Medication Reconciliation, Care Transitions and Patient Engagement

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We have no conflict of interest to declare.

We do not have any relevant financial relationships with any commercial interests.

OBJECTIVES

- ✓ Define the current problems/trends with medication reconciliation across settings of care.
- ✓ Discuss what the East Lansing Collaborative for Care Transitions has done to address Med Rec for persons in the community.
- ✓ Identify how the PAM tool helps clinicians, coaches and other healthcare professionals improve Patient Engagement to improve medication adherence and chronic disease management.

Medication Reconciliation Defined

* 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 admission, transfer, and/or discharge orders.

Medication Reconciliation

* Is a key process to improve patient care
* Is a patient-centered process focusing on patient safety
* Requires an interdisciplinary, collaborative approach
* Must be based on a culture of accountability
* Should be standardized
* Requires coordinated communication
* Requires use of HIT solutions
* Requires continuous quality improvement

* Improving Care Transitions: Optimizing Medication Reconciliation; APhA and ASHP whitepaper, March 08, 2012

What's the Problem?

* Medication management is one of the most significant factors contributing to unnecessary hospital readmissions.
* The majority of medication errors occur during times of transitions; approximately half of hospital related medication errors and 20 percent of adverse drug events are due to poor communication at transitions
* 19% to 23% of adults experience an adverse event after hospital discharge most often related to medications

Problems Continued

* Approximately 30% of hospital admissions of older adults are drug related, with more than 11% attributed to medication nonadherence and 10–17% related to adverse drug events
* Persons with chronic disease, especially depression, have a higher incidence of nonadherence to their medication regimen
* The health care system has no protocol for documenting medications consistently across care settings.

Capitol Area Collaborative

* The goals of the medication Subcommittee:
  * Raise awareness of medication problems that arise at transitions of care
  * To support patient safety at all transitions
  * Encourage healthcare providers to develop improved medication reconciliation processes
  * Improve the patient's ability to self manage medication therapy independently or with family

The Sparrow/Burcham Project

* Both organizations are members of the Community Collaborative **"Capital Area Collaborative for Care Transitions"**
* Burcham participates on the Sparrow Hospital sponsored "Skilled Nursing Facility Readmissions" group
* Richard and Barbara identified a common interest and began work to design a pilot to address medication reconciliation at transition

Motivating Factors for Burcham Hills

* Time spent by admissions nurse to reconcile medications
  - 3 different documents sent from hospital with conflicting medication lists
  - Limited access to a contact at hospital to verify medication orders
* Client dissatisfaction with medication availability at admission to Burcham
* Missing C-II scripts resulting in inability to provide timely pain medication administration

Motivating Factors for Sparrow

* Improve discharge medication reconciliation process
* Provide 48-hour medication "bridge" to allow for smoother transition of patients from hospital to skilled nursing facility
* Reduce 30-day readmissions

Our Planning Process

* Agreement that there was improvement opportunity
* Agreement that patient outcomes were each setting's responsibility during transition
* Identified a "One Source of Truth" both settings would acknowledge
* Agreed upon process and outcome measures

Outcomes for Intervention Group

* Admission nurses are very pleased:
  * Admission process has been decreased 30-60 minutes per client for Sparrow patients
  * Med Techs are available to answer questions as needed
* Patient satisfaction with continuity of medication administration is excellent
* Ability to manage pain is significantly improved

Outcomes for Nonintervention Group

* Survey interview of clients admitted from hospitals other than Sparrow in May, 2013
  * 50 % of the persons admitted from a hospital other than Sparrow with a pain related diagnosis experienced delays in receiving scheduled medications.
  * 50% had difficulty in continuity of pain medication orders, experiencing breakthrough pain.
  * Staff time required to reconcile and obtain medications averaged .75 hours per admission

Care Transitions Program Overview

* Care Transitions programs provide services to help people transfer from one level of care to another
* Tri-County Office on Aging's Care Transition Program currently focuses on the transition from the acute care hospital to the community using the Bridge Care model which is an evidence-based social work model centered on the psycho social determinants of health care
* The program's duration is 30 days with the primary care location being the clients home

Care Transitions Program Interventions

- Complete bio-psycho-social assessment
- Crisis management
- Linkage to various community based organizations
- Assessment of health literacy and health education reinforcement
- Advanced Care Planning discussions
- Medication assistance/education
- Communication with the physician regarding post hospitalization appointments
- Planning for long term for needs

Why is Medication Management Important- Definitions

* "A medication error is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, procedures, and systems, including prescribing, order communication, product labeling, packaging, and nomenclature, compounding, dispensing, distribution, administration, education, monitoring, and use"
* *NCCMERP- National Coordinating Council for Medication Error Reporting and Prevention*
* An adverse drug event (ADE) is defined as harm experienced by a patient as a result of exposure to a medication
* *US Dept. of Health and Human Services Agency for Healthcare Research and Quality March 20*

Why is Medication Management Important- Statistics

* ***US Dept. of Health and Human Services Agency for Healthcare Research and Quality March 2015***
- There are over 10,0000 prescription medications available to clinicians
- Almost one-third of adults in the United States take 5 or more medications
- ADEs account for nearly 700,000 emergency department visits and 100,000 hospitalizations each year
- ADEs affect nearly 5% of hospitalized patients, making them one of the most common types of inpatient errors
- Ambulatory patients may experience ADEs at even higher rates
- Transitions in care are also a well-documented source of preventable harm related to medications

Why is Medication Management Important- Statistics

Institute of Medicine Report Brief 2006

- About 530,000 medication-related injuries occur annually among Medicare recipients at outpatient clinics
- ***FitzGerald, R. J. (2009). Medication errors: the importance of an accurate drug history. British Journal of Clinical Pharmacology, 67(6), 671–675. http://doi.org/10.1111/j.1365-2125.2009.03424***
- Patients can reduce the chance of errors when they maintain a medication list and take it to all medical encounters

What We Know

* A medication error is not an adverse event until it causes harm to the patient
* Medication errors are common and often occur when patients move between healthcare settings
* Medication errors can be decreased when a client has and uses a list
* Reconciliation time can be reduced at all settings when the patient has an updated list

What We Wanted to Find Out

* Could the Care Transitions Social Workers (CTSWs) (formerly Bridge Care Coordinators) use education and empowerment interventions to increase the utilization of a medication list
* Using questions modeled after Dr. Eric Coleman's Patient Activation Assessment, CTSWs scored each client at the start and end of care (30 day program) on a 4 point scale
* During the 30 day Care Transitions intervention, personalized education was provided based on the clients individual needs

Measurement Tool

- Demonstrates effective use of some type of medication system (medication organizer, flow chart, etc)
- Understands the purpose, when and how to take, and possible side effects of each medication
- Able to accurately update medication list
- Agrees to take and discuss medication list with PCP and/or Specialist

Keeping an Accurate Medication List

* Should include all medicines (even over the counter and herbal remedies)
* Helps providers avoid drug interactions, thus keeping you from being admitted unnecessarily
* Could assist in lowering cost of medications (sometimes medicines serve dual purposes)
* An accurate medication list can be shared with all providers at all appointments to ensure it is updated appropriately and to ensure the providers knows what you are taking
* Can assist in emergency treatment to be able to give them an up to date accurate list of medications you are taking, and in some cases can speed up treatment

Why it's Your Responsibility to Keep an Accurate and Up to Date Medication List

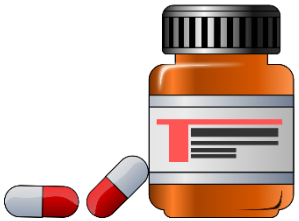
* You are the only person at all appointments
* You are the one that communicates information across providers
* There is no "magic" list in the computer at your provider's office or the hospital
* Your list should be taken to all appointments with all providers and to the pharmacy when you have your prescriptions filled

How Your Healthcare Team Can Help You

* Understand your medications (how to take them, when to take them, why you are taking them, etc) – ask these questions
* Assist in lowering your cost by reviewing your current medications to see if there might be other options – ask
* Assist you in achieving your lifestyle goals (quality of life, side effects, etc)

How to Keep Your List Updated

* Add medications as soon as you obtain a new one
* Remove medications as soon as your doctor tells you to stop
* Always use four key elements on your list: name, dose, frequency, what it is for



Why You Need to Know What Your Medications are For, How to Take Them, and What Potential Side Effects Are

* To be able to identify and inform your provider when you are experiencing a potential side effect
* To ensure that you are taking the medication at the right time
* To ensure that you are taking the medication correctly (certain foods, or special instructions)
* Do not stop taking a medicine without consulting your provider first to avoid an adverse event

Signs That You May Need to Get Help to Keep Your List Accurate

* You forget to take your list with you
* Your list is not up to date
* You are forgetting to take your medications
* You are confused about your medications
* You are having difficulty getting your prescriptions filled
* If you are feeling overwhelmed

Results

* Total number of surveys- 1,008
* Number of surveys w/all positive responses- 716
* Unable to collect completed data- 157 (died or unable to complete closure)
* Remaining surveys- 135
* 1 score decreased
* 39 score stayed the same
* 95 score improved
* 70% increase in appropriate utilization of a medication list

PAM Tool

* **Takes Individuals from Disengaged to Activated**
* PAM is the gold-standard for measuring health activation.
  * With over 200 peer-reviewed published studies validating its design and results
* **A Single Point Change in PAM Score is Valuable**
  * Each point increase in PAM score correlates to a 2% decrease in hospitalization and 2% increase in medication adherence.