

BEST PRACTICE INTERVENTION PACKAGE

Improving Management of Oral Medications



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Table of Contents

ACKNOWLEDGEMENTS	2
TABLE OF CONTENTS	4
QUICK START GUIDE	5
SKILLED NURSING TRACK:	43
THERAPY TRACK:	45
MEDICAL SOCIAL WORKER TRACK:	48
HOME HEALTH AIDE TRACK:	49

QUICK START GUIDE

QUICK START GUIDE: A brief guide and introduction to the Best Practice Intervention Package (BPIP) contents.

INTRODUCTION: A brief introduction to the topic of this BPIP, Oral Medication Management.

LEADERSHIP TRACK (PAGE 9): Designed for **agency leadership and the quality or implementation team**. Although this section is designed for leadership and the implementation team, it is divided in sections so that it can be printed and shared with other staff. You will see similar features in each BPIP such as the *Guide for using the BPIPs*. You'll also see new features specific for this educational package.

Contents include:

- **A Guide for using the BPIPs**
- **Best Practice Intervention Schedule and Suggested Timeline**
- **Focus: Importance of Medication Management**
- **Checklist for Agency Leadership (Select interventions)**
- **Tools and Resources**
- **Links to Success Stories**
- **Organizational Culture**
- **Physician Perspective**

DISCIPLINE TRACKS: These 2-page guides are designed for the following disciplines:

- [Skilled nurse](#) (page 43)
- [Therapist](#) (page 45)
- [Medical social worker](#) (page 48)
- [Home health aide](#) (page 49)

The content is very similar between the discipline tracks since they are designed to be **interdisciplinary**. They will include discipline specific best practice(s) and **checklist**. We suggest printing front/back for ease of distribution **or** sending electronically to staff.



To keep current with ways to improve the quality of medication management take advantage of [Social Networking opportunities](#). Review the message boards and blog for Quick Tips and Fun Facts.

ASSOCIATED RESOURCES includes supportive resources for the topic of this BPIP. In addition to the information in this package, links to a number of important additional resources are provided on the [Medication Management BPIP Web page](#) at www.homehealthquality.org. *For a complete listing of tools see pages 23-25. This logo indicates tools and resources.*



INTRODUCTION

MEDICATION MANAGEMENT...AN OPPORTUNITY FOR HOME CARE

The goal of this Best Practice Intervention Package (BPIP) is to provide home care leaders with guidance on medication management and provide clinicians with resources to help them assess and improve patient's ability to manage medications. Making sure patients are receiving the correct medication, taking it correctly and monitoring for side-effects is a task very familiar to home care nurses. Home care staff are confronted with multiple challenges with medication management and can tell numerous stories of patients not taking medications due to financial constraints or concerns about untoward affects of the medication. The issues that surround medication management and safety with medication use are immense.



- Medication adherence can often be a problem among older adults and requires additional resources and strategies on the part of health care providers (MacLaughlin).
- A recent study of community dwelling older people receiving home care, suggests that **64% made medication errors** (DeBartolomeo, et.al.).
- An assessment of the prevalence and risk factors of medications in home care patients found both under- and over-adherence were common in the two week period following hospitalization. Additionally, poor cognition and a greater number of medications were associated with under-adherence (Gray, et. al.).
- Another area of concern is the alarming number of **preventable hospital admissions** in older patients from Adverse Drug Events (ADE) (Chan, et. al.). Issues surrounding ADEs include overuse: polypharmacy and overdosing, as well as underuse: underprescribing and nonadherence (Pham and Dickman).

The Medication Management BPIP is designed to help agencies evaluate their medication protocols and processes. There are educational tools for clinicians and patients, guidance for leaders and suggestions on ways to measure improvement efforts. There is guidance on the risks for medication adverse effects and medication errors during patient care transitions since both of these risks cause **avoidable hospital admissions**. The importance of medication management needs to be a priority in every home care agency. Please take advantage of the BPIP to make medication management a priority at your agency.

Did You Know?

- Adverse drug events cause over 700,000 emergency department visits each year. Nearly 120,000 patients each year need to be hospitalized for further treatment after emergency visits for ADEs. [[Centers for Disease Control and Prevention](#) (CDC)]
- Older adults (65 years or older) are twice as likely as others to come to emergency departments for ADEs and nearly seven times more likely to be hospitalized after an emergency visit. (CDC)
- Currently, only 43% of home care patients nationally improve in their ability to manage their oral medications by discharge. (April 2010 [Home Care Compare](#), from Home Health Outcome and Assessment Information Set (OASIS) B-1 during the time period 1/09-12/09.
- The Institute of Medicine report “Preventing Medication Errors” estimates there are at least 1.5 million preventable ADEs each year in the United States and the true number may be much higher.
- The drug regimen review is required by the Medicare Condition of Participation 484.55 to be completed at every comprehensive assessment time point.
- One of [The Joint Commission](#)’s National Patient Safety Goals for Home is to accurately and completely reconcile medications across the continuum of care.
- One of the [Community Health Accreditation Program, Inc.](#) (CHAP) medication standards requires a comprehensive review of all current

INSIGHTS

Medication Management includes assessment, reconciliation, simplification and **ongoing** medication assessment and review throughout the episode.

Judith L. Miller

Healthcare Quality Strategies, Inc.
East Brunswick, NJ

INSIGHTS

Agency leaders must commit time and financial resources for staff education and improvement strategies for medication management.

Kathleen Flannery
Deborah Whealton
Kennedy Home Health Care
Voorhees, NJ

medications at admission and as new medications are ordered or current medications are changed.

- OASIS-C requires a comprehensive medication review by one clinician, but other staff may collaborate in the review. Agency policy and practice will determine this process and how it is documented. [OASIS –C Guidance Manual; OASIS Item Guidance [Centers for Medicare and Medicaid Services](#) (CMS)]

CARE TRANSITIONS AND ADVERSE MEDICATION EVENTS

It is critical to communicate medication information at the time of transitions as patients are moving between health care practitioners and settings as their condition and care needs change during the course of a chronic or acute illness. Home health agencies participating in the Care Transitions project are working across settings to find collective ways to communicate information on medications and other important patient information when the patient is being transitioned from one care setting to another. Home health agencies in the Care Transitions project and across the country are **embracing opportunities to work on improving medication information exchange between care settings.**

Home health agencies have acknowledged that working with other providers on improving medication management during transfers is a critical step towards providing a safer environment for the patient. It is enlightening to view the patient's care from ***not only the interdisciplinary angle, but now the multi-provider vantage point.*** Every provider brings a unique perspective to the table with the overall goal of improving the patient's well being. Many home health agencies have shared their best practice application ideas and techniques through [INSIGHTS](#) and Success Stories. Look for these throughout the BPIP and on the [BPIP Web page.](#)

INSIGHTS

Our care transition project has the hospital, home care agency, and nursing home meeting and reviewing the medication process during transitions. This has helped identify how medication discrepancies occur from hospital discharge to home. It is important that **consistent medication information** is given across settings. Medication management may be the single most important thing we do!

Susan Ambrosy,
Quality Manager
Seton Health Home Care
Troy, NY

LEADERSHIP



This BPIP will review best practices **of improving management of oral medications**. As a reminder, the BPIPs are broken down into leadership tracks, which are directed towards leadership and Performance Improvement (PI)/Quality Improvement (QI) teams, and individual discipline tracks. The discipline tracks are 1-3 pages educational guidelines for specific disciplines. Although the package is broken down into individual tracks, all information is intended for an

interdisciplinary focus.

As in the first BPIP (January 2010), many best practice implementation suggestions (or insights) have been acquired from home health leaders, nurses and therapists. You will see them throughout the BPIP. Some are recurring **because the interventions and strategies work for so many home care agencies**. Review the information shared by home care agency leaders and clinicians and adapt it to your own agency!

OASIS-C has brought several changes to medication evaluation and management. OASIS-C includes:

- A **complete drug regimen review** for any potential clinically significant medication issues (M2000)
- Documentation of **follow-up with the physician** regarding clinically significant medication issues, including medication reconciliation (M2002 and M2004)
- **High-risk drug education** to the patient/caregiver (M2010)
- **Drug Education to the patient/caregiver** (M2015)
- Assessment of **management of oral medications** (M2020)
- Assessment of **management of injectable medications** (M2030)

“Our nurses like OASIS-C –it is more relevant and easier to use the OASIS to **develop the plan of care**”.

Kathleen Flannery
Deborah Whealton
Kennedy Home Health
Care
Voorhees, NJ

TIP: OASIS-C M2020

M2020 identifies the patient’s ability to take **ALL** oral medications reliably and safely at all times. This differs from M0780 which assessed the majority of meds. Make sure your staff understands this important change! (OASIS –C Guidance Manual; OASIS Item Guidance [CMS](#))



Most home health agency leaders are **very familiar** with the OASIS Items described above. Under OASIS-C, home care professionals are **now able to align the assessment with medication interventions**. The focus of this package will be on **improving management of oral medications** (M2020), which includes medication reconciliation and teaching.



A GUIDE FOR UTILIZING THE BPIP

1. Begin each quarterly BPIP by having the leadership in your agency review the leadership track.
 - a. Be selective with tools and interventions
 - b. Use/modify existing tools as appropriate
2. Check the [BPIP Timeline](#) (on the following page) and schedule a plan for improvement on your agency calendar.
3. Use a team approach with representation from all levels of staff. For **tips on developing a team**, refer to page 15 of the January 2010 BPIP: [Fundamentals of Reducing ACH](#)
4. Although a team guides the effort, try to involve **all staff** in selecting tools and changing processes.
5. **Encourage your staff to actively participate** by visiting the campaign Web site at www.homehealthquality.org and register under “Agency Registration”. This registration system is designed to have multiple people from the same agency register using the same provider number.
6. Utilizing graphs when educating staff can be very effective. **Share your HHQI data reports with all staff monthly**. Become educated and familiar with what the data reports mean and why they are important. Use the reports to promote quality improvement and data transparency at each case conference or staff meeting. Look for ways to **meaningfully display the data** and educate the staff on **how the data actually relates to the work they perform on a day to day basis**. Relate it to how the interventions promoted in the BPIPs may improve the ACH **and** management of oral medication rates within their agency.

INSIGHTS

- Need **interdisciplinary team** to focus improvement efforts
- Teach each discipline to understand their responsibility with medications
- Ensure all disciplines **assess medication management the same way**
- Make medication management an **annual competency** for clinicians

Susan Snow, QI Coordinator
GHS Home Health
Greenville, SC

BEST PRACTICE INTERVENTION PACKAGE TIMELINE

HHA BPIP Implementation Timeline	Release Date 4/28/2010	Within 2 weeks __/__/2010	Within 4 weeks __/__/2010	Within 6 weeks __/__/2010	Within 8-10 weeks __/__ 2010
	Download BPIP Package	Schedule team to review package	Initiate Staff Education	Implementation of New tools/process changes	Begin evaluation of process changes
	Audit records to determine reasons for NOT improving in Medication Management	Team selects tools/resources based on audit and staff input	QI Resource: Encourage Improvement Efforts	Track improvement efforts with calls or a mailed survey to patients 30 days after admission to assess medication understanding	Revise Process as necessary
		Test of change on small group (e.g. Plan/ Do/ Study/ Act)			
		Plan staff education			

BEST PRACTICE INTERVENTION PACKAGE SCHEDULE

Release Date	Topic
<i>Published</i> January 28, 2010	Fundamentals of Reducing Acute Care Hospitalization
April 28, 2010	Medication Management
July 28, 2010	Fall Prevention
October 28, 2010	Cross Setting I (Working and Aligning with Other Health Care Providers/Communication)
January 28, 2011	Cross Setting II (Chronic Care/Telehealth)
April 28, 2011	Cross Setting III (Medical Homes and Pioneering Ideas)

TRACKING DATA AND MEASURING PROGRESS

HHQI Data Reports

- Individualized HHQI reports may be obtained through a **secure login** at <https://secure.homehealthquality.org>
 - ACH reports
 - Oral Medication reports
- The reports will be changing to reflect **OASIS-C data** in April 2010 and include data for:
 - Scores for Drug Regimen Review (M2000)
 - Scores for follow-up with physician on clinically significant medication issues, including medication reconciliation (M2002)
 - Scores on high-risk medication education (M2010)
 - Percentage improvement on management of oral medications (M2020)
- For help with reports, [click here](#).
- The CASPER reports are in a static period for the transition from OASIS B1 to OASIS-C, but agencies that are registered for the HHQI Campaign **and also register for the HHQI data reports** will have access to reports on some OASIS data (ACH and Oral Medication)
- **Directions to sign up for the HHQI reports** are posted on the [HHQI Web page](#) (*Quick Start Guide to Data Access Reports*)
 - This can also be located by going to www.homehealthquality.org and clicking on link to HHQI Data Access System.



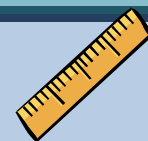
TIP: Home Health Quality Measures are a moving target

As discussed on page 9 OASIS-C has improved clinician's ability to assess medications. The national rate for M0780 remains at 43% (April 2010 HH Compare), but this is going to change with M2020. Using M2020 the clinician can more **accurately assess oral medication management and plan interventions**. The OASIS-C **M2020** assesses **ALL medications**, so this may make an impact in agency, state and national outcomes for this measure!!! The measure allows **for more opportunity for improvement**. State and national benchmarks may be higher with M2020 than they were for M0780. The quality measures are moving targets, so **set your goal for this measure higher than the current national or state average**.

INSIGHTS

*"Take advantage of **benchmarking** to measure your progress".*

Linda Sohl
Director of Compliance and QM
Dominican Sisters Family Health Service
Ossining, NY



EDUCATION TIPS FOR THE MEDICATION MANAGEMENT BPIP



Below are a few suggestions to **help implement the usage of the Medication Management Best Practice Intervention Packages** in your agency.

- Posters located in strategic and high-traffic areas (supply rooms, restrooms, charting areas, mailbox areas)
- Review [FAQs](#) at www.homehealthquality.org
- Send weekly updates in the form of short e-mails to your employees
- Copy and distribute the Discipline Tracks - either electronically or paper
- [BPIP Webinars](#)– Schedule a time for the staff to watch these together and encourage the staff to attend these presentations
- Post information updates on agency home page for clinicians or in electronic newsletters
- Copy and distribute the **Case Studies** ([BPIP Associated Resources](#)) and exercises (use as an individual or group self-study). Consider using these as a team learning activity
- [Audio recordings / Podcasts](#) – Have CD's burned and available for the staff to “grab and go”
- Live Chat Sessions: Promote employee participation by asking the staff to enter questions to be answered during the Live Chat
- Regular cell phone reminders

Research strongly supports three strategies to ensure that patients use medications correctly:

- Simplifying medications
- Assuring the patient has support
- Using multifaceted programs that address an array of adherence barriers.

Medication Management: *Evidence Brief*

Center for Home Care Policy & Research

[Home Healthcare Nurse Journal](#)

June 2009

CHAMP (Collaboration for Homecare Advances in Management and Practice) INSIGHTS:

Best Practice - Using scripts to improve medication reconciliation

- A thorough medication reconciliation includes an accurate list of all of the medications a patient is taking.
- Patients may not report over-the-counter medications they are taking because they think of them as “harmless” or don’t consider them medications.
- A script can help patients more consistently report their OTC medications.
- For example, instead of “What medications are you taking?” ask “Do you regularly take an over-the-counter medication for: constipation, diarrhea, pain like a headache, arthritis, muscle aches, sleep, heartburn, upset stomach, skin problems?”
- Participants in the [CHAMP Program](#) found that patients reported 1-2 additional medications when asked using a script compared to the agency’s usual practice for medication reconciliation.
- [Click here](#) for a collection of sample scripts you can use with your patients.

**Laura E. Peterson, BSN, SM
Lead Faculty
The CHAMP Program**

FOCUS: MEDICATION MANAGEMENT

One of the Home Health Quality Improvement National Campaign goals is to improve management of oral medications. Although the impact of the new OASIS-C medication measures will be reviewed, the focus of this resource is to **assist agency leaders and staff to focus improvement efforts on management of oral medications (OASIS-C measure 2020)**. Multiple organizations have different resources to support these improvements. CHAMP (Collaboration for Home Care Advances in Management and Practice), Center for Home Care Policy & Research, and the Visiting Nurse Service of New York have shared their insights and tools for this BPIP (Sidebars on pages 14 and 15).

A hallmark of medication management is medication reconciliation which is the process of comparing a patient’s medication orders to all of the medications the patient is taking. This reconciliation is completed to detect and avert adverse drug interactions and medication errors such as omissions, duplications, and dosing errors ([Joint Commission](#)). As mentioned before, this should be done at every transition of care.

Medication reconciliation ensures that information about a patient’s drug type and dosage is accurate and available at key points in the healthcare continuum (Clancy). The medication reconciliation process must be a clear and exact procedure that all staff members understand. Improving medication reconciliation also offers opportunities for providers to improve communication with each other.

Upon completion of medication reconciliation, the clinician must accurately assess the patient’s **ability** to manage his / her medications (M2020) and then **plan interventions** to assist in improving the management of his / her medications. The following evidence-based practices were found to be significantly associated with above average oral medication outcome rates:

- 1) Use of reminder strategies (cueing strategies such as alarm use, the location of medications and written notes on doors)
- 2) Use of phone follow-up intervention by agency staff
- 3) Repetition of patient medication education at future home care visits

- 4) Use of medication simplification strategies for patients taking multiple medications. (Shearer, 2009)

Many of the tools and resources provided with this BPIP will assist with these practices (page 27-36). The tools and resources selected for this package include tools for clinicians and as well as patients.

Medication simplification provides an opportunity to better assess the patient's medications.



Polypharmacy, which is the use of multiple medications to treat a host of medical conditions, contributes to medication adverse events (Arcangelo). Additionally, **inappropriate medications** can cause adverse drug events among older people (Chrischilles). All clinicians should become familiar with medications which should be used cautiously in the elderly population and high-alert (or high-hazard) medications. Resources to assist clinicians with this are found in many drug and reference books. Most home health electronic medical record system has medication alerts for clinical staff. Resources are included on the [BPIP Associated Resources Web page](#) as well.

Make sure and mark your progress by measuring your data. An important component of improvement is measurement. Evaluate your improvement plan by reviewing records and talking to staff when patients are hospitalized and/or go to the emergency department. Are any of the hospitalizations or emergency department visits avoidable? Survey patients by phone or mailing 30 days post admission to evaluate their ability to understand and safely management medications. Evaluate agency data; page 12 has information on the new HHQI reports. Use the data not only to track progress, but to keep staff informed and set new goals.

The goal for everyone working with home care patients is to achieve safe medication usage while promoting the patient's independence. Although multiple strategies and the effort of many home health care team members may be required, this could easily

Experience from hundreds of organizations has shown that poor communication of medical information at transition points is responsible for as many as 50 percent of all medication errors and up to 20 percent of adverse drug events in the hospital. [Institute for Healthcare Improvement](#) (IHI).

be the difference between the patient remaining in the home and returning to the hospital.

CHAMP (Collaboration for Homecare Advances in Management and Practice) INSIGHTS:

S-B-A-R: A best practice to improve communication about medication

- Differences in the way that nurses and physicians communicate information about patients can interfere with collaborative communication about medication-related issues like drug-drug interactions or therapeutic duplication.
- Use the SBAR technique to improve communication with physicians about medication issues.
- **Situation:** Briefly identify the patient and the problem.
- **Background:** Review pertinent information related to the situation.
- **Assessment:** Say what you think the problem or issue is.
- **Recommendation:** State your recommendation or what you would like the physician to do.
- Participants in the [CHAMP Program](#) who use SBAR report more effective nurse-physician interactions and increased staff satisfaction with their communication.
- An SBAR Worksheet is available [here](#), and [click here](#) for slides you can use to review the SBAR technique with your staff.

Laura E. Peterson, BSN, SM
Lead Faculty
The CHAMP Program

CHECKLIST FOR AGENCY LEADERSHIP

How to use:

1. Review this checklist and **select a few interventions** that are appropriate for your agency. Remember, these activities are designed for agencies with **varied degrees of best practice implementation.**
2. Review this checklist and **select a few interventions** that are appropriate for your agency after targeting areas for improvement. Remember, these activities are designed for agencies with **varied degrees of best practice implementation.**
 - Chart reviews and staff input can help identify areas that need improvement. (For example, focus area may be improving patient education, medication reconciliation and/or resources for staff.)
 - The improvement team should make intervention selection with **staff input**
 - Select 3-4 interventions to begin
 - Depending on the size of your agency, **plan small trials** with new tools and processes, evaluate effectiveness and then move to total agency implementation

[Remember steps of Outcome Based Quality Improvement (OBQI) and Plan/Do/Study/Act (PDSA)]

 - Add to intervention selection as team/staff sees other areas for improvement
3. Utilize the ‘assigned to’ and ‘notes’ if needed.
4. Refer to the [BPIP timeline](#) to plan implementation of the selected interventions.
5. You may want to revisit this list after a few weeks and consider additional interventions.
6. The checklist is placed on the next page—so the checklist can be printed independent of the additional leadership information.

INSIGHTS

Medication Reconciliation is NOT just asking the patient what medications they are taking!

It is:

Putting your hands on **every medication bottle** including:

- Eye drops
- OTC pain meds
- Vitamins
- Herbals

Click here to see the form that Infirmiry HomeCare of Grove Hill uses to evaluate medications. (Patient Medication Review Questionnaire)



*Tiffany Alford, Director of Nursing, LHC Group
Infirmiry HomeCare of Grove Hill, Grove Hill, AL*

<p><u>CHECKLIST FOR AGENCY LEADERSHIP</u></p> <p><u>SUGGESTED ACTIVITIES</u></p>	<p><u>ASSIGNED TO:</u></p>	<p><u>NOTES</u></p>	<p><u>DATE</u> <u>(IF SELECTED)</u></p>	<p><u>COMPLETION</u></p>
<ul style="list-style-type: none"> ○ Evaluate your staff medication education program Does it include: ○ Annual competency? ○ Case studies (under associated resources) for application/comparison? ○ Observation by peers? ○ All staff and responsibilities specific for each discipline? ○ Initial education during orientation and 2-3 month follow up for all new clinicians? ○ A review and discussion of each OASIS measure that relates to medications? ○ Focus on the intent of the OASIS measure? ○ Use teach-back methods ○ Review of potential medication errors or adverse events such as: <ul style="list-style-type: none"> ○ Identification of look-alike, sound alike medications; high-risk/high-alert meds ○ Potentially inappropriate medications for older adults (Refer to drug books, handout in tool section –Potentially Inappropriate Medications for Older Adults; Beers Criteria) ○ Accurate communication during hand over/transitions ○ Monitoring medication effectiveness ○ Patient education ○ Consider role play or observation to assess staff competence in all of the above 				

<p><u>CHECKLIST FOR AGENCY LEADERSHIP</u></p> <p><u>SUGGESTED ACTIVITIES</u></p>	<p><u>ASSIGNED TO:</u></p>	<p><u>NOTES</u></p>	<p><u>DATE</u> <u>(IF SELECTED)</u></p>	<p><u>COMPLETION</u></p>
<ul style="list-style-type: none"> ○ Review and provide resources for staff in high-alert (or high-risk/high-hazard) medications <ul style="list-style-type: none"> ○ List of High-Alert Medications (Institute for Safe Medication Practices [ISMP]) ○ IHI: Getting Started Kit: Prevent Harm from High-Alert Medications 				
<ul style="list-style-type: none"> ○ Make lists of high-risk medications that are frequently encountered and contact a pharmacist to provide staff education in these medications and/or pharmaceutical companies for professional and patient education information to be used by staff. Look for innovative ways improve medication safety such as http://www.homemedics.org/. 				
<ul style="list-style-type: none"> ○ Ensure that your staff understands that the Drug Regimen Review is required by the Medicare Condition of Participation 484.55 to be completed at every comprehensive assessment time point. “The comprehensive assessment must include a 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 and noncompliance with drug therapy.” CMS 				
<ul style="list-style-type: none"> ○ Establish an interdisciplinary drug regimen review process for ‘therapy only’ cases. This may include nursing review, electronic resourcing for therapists or providing therapist with medication resources (e.g. drug reference book). Provide process and education for therapy when nursing referral should be requested for medication management issues. 				
<ul style="list-style-type: none"> ○ Implement an interdisciplinary approach to medication assessment and teaching. Begin by a brainstorming session to generate ideas of how to improve medication management with your patients. 				

<p><u>CHECKLIST FOR AGENCY LEADERSHIP</u></p> <p><u>SUGGESTED ACTIVITIES</u></p>	<p><u>ASSIGNED TO:</u></p>	<p><u>NOTES</u></p>	<p><u>DATE</u> <u>(IF SELECTED)</u></p>	<p><u>COMPLETION</u></p>
<ul style="list-style-type: none"> ○ Establish a Medication Management Improvement team, including staff from all disciplines. Enlist guidance of pharmacist, if possible (within system or local pharmacist). 				
<ul style="list-style-type: none"> ○ Establish rapport with your State University Pharmacy program---some have a hotline for questions and education to staff. 				
<ul style="list-style-type: none"> ○ Use the <i>Medication Management: Tips for Staff</i>(Lakeland Hospice and Home Care). Print and use as staff education. 				
<ul style="list-style-type: none"> ○ Select one (or both) of the success stories to share with staff. Also, routinely share your agency success stories with the staff (e.g., when patient improves with medication management after interdisciplinary staff intervention). 				
<ul style="list-style-type: none"> ○ Review the care of patients who do not improve on M2020 to evaluate if interventions were appropriate. Compare staff to see if some clinicians are more successful and have them share their strategies. Make sure staff is consistent with implementing an improvement plan. 				
<ul style="list-style-type: none"> ○ Develop a process to assure primary care physician/provider follow up appointment is scheduled and completed. 				
<ul style="list-style-type: none"> ○ Establish protocol for identifying and reconciling medications and educate staff in protocol. 				
<ul style="list-style-type: none"> ○ Evaluate Medication Reconciliation Process. A Medication Reconciliation process should include: (from Joint Commission and IHI) ○ A review of all current medications, including those prescribed but not picked up from pharmacy. ○ Asking patient/caregiver what OTC medications and herbals they may take even on an infrequent basis 				

<p><u>CHECKLIST FOR AGENCY LEADERSHIP</u></p> <p><u>SUGGESTED ACTIVITIES</u></p>	<p><u>ASSIGNED TO:</u></p>	<p><u>NOTES</u></p>	<p><u>DATE</u></p> <p><u>(IF SELECTED)</u></p>	<p><u>COMPLETION</u></p>
<ul style="list-style-type: none"> ○ Compare patient’s list to hospital discharge list and/or referral information ○ Assess list for duplicate medications, omissions (on referral or hospital discharge list but patient is not taking), dosing errors, potential drug interactions ○ Make a list of medications and place in patient home chart so it is visible to all disciplines and patient/caregiver <ul style="list-style-type: none"> ○ The medication list in the home chart must be kept updated and consistent with the patient’s record. ○ Include dosages, drug schedule, immunizations, drug allergies and drug intolerances on the list ○ Complete at each care setting transition, including physician appointments when medications are changed or reordered. ○ Have patient/caregiver complete a medication list (with help) and encourage them to carry list and share with all health care providers. Encourage them to keep this list current and take responsibility for it. 				
<ul style="list-style-type: none"> ○ Initiate discussion with other providers on medication reconciliation and medication information during patient transitions. This should include: <ul style="list-style-type: none"> ○ Hospitals ○ Nursing Homes ○ Physician Offices 				
<ul style="list-style-type: none"> ○ Include lead hospital pharmacist in evaluating care transitions 				
<ul style="list-style-type: none"> ○ Use computerized health record features for information on medication interactions, precautions, side effects, and to improve coordination of medication assessment and teaching. 				
<ul style="list-style-type: none"> ○ Develop and post a graph of agency oral medication rate (M2020). These are available at HHQI Data Access System 				

<p><u>CHECKLIST FOR AGENCY LEADERSHIP</u></p> <p><u>SUGGESTED ACTIVITIES</u></p>	<p><u>ASSIGNED TO:</u></p>	<p><u>NOTES</u></p>	<p><u>DATE</u> <u>(IF SELECTED)</u></p>	<p><u>COMPLETION</u></p>
<ul style="list-style-type: none"> ○ Measure your progress! ○ Use HHQI data reports ○ Develop and collect measurement data for ‘real-time’ data (e.g. documentation of medication instruction; evaluate discharge records when patients don’t improve in medication management) ○ Share measurement results and progress with staff 				
<ul style="list-style-type: none"> ○ Review the BPIP Insights (tips from other home care leaders and clinicians) to see which are appropriate for your agency. A few strategies used by these home care agencies to improve medication management are: ○ Frontloading visits with focus on assessing medication compliance and providing medication education. ○ Telehealth—incorporate medication assessment ○ Phone monitoring to review medications and continue patient education 				
<ul style="list-style-type: none"> ○ Use the educational information available on www.homehealthquality.org <ul style="list-style-type: none"> ○ Podcast ○ Recorded Webinar ○ FAQs about the campaign 				
<ul style="list-style-type: none"> ○ Send patient’s primary care physician a list of all current patient medications within 24 hours of admission to home care. 				
<ul style="list-style-type: none"> ○ Use a paper Personal Health Record or computerized record for technology savvy patients and teach patient to keep it updated with current medication list. 				
<ul style="list-style-type: none"> ○ Include family members in medication management by having patient and family make list of medications on Medication List/Personal Health Record (see examples of these forms in Associated Resources) 				
<ul style="list-style-type: none"> ○ Case conference patients who have potential for nonadherence or difficulty with obtaining medications. 				

<u>CHECKLIST FOR AGENCY LEADERSHIP</u> <u>SUGGESTED ACTIVITIES</u>	<u>ASSIGNED TO:</u>	<u>NOTES</u>	<u>DATE</u> <u>(IF SELECTED)</u>	<u>COMPLETION</u>
<ul style="list-style-type: none"> ○ Use therapy for cognitive and functional assessments/interventions when these contribute to medication non-adherence. 				
<ul style="list-style-type: none"> ○ Contact patient’s pharmacy to let them know patient is on home care services. Enlist their services in providing tools to assist the patient with self-management. 				
<ul style="list-style-type: none"> ○ Coach patient to set a health care goal that includes medication management to improve medication compliance. 				
<ul style="list-style-type: none"> ○ Reassess Patient Medication Information. Is it: <ul style="list-style-type: none"> ○ Written in an easy to read text and include visuals? ○ Appropriate for various literacy levels? ○ Include education on high-risk medications? ○ Written in patient’s native language. 				



SELECTED TOOLS AND RESOURCES

There are many tools and resources to improve management of oral medications. The tools in this package:

- may be familiar to many HHAs (Medication Simplification),
- are new or recently revised to reflect OASIS-C and
- have been developed by agencies featured in the INSIGHTS and Success Stories.

Look for links to the numerous tools and resources throughout the package. Every tool and resource that we reference in this package can be located under Associated Resources on the Medication Management BPIP Web page. Due to the number of tools and resources, it is easy to select too many. So, it is suggested that you **choose carefully** which tools you would like to use and select a few that are best suited for your prioritized interventions. So please peruse the tools under Associated Resources on the [Medication Management BPIP Web page](#) and pick and choose what you would like to use!



The tools included as part of this package (pages 27-36) are:

Tool	Designed for:
M2020 Quick Guide (Stratis Health)	Clinician education
Potentially Inappropriate Medications In Older Adults [Healthcare Quality Strategies, Inc., (HSQI) as part of the New Jersey Drug Safety Initiative (NJDSI)]	Clinician Education
Medication Management Tips for Staff (Lakeland Hospice and Home Care—Success Story)	Poster/Clinician Reminder
Medication Management Care Planning Tool	Clinician Education
Patient Medication Review Questionnaire (HomeCare of Grove Hill/LHC Group)	Clinician/Patient Resource
Taking Charge of My Warfarin: New Jersey Drug Safety Initiative (HSQI, NJDSI)	Patient Education



Tools available through Web links	
Tool:	Designed for:
Clinician and Consumer Medication Guides (AHRQ)	Medication education for clinicians and patients organized by disease process (2 Links—one for clinician and one for consumer) Many also available in Spanish. Click on <i>Información en español</i> in the Webpage toolbar
Institute for Safe Medication Practices (ISMP)	ISMP List of High-Alert Medications ISMP Oral Dosage Forms That Should Not Be Crushed ISMP List of Error Prone Abbreviations ISMP List of Confused Drug Names
Speak Up: Help Avoid Mistakes With Your Medications (Joint Commission)	Patient resource on avoiding medication errors Also available in Spanish
Blood Thinner Pills: Using them Safely (AHRQ)	Patient education Also available in Spanish
How to Create a Pill Card (AHRQ)	Online resource to design medication card ◦ (Additional drug images available here)
Create a Drug Schedule (My Pill Box)	Patient Resource
Universal Medication Form for Patients (IHI)	Medication List
Medication List (Massachusetts Coalition for the Prevention of Medication Errors)	Medication List that includes a place for patient data, medical conditions, etc.
Your Role in Safe Medication Use (Massachusetts Coalition for the Prevention of Medication Errors)	Medication Safety Guide for patients



Tools included on the BPIP Web page under [Associated Resources](#)

Tool:	Designed for:
Home Health Medication Discrepancy Tool: Georgia Medical Care Foundation (GMCF)	Documentation form for medication discrepancies
Warfarin Drug-to-Drug Interaction Guidelines (HSQI, NJDSI)	Clinician Education
Guidelines for Fax Form to Physician with Potential Medication Interactions Fax Form: Potential Medication Interaction (Dominican Sisters Family Health Service-- Success Story)	Fax form and guidelines for potential medication interactions
Beers Criteria: Potentially Inappropriate Medication Use in Older Adults: Independent of Diagnoses or Conditions (2002 Criteria)	Resource for clinicians
Medication Nonadherence: A Staff Education Tool	Clinician Education
Case Studies	Clinician Education
Medication Compliance Aids—Selection Criteria	Illustrated guides of multiple medication compliance aids
Patient INR Test (record) Dominican Sisters Family Health Service (Success Story)	Form to record patient INR test results
Medication Tips: Simple Steps for Medication Safety (HSQI, NJDSI)	Patient Education Copy back/front to make a tri-fold
Personal Health Record (GMCF)	Patient Use
Medication Safety and You (Understanding Dietary Supplements) (HSQI, NJDSI)	Staff and Patient Education
Medication Safety and You (Are you taking a blood thinner?) (HSQI, NJDSI)	Patient Education
High Alert Medication Education (Piedmont Home Care)	Patient Education
Medication Cards (VNA of Middlesex-East & VN Hospice)	Medication Card Template for Patient Education
Anticoagulation Patient Teaching Booklet (Dominican Sisters Family Health Service-- Success Story)	Patient Education



INSIGHTS

- Supply patients with medication cassettes, even those who may not seem to need them; we encouraged pre-fills by families and patients as well, especially in the first couple of weeks after hospital discharge.
- We developed medication cards for specific categories of medications; the med profile supplied to patients is not always the most patient friendly. We made them very readable and the patients seem to realize the importance of compliance when given individual cards. These seemed to be better received by patients and families, especially for the more important medications.
[*Click here for a sample of VNA's medication cards*](#)
- Front loading visits: If a patient has many new medications or dosage changes based on a change in condition, or displays a heightened sense of anxiety, we often visit for 2-4 days in a row to provide an assessment, education of medication purpose, doses and times to be taken. This has helped us with patient medication compliance.
- Telephonics: We often put patients on the weekend list for a telephone call by a nurse to assess medication compliance. Often these patients do not need or wish for a visit but are good candidates for support or for us to answer specific questions that may have come up between visits. These patients have often been admitted mid or late week and have received 2-3 visits for medication teaching and management.
- Transition of Care Team: We are members of an interdisciplinary team dedicated to easing patients' transition from one level of care to another. A big piece of this has been focused on medication reconciliation, which has assisted us in receiving clear, accurate medication information at the time of referral. It is an ongoing process that we anticipate will continue to alleviate the ongoing problem of med reconciliation
- Computer point of care: 100% of our clinicians utilize the point of care system which assures all medications entered are available in every part of the medical record, assisting with interdisciplinary communication and enhanced teaching resulting in improved compliance on the patients' part.

*Merry Beth Rucker, CEO
VNA of Middlesex-East & VN Hospice
Wakefield, MA*

The VNA of Middlesex-East & VN Hospice CEO is presenter for the [National Association for Home Care & Hospice](#) webinar **“Dramatically Reducing Hospitalization Rates: What Works, What Doesn't”**



Medication QUICK GUIDE

Tips for accurate M2020 assessment

- **Assess patient's ABILITY**
 - Focus on what the client is able to do, not on compliance or willingness.
 - The intent of the item is to identify ability. Ability can be affected either permanently *or* temporarily by physical impairments, emotional/cognitive/behavioral impairments, sensory impairments, and/or environmental barriers
 - Providing an intervention can change the patient's ability so it is important to report patient ability before the intervention occurred

- **OBSERVE patient manage their medications**
 - A combined observation/interview approach with the patient or caregiver is necessary to determine the most accurate response for M2020.
 - Observe patient gathering their medication supplies and the area where medications are stored. Consider: Is the process organized? What compliance aids are used? Are there functional / cognitive limitations?
 - Observe patient opening medication containers. Is assistance needed or used?
 - Ask the patient to state the proper dosage, time and frequency for each medication. How does the patient's response compare to the medication directions? Are there cognitive/mental limitations?
 - Check the medication bottles for instructions and compare dosage and frequency with any medication list the patient utilizes.
 - The M2020 question says, "all"—so evaluate patient's ability to take ALL oral medications reliably and safely.

OASIS Implementation Manual, 09/09



This material was created by Stratis Health, the Medicare Quality Improvement Organization for Minnesota, and modified and distributed by This material was prepared by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication Number: 9SOW-WV-HH-BBK-031210B. App. 03/10.

Potentially Inappropriate Medication (PIM) in Older Adults

Drugs to Avoid	Drug Class	Concerns	Possible Alternatives*
Propoxyphene (Darvon [®] , Darvocet [®])	Opioid Analgesic	Offers no clinical advantage over acetaminophen (APAP) alone with greater potential for adverse effects ^{1,2,3} ; may increase risk for fall and hip fractures. ⁴	Mild Pain: acetaminophen, NSAIDs (short-term use)** Moderate-Severe Pain: hydrocodone/APAP (Vicodin [®]), morphine (MS Contin [®]), oxycodone (OxyContin [®]) oxycodone/APAP (Percocet [®]); transdermal or buccal fentanyl (Duragesic [®] , Actiq [®] , Fentora [®]) Topicals (neuropathic pain, arthritis): lidocaine (Lidoderm [®]), capsaicin (Zostrix [®])
Hydroxyzine (Vistaril [®] , Atarax [®])	1st Generation Antihistamines	Can cause anticholinergic adverse effects (dry mouth, urinary retention, constipation, blurred vision, confusion), cognitive impairment, excessive sedation, drowsiness, weakness, hypotension, and falls. ^{5,6,7} Trimethobenzamide: less effective than other antiemetics and may cause extrapyramidal adverse effects, confusion. ⁸	Allergy Symptoms: low-anticholinergic affinity antihistamines, e.g., loratadine (Claritin [®]), cetirizine (Zyrtec [®]), levocetirizine (Xyzal [®]) Mild Itching/Rash: topical diphenhydramine (Benadryl [®] cream), topical corticosteroids Cough: dextromethorphan (Robitussin [®] DM, etc.) Insomnia: zaleplon (Sonata [®]), ramelteon (Rozerem [®]), or eszopiclone (Lunesta [®]); short-acting benzodiazepine, e.g., estazolam (ProSom TM) Nausea/Vomiting: ondansetron (Zofran [®]), granisetron (Kytril [®]), dolasetron (Anzemet [®]), short-term use of prochlorperazine (Compazine [®])
Cyproheptadine (Periactin [®])			
Promethazine (Phenergan [®])			
Trimethobenzamide (Tigan [®])			
Others: Dexchlorpheniramine; Diphenhydramine			
Cyclobenzaprine (Flexeril [®] , Amrix [®] , Fexmid [®])	Skeletal Muscle Relaxants	Can cause anticholinergic adverse effects, dizziness, sedation, orthostatic hypotension, and weakness. ^{6,7} Questionable efficacy. ^{8,9}	Muscle Spasticity: low-dose baclofen or tizanidine (Zanaflex [®]); botulinum toxin injection ¹² Muscle/Back/Nerve Pain: use nondrug therapies; tizanidine, topical capsaicin (Zostrix [®]); lidocaine (Lidoderm [®]); or small amounts of topical menthol/methyl salicylate (BenGay [®] , Icy Hot [®])
Metaxalone (Skelaxin [®])			
Carisoprodol (Soma [®])			
Others: Methocarbamol (Robaxin [®]); Chlorzoxazone (Paraflex [®]); Orphenadrine (Norflex [®])			
Atropine (Lomotil [®] , Lonox [®] , Donnatal [®])	Gastrointestinal Antispasmodics (includes combinations)	Highly anticholinergic ⁶ ; may impair memory and cognitive functioning ⁷ ; questionable efficacy in the elderly.	Intestinal Spasms: assess for and avoid GI irritants, make dietary modifications, reduce stress Irritable Bowel Syndrome (pain/gas/bloating predominant): make dietary and lifestyle changes; citalopram (Celexa [®]), paroxetine (Paxil [®]) ¹³ , low-dose desipramine (Norpramin [®]); constipation predominant: lubiprostone (Amitiza [®]) Diarrhea: loperamide (Imodium [®]) Constipation: dietary modifications, psyllium (Metamucil [®] , etc.), polyethylene glycol (MiraLAX [®])
Dicyclomine (Bentyl [®])			
Hyoscyamine (Levsin [®] , Levbid [®] , NuLev [®] , Donnatal [®])			
Scopolamine (Transderm Scop [®])			
Propantheline (Pro-Banthen [®])			

Medications included account for approximately 75% of the PIMs for New Jersey Medicare Part D participants based on Healthcare Quality Strategies, Inc.'s (HQSI's) analysis of Medicare Part D claims obtained from the Iowa Foundation for Medical Care.

PIMs are medications that should generally be avoided in the elderly because the risks associated with their use may outweigh the benefits. The list is not intended as an absolute prohibition against prescribing these medications. Older adults are generally more sensitive to drugs with central nervous system (CNS) and/or anticholinergic side effects. Side effects may develop in those who have previously tolerated therapy.

*Possible alternatives are not meant as an exhaustive list. Formularies vary. Check with drug plan to ensure coverage. Use caution when initiating/discontinuing medications. Appropriate tapering recommended.

**New guidelines for chronic pain management in the elderly do not recommend NSAIDs or COX-2 inhibitors for the treatment of persistent pain for patients over 75 years of age. The guidelines will be published in the August 2009 issue of the *Journal of the American Geriatrics Society*.

Note: This document is intended for educational purposes only as a general guide to identify drugs that might be inappropriate and is not intended to override a clinician's judgment in individual patient management. Prescribing decisions are complex and must be based on an individual's full clinical picture.

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Medication Management Tips for Staff

Remember the clinician completing the assessment is reporting the patient's ability **BEFORE** providing skilled intervention -- not after.

Patient ability	Involve caregivers
<ul style="list-style-type: none"> Complete the OASIS assessment as you see the patient—not as you hope they are! 	<ul style="list-style-type: none"> May have to look for additional support for assistance (friends, neighbors – keeping confidentiality in mind)
'Show me'	Ongoing medication assessment and teaching
<ul style="list-style-type: none"> Nurses need to be savvy—patients can't always do what they tell you they can do 	<ul style="list-style-type: none"> Assess for medication compliance on each SN visit
Medication reconciliation	Continuous staff education
<ul style="list-style-type: none"> Patients often assume that they should continue all the meds they were on before. Patients often acknowledge agreement with hospital discharge medication teaching and have forgotten it by the time they get home! 	<ul style="list-style-type: none"> OASIS and Best Practices
Therapists and Medical Social Workers	Consistency between settings
<ul style="list-style-type: none"> Interdisciplinary focus on medication management to assess reasons patient can't manage medications 	<ul style="list-style-type: none"> Patient medication card/list—have the patient responsible for this by taking to doctor appointments Work with other providers: Hospitals, Nursing homes, Physician offices and outpatient pharmacies to improve medication information and compliance between transfers to other settings

Information provided by Esther Zosel, Home Care Manager and Shirley Brause, Assistant Home Care Manager, Lakeland Hospice and Home Care, Fergus Falls, MN. This material was developed by and is distributed by the West Virginia Medical Institute, the Quality Improvement Organization supporting the Home Health Quality Improvement National Campaign, under contract with the Centers for Medicare & Medicaid Services (CMS), an agency of the U.S. Department of Health and Human Services. The contents presented do not necessarily reflect CMS policy. Publication Number: 9SOW-WV-HH-BBK-032410. App. 01/10.

Medication Management Care Planning Tool

Purpose: To improve assessment of patient's medication management performance and assist selecting strategies to support improved medication management

Patient Behavior or Comments	Problem/ Barrier	Assess	Strategies/Interventions
<ul style="list-style-type: none"> • Fills only some prescriptions • Takes only some medications • "I don't want to be on a lot of medications." • "I don't think it's good for me to take medications." • Someone I know took pills like those and got worse so I don't want to take them." 	<ul style="list-style-type: none"> • Fearful or anxious about addiction or dependence OR • Fearful of undesired effects of medications 	<ul style="list-style-type: none"> • Allow/encourage patient to express, elaborate on concerns • <i>Fear or anxiety is a legitimate emotional inability to take some or all meds</i> 	<ul style="list-style-type: none"> • RN referral to address fears, provide education on purpose, effects, and side effects of medication(s) • SW referral for brief counseling related to fears/anxiety • Rule out financial barriers
<ul style="list-style-type: none"> • "I have trouble reading all that stuff on the bottles." • Resists requests to read information on medication labels or other medication information 	<ul style="list-style-type: none"> • Limited literacy 	<ul style="list-style-type: none"> • Ask if patient learns better by hearing, seeing demo or reading • Assess reading ability to determine literacy (how does patient manage other print information?) 	<ul style="list-style-type: none"> • OT referral to address alternate means of information acquisition • Try visual model of meds/dosages (i.e. picture of meds for times and dosage) • Try audio recordings of med instructions • If instruction too complicated for model or audio recording, enlist caregiver to supervise complex dosing
<ul style="list-style-type: none"> • "I have trouble reading the labels." • "I can't tell which pill is which, they look alike." • Unable to: <ul style="list-style-type: none"> ○ read information on container OR ○ read other instructional material OR ○ discern shapes/shadings or discriminate between pills 	<ul style="list-style-type: none"> • Visual impairment 	<ul style="list-style-type: none"> • Does patient have/use corrective lenses? • Does patient have/use magnification beyond corrective lenses? 	<ul style="list-style-type: none"> • Consult pharmacy re: system to color code or apply large print or high contrast label to containers • OT referral for low vision compensation strategies • Large print/high contrast model (example) for dosing or filling mediplanner

Medication Management Care Planning Tool



	Patient Behavior or Comments	Problem/ Barrier	Assess	Strategies/Interventions
	<ul style="list-style-type: none"> • “I have trouble swallowing pills, especially those big ones.” • Patient coughs or gags when attempting to take pills • Patient is on a modified diet for dysphagia 	<ul style="list-style-type: none"> • Dysphagia or uses technique that risks aspiration 	<ul style="list-style-type: none"> • Is patient on dysphagia diet? • Observe patient’s technique to administer/swallow pills and if coughing or gag occurs 	<ul style="list-style-type: none"> • OT or SLP consult for swallowing eval and dysphagia intervention • Consult with pharmacist to determine if: <ul style="list-style-type: none"> ○ Meds can be crushed, or cut ○ Meds can be administered in semisolids (pudding/applesauce) ○ Med is available in a different form i.e. liquid ○ Med is available in a smaller size?
	<ul style="list-style-type: none"> • Patient leaves pill containers open or leaves pills out of containers • Patient doesn’t take meds if containers are securely capped • Patient can’t open caps or close securely, or spills contents when trying to open container • “I can’t get the bottles open” 	<ul style="list-style-type: none"> • Fine motor skills (grasp, dexterity) impairment and/or joint pain 	<ul style="list-style-type: none"> • Observe performance 	<ul style="list-style-type: none"> • OT referral to analyze and simplify task • Consult with patient, family and pharmacist re: appropriateness of non-child proof containers • Explore other dispensing containers (eg. punch packs) • Consider having pharmacist or caregiver set up mediplanner with easy-open compartments

Medication Management Care Planning Tool



	Patient Behavior or Comments	Problem/ Barrier	Assess	Strategies/Interventions
	<ul style="list-style-type: none"> • “I remember my medications in the morning but I forget about those new ones I’m supposed to take later in the day.” • “Sometimes I remember to take my pills and sometimes I don’t.” • “Some days I get up early and other days I stay in bed all day.” • Patient has few routines or daily routine varies on different days of the week • New meds or new dosing times have been added to existing medication schedule • Patient is missing new dosing times but seldom misses long established dosing times 	<ul style="list-style-type: none"> • May be a cognitive/memory impairment but also: • Lack of established routine limits ability to routinize medications OR • Patient has established routine on some days (and takes meds) but not on other days OR • Additional dosing times are not yet routinized 	<ul style="list-style-type: none"> • Assess for presence and consistency of routine and if there are alternate routines (eg dialysis or attending day program) • What are the routines associated with dosing times that patient seldom misses • What interrupts successful routines 	<ul style="list-style-type: none"> • Rule out cognitive (memory) impairment: does the patient have problems remembering other daily tasks? • OT referral to assess for presence and stability of routines and to incorporate new dosing times into established routines • Consult with prescriber re: options for reducing number of dosing times or synchronizing dosing times with most stable and consistent daily routines • Consider portable (1 day) mediplanner to take along on days when routine is different or locate second mediplanner in location where patient will be at later dosing time
	<ul style="list-style-type: none"> • “I just can’t remember to take my medications.” • “I can’t keep track of whether I took my medications or not.” • Pill count shows many doses missed or fewer doses left than refill date indicates • Patient exhibits memory deficits in other activities 	<ul style="list-style-type: none"> • Memory disorder (temporary or permanent) 	<ul style="list-style-type: none"> • Rule out reversible causes of memory problems (UTI, medication interactions, overdosing, use of OTC meds affecting cognitive status) • Assess for depression • Assess for cognitive impairment 	<ul style="list-style-type: none"> • Consult with physician/prescriber re: <ul style="list-style-type: none"> ○ UTI ○ Interactions ○ Beers list meds • OT or SLP referral for cognitive assessment • OT or SLP referral for alternative storage/dispensing devices • Consider use of pre-filled mediplanner to provide visual reminder • Work with caregivers on strategies to involve patient in medication administration but reduce risk of over or underdosing

Medication Management Care Planning Tool



	Patient Behavior or Comments	Problem/ Barrier	Assess	Strategies/Interventions
	<ul style="list-style-type: none"> • “My (daughter/friend/spouse, etc) gives me my medicine when I need it. I don’t even think about it.” • “My (daughter/spouse/family) doesn’t want me to take my medicine without help. • Caregivers express anxiety or resistance to having self-administer medications 	<ul style="list-style-type: none"> • Lack of knowledge about medications • Risk of over or undermedicating if knowledgeable caregiver is not present 	<ul style="list-style-type: none"> • Knowledge of purpose/dosing of each medication • Alternatives patient or caregivers have established in case caregiver is not present • Observe patient demonstrating physical task of dispensing and administering medication 	<ul style="list-style-type: none"> • Work with patient and caregiver to engage patient in all aspects of administration that s/he is capable of performing • Work with patient and caregivers on strategies to ensure that patient can safely and accurately administer PRN medications
	<ul style="list-style-type: none"> • “It’s too much trouble to go to the (bathroom/kitchen/etc) to get my medicines.” • “I can only go up and down the stairs once a day so I can’t get back there to take my medicine.” • “We have to keep my pills where the children can’t get them, but then it’s hard for me to reach.” • Patient is unable to access or has difficulty accessing where medications are stored 	<ul style="list-style-type: none"> • Medications are inaccessible 	<ul style="list-style-type: none"> • Ask patient to retrieve medications (instead of having them out prior to your visit) • Observe retrieval and patient’s endurance, mobility, balance, reach to successfully retrieve meds 	<ul style="list-style-type: none"> • Work with patient and caregivers on options to store medications where they are accessible to patient at all dosing times but not accessible to children, pets or adults with cognitive impairment • OT or PT referral to improve activity tolerance and/or mobility • OT referral to develop environmental adaptations to optimize medication accessibility





Patient Medication Review Questionnaire

Do you take any over-the-counter medication for any of the following?

- Aches and pain
- Headaches
- Indigestion
- Constipation
- Sinus congestion
- Cough
- To help you sleep


Do you use any of the following?

- Arthritis rub
- Aspirin, Ibuprofen, Acetaminophen (i.e. Tylenol, Advil, Motrin, Aleve)
- Vitamins
- Herbs
- Eye drops
- Inhalers
- Nose spray
- Breathing treatments
- Oxygen
- Insulin
- Allergy shots
- IV meds
- Other IV/injections with physician or outpatient
- Suppositories
- Topical medicated creams
- Chemo

For any box that is checked, list specific item on medication list.

IT'S ALL ABOUT HELPING PEOPLE.®

Taking Charge of My Warfarin

 I will talk to the doctor who manages my warfarin (also called Coumadin[®], Jantoven[®]) if I:

- **START** any new prescription drug(s) or over-the-counter product(s), including vitamins and supplements
- **STOP** any prescription drug(s) or over-the-counter product(s)
- **CHANGE** the dose of any prescription drug(s) or over-the-counter product(s) that I already I take or have a major change in the foods I eat (high vitamin K-content foods)
- **EXPERIENCE bothersome bleeding**, such as:
 - Gums that won't stop bleeding
 - Severe bruises or bruises that appear for no reason


 When I call my doctor's office I will say:

1. **My name is** (state your name).
2. **The doctor who prescribed my warfarin is** (state your doctor's name).
3. **I was told to call when any of my medications change or if I have noticed bleeding.**
4. **I am calling to tell you** (describe bleeding or change to medications).
5. **Does the doctor have any new instructions for me?** (Write down and follow any new instructions.)

I will seek immediate medical attention from my doctor, the emergency room, or 911 if I notice:

 **Serious bleeding** I can see, including:

- Vomit that shows blood or looks like coffee grounds
- Stool or bowel movements that show blood or are very dark and tar-like
- Urine that is pink, red, or unusually dark
- Phlegm (mucus) that shows blood

 **Major changes** in how I feel, including those resulting from:

- Severe abdominal pain
- Headaches that are severe or won't go away
- Confusion or decreased alertness
- Dizziness or lightheadedness
- A serious fall or hitting my head

The doctor who manages my warfarin is:

My doctor's phone number is:

(____) ____-_____



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ORGANIZATIONAL CULTURE



Establishing a culture of safety takes commitment from agency leaders. Leaders and quality managers must work proactively to create such a culture to find errors in your processes **before they occur** (see Insights by Linda Sohl).

- Does your staff feel comfortable reporting potential and actual problems?
- Are they encouraged to propose solutions?
- Is your staff involved in risk management processes?
- Do managers

enlist staff concerns and ideas?

Something often heard by quality managers is that ‘our patients are sicker and can’t improve’. Although that may or may not be true, adopting the attitude of “our patients are different (or worse off) than everyone else’s” needs to be addressed with staff. This idea of “terminal uniqueness” is a negative thought process amongst staff which can hinder best practices (<http://www.studergroup.com>).

Changing the organizational “thinking” is most effective when initiated by the agency leadership followed by staff buy-in. The determination of positive or negative team attitude will be based primarily upon the actions of agency leadership.

Additionally, working as a team will help shift attitudes from the ‘not much we can do’ attitude to ‘what can we do to improve this person’s quality of life’. An agency that works as a team has more understanding and more options on how to improve patient outcomes. Use scripts and role playing to stimulate discussion on some of these issues. Susan Snow (Insights) has some great tips on establishing a ‘team’ culture which helps staff realize and accept change.

INSIGHTS

Create a culture of safety:

Focus efforts on looking for potential errors before they occur

Staff must feel comfortable to report problems or errors

Linda Sohl
Director of Compliance and QM
Dominican Sisters Family Health
Service
Ossining, NY



INSIGHTS

Shift attitudes **from** ‘our patient’s can’t get better’ **TO** ‘we can try to improve most patients’.

We make a commitment to work together as a **team**.

Staff must have a voice in agency operations.

Financial and clinical managers must work together as a team.

Our care for our patients extends **beyond what is expected**. Our agency has established a special needs fund and food pantry to service our patients.

Susan Snow, QI Coordinator
GHS Home Health
Greenville, SC

SUCCESS STORIES



There are 2 success stories featured in the [Medication Management Best Practice Intervention Package](#). These agencies both share the fact that their improvement is an ongoing work and success is often measured by small, steady improvements. The stories are accompanied by tools and resources the agencies use, so please check them out!

**Lakeland Hospice and Home Care
Fergus Falls, MN**

Dominican Sisters Family Health Service

INSIGHTS



Medication management is an initiative supported by a number of collaboratives and agencies including CHAMP, OBQI, HHQI, and the Joint Commission (National Patient Safety Goals). Working with these organizations and resources guided our agency to establish processes related to the OASIS-C medication management questions. Whenever possible, agencies should take advantage of these opportunities.

Linda Sohl
Director of Compliance and QM
Dominican Sisters Family Health Service
Ossining, NY

PHYSICIAN ADVISORY GROUP

The HHQI Campaign has an advisory physician group that meets quarterly to review specific best practices. One of the HHQI Campaign goals is to improve care between settings, and the HHQI Physician Advisory Group shares their input on achieving this goal.

What would improve communication between primary care physicians and home health care nurses regarding medication management issues?

Home health agencies nurses could:

- Send the primary care physician an updated medication list ASAP as part of medication reconciliation.
- Provide a **printed medication list** (not handwritten)
- Alert primary care physician if patient is not compliant with the primary care physician's medication regimen **for any reason** (cost, transportation issues, etc)
- Medication(s) changed by another physician/provider from primary care physician's regimen
- Complete medication reconciliation with patient in their home and communicate a current medication list to the primary care physician
- Alert primary care physician for any prescribed medications that patient has a known allergy to or a prior adverse drug event
- Teach patient to carry a Personal Health Record that includes a current medication record
- Teach patient to '**own**' their medication record

Standard for home care: Send a **current medication list** (of all medications!) to the primary care physician's office by next business day for all patients who have transitioned from one care setting to another (i.e. hospital to home, nursing home to home).

Watch for **Enforced Adherence:** This occurs when a patient has **not been compliant** with his/her medication regimen and then suddenly becomes compliant due to a hospitalization and home health visits. This can occasionally lead to higher medication levels, even toxicity. The medication dosage may need to be lowered and the patient instructed on the importance of compliance.

Medication Reconciliation should be a part of every transition between provider settings and at every comprehensive assessment time point.

What does the primary care physician want to know regarding medication discrepancies?

- Concerns that the medication regimen might harm the patient
- Changes in the medication regimen that were not ordered by the primary care physician

- Problems with medications
- Over the counter/non-prescription drugs being used by the patient

How can clinical staff improve communication with physicians?

- Know how the physician prefers communication (e.g. fax, phone, etc)
 - Use SBAR! (See sidebar on page 15 for more guidance on SBAR)



TIP: The following pages are perspectives from a physician and pharmacist on medication management in the home health setting. Consider sharing this with agency professional advisory committee.



INSIGHTS

Medication Management

- Evaluate for duplicate medications
- Evaluate for High Risk Drugs (M2010)
 - Our agency uses a high risk medication education form for medication education.
- Begin interventions by establishing goal if patient will be independent with medications **or** require some type of device (pill box). (M2020)

Penny Winters R.N. Quality Coordinator
 Piedmont Home Care, Lexington, NC (Subsidiary of Medical Services of America)

PHYSICIAN PERSPECTIVE

Medication Management in the Home Health Setting



Assuring patients receive their prescribed medications without interruption is extremely important in preventing initial hospitalizations and subsequent readmissions. When managing patients outside of the physician's office, at home or in another facility, it is often challenging for physicians to maintain a current and accurate medication profile. This is especially true if other prescribers are involved in the patient's care. In addition, it is particularly important to maintain treatment and medication records when patients transition from one source or site of care to another.

When patients are managed at home with the aid of home health nursing and other supportive services the ideal scenario would resemble a small community. The physician involved in the patient's outpatient management would also be involved in their hospital stay. There would be one pharmacy involved in providing outpatient medications and one home health agency delivering care at the home. They would all be familiar with the patient and the available resources from family members or others in the community. The physician, the pharmacist, and the home health nurse would be familiar with each other and communicate on a regular basis regarding the patient's needs.

Health care delivery has been moving away from this ideal scenario. Lack of integration and fragmentation of care contribute to medication management issues. The patient followed by a primary care physician as an outpatient often arrives at the emergency room for care without information regarding their past or present medical history, medication list, allergies, and prior treatments. The emergency room physician is forced to look for outside sources of information and obtain expensive testing to evaluate the patient. For admissions, the patient is referred to a hospitalist physician who is unfamiliar with the patient. This may result in additional repetitive testing and medication errors. Following the admission, home health care may be arranged. The patient's original primary care physician is often contacted to verify the patient's treatment and medication. **The primary care physician is often unfamiliar with the recent treatment the patient has received. Each of these Transitions is an opportunity for errors and waste due to lack of knowledge regarding the patient's care.**

To overcome the potential knowledge deficits of each new provider a collaborative systematic approach must be adopted and followed for each transition of care. Physicians must be particularly attentive to ensure that they have all of the necessary information available regarding the patient's medication. The home health nurse, the pharmacist, and the payer must also share information efficiently. In the present health care environment reconciliation sheets may be used at each transition of care to identify new and old medications (home and hospital medications). As electronic records evolve, the primary care clinic's, the hospital's, or the pharmacy's records may become common reference points for providers to access information. Ultimately, the medication record may evolve to a personal health record available to all providers of care in any setting at any time. However, to achieve this on a wide scale will require systemic and regulatory changes.

Justin Bartos, MD, North Hills Family Medicine, AAFP Commission on Quality and Practice

PHARMACIST PERSPECTIVE

Collaborating to Improve Medication Safety

Assuring safe medication use for our elders receiving services in the home is the overarching purpose of this package of medication management intervention best practices and resources (BPIP). The timing of this BPIP could not be more opportune, given a number of recent changes at the federal level that potentially can impact home and community-based medication management in very constructive ways.



As the BPIP states, changes in OASIS-C offer home health agencies an opportunity to improve oral medication management by aligning assessment with medication interventions; and to implement some of the best practices and tools home health leaders across the country have tested, and found to be effective. The BPIP brings together tools, insights, and a wealth of resources to improve the evaluation and management of meds, and facilitate care coordination and interdisciplinary actions highlighted by OASIS-C.

The federal Healthcare Reform legislation is on all of our minds at this time. The legislation offers opportunities to implement projects that demonstrate the value of evidence-based practice, models of care coordination and transition among care settings, and team-oriented collaboration in patient care. It also has a provision for Medication Therapy Management in Treatment of Chronic Disease (MTM), a component that may increase pharmacy collaboration in the care of patients with complex drug regimens. This is an opportunity welcomed by pharmacists who have been providing various medication management services for decades for home and community care agencies.

During the 25 years that I've been involved in home care medication improvement projects, I've observed many positive changes in medication management and medication safety across the continuum of health care. Usually the best changes seem to occur when agencies are ready for change, and leadership and staff are on the same page about an improvement activity. The Medication Management BPIP offers something for each level, from leaders indirectly involved with patient care, to home health aides who provide the most direct-and personal care- and who often have the best knowledge about what really happens in the home.

A recent personal incident reinforced the importance of efficient medication management when my 83-year mother was hospitalized with an apparent TIA. When the discharge nurse reviewed mother's medication regimen (that included high-risk blood thinners) with us, we discovered that the medication regimen had not been correctly reconciled. This experience brought home how critical a good medication reconciliation process is at a transition in care, and highlighted what an important role patients and family have in managing their medications and advocating for each other. We're all in this together.

There is always room for improvement. My hope is that agencies from hospital to home or residential care will collaborate in implementing at least one of these best practices to improve medication management for our venerable seniors.

Dennee Frey, PharmD
Project Consultant, Medication Management Information System (MMIS)
Partners In Care Foundation

Skilled Nursing Track: Focus on Medication Management

Improving Medication Management is one of the most important roles of a home care nurse. It is a significant component of decreasing avoidable hospitalizations and improving patient safety and care transitions.

SN CHECKLIST:

Do you:

- Complete **medication reconciliation** including assessment for over-the-counter medications / herbs / nutritional supplements/topical medications at SOC/ROC/Discharge and transfer to rehab if SN services complete?
- Send a **current, complete typed medication list** to the primary care physician's office by next business day for all patients who have transitioned from one care setting to another (i.e. hospital to home, nursing home to home)?
- Enlist support of pharmacy and primary care physician during medication reconciliation?
- Look at ALL bottles in home and confirm names?
- Recommend disposal of any expired or discontinued medications?
- Follow up with any medication changes after all physician appointments?
- Use '**Show Me**' to assess medications? (Not just ask the patient to tell you!)
- On assessment, teach staff to focus on the **INTENT** of the OASIS-C question?
- Complete a Drug Regimen Review at every comprehensive assessment time point?
- Teach patient to use reminder strategies (cueing strategies such as using alarm clock, location of medications, written notes)?*
- Use planned and documented phone monitoring as a follow up intervention?*
- Use **scripts** when doing assessment medication. Ask quality or nursing leaders for sample scripts—they are available in the leadership section of this package?
- Use probing questions such as 'What do you take if you can't sleep?'
- Use repetition of patient medication education at future home care visits?*
- Use **Teach-Back** to evaluate patient understanding of medications including precautions on high-risk medications?
- Use medication simplification strategies for patients taking multiple medications?* (Medication Simplification Tool)
- Understand potentially inappropriate medications among older adults?



INSIGHTS

Medication Reconciliation Is:

Clinician looking at every medication bottle the patient takes
 Asking patient 'Is this everything you take?'
 Asking patient about herbal supplements, vitamins and other OTC drugs

Is NOT:

Clinician only looking at the patient's hand written list **OR** hospital discharge summary
 Clinician assuming the patient medication list and/or discharge summary are all the medications the patient takes

Susan Ambrosy, Quality Manager
 Seton Health Home Care
 Troy, NY

- Use strategies to improve patient compliance with medication regimen?
- Use a **patient-centered approach to medication teaching**—teach patients to be their own advocate so they ‘carry’ an accurate list of medication and a list of their allergies?
- Enlist the support of other disciplines to improve medication compliance? (e.g. MSW if financial restrictions, OT/PT if functional deficits, SLP for cognitive deficits)
- Ask patient to explain the purpose of medication?
- Include caregivers in medication management / teaching?
- Promote patient self-management so that the patient/family takes responsibility and accountability in medication management?

*Found to be an evidence-based practice significantly associated with above average oral medication outcome rates (Shearer, 2009).

‘Show Me’ is asking the patient to demonstrate how they take their pills (open bottles, etc). *Patients can’t always do what they tell you they can do.*

‘Teach Back’ is a technique providers ask patients to state in their own words (i.e. teach back) key concepts, decisions, or instructions just discussed. For more information visit

<http://www.healthliteracy.com/>

INSIGHTS

Use a **patient centered approach** to medication teaching—teach patients to be their own advocate so they ‘carry’ an accurate list of medication.

Susan Ambrosy, Quality Manager
Seton Health Home Care, Troy, NY

OASIS-C has brought several changes to medication evaluation and management. OASIS-C includes

- A **complete drug regimen review** for any potential clinically significant medication issues (M2000)
- Documentation of **follow-up with the physician** regarding clinically significant medication issues, including medication reconciliation (M2002 and M2004)
- **High-risk drug education** to the patient/caregiver (M2010)
- **Drug Education to the patient/caregiver** (M2015)
- Assessment of **management of oral medications** (M2020)
- Assessment of **management of injectable medications** (M2030)

INSIGHTS

Medication Reconciliation is NOT just asking the patient what medications they are taking!

It is:

Putting your hands on **every medication bottle** including:

- Eye drops
- OTC pain meds
- Vitamins
- Herbals

Tiffany Alford, Director of Nursing
LHC Group, Infirmery HomeCare of Grove Hill
Grove Hill, AL

Therapy Track: Focus on Medication Management

Improving medication management is a significant component of decreasing avoidable hospitalizations, improving patient safety and care transitions.

THERAPIST CHECKLIST:

Do you:

- Complete **medication reconciliation** at SOC/ROC/Discharge?
- Inform registered nurse of all medication changes after all physician appointments?
- Use **'Show Me'** to assess medications? (Not just ask the patient to tell you!)
- On assessment teach staff to focus on the **INTENT** of the OASIS-C question?
- Look at ALL bottles in home and confirm names?
- Complete a Drug Regimen Review at every comprehensive assessment time point?
- Request consult for skilled nursing for any 'therapy only' patient that has knowledge deficits about medications or expresses confusion about medication schedule?
- Enlist support of MSW if concerns about patient being able to afford medications?
- Use medication simplification strategies for patients taking multiple medications?*
- Understand potentially inappropriate medications among older adults?
- Use strategies and other disciplines to improve medication management?
- Have resources (e.g. drug reference book) for medication evaluation?
- Use a **patient-centered approach to medication teaching**—teach patients to be their own advocate so they 'carry' an accurate list of medication and a list of their allergies?
- Promote patient self-management so that the patient/family takes responsibility and accountability in medication management?

*Found to be an evidence-based practice significantly associated with above average oral medication outcome rates (Shearer, 2009).

'Show Me' is asking the patient to demonstrate how they take their pills (open bottles, etc). *Patients can't always do what they tell you they can do.*



INSIGHTS

Medication Reconciliation Is:

Clinician looking at every medication bottle the patient takes
 Asking patient 'Is this everything you take?'
 Asking patient about herbal supplements, vitamins and other OTC drugs

Is NOT:

Clinician only looking at the patient's hand written list **OR** hospital discharge summary
 Clinician assuming the patient medication list and/or discharge summary are all the medications the patient takes
 Susan Ambrosy, Quality Manager
 Seton Health Home Care
 Troy, NY

OASIS-C has brought several changes to medication evaluation and management. OASIS-C includes

- A **complete drug regimen review** for any potential clinically significant medication issues (M2000)
- Documentation of **follow-up with the physician** regarding clinically significant medication issues, including medication reconciliation (M2002 and M2004)
- **High-risk drug education** to the patient/caregiver (M2010)
- **Drug Education to the patient/caregiver** (M2015)
- Assessment of **management of oral medications** (M2020)
- Assessment of **management of injectable medications** (M2030)

INSIGHTS

The VNA of RI uses an electronic medical record inclusive of a medication/drug interface that empowers all staff to:

- validate drug interactions
- drug-disease contraindications
- duplicate drug therapy
- also individualize drug education

RN and Therapy Assessments should include:

- Sleep/Awake cycle
- Pain management
- Bowel/Bladder function
- Vital signs, including 3 Positional BP

This will assist in assessment in compliance and effectiveness of meds.

Also assessment of ability to open “Bubble Packs”, child proof bottles, med packs correctly.

Look at prior day’s med pack for compliance and cognition.

Assess vision to determine if can see or recognize correct medication.

Look at **all** meds (OTC, prescription, herbals, topical) in home to check if expired meds or d/c meds that should be encouraged to be properly disposed. Involve CG in compliance and management of meds.

Colleen Rose PT, COS-C
Quality Manager, VNA of RI

INSIGHTS



- Medication management is an Activity of Daily Living (ADL) (AOTA, 2008). For patients who want to stay in their homes, it may be the most important ADL!
- Assess routines! Even patients with memory problems can take medications on schedule if meds are part of an established routine. Work with the nurse to incorporate any new medications into existing routines (morning ADLs, mealtimes, watching soap operas, etc.
- Implement compensatory strategies for impairments that can affect medication management.
 - *Low vision*: large print, and/or tactile cues for medication containers, illumination and high contrast in med dispensing area.
 - *Limited grasp/dexterity*: easy open pill containers or mediplanners.
 - *Memory deficits*: pill alerts, timed dispensing aids, shift medication times to coincide with habitual activities.
- Address problems that can lead to medication non-adherence. If patient takes
 - Diuretic: work on timed voiding and easy to don/doff clothing to avoid incontinence.
 - Meds affecting balance: work on strategies to reduce rushing and rapid position changes during activity.
 - Meds affecting alertness: incorporate precautions for high risk activities (use of microwave instead of stovetop, etc.)

Carol Siebert, MS, OTR/L, FAOTA
Principal, The Home Remedy
Chapel Hill, NC

Karen Vance, OTR
Supervising Consultant
BKD, LLP

Medical Social Worker Track: Focus on Medication Management

Patient's and/or caregiver's ability to manage medications is a crucial component to helping the patient self-manage. Medication management issues are frequently compounded by lack of financial resources to pay for medications and/or need for increased caregiver support. A recent study of community dwelling older people receiving home care, suggests that **64% made medication errors** (DeBartolomeo, et.al.). Medication mismanagement can lead to additional problems, including hospitalizations. Medical social workers can help promote patient medication safety by enlisting caregiver and community support to help the patient safely manage all aspects of their care in their home, including medications.

MEDICAL SOCIAL WORKER

CHECKLIST:

Do you:

- Participate in case conferences when patient nonadherence medication issues are discussed?
- Receive referrals to assist patient with financial support for medications?
- Assist clinicians in determining underlying non-adherence issues (financial, other)?
- Receive referrals to evaluate patients for signs/symptoms depression and/or high risk behaviors?
- Share information on local community resources with clinicians?
- Encourage the patient/caregiver in health care goal setting?
- Receive referrals to assist patient with caregiver support to improve ability to manage medications?
- Provide education to other disciplines on what social workers can do to help patients maintain independence in home?
- Know the home care agency's medication reconciliation process?
- Receive referrals for emotional issues related to medication non-adherence (fear of addiction, drug diversion or overmedicating or health beliefs and expectations)?



INSIGHTS

Use a **patient-centered approach** to medication teaching—teach patients to be their own advocate so they ‘carry’ an accurate list of medication.

Susan Ambrosy, Quality Manager
Seton Health Home Care
Troy, NY



Polypharmacy: the use of multiple medications to treat a host of medical conditions, contributes to medication adverse events (Arcangelo).

Potential Inappropriate Medications In Older Adults (PIMs) (New Jersey Drug Safety Initiative): PIMs are medications that should generally be avoided in the elderly because the risks associated with their use may outweigh the benefits. Older adults are generally more sensitive to drugs with central nervous system (CNS) and/or anticholinergic side effects. Side effects may develop in those who have previously tolerated therapy.

Home Health Aide Track: Focus on Medication Management

The Home Health Aide can help nurses evaluate medication compliance for their patients. Be alert for anything a patient or caregiver may say to you that sounds inconsistent with what is on the medication list. For example, if the patient takes pills at times inconsistent with the medication list, this should be reported to the nurse or therapist. Let the nurse know if you find pills in the bed sheets, under the bed, etc. when helping the patient bathe or dress. Often the home health aides are privileged to conversations that other disciplines are not. During a conversation with you, the

patient/caregiver may feel more comfortable sharing medication information such as concerns about taking pills due to potential side effects. It is important to **not assume that the nurse or therapist are aware of these issues**. As a member of the home health interdisciplinary team, your role in reporting issues about medications is vital.

HOME HEALTH AIDE CHECKLIST:

Do you:

- Participate in case conferences when patient nonadherence medication issues are discussed?
- Report possible medication side-effects? Use the STOP and WATCH (Interact) from the January 2010—could be symptoms of a medication adverse event.(Ask your nurse manager/QI nurse for a copy)
- Know where the patient medication list is kept in the home?
- Share concerns about medication noncompliance with nurses or supervisors?
- Ask patient if they have all their medications and is there anything you need to tell the nurse about the medications?
- Report other factors that you may have noticed when caring for the patient that could impact the ability to safely take medications?
 - Problems with vision (needs new glasses, blurry vision)
 - Problems with physical ability (weakness in hands, lacking coordination)
 - Report to RN or supervisor any pills found that are dropped by patients
 - Difficulty swallowing (chewing, coughing or “spitting up” after taking medications)
 - Confusion
 - Financial problems (either stated or evident by not enough food or other necessities)
 - Patient stating the medication makes them sick
 - Patient/caregiver stating fear that the medication may cause addiction
 - If pill boxes are in use, scan for any unopened slots and update the patient’s nurse



INSIGHTS

- Need **interdisciplinary team** to focus improvement efforts
- Teach each discipline to understand **their responsibility** with medications

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Definitions

Adverse Drug Events (ADE): An adverse event involving medication use. [AHRQ](#)

High-alert/High-hazard/High-risk Medications: Medications that have the highest risk of causing injury when misused are known as high-alert medications. [The Joint Commission](#)

Medication adherence: The extent to which individuals take their medications as prescribed by their doctor is known as medication adherence. Failure to take medications as prescribed is termed nonadherence. Medication nonadherence, either willful or inadvertent, can include:

- Failing to initially fill or refill a prescription
- Discontinuing a medication before the course of therapy is complete
- Taking more or less of a medication than prescribed
- Taking a dose at the wrong time. [Adult Medication](#)

Medication reconciliation: Medication reconciliation is the process of creating the most accurate list possible of all medications a patient is taking — including drug name, dosage, frequency, and route — and comparing that list against the physician's admission, transfer, and/or discharge orders, with the goal of providing correct medications to the patient at all transition points within the hospital. [IHI](#)

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