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Practical Tips for Medication Management

Presented by Judy Adams, RN, BSN,
HCS-D, HCS-O of
Adams Home Care Consulting, Inc.



MEDICAL SUPPLIES FOR CARE AT
HOME SINCE 1957

Webinar Objectives

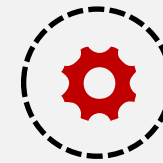
This 90 minute webinar is devoted to promoting best practices in medication management for home health. The program will:



Provide a brief overview of projects that have reduced negative consequences of improper medication management



Discuss the accurate scoring of the OASIS items related to medication management

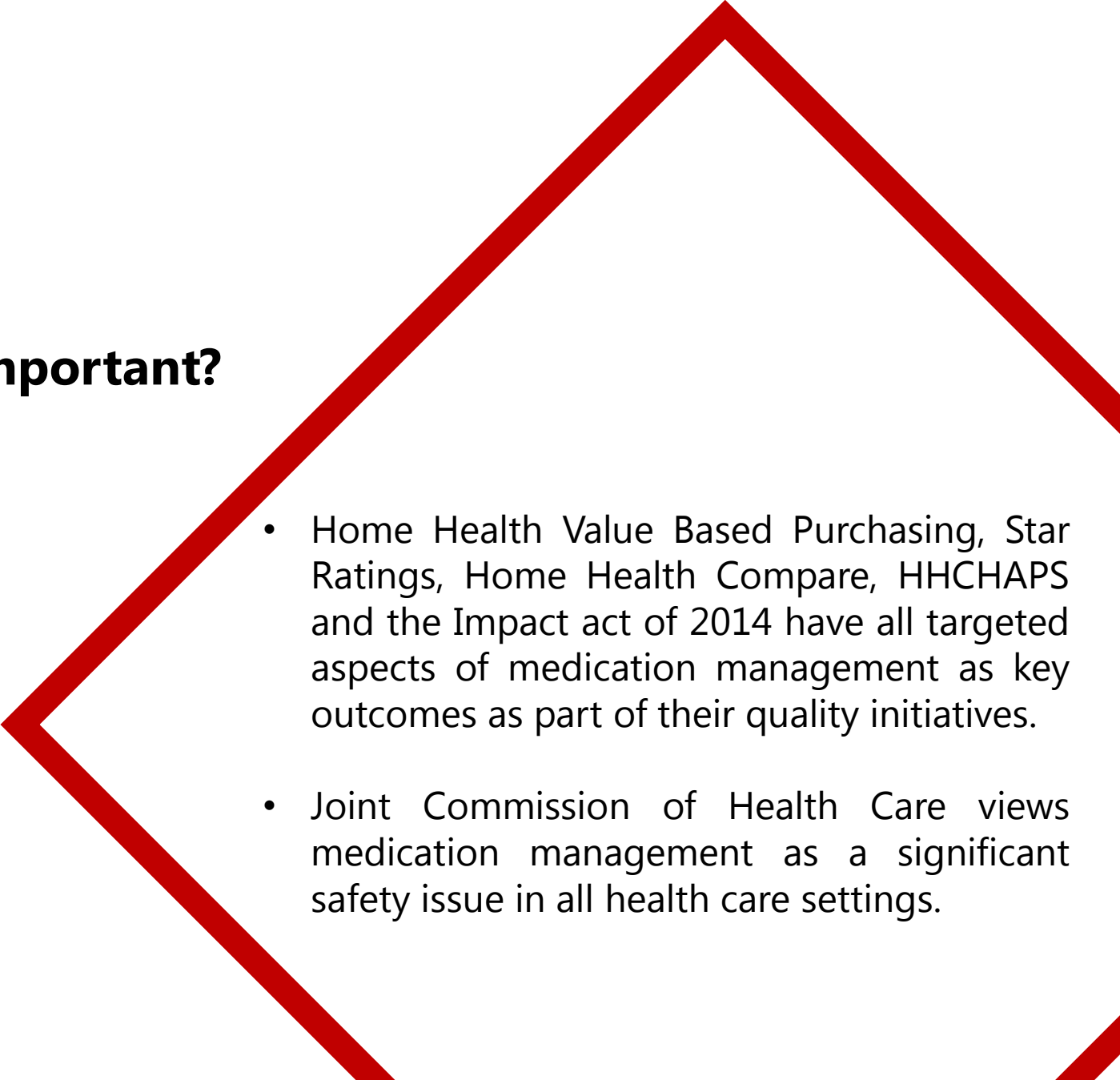


Identify tools available to improve medication management





Why Is Medication Management Important?

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- Home Health Value Based Purchasing, Star Ratings, Home Health Compare, HHCHAPS and the Impact act of 2014 have all targeted aspects of medication management as key outcomes as part of their quality initiatives.
 - Joint Commission of Health Care views medication management as a significant safety issue in all health care settings.



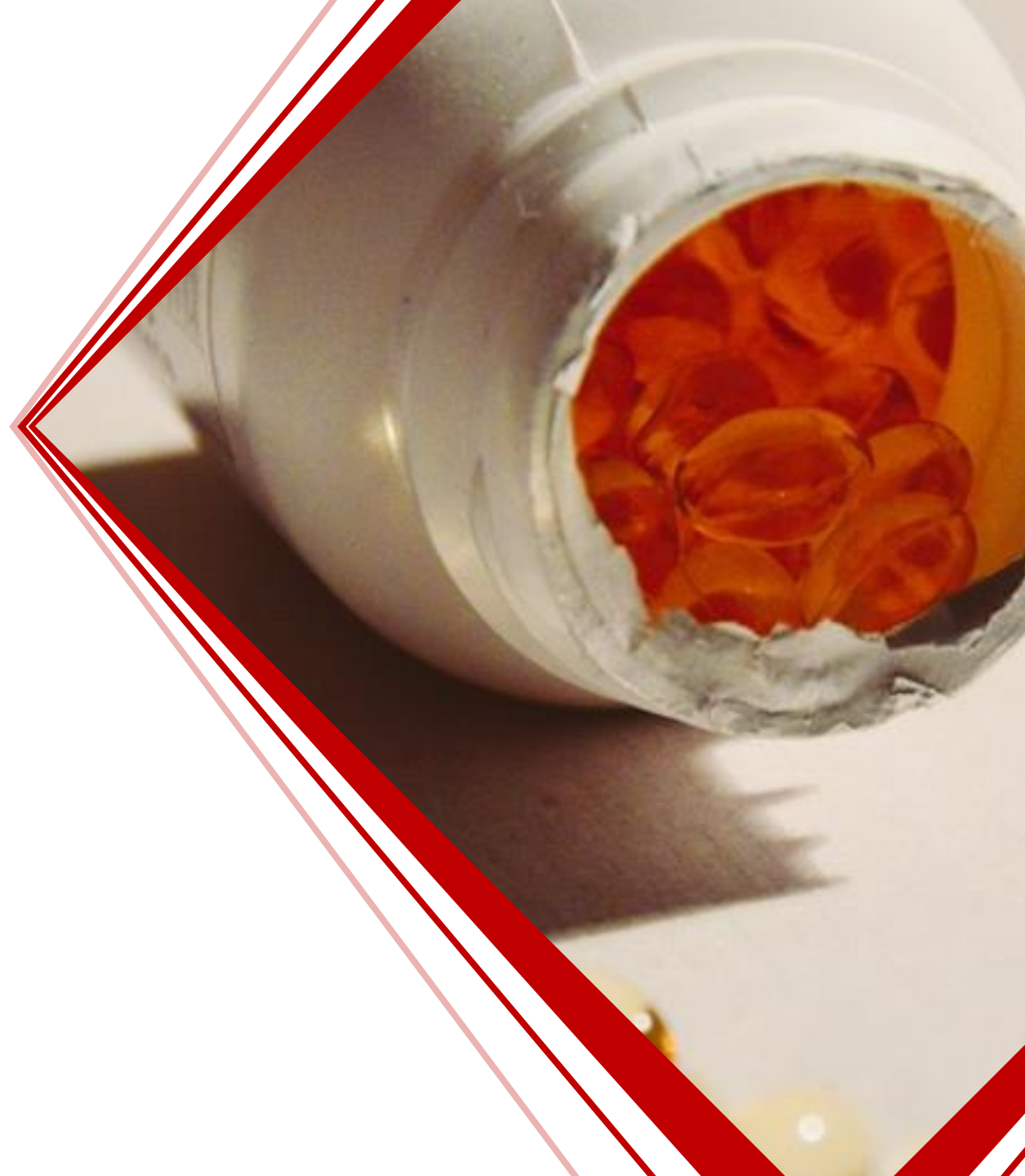
Why Is Medication Management Important?

- Medication related issues are a leading cause of hospitalization/re-hospitalization for all patients, but particularly for older patients.
- Home health clinicians have the unique advantage of being able to see all the medications in a patient's home and may be the one setting that can best identify potential clinically significant issues involving the medications a patient is taking



Facts Related to Prescription Drugs

- Medication-related problems are common, costly and often preventable in older adults
- Half of the 20 most commonly prescribed medications taken by older adults may raise the risk of falls
- In the US, 1/3 of seniors take eight or more medications daily.
- The public, payers and regulators are increasingly demanding action to reduce medication errors.



Medication Adherence Issues

- In 2007, WHO projected probably only 50% of patients typically take medications as prescribed.
- Updated Study in 2009
- Nonadherence with medications = \$290 billion
- 37% did not finish medications
- 31% skipped doses
- 23% did not fill prescription





Reported Statistics Related to Medication Issues

- “Roughly \$100 billion per year and estimates of the share of hospital admissions related to non-adherence are as high as 10 percent” (Hubbard & McNeill, 2012).
- Approximately 1.5 million preventable adverse drug events occur annually 7,000 deaths per year are related to medication use.
- Adverse drug events account for an estimated 2.5% of emergency room visits for unintentional injuries





Brief Review of Projects Demonstrating Positive Impact on Medication Management



ANA Reported Studies

2011 project on Community-based Care Coordination by Atherly and Thorpe involving patients 65 years of age and older living in the community, demonstrated significant cost reductions among high-cost chronically ill Medicare patients using nurse care coordination to educate and empower patients.

“Value of Nursing Care Coordination”, ANA, June 2012



ANA Reported Studies

Study by Laughlin and Bissel in 2010 described telephone outreach using RN care coordination: Most frequent activities were medication management (89%), self-referral to a primary care provider (51%) and care coordination among providers of service (20%) Findings suggested patients were frequently discharged from hospitals without medication knowledge or financial access to medications.

“Value of Nursing Care Coordination”, ANA, June 2012



Medication Management Intervention Across Transitions

- Problems related to medication management consistently included:
- Incomplete documentation of prescribed medications
- Incomplete orders
- Inconsistent documentation of medications patients were taking especially when there were a number of providers involved in the patient's care
- Non-adherence to prescription medications
- Incorrect dosages of prescription meds



Medication Management Intervention Across Transitions Continued

Ellenbecker, Frazier, and Verney (2004) collected self-reported data from 101 home health nurses about clients' home medication management.

78% of the patients were taking five or more medications, and 21% of patients reported to the home health nurses a lack of understanding about how to take their medications after discharge from the hospital.



Medication Management Intervention Across Transitions Continued

- A retrospective study by Foust, Naylor, Bixby and Ratcliffe (2012) recommended:
- patient discharge instructions and hospital discharge records need to be reconciled before patient discharge
- providing clear, concise patient teaching about medications and instructions at the time of discharge
- utilizing home health nurses for additional post-discharge support and teaching, as well as medication reconciliation in the home environment



Medication Management Intervention Across Transitions Continued

- McDonald and Peterson (2008) point out the importance of medication reconciliation and improving medication management specifically in the older population with home health services.
- The Visiting Nurse Associations of America Curricula for Homecare Advances in Management and Practice (VNAA CHAMP) program was developed to translate evidence to practice.



Medication Management Intervention Across Transitions Continued

- Setter, Corbett, and Neumiller (2012) described the role of the home health care nurse with patient care during transitions, and the importance of medication reconciliation and medication management.
- Medication reconciliation and teaching, if done consistently with each transition of care, for every patient, and communicated with the patient and among the health care team, supports
 - Decreased medication discrepancies
 - Improved patient adherence
 - Decreased potential for adverse events
 - Lower probability of re-hospitalization.



CRVNA Home Medication Reconciliation Program Model

- The Concord Regional Visiting Nurse Association (CRVNA) implemented a Home Medication Reconciliation Program.
- The selected patients were adults ages 65 or older who are high-risk, chronically complex with comorbid disease processes, are on multiple medications, have had a recent hospital admission, are challenging to manage due to complex disease and social factors, and may lack support systems at home.



Data Collection by CRVNA transition nurse with every transition of care

Measurable data points included:

- Home medication reconciliation completed with the DC list and meds in the home;
- Patient's readiness for change and ability to self-manage medications
- Assessment of health literacy and teach back completed;
- Discharge instructions and medication list available, legible, and easy to understand;
- Barriers to care including financial issues identified;
- Any needed community resources or services were in place; and
- Follow up with a primary care provider was scheduled.



Issues Identified at Patient, Provider and System Levels

Patient-level issues included:

- Intentional nonadherence
- Unintentional non-adherence
- Lack of knowledge of reason for prescribed medications
- Sight or dexterity limitations
- Cognitive impairments
- Adverse drug reactions or side effects
- Financial barriers



Issues Identified at Patient, Provider and System Levels

Provider-level issues included:

- Illegible or confusing discharge or medication instructions
- Prescribing medications that are considered inappropriate for older adults
- Number of medications prescribed
- Duplicate medication orders with differing dosing instructions



Issues Identified at Patient, Provider and System Levels

System-level issues included:

- incomplete discharge instructions or medication list
- conflicting information from different providers across the system (i.e. primary care, cardiologist, and orthopedic surgeon)
- different informational sources from different providers
- lack of appropriate services in place for return to the community



Top Findings at Each Level

Patient level:

- Number of medication errors (medications not on the discharge medication list or duplicate medications listed),
- Number of patients who did not have all medications in the home
- Unintentional non-adherence (did not understand how to take medication correctly or was not given the correct dosing instructions)

Provider level:

- Discrepancies between the medication list at discharge and the primary care provider's medication list on record, and
- Illegible or confusing discharge instructions or medication instructions.

Structure level:

- Discharge instructions or medication list incomplete or unavailable,
- Patient did not have new prescription after discharge



Drug Regimen Review = Major Issue in Home health

About 3,000 home health agencies inadequately tracked or reviewed new patients' meds In the period between January 2010 and July 2015, according to a Kaiser Health News analysis of federal inspection records





Drug Regimen Review = Major Issue in Home health

In one example, a 66-year-old patient was erroneously given methotrexate rather than the diuretic metolazone following a hospitalization for congestive heart failure in 2013. The methotrexate caused mouth and throat sores, bleeding from the nose and bowels, and ultimately destroyed her ability to create blood cells. The patient died of multiple organ failure caused by the medication.



Drug Regimen Review = Major Issue in Home health

The HHA caring for the patient failed to catch the medication error.

“Less than a year before, a state inspector had cited the agency for inadequately reviewing medications for three patients, and the agency had pledged to make improvements. Still, neither of two agency nurses who visited at home stopped her from taking the wrong drug.”





**Ensure Accurate Scoring
OASIS C2 Medication
Related Items**

(M2001) Drug Regimen Review

(M2001) **Drug Regimen Review:** Did a complete drug regimen review identify potential clinically significant medication issues?

Enter Code

- 0 No - No issues found during review *[Go to M2010]*
- 1 Yes - Issues found during review
- 9 NA - Patient is not taking any medications *[Go to M2040]*



(M2001) Drug Regimen Review

- If there is no information available or items cannot be assessed or elements are skipped (i.e., drug-to-drug interactions), a dash (–) should be reported, indicating the drug regimen review was not completed.
- Guidance indicates use of a dash should be a rare situation, primarily in situations where there is an unexpected transfer, discharge or the patient dies before the item can be collected.
- A positive response on M2001 is required for calculation of IMPACT Measure: Drug Regimen Review with Follow-up for Identified Issues.





Comprehensive Drug Review

- Applies to all patients being seen by the agency, regardless of whether OASIS specific requirements apply.
- Documentation in the clinical record should clearly show medication review and education provided.

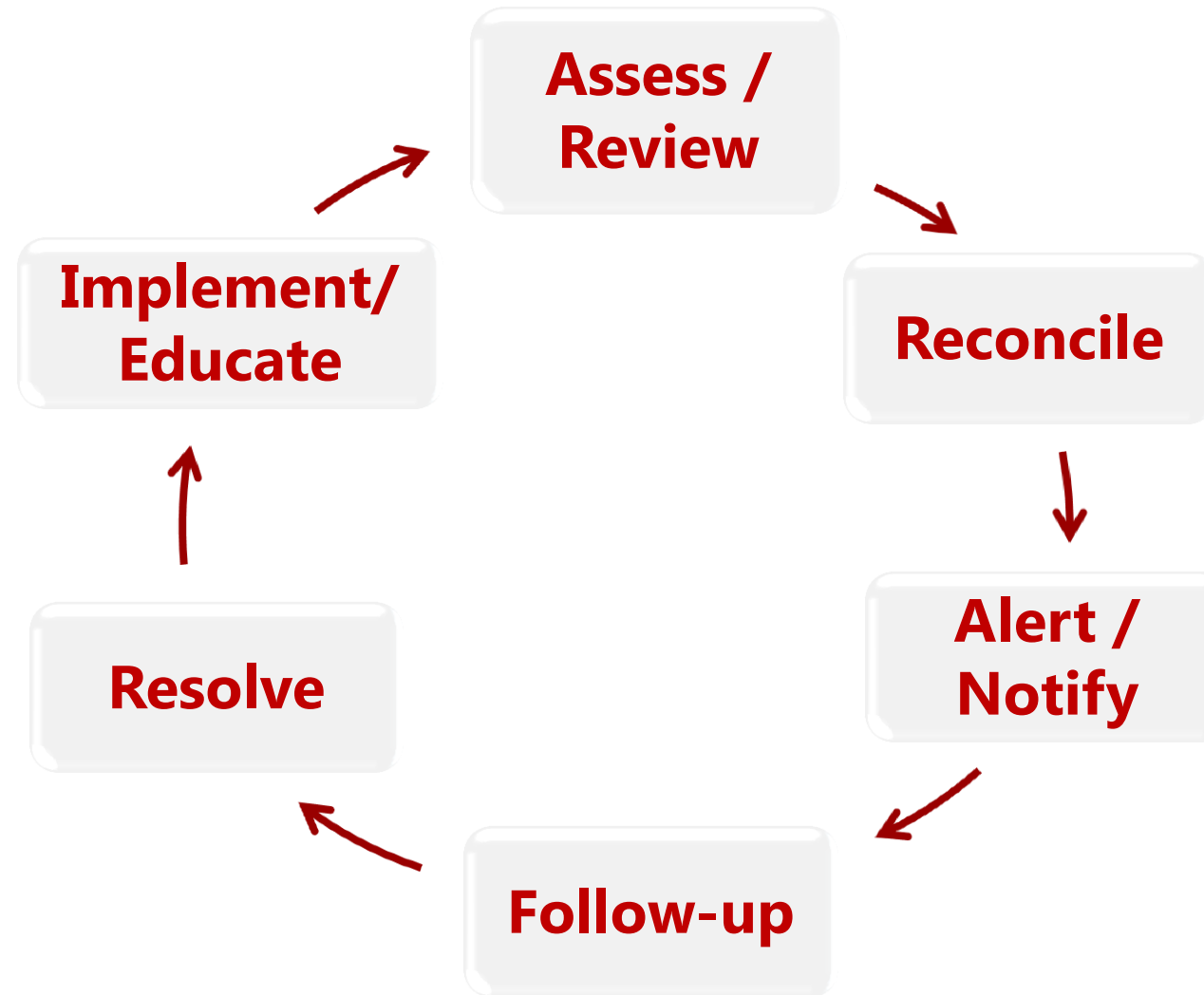


Comprehensive Drug Review

- The home health comprehensive assessment must include review of all medications the patient is currently using in order to identify any potential adverse effects and drug reactions, including:
- ineffective drug therapy
- significant side effects
- significant drug interactions
- duplicate drug therapy
- noncompliance with drug therapy.
- Includes all prescription, over the counter medications, herbals, oxygen & TPN a patient is using.



DRUG REGIMEN REVIEW PROCESS



- The patient's list of medications is reviewed and updated on an on-going basis.
 - While OASIS C2 only requires a comprehensive drug review at SOC/ROC, completing it at **each OASIS time point is best practice**, including assessment of the patient's current knowledge and ability to take medications.

DRUG REGIMEN REVIEW



DRUG REGIMEN REVIEW

- Drug review should also be a part of every visit throughout care and is not limited to just the designated OASIS time points.
- Throughout the episode of care, drugs and treatments ordered by the patient's physician that are not documented on the care plan should be documented in the clinical record including all over-the-counter drugs.

Clinically Significant Medication Issues May Include

Adverse Drug Reaction	Duplicate Therapy
Ineffective Drug Therapy	Omissions
Side Effects	Dosage Errors (high or low)
Drug-Drug Interactions or Drug-Food interactions	Nonadherence (knowledge limitations as well as purposeful/accidental noncompliance)





Clinically Significant Medication Issues May Include

- **Clinically Significant Issues** : an issue that in the care provider's clinical judgment, requires physician/physician-designee notification by midnight of the next calendar day (at the latest).
- Includes **potential and existing** clinically significant medication issues as well.
- Any circumstance that does not require this immediate attention is not considered a potential or actual clinically significant medication.

MEDICATION RECONCILIATION



- Process of creating the most accurate list possible of all medication a patient is taking, including
 - drug name
 - dosage
 - frequency
 - route
 - comparing that list against the physician's admission, transfer, and or discharge orders
 - Comparison ensures the patient is taking the correct medication at all transition points in care [or any time a comprehensive assessment is required].

MEDICATION RECONCILIATION



Reconciliation is not asking the patient what medications he is on. It is putting your hands on the bottle.

THE IMPORTANCE OF MED RECONCILIATION

- Medication reconciliation is critical to providing safe patient care across all spectrums of care available.
- All health care providers and settings must support efforts to achieve accurate medication reconciliation.



THE IMPORTANCE OF MED RECONCILIATION

- Issues related to medication reconciliation.
 - Patient's lack of knowledge of medications, especially at transition time points.
 - Lack of standard location of medication information in medical records.
 - Lack of integration of patient health records across the continuum.
 - Use of multiple pharmacies to obtain medications.
 - Involvement of numerous "specialty" physicians in managing multiple chronic conditions.



DRUG REGIMEN REVIEW

- The label on the bottle of a prescription medications constitutes the pharmacist's transcription or documentation of the order. This information can be noted in the patient's clinical record and listed on the physician's plan of care for new prescriptions received during the episode of care since it is consistent with acceptable standards of practice.
- When the patient is receiving therapy only services, collaboration between the therapist and nursing staff is allowed to complete the drug regimen review.

DRUG REGIMEN REVIEW RESPONSE 1

- Situations where the clinician may determine that a potential clinically significant issue exists based on clinical judgment:
 - Patient's list of medications from the inpatient facility discharge instructions **DO NOT** match the medications the patient shows the clinician at the SOC/ROC assessment visit.
 - Assessment shows that diagnoses/symptoms for which the patient is taking medications are **NOT** adequately controlled.
 - Patient seems confused about when and how to take medications indicating a high risk for medication errors.

DRUG REGIMEN REVIEW RESPONSE 1

- Situations where the clinician may determine that a potential clinically significant issue exists based on clinical judgment:
 - Patient has **not obtained medications** or indicates that he/she will probably not take prescribed medications because of financial, access, cultural, or other issues with medications.
 - Patient has S/S that's could be adverse reactions from medications.
 - Patient has multiple non-prescribed medications (OTCs, herbals) that could interact with prescribed medications.
 - Patient has a complex medication plan with medications prescribed by multiple physicians and/or obtained from multiple pharmacies so that the risk of drug interactions is high.

Survey Review Topics Related to Drug Regimen Review

- The HHA must have procedures that address:
 - How drug review is conducted for therapy only cases
 - How drugs are reviewed when medication orders are modified or changes after the SOC comprehensive assessment in multi-disciplinary cases and in therapy-only cases.
 - Process for reconciling medications when there are inconsistencies between the prescription bottles and the clinical record.





SURVEY REVIEW TOPICS RELATED TO DRUG REGIMEN REVIEW

- The HHA must have procedures that address:
 - The criteria or resource used to identify potential adverse effects and drug reactions.
 - Process to follow when a patient is found to be noncompliant with medications.
 - How the agency responds to prescriptions from physicians other than the physician responsible for the patient's home health care.
 - What actions does the HHA require its personnel to take if HHA personnel identify patient sensitivity or other medication problems?

(M2003) **Medication Follow-up:** Did the agency contact a physician (or physician-designee) by midnight of the next calendar day and complete prescribed/recommended actions in response to the identified potential clinically significant medication issues?

Enter Code

0 No

1 Yes

- M2003 is completed at SOC/ROC
- If the qualified clinician determines the patient is experiencing problems with his/her meds or identifies any potential adverse effects and/or reactions, **the physician must be alerted and respond with recommendations that are implemented by midnight the next day.**
- Recommended actions must also occur within the allowed timeframe for the SOC/ROC (CMS Qtrly Q&A #22, 10/16)



Definition: **Physician Contact**

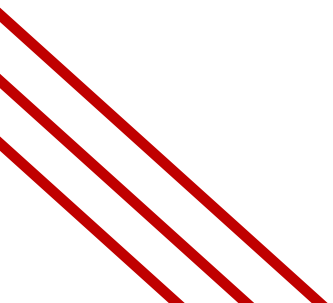
- Contact with physician is defined as communication to the physician or physician-designee (made by telephone, voicemail, electronic means, fax, or any other means) that appropriately conveys the message of patient status.
- Communication can be directly to/from the physician or physician-designee, or indirectly through physician's office staff on behalf of the physician or physician-designee, in accordance with the legal scope of practice.

M2003/M2005: MEDICATION RECONCILIATION

- Physician notification alone is **NOT** medication reconciliation.



M2003/M2005: MEDICATION RECONCILIATION

- Medication follow-up and reconciliation **require**:
 - **2-way communication** with the physician or physician designee regarding the potentially significant medication issue **AND**
 - **Completion of the prescribed / recommended actions** no later than 12 midnight of the next calendar day.
 - Documentation of the communication with the physician.
- 

M2003: RESPONSE GUIDANCE

- If the physician/physician-designee recommends an action that will take longer than the allowed time to complete, enter **Response 1 – Yes** as long as the agency has taken whatever recommended actions are possible to comply with by midnight of the next calendar day.
 - Includes when a weekend “on-call” physician unfamiliar with the patient directs agency to call the PCP on Monday for further orders.
(CMS Qtrly Q&A #21, 10/16)



M2003: RESPONSE GUIDANCE

- When multiple potential clinically significant medication issues are identified at the SOC/ROC, all must be communicated to the physician/designee, with completion of **ALL** prescribed/recommended actions that are possible to comply with by midnight of the next calendar day in order to enter **Response 1 –Yes**.

M2003: RESPONSE GUIDANCE

- If the physician's/designee's response to notification of potentially significant issues is that there are no new orders or instructions related to the plan of care, this completes the requirement for 2-way communication. Enter **Response 1 – Yes.**
- There **must be documentation of MD response if MD states “no changes needed” in the medical record**

M2003: RESPONSE GUIDANCE

- If a potential clinically significant medication issue was identified, and the clinician attempted to communicate with the physician, but did not receive communication back from the physician/physician designee until after midnight of the next calendar day, enter **Response 0 – No.**



M2003 EXAMPLE

- During the SOC comprehensive assessment visit, the nurse completes a drug review and identifies the patient is taking **two antihypertensive meds, one of which was newly prescribed during her recent hospital stay and another that she was taking prior to her hospitalization.**
- During the home visit, the nurse contacts the physician's office, and leaves a message with the office staff providing notification of the potential duplicative drug therapy and a request for clarification.

M2003 EXAMPLE



- The next day the nurse returns to the home to complete the comprehensive assessment and again contacts the physician from the patient's home.
- The physician's office nurse reports to the nurse that the physician would like the patient to continue with only the newly prescribed antihypertensive and DC the previous medication.
- The nurse educates the patient on DC of the medication taken prior to her hospitalization and counsels on destroying the medication or storing it away from current meds.
 - **How would you respond to M2001 and M2003?**

M2003 EXAMPLE

- **M2001: Response 1 - Yes, issues found during review**
- **M2003: Response 1 – Yes, the nurse contacted the physician and the issue was resolved by midnight the next calendar day.**

Rationale:

- Because the issue identified was determined by the clinician to be clinically significant, requiring physician contact by midnight of the next calendar day it meets the criteria for a potential clinically significant medication issue (M2001).
- As the clinically significant issue was resolved by physician contact and completion of prescribed/recommended actions by midnight of the next calendar day, the criteria for M2003 were met.

(M2005) Medication Intervention: Did the agency contact and complete physician (or physician-designee) prescribed/recommended actions by midnight of the next calendar day each time potential clinically significant medication issues were identified since the SOC/ROC?	
Enter Code	0 No
<input type="checkbox"/>	1 Yes
	9 NA – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications

- Completed at Transfer, Discharge from agency and Death at home
- Wording emphasizes that action must be taken "**each time**" a clinically significant medication issue was identified at the time of or since the most recent SOC/ROC.
- Notification to the physician, response from the physician and implementation of any ordered intervention possible must all be completed by 12 MN the following calendar day.



M2005 MEDICATION INTERVENTION

If multiple potential clinically significant medication issues were identified since the SOC/ROC, **all** must have been communicated to the physician/physician-designee with completion of all prescribed/recommended actions occurring by midnight of the next calendar day in order to enter Response 1-Yes.

M2005 MEDICATION INTERVENTION

Response 0- No is entered if any potential clinically significant medication issue was identified **at the time of or anytime since the SOC/ROC**, and was **not both** communicated to the physician and addressed through completion of any physician recommended action.

M2005 MEDICATION INTERVENTION

If a clinically significant medication issue was identified at that most recent SOC/ROC visit, the **issue would be reported at both the SOC/ROC on M2003 and again at transfer/DC/death at M2005.**

M2005 EXAMPLE

- During a discharge assessment visit, the nurse reviews the patient's medication list and confirms that no potential clinically significant medication issues are present.
- In reviewing the clinical record there is documentation that a drug regimen review was conducted earlier in the episode, and no potential clinically significant medication issues were identified. There is no other documentation to indicate that potential clinically significant medication issues occurred during the episode of care.

How would you answer M2005?



M2005 EXAMPLE

- **M2005: Response 9 (NA) – There were no potential clinically significant medication issues identified since SOC/ROC or patient is not taking any medications.**
- **Rationale:**
 - The item is reported as NA because there is documentation the agency looked for potential clinically significant medication issues and no issues were found.
 - Had there been documentation that a potential clinically significant medication issue had occurred during the episode, and there was no documentation indicating follow-up with the physician by midnight of the next calendar day to complete recommended actions, **Response 0 (NO) would be entered.**

(M2010) Patient/Caregiver High Risk Drug Education: Has the patient/caregiver received instruction on special precautions for all high-risk medications (such as hypoglycemics, anticoagulants, etc.) and how and when to report problems that may occur?

Enter Code <input data-bbox="254 435 336 539" type="checkbox"/>	0 No 1 Yes 9 NA Patient not taking any high risk drugs OR patient/caregiver fully knowledgeable about special precautions associated with all high-risk medications
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- Identifies if clinicians instructed the patient and/or caregiver about all high-risk medications the patient takes.
- High risk medications are those identified by quality organizations as having considerable potential for causing significant patient harm when they are used erroneously.
- Includes discontinued high risk meds that are being taken in error and staff had to educate patient/CG. (CMS Q&A #162.1, 04/15)



M2010: Scenario

- Mr. Green who has a history of HTN is being admitted for management of COPD following discharge from the hospital.
- The patient's HTN is controlled now using a diuretic and a low salt diet.
- During the medication review, the clinician finds that the patient is currently taking an antihypertensive which was discontinued before his discharge from the hospital.

M2010: Scenario

The clinician knows that the antihypertensive is a high risk drug. He validates with the physician that the drug should be discontinued and instructs the patient not to take the drug.

How should M2010 (High Risk Drug Education) be answered?

Answer: Response 1, Patient was educated

If the patient was taking a high risk medication in error and was educated by Agency staff to discontinue the medication as well as the special precautions they need to take and how and when to report a problem that occurs as a result of taking that medication, M2010 may be answered "**Yes**".

M2016 Patient/Caregiver Drug Education

(M2016) Patient/Caregiver Drug Education Intervention: At the time of, or at any time since the most recent SOC/ROC assessment, was the patient/caregiver instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, adverse drug reactions, and significant side effects, and how and when to report problems that may occur?	
Enter Code <input type="checkbox"/>	0 No 1 Yes 9 NA – Patient not taking any drugs

- Completed at transfer and discharge.
- Did the clinicians instruct the patient and/or caregiver about how to monitor the effectiveness of all medications, S/S of adverse drug reactions and significant side effects, plus how and when to report problems at the time of or since the most recent SOC or ROC.





M2016: Guidance

- Applies to all prescribed and OTC medications by any route, including new medications and oxygen.
- Documentation should support interventions to educate patient/CG or reason why interventions were not completed. For example:
 - Completion of medication education flow sheet.
 - “Patient transferred to nursing home prior to completion of medication education for caregiver.”
- Item is used to calculate process measures to capture the agency’s use of best practices following comprehensive assessment



Medication Teaching Tips

While med teaching begins at SOC visit, ongoing med review and education/reminders provided at every visit support ongoing evaluation and understanding of meds.

Utilize standardized medication teaching tools and provide written drug information.

Continuously evaluate and document patient and caregiver's response to teaching using visual teaching tools, return demonstration and "teach back" principles.

Team with local pharmacists or pharmacy educational programs regarding options to simplify patient's medication regimens (e.g., number and doses of medications).



Medication Teaching Tips

To help with HHCAHPS scores, start teaching on medications with a statement similar to “Let’s talk about your medications”.

Check the medication list each visit to ensure all prescribed and OTC medications are listed.

Document all medication teaching in a designated location in patient record.

Perform drug regimen review and medication reconciliation on each visit to identify and resolve any new or unresolved issues throughout care.

Be sure to assess and educate on all medications deficits at the discharge visit.





Strategies and Tools to Improve Medication Management

Possible Tools and Tips

- Use a medication checklist to guide in asking about medications on the comprehensive assessment.
- As you walk through the house as part of the assessment, ask the client to show you where the medications are kept.
- While making visits, look for medications bottles
 - on the kitchen table,
 - counters,
 - Next to the bed
 - next to the patient's favorite sitting chair



Possible Tools and Tips

- Give the patient a list of medications to take to the doctor for any doctor visits.
- On each visit, ask if the patient has seen his/her doctor since your last visit. (Even better if every clinician asks and funnels the information to the nurse.)
- Have you started taking any new medication or has your doctor made any changes in your medications or treatments since my last visit?
- Example: Has the doctor made any changes to your BP/breathing meds since I was last here?



Medication Check List

Where do you keep your medications?

Do you keep any medications in your bedside table? Yes / No

Do you have medication in your bathroom cabinet? Yes / No

Do you have any medications in your kitchen cabinet? Yes No

Do you have any medication in your closet? Yes No

Do you have any medications in your refrigerator? Yes / No

Do you take any over the counter medications? Yes / No

What do you take if you have a headache?

What do you take if you are constipated/cannot have a bowel movement?

What do you take if you have diarrhea?

What do you take if you get a cold?

Do you take any herbal remedies or Vitamins? Yes / No

Medication Check List

- Do you take blood thinners? Yes / No
- Medicine for chest pain? Yes/No
- Do you take any type of medication by injection (shots)?
- Insulin? Yes/ No
- Any other medication? Yes No
- Do you use oxygen all the time or on an as needed basis? Yes / No
- Do you use inhalers or a nebulizer? Yes/ No
- Do you use ear, eye or nose drops? Yes / No
- Do you use creams or ointments? Yes/ No
- What kind
- Why?
- Do you have any medications in the home that you do not take? Yes/No
- Where do you keep those?



Medication Check list

- Did the hospital give you a discharge medication list. Yes/No
- Do you have prescriptions that have not been filled? Yes / No
- What pharmacy do you use to get your medications?
- Do you ever use any other pharmacy to get your medications? Yes/No

If yes, where?:

- Does anyone help you to take your medications?
- Get your medications and bring them to you?
- Remind you to take your medications?
- Fill a medication box or put the medicines in containers for you?



Testing ability to access medications

- Can you show me how you open your medication bottles?
- Have patient demonstrate ability to open medication bottle. Yes/No
- Is the patient able to read the label or otherwise correctly identify the medication? Yes/No
- Is the patient able to verbalize directions on medication bottle? Yes/No
- Can the patient tell you any other way they identify their medications? Yes/No
- Can you get to where your medications are stored?
- Can you get water or other liquid to take your medication with?



Beers Criteria for Potentially Inappropriate Medication Use in Older Adults

- Potentially inappropriate medications (PIM) continue to be prescribed and used as first line treatment for the most vulnerable older adults, despite evidence of poor outcomes.
- Criteria are divided into three categories:
- Potentially inappropriate medication and classes to avoid in older adults,
- Potentially medications and classes to avoid in older adults with certain diseases and syndromes that the listed drugs can exacerbate, and
- Medications to be used with caution in older adults was added beginning in 2012.



AGS Beers Criteria –Educational Tool & Quality Measure

- Research has shown that a number of PIMs have limited effectiveness in older adults and are associated with serious problems such as delirium, gastrointestinal bleeding, falls and fractures.
- In many instances, a safer non-pharmacological therapy could be substituted for the use of these medications , highlighting a “less is more approach” is often the best way to improve health outcomes in older adults.



AGS Beers Criteria –Educational Tool & Quality Measure

- Updated criteria should be viewed as a guideline for identifying medications for which risks of their use in older adults outweighs the benefits.
- Medications that have a high risk of toxicity and adverse effects in older adults and limited effectiveness and all medications in Table 2 should be avoided in favor of alternative safer medications or a nondrug approach.
- The drug-disease or –syndrome interactions summarized in Table 3 are particularly important in the care of older adults because they often have multiple comorbidities



Sample Medication Simplification Protocol

- **Purpose:** To encourage a standardized and collaborative approach to simplifying complex medication regimens.
- **Target:** Patients on multiple medications (>8) will be targeted for Medication Reduction/Simplification Strategies:
- **Process:** Agency staff will work collaboratively with the organization or community based pharmacist and/or physician to apply criteria and meet goals.

Texas Health Care Assoc. Website, Best Practices

[tp://www.txhca.org/BestPractices/MedMgmt/medbeer1.pdf](http://www.txhca.org/BestPractices/MedMgmt/medbeer1.pdf)



Sample Medication Simplification Protocol

- 1) Encourage use of a single pharmacy to enhance regimen review and collaboration with pharmacist.
- 2) Consider discontinuation/substitution of medications included on "Beer's List".
- 3) Consider opportunities to decrease administration frequency through use of sustained-release or long acting products.
- 4) Consider modifying administration time for medications with actions or side effects that interfere with ADLs or quality of life

Texas Health Care Assoc. Website, Best Practices

[tp://www.txhca.org/BestPractices/MedMgmt/medbeer1.pdf](http://www.txhca.org/BestPractices/MedMgmt/medbeer1.pdf)



Sample Medication Simplification Protocol

- 5) Consider non-pharmacologic approaches.
- 6) Consider reduction of multiple medications to treat a single condition, unless combination therapy is intentional
- 7) Consider opportunities to time doses within established patient routines
- 8) Remove/Discard unnecessary or expired drugs to prevent confusion

Texas Health Care Assoc. Website, Best Practices

[tp://www.txhca.org/BestPractices/MedMgmt/medbeer1.pdf](http://www.txhca.org/BestPractices/MedMgmt/medbeer1.pdf)



Team up with Pharmacy Personnel

Several HHAs have had great success with medication review and simplification by teaming with pharmacy personnel to review and revise patient's Medication regimens.



Team up with Pharmacy Personnel

- Enter into an agreement with a school of pharmacy, hospital pharmacy (if part of a health system) or a community pharmacy to conduct medication reviews for patients with many medications or complex regimens to:
- Review and identify alternatives for their medication regimen to reduce the number of meds that may be duplicative, inappropriate or drugs that are no longer necessary,
- Identify substitutes for high risk drugs for the older patient that provide less risk to the patient, non-pharmaceutical options, and suggestions to streamline and simplify the medication schedule.
- Make recommendations to the patient's physician and home health team on better medication options to increase efficacy, compliance and safety



Improving Medication Adherence

- Everyone in healthcare has a significant role in improving medication adherence
- Recommendations:
- Increased education about medication adherence that captures public attention, increases their understanding, and enhances their motivation to take prescribed medication in the recommended way.
- Only by making the public aware of the role individuals play in the management of their own health conditions will we empower people to ask questions about their medicines, fill their prescriptions, and follow their treatment regimens as recommended.

Improving Medication Adherence

- Using verbal discussion, reinforced with written materials, helps patients understand their medical condition and treatment.
- Clear information in patient language leads to correct management of medication administration, timing, why and how long to take meds.
- Educate patient in the array of medication adherence aids and devices available (dosing reminders, pill boxes, pill reminder programs).
- Tailoring the medication regimen to the patient's daily schedule and lifestyle.
- Instruct in home monitoring activities and record keeping.

The Barriers - Over 250 barriers (recorded in the literature)

PATIENT RELATED	MEDICATION RELATED	PROVIDER RELATED	HEALTH SYSTEMS RELATED
<p>Forgetfulness Lack of knowledge Value of therapy Cultural/Ethnic Denial Financial Health literacy Social support</p>	<p>Complex regimens Side effects Multiple medications Length of therapy</p>	<p>Poor relationship and / or poor communication Disparity around cultural or religious beliefs Lack of feedback /ongoing reinforcement Emphasizing negative aspects of the medication vs benefits</p>	<p>Type of health insurance Insurance/ Pharmacy benefit design</p>



Keep A Record Of Your Medications!

Medication Name	Other Name	Directions	Use	Prescriber	Other information
Omeprazole 20mg	Prilosec	Take 1 capsule in the evening	Heartburn/ Indigestion	Dr. Sam Jones	Take on an empty stomach
Tylenol Extra Strength 500mg	Acetaminophen	Take 1-2 tablets every 6 hours as needed	Arthritis Pain		Do not take more than 8 tablets in a day Don't drink alcohol

Provide patients with a current list of medications they can bring to every physician appointment, ER visit and hospital admission.

Source: Generations Senior Resources sample power point with key talking points: Getting the Best from your Medications, Cardinal Health Foundation, Ohio State College of Pharmacy



More Tools and Tips



| Agencies should develop a process to easily identify the addition of new medications, changes in dosage, and education provided related to medications throughout the episode of care to assist clinicians to easily identify if there have been any changes over the length of stay such as...



More Tools and Tips



- | A manual or electronic medication profile that can be updated throughout the care episode
- | A designated location in the record for all clinical staff to record changes and education on medication.
- | A flow sheet to document ongoing medication education to the patient and/or caregiver, or a designated area in the medical record where this information can be easily found.

Refer to additional tools available listed on the resource slides number 60-62



What Questions Do You Have?

Presented by:

Judy Adams, RN, BSN, HCS-D, HCS-O
Adams Home Care Consulting, Inc.

Durham, NC

Email: jradams31@gmail.com

Phone: (919) 294-6674

CE Credit Provided by:

Capital Nursing Education

California BRN provider # 16028

Capitalnursingeducation@gmail.com

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- Home Tube Feeding: Why You Need a Registered Dietitian
- What You Should Know if You're Considering Homemade Tube Feeding for Your Child
- How to Transition From Tube Feeding to Eating by Mouth

OstomyLife

- Tips for Swimming With an Ostomy - More Security | Ask Laura
- I Don't Want an Ostomy Bag - Top Concerns Video for Those Facing Ostomy Surgery
- Going Back to Work After Ostomy Surgery
- What to Expect at an Ostomy Support Group

Urological

- Appropriate and Inappropriate Use of Indwelling Urethral Catheterization (IUC)
- New Urology Center to Open Near St. Joseph Hospital
- Managing My Neurogenic Bladder
- Treat Older Prostate Cancer Patients According to Fitness, Not Age: Guidelines

Caregivers **Spinal Cord Injury** **Incontinence**

You can find more useful information in our online communities at: shieldhealthcare.com/community

View past and upcoming webinars at: shieldhealthcare.com/webinars

Resources

<https://www.ismp.org/tools>

Tables on error-prone abbreviations, frequently confused drug names, high alert medications in the community, BEERs

<http://www.champ-program.org/page/101/geriatric-medication-management-toolkit>

Clinically-focused and validated tools to help you, and patients and their caregivers, identify patients at increased risk of experiencing a medication-related problem;

Intervention tools for homecare professionals, patients and their caregivers, to facilitate implementing proven strategies to manage medications;

Tools to help you, patients, and caregivers communicate more effectively about medication risks with other providers; and

Guidelines and evidence-based best practices that provide an overview of the evidence for reducing medication-related problems and adverse drug events in older people.



Resources - Continued

- A Medication Management Intervention Across Transitions, Diane Davis, University of Massachusetts, Doctor of Nursing Practice Capstone Project 2015
 - www.Scholarwork.umass.edu/cgi/viewcontent.cgi?article=1048&context=nursingdnp-capstone.
- Enhancing Prescription Medicine Adherence: A National ACTION Plan, 2007, 2009, 2011 & 2012.
 - www.talkaboutrx.org/documents/enhancing-prescription-medicine-adherence.org
- National Council on Patient Information and Education (NCPIE)
 - One of the original patient safety coalitions, NCPIE has been working to advance the safe, appropriate use of medicines through enhanced communication since 1982.
 - <http://www.talkaboutrx.org/>



Resources - Continued

- Understanding Medication Adherence to Achieve the Triple Aim: Better Health – Better Care – Better Costs
 - http://app.ihl.org/FacultyDocuments/Events/Event-2206/Presentation-7795/Document-6005/L16_Presentation.pdf
- American Geriatrics Society Updated Beers Criteria for Potentially Inappropriate Medication Use in Older Adults
- Senior Resources Getting Best results from Your Medications – Free senior education power point with talking points
 - <http://www.generationrx.org/take-action/senior/>
- Script Your Future – free tools and information for patient education
 - www.Scriptyourfuture.org

