
https://familycaregiversonline.net/the-2026-ags-beers-criteria/; www.healthinaging.org

American Geriatrics Society (AGS) Beers Criteria®

- Tricyclic antidepressants
  - Amitriptyline, nortriptyline
  - Strong anticholinergic effects, sedation, orthostatic hypotension, cardiac conduction issues
- Opioids and central nervous system (CNS) depressants
  - Meperidine, carisoprodol
  - Avoid concurrent use with benzodiazepines; increased fall, fracture, and respiratory risk
- Sulfonylureas and endocrine agents
  - Glyburide, chlorpropamide
  - Prolonged hypoglycemia risk; prefer shorter-acting agents in older adults

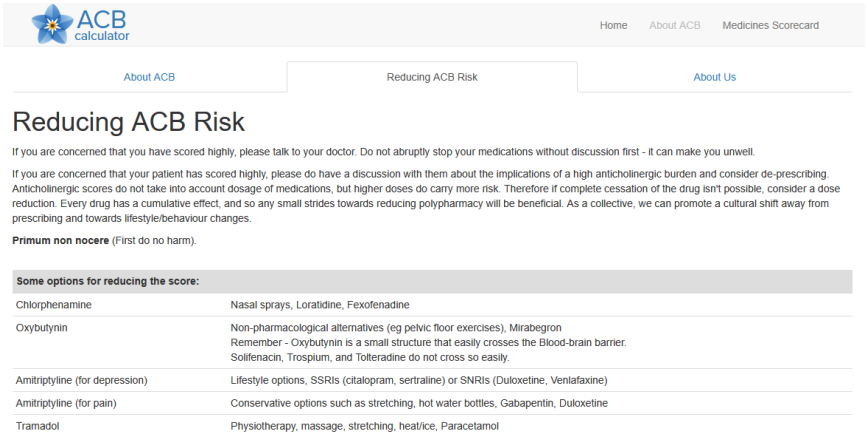
AGS Beers Criteria®. *J Am Geriatr Soc*. 2023;71:2052–2081. doi:10.1111/jgs.18372.
AGS Beers Criteria® Alternatives Panel. *J Am Geriatr Soc*. 2025;73(9):2657–2677. doi:10.1111/jgs.19500
https://familycaregiversonline.net/the-2026-ags-beers-criteria/; www.healthinaging.org

Anticholinergic Burden (ACB)



A Universal Pharmacological-Based List of Drugs with Anticholinergic Activity: https://pmc.ncbi.nlm.nih.gov/articles/PMC9863833/
Anticholinergic Burden Calculator: www.acbcalc.com/

Anticholinergic Burden (ACB)



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www.acbcalc.com/pages/reducing

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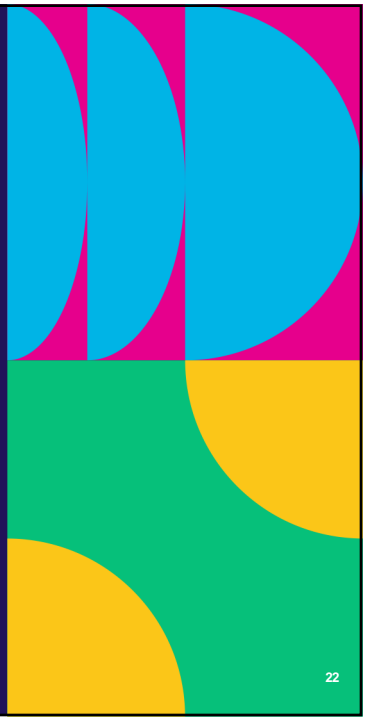
Case Study



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Case Study

Patient Profile

- 70-year-old woman presenting for comprehensive medication review (CMR)
- History:
  - Overactive bladder, depression, seasonal allergies, chronic insomnia, hypertension, osteoarthritis
- Renal function mildly reduced for age
- Uses pill organizer; manages own medications independently
- Daughter reports increasing forgetfulness in the evenings

Presenting Symptoms

- Increasing dry mouth and constipation over the past 6 months
- Daytime drowsiness and blurred vision
- Two recent near-falls raise safety concerns
- Evening forgetfulness noted by family
- Symptoms consistent with cumulative anticholinergic effects

Case Study

Medication	Indication	ACB	Comments
Oxybutynin ER 10 mg daily	Overactive bladder	3	High-potency anticholinergic; likely contributor to dry mouth, constipation, cognitive effects
Amitriptyline 25 mg at bedtime	Insomnia/pain	3	Strong anticholinergic; increases sedation and fall risk
Diphenhydramine 25 mg at bedtime PRN	Sleep/allergies	2	Common OTC contributor to anticholinergic burden
Cetirizine 10 mg daily	Allergic rhinitis	1	Lower burden than first-generation antihistamines but still contributes
Metoprolol succinate 50 mg daily	Hypertension	1	Low anticholinergic burden
Amlodipine 5 mg daily	Hypertension	0	Calcium channel blocker; no anticholinergic properties; commonly paired with beta-blocker
Vitamin D3 1,000 IU daily	Bone health	0	Supplement for bone health/fall prevention; no anticholinergic burden

Case Study

Medication	Indication	ACB	Comments
Oxybutynin ER 10 mg daily	Overactive bladder	3	**Total ACB Score = 10** A score of 3 or more is clinically significant in adults over 65, associated with increased risk of cognitive impairment, falls, delirium, constipation, urinary retention, and reduced adherence.
Amitriptyline 25 mg at bedtime	Insomnia/pain	3	
Diphenhydramine 25 mg at bedtime PRN	Sleep/allergies	2	
Cetirizine 10 mg daily	Allergic rhinitis	1	
Metoprolol succinate 50 mg daily	Hypertension	1	
Amlodipine 5 mg daily	Hypertension	0	
Vitamin D3 1,000 IU daily	Bone health	0	

Case Study: Deprescribing High-Burden Drugs

How to Deprescribe

1. **Identify and quantify burden:** Use ACB calculator to total score and Beers Criteria to highlight strongest contributors
2. **Clarify treatment goals:** Evaluate whether each medication is still effective and aligned with patient priorities
3. **Target one drug at a time:** Start with highest burden and lowest ongoing benefit
4. **Taper when needed:** Avoid abrupt stops; rebound insomnia or cholinergic rebound may occur
5. **Recommend safer alternatives:** Match each indication with lower-burden or non-drug options
6. **Monitor and follow up:** Reassess symptom control, cognition, falls, and adherence
7. **Communicate with prescriber:** Provide burden score, suspected effects, proposed taper, and substitutes

Case Study: Deprescribing High-Burden Drugs

Drug-Specific Approach

- **Diphenhydramine (ACB 2) plus Beers Criteria:**
  - Discontinue; replace with sleep hygiene measures
- **Amitriptyline (ACB 3) plus Beers Criteria:**
  - Gradual taper; consider non-drug sleep strategies or topical pain options
- **Oxybutynin (ACB 3) plus Beers Criteria:**
  - Taper or step down; try bladder training, timed voiding, pelvic floor therapy
- **Cetirizine (ACB 1) plus Beers Criteria:**
  - Assess seasonal need; consider as-needed use or discontinuation outside allergy season

Case Study: Pharmacist Recommendation & Follow-Up

Sample Recommendation

Mrs. J has an estimated ACB score of 10, driven primarily by oxybutynin, amitriptyline, and diphenhydramine. Her current symptoms are consistent with anticholinergic adverse effects. In addition, these drugs also appear on the Beers Criteria.

Recommended actions:

- First, discontinue diphenhydramine
- Reassess ongoing need for amitriptyline and oxybutynin
- Structured taper with lower-burden alternatives where appropriate
- Follow up: sleep, bladder symptoms, bowel function, BP, cognition, fall risk

Case Study: Pharmacist Recommendation & Follow-Up

Counseling & Monitoring

Patient counseling:

- Anticholinergic effects are cumulative across multiple medications
- Do not stop chronic medicines abruptly unless instructed
- Review OTC sleep and allergy products at each visit

Key outcomes to track:

- Fewer falls, improved alertness, less constipation and dry mouth
- Monitor for withdrawal or recurrence of original condition

Teaching note:

Use validated ACB tools as a screening aid, not the sole basis for decisions. Deprescribing should account for indication, therapy duration, patient goals, and prescriber collaboration.

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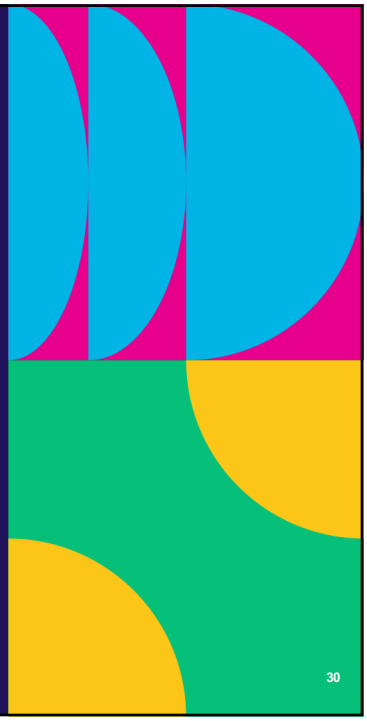
Supporting LTC and Aging-in-Place Services



What's the Opportunity?

We can successfully keep patients in their homes

Pharmacy as the patient-centered healthcare hub:

- Standardize med lists, close communication loops, identify risks proactively
- Interact with patients more frequently than any other provider

Higher-touch services become differentiators:

- Adherence support, monitoring, reconciliation, and remote patient care
- CMS programs (GUIDE, ACCESS) strengthen sustainability and outcomes

Sustainable growth requires design:

- Success depends on partnerships and services that fit real workflows
- Scalable billing/contracting paths needed - not just "extra work"

Valliant SN, Burbage SC, Pathak S, Urick BY. *J Managed Care & Specialty Pharmacy*. 2022;28(1):85–90.
Chisholm-Burns MA, et al. *Med Care*. 2010;48(10):923–933.
American Society of Consultant Pharmacists. www.ascp.com/general/custom.asp?page=mstoc

LTC and Aging-in-Place Support: Who to Contact and Why

Clinical & Rehabilitation Services

- Home health agencies:
  - Skilled nursing, therapy, and aide support for post-hospital recovery
- Occupational therapists:
  - ADL independence training and adaptive equipment recommendations
- Physical therapists:
  - Balance, strength, fall prevention, and safe mobility at home
- Personal care/in-home supportive care:
  - Hands-on ADL help, medication reminders, and companionship

Personal Care & Community Support

- Home health aides & personal support:
  - Direct personal care and daily task assistance
- Homemaker & companion services:
  - Meal prep, errands, housekeeping, and social engagement
- Consumer-directed attendant services:
  - Self-arranged in-home personal care and household help
- Area agencies on aging & community programs:
  - Meals, transportation, respite care, and emergency response systems

ADL: Activities of Daily Living

LTC Pharmacy at Home: Example Patient Qualification Considerations

- Identify patients with qualifying care needs, ADL/IADL barriers, chronic conditions, multiple maintenance medications, and limited mobility
- Document qualification pathway and supporting information
- Align packaging, delivery, reassessment, and communication workflows
- Confirm payer, contract, state, and CMS requirements before implementation
- Use structured documentation to support consistency and audit readiness

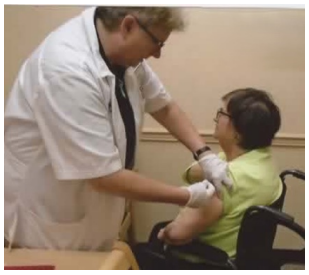
IADL: Instrumental Activities of Daily Living
www2.ccwdata.org/web/guest/home; www.ncbi.nlm.nih.gov/books/NBK470404
www.pharmacyathome.org; https://cpesn.com/pharmacy-care-home

Opportunity To Improve Patient Outcomes with Vaccines

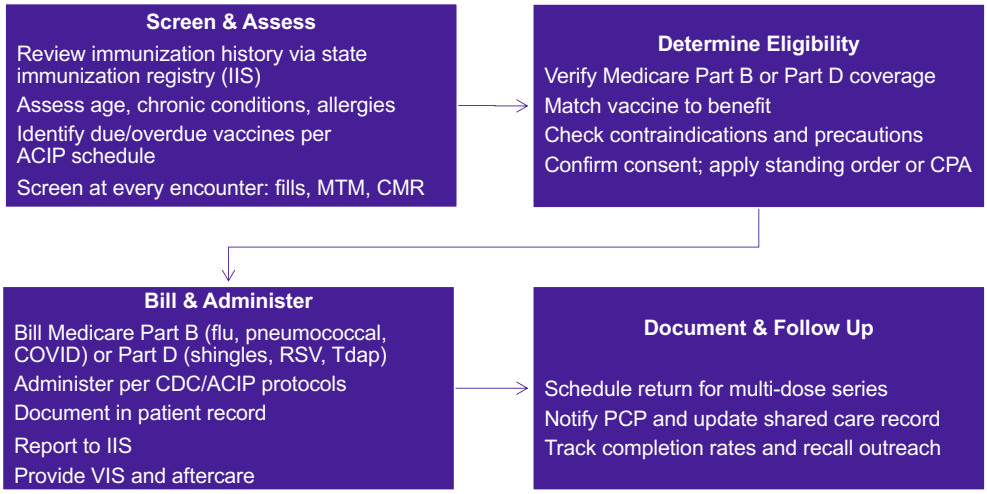
"Adult vaccination should focus on maintaining independence and quality of life.

It is crucial to protect against the "Domino Effect," as preventable diseases can lead to severe health declines, extended hospital stays, and the inability to remain in their home."

- Leanne Haley-Brown, RPh,
  CPESN® Pharmacy Care at Home Lead



Vaccine Screening & Administration: Workflow



ACIP: Advisory Committee on Immunization Practices
IIS: Immunization Information Systems
RSV: Respiratory Syncytial Virus
CPA: Collaborative Practice Agreement
MTM: Medication Therapy Management
VIS: Vaccine Information Statement

Medicare Vaccine Coverage: Part B vs. Part D

Vaccine	Medicare Type	Patient Cost	Schedule	Key Notes
Influenza	Part B	$0 (no deductible)	One dose annually, every fall	All Medicare beneficiaries; high-dose/adjuvanted for 65+
Pneumococcal	Part B	$0 (no deductible)	Single dose (PCV20 or PCV21) or PCV15 + PPSV23 series	For adults 50+ or 19-49 with risk factors per ACIP
COVID-19	Part B	$0 (no deductible)	Updated annually per ACIP	All Medicare beneficiaries
Shingles	Part D	$0 (no deductible)	2 doses, 2-6 months apart	For adults 50+ and immunocompromised adults 19+
RSV	Part D	$0 (no deductible)	Single dose	For adults 75+ and those 50-74 at increased risk; newer vaccine, growing uptake
Tdap	Part D	$0 (no deductible)	One dose if never received, then Td or Tdap booster every 10 years	Assess vaccination history if records are incomplete/unknown
Hepatitis B	Part B or Part D	$0 (no deductible)	2- or 3-dose series depending on product and patient factors	60+ with risk factors or requesting protection

PCV: Pneumococcal Conjugate Vaccine; PPSV: Pneumococcal Polysaccharide Vaccine
Centers for Disease Control and Prevention (CDC). www.cms.gov/files/document/mln908764-medicare-part-d-vaccines.pdf

Addressing Vaccine Hesitancy: Talking Points

"I don't think I need it."	*Response:* Flu and pneumonia hospitalize 500K+ adults 65+ yearly; vaccines cut that risk
	Response: RSV is newly preventable; many people are unaware they qualify
	Response: Today's visit is a chance to stay ahead of preventable illness
"I'm worried about side effects."	*Response*: Vaccines cannot cause infection; soreness and fatigue are normal immune responses
	Response: Serious reactions are rare; benefits far outweigh risks for 65+ adults

Addressing Vaccine Hesitancy: Talking Points

"It costs too much."	*Response:* Flu, pneumonia, and COVID vaccines are covered under Medicare Part B at no cost
	Response: Shingles, RSV, and Tdap vaccines are covered under Medicare Part D
	Response: We can verify your coverage right now before administering
"I don't trust vaccines."	*Response*: Recommended by CDC/ACIP based on decades of safety data
	Response: As your pharmacist, I review your full med profile and would not recommend something unsafe

Addressing Vaccine Hesitancy: Communication Strategies

Motivational Interviewing	• Ask, listen, affirm, then inform • Avoid confrontation; validate concerns before responding • Document hesitancy reasons for follow-up at next visit
Leveraging Trust	• Pharmacists are among the most trusted healthcare professionals • Normalize vaccination as routine preventive care, not a special event • Share simple stats, not complex data; stories resonate more than numbers
Follow-up, Documentation, and Recall	• Participate in standing orders so patients can say yes on the spot • Follow up with undecided patients at refill touchpoints • Track and recall: persistent gentle outreach converts hesitancy over time

Opportunity To Improve Patient Outcomes with Community Health Workers (CHWs)

"Within the walls of the pharmacy, we have seen the Community Health Workers become the 'problem solvers.' If a patient comes in with a SDoH issue, whether directly pharmacy related or not, the Community Health Worker is the person other staff members turn to."

Tripp Logan, PharmD
CPESN® Community Health Network Lead Luminary

Community Health Workers in Pharmacy: Closing Care Gaps

Patient-Facing Roles

- Assess medication storage, adherence, and safety via home visits
- Screen for SDOH: food, transportation, housing, isolation
- Deliver culturally relevant health education on chronic conditions
- Support post-discharge follow-up to reduce readmissions
- Connect patients to community resources and assistance

Pharmacy Coordination Roles

- Liaison between pharmacist, prescriber, and patient
- Assist with med reconciliation and refill coordination
- Flag patients for pharmacist review on vaccine/disease gaps
- Document interactions for quality metrics and value-based care
- Train pharmacy technicians as CHWs to expand capacity

Care Interventions Improve Outcomes

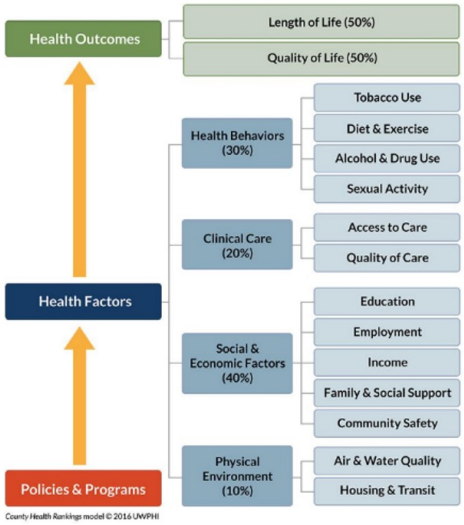
Health starts where we live, learn, work, and play.

Let us help you access the essential resources you need to be healthy:

- ***Food***
- ***Transportation***
- ***Medication***
- ***Access to Healthcare***

Robert Wood Johnson Foundation, "Health starts where we live, learn, work, and play."
County Health Rankings & Roadmaps, University of Wisconsin Population Health Institute & Robert Wood Johnson Foundation.

SDOH Comprises 40% of Health Outcomes



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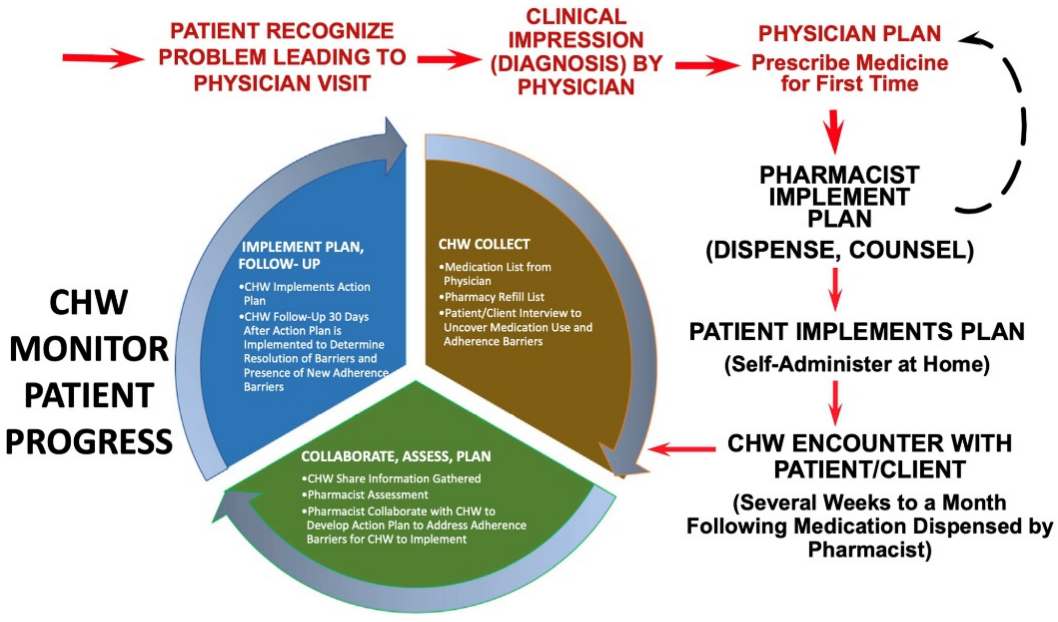

Bandiera, C., Mistry, S. K., Harris, E., et al. *Health Expectations* 2026;29(2):e70630.

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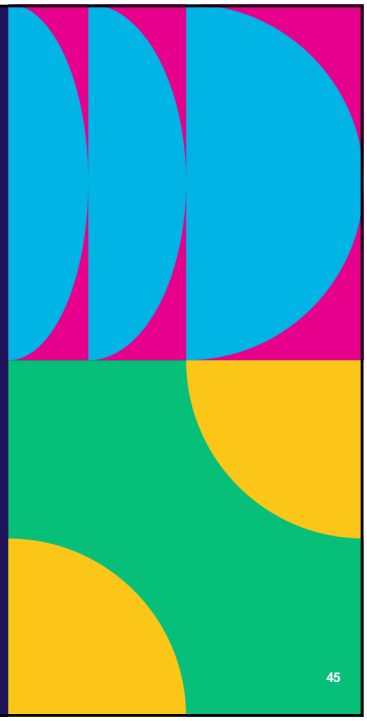
Case Study



Case Study

Patient Profile & CHW Intervention

- 82-year-old male, lives alone
  - 14 meds across 4 prescribers
- Post-discharge from heart failure; high readmission risk
- CHW home visit within 48 hours of discharge
  - Found expired meds, duplicates, no pill organizer
- Food insecurity; missed appointments due to transportation
- Med reconciliation with pharmacist reduced regimen to 9 meds
- Connected to Meals on Wheels, pharmacy delivery, follow-ups

Outcomes at 90 Days

- Meds reduced from 14 to 9; ACB score from 7 to 2
- Zero readmissions at 30/90 days (vs. 23% baseline)
- Adherence: ~50% to 92% via packaging and med sync
- SDOH barriers resolved: food, transport, isolation
- ~$12,400 cost avoidance per avoided readmission
- Improved energy, fewer side effects, greater confidence
- Reduced confusion; no further falls

The Business Case for Pharmacy-Based CHW Programs

Without CHW Program

- 30-day readmission: ~18-25% in high-risk older adults
- Cost per readmission: ~$12,400-$15,200
- Adherence: ~40-60% in polypharmacy patients
- SDOH screening rarely performed
- Med errors in ~66% of discharges
- ~$26B in preventable readmissions (Medicare)
- Engagement limited to dispensing and counseling

With CHW Program

- Readmissions reduced ~15-40% with CHW follow-up
- ~$2.47 ROI per $1 invested (*Lancet* 2026)
- Adherence improved to ~85-92% with home visits + med sync
- ~48% of SDOH referrals resolved (*JAPhA* 2025)
- ~$240/member/month savings in Medicaid (CPESN)
- ~$40K+ vaccine revenue per pharmacy (CPESN Missouri)
- CHW certification now available for technicians in multiple states

Rashid M., Fu M., Jitareewong P., et al. *Lancet Reg Health Am* 2026;58:101469.
Daly C.J., Iqbal D.N., Chen E.L., et al. *J Am Pharm Assoc* 2025;65(6):102490.

CHW Implementation Checklist

Foundation & Training (Months 1-3)

- ✓ Identify CHW candidates among pharmacy technicians
- ✓ Enroll in accredited CHW certification program
- ✓ Define service scope: SDOH, home visits, transitions, vaccines
- ✓ Build community referral resource directory
- ✓ Establish pharmacist-CHW workflow and documentation
- ✓ Set up encounter and outcomes tracking system
- ✓ Identify pilot cohort: high-risk, polypharmacy, post-discharge

Launch & Scale (Months 4-6)

- ✓ Launch pilot with 15-25 patients via home visits/phone calls
- ✓ SDOH screening at every encounter (PRAPARE/AHC)
- ✓ Integrate referrals into med sync and refill cycles
- ✓ Track readmissions, adherence, referrals, vaccine uptake
- ✓ Explore Medicaid billing, value-based care, and grant funding
- ✓ Present outcomes to prescribers, facilities, payers
- ✓ Evaluate, expand volume, pursue sustainable funding

PRAPARE Screening Tool: prapare.org; AHC: Accountable Health Communities Health-Related Social Needs (HRSN) Screening Tool: www.cms.gov/priorities/innovation/files/worksheets/ahcm-screeningtool.pdf

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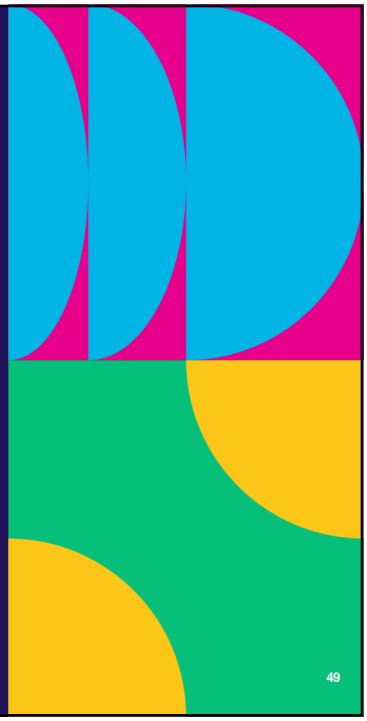
Coordination of Care



Coordination Strategy: Caregiver Enablement and Monitoring

Caregiver Enablement Toolkit

- Secure caregiver buy-in for adherence packaging
- Use teach-back to confirm caregiver understanding
- Provide guidance for missed doses, side effects, refills
- Keep med list current; normalize escalation pathways
- Coordinate community support through a CHW

Monitoring Touchpoints

- Align check-ins to med sync refill cycles and transitions
- Vaccine screening updates
- Assess adherence, adverse effects, and barriers
- Document consistently to surface trends
- Clear escalation pathway for timely med adjustments

Coordination Strategy: Hospital Discharge to Aging-at-Home

Pre-Discharge Preparation	Discharge Handoff	Post-Discharge Follow-Up
• Hospital notifies pharmacy of discharge and med list • Pharmacy reviews orders against profile for conflicts • Physician confirms therapy goals, stops, and new meds • Patient educated on changes before leaving	• Pharmacy reconciles full discharge med list • Discrepancies clarified with prescriber before dispensing • Patient gets one verified med list with clear instructions • Adherence packaging ready from day one	• Pharmacy follow-up within 48-72 hours • Reports side effects, confusion, or missed meds to prescriber • Prescriber adjusts therapy based on pharmacy findings • Ongoing monitoring, vaccine screening, CHW updates

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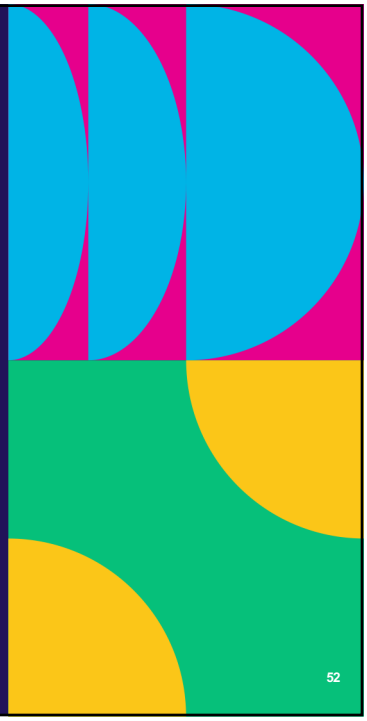
Action Plan and Next Steps



Pharmacy Service Opportunities

Clinical Optimization

- Verify therapy, resolve discrepancies, clarify orders fast
- Recommend deprescribing when needed; monitor high-risk meds
- Identify duplications; simplify schedules
- Ensure regimens are patient-manageable
- Build robust vaccination program

Administration & Communication

- Offer unit-dose packs and clear labels to reduce confusion
- Define contacts for changes; set response times
- Establish pharmacy-care team communication workflows
- Include patients in decision-making
- Add a CHW to support SDOH needs

Quality & Safety

- Perform ongoing safety reviews and trend tracking
- Flag high-risk meds and frequent changes
- Track Beers/ACB drugs; consult-level communication
- Position pharmacy as a proactive safety partner

Action Plan: Next Steps in the Next 30 Days

What opportunity will you choose?

- ❑ Implement a more robust vaccine program?
- ❑ Work on staff training for expanded service roles, like CHW?
- ❑ Something new?

Action Plan: Next Steps in the Next 30 Days

Scope Your Population

- ❑ Define target population/setting
  - Pick LTC partner type or aging-in-place segment; set one inclusion trigger
- ❑ Select core service + done criteria
  - Make it repeatable; define completion in plain language

Design the Workflow

- ❑ Build closed-loop communication
  - Specify contacts, send recommendations, and confirm implementation to close the loop
- ❑ Create caregiver materials
  - Maintain a simple med list format, a community resource guide, vaccine hesitancy materials, or a “what to do when” guide

Pilot and Measure

- ❑ Commit to training for staff to expand roles
- ❑ Pilot with a small cohort
  - Run a short test to validate steps, timing, and handoffs before scaling
- ❑ Decide what to measure
  - Pick a few process and outcome signals; review monthly

Questions?

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Cost avoidance per avoided readmission (~$12,400):

Agency for Healthcare Research and Quality (AHRQ). Healthcare Cost and Utilization Project (HCUP) Statistical Briefs: Conditions with the Largest Number of Adult Hospital Readmissions. https://hcup-us.ahrq.gov/

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Medication errors in 66% of discharges:

Forster AJ, Murff HJ, Peterson JF, Gandhi TK, Bates DW. The incidence and severity of adverse events affecting patients after discharge from the hospital. Ann Intern Med. 2003;138(3):161–167. doi:10.7326/0003-4819-138-3-200302040-00007

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Cost savings of $240/member/month (Medicaid):

CPESN Community Health. Pharmacy technicians with community health worker training can improve the value of the pharmacy in health care. Pharmacy Times (McKesson ideaShare 2023). https://www.pharmacytimes.com/view/pharmacy-technicians-with-community-health-worker-training-can-improve-the-value-of-the-pharmacy-in-health-care

Vaccine gap closure revenue ($40,000+ per pharmacy):

CPESN Missouri / Missouri Pharmacy Association. CHW Vaccine Gap Closure Program. https://www.morx.com/Web/Web/Resources/CHW_Resources.aspx

$26 billion in preventable readmissions (Medicare):

Jencks SF, Williams MV, Coleman EA. Rehospitalizations among patients in the Medicare fee-for-service program. N Engl J Med. 2009;360(14):1418–1428. doi:10.1056/NEJMsa0803563

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