Fitting the Counseling Piece into Medication Reconciliation

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Conflict of Interest Statement

- Carrie Vogler has no conflicts of interest to disclose.
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Objectives

- Explore the importance of medication reconciliation in the health care system
- Evaluate different medication reconciliation models or programs
- Identify the barriers involved in successful patient counseling
- Describe and demonstrate different interview techniques used to improve patient counseling

How would you describe your facility?

A. Community or Outpatient Pharmacy
B. Hospital with <150 beds
C. Hospital with 150-500 beds
D. Hospital with >500 beds
E. Other practice site

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Which of the statements best describes when you perform patient counseling?

A. I counsel all patients who have medication changes
B. I only counsel patients when consulted by a physician or nurse
C. I counsel patients only on specific high risk medications such as warfarin
D. I rarely counsel patients due to the pharmacy's location (e.g., basement), time, resources, or other reasons

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How familiar are you with the BOOST and MATCH programs?

A. I use either the BOOST or MATCH process at my institution
B. I am familiar with the programs but my institution does not use them
C. I have heard of the programs but I do not know what they are
D. I have never heard of these programs

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Why Focus on Medication Reconciliation? Statistics on U.S. Prescription Drugs

- Per 2005-2008 data, the question *"In the past month, percent of persons using at least X prescription drug (s)"* revealed:
  - One prescription drug: 47.9%
  - Three or more prescription drugs: 21.4%
  - Five or more prescription drugs: 10.5%
- Per 2008 data, the table below provides statistics stratified by type of medical visit:

Types of Medical Visits	Number of Drugs Ordered or Provided	Percent of Visits Involving Drug Therapy
Physician Office Visits	2.3 billion	74%
Hospital Outpatient Department Visits	280.1 million	76%
Hospital Emergency Department Visits	238.3 million	78%

Source: Centers for Disease Control and Prevention. FastStats. Available at http://www.cdc.gov/nchs/fastats/drugs.htm. Accessed 7/19/2012.

The Joint Commission

Medication reconciliation consists of 5 steps:

1. Develop a list of current medications
2. Develop a list of medications to be prescribed
3. Compare the medications on the two lists
4. Make clinical decisions based on the comparison
5. Communicate the new list to appropriate caregivers and to the patient

Source: The Joint Commission. Hospital: 2012 National Patient Safety Goals. Available at: http://www.jointcommission.org/standards_information/npsgs.aspx. Accessed 8/13/2012

Medication Reconciliation Facts

- Approximately 1.5 million preventable adverse drug events (ADEs) occur annually due to medication errors, at a cost of $3 billion per year.
- ADEs account for 2.5% of estimated emergency department visits for all unintentional injuries and 6.7% of those leading to hospitalization.

Source: Preventing Medication Errors: Quality Chasm Series (2007). Committee on Identifying and Preventing Medication Errors, Philip Aspden, Julie Wolcott, J. Lyle Bootman, Linda R. Cronenwett, Editors.
Budnitz DS, Pollock DA, Weidenbach KN, et al. National surveillance of emergency department visits for outpatient adverse drug events. *JAMA* .2006;296(15):1858-66.

Avoiding Readmissions: Preventable ADEs After Hospital Discharge

- 400 consecutive hospitalized general medicine patients discharged home
  - 19% of patients had an adverse event (AE) within 3 weeks of discharge
  - 66% of AEs were adverse *drug* events (ADE)
  - Most ADEs were preventable or ameliorable
- System modifications recommended by authors:
  - Evaluate patients at discharge to identify unresolved problems
  - Educate patients about drug therapies, side effects, and what to do if new or worsening signs/symptoms
  - Improve monitoring of therapies and patients' overall condition

Source: Forster et al. The Incidence and Severity of Adverse Events Affecting Patients after Discharge from the Hospital. *Ann Intern Med.* 2003;138:161-167.

Pharmacist Impact on Medication Reconciliation

- 36% of patients had medication errors at admission, of which 85% originated from the patient's medication history
- Pharmacist shown to reduce physician visits, ED visits, decrease hospital days, and overall health care costs
- Med rec reduced discharge medication errors from 90% to 47% on a surgical unit and from 57% to 33% on a medical unit of a large academic medical center

Source: Gleason KM et al. Results of the MATCH study: an analysis of medication reconciliation errors and risk factors at hospital admission. *J Gen Intern Med.* 2010 May;25(5):441-7.
Improving Care Transitions: Optimizing Medication Reconciliation. American Pharmacist Association and American Society of Health-System Pharmacists. March 2012. Accessed 8/12/12/ at: http://www.ashp.org/DocLibrary/Policy/PatientSafety/Optimizing-Med-Reconciliation.aspx

Barriers to Medication Reconciliation and Patient Counseling

- Time
- Incomplete, non-standardized medication lists
- Insufficient communication among health care professionals
- Lack of established best practices
- Health Literacy, cognitive status or non-English speaking patients

Source: Improving Care Transitions: Optimizing Medication Reconciliation. American Pharmacist Association and American Society of Health-System Pharmacists. March 2012. Accessed 8/12/12/ at: http://www.ashp.org/DocLibrary/Policy/PatientSafety/Optimizing-Med-Reconciliation.aspx

Current Evidence: Implementing Bundled Interventions

Pre-Discharge Intervention	Bridging Interventions	Post-Discharge Intervention
• Patient education • Med Rec • Discharge planning • Scheduling follow-up appointment	• Transition coaches • Continuity across settings • Patient-centered discharge instruction	• Follow-up telephone calls • Patient-activated hotlines • Timely communication with next clinician of service • Timely follow-up with ambulatory clinician

Note: Individual components of these change packages have not been tested by themselves and might not reduce the risk for 30-day rehospitalization.

Source: Hansen et al. Interventions to Reduce 30-Day Rehospitalization: A Systematic Review. *Ann Intern Med.* 18 October 2011;155(8):520-528.

Counseling opportunities for pharmacists

Opportunities to Educate and Communicate

Med History, Reconcile → Order, Transcribe, Clarify → Procure, Dispense Deliver → Administer → Monitor → Educate, Discharge

- Use Medication Reconciliation as an opportunity to educate patients throughout their hospital stay
- Empower patients to ask questions
- Trace patients through hospitalization to identify opportunities for interaction

ED → Admission → Intra-hospital Transfer → Discharge → Post-Discharge

Does Med Rec Impact the Patient Experience?

Hospital Consumer Assessment of Healthcare Providers and Systems (HCAHPS) Domains:

- Communication with Nurses
- Communication with Doctors
- Responsiveness of Hospital Staff
- ***Pain management****
- ***Communication about medicines****
- ***Discharge information****
- Cleanliness of hospital environment
- Quietness of hospital environment
- Overall rating of hospital
- Willingness to recommend hospital

**Impacted by Medication Reconciliation and Patient Education*

Source: HCAHPS Fact Sheet. Available at: http://www.hcahpsonline.org/facts.aspx. Accessed 7/19/2012

New CMS HCAHPS Care Transitions Questions (Effective January 1, 2013)

- During this hospital stay, staff took my preferences and those of my family or caregiver into account in deciding what my health care needs would be when I left.
- When I left the hospital, I had a good understanding of the things I was responsible for in managing my health.
- ***When I left the hospital, I clearly understood the purpose for taking each of my medications.***

Source: Centers for Medicare & Medicaid Services. Hospital Inpatient Prospective Payment Systems for Fiscal Year 2013 Rates. 42 CFR Parts 412, 413, 424, and 476 [CMS-1588-F]. Available at: http://www.ofr.gov/OFRUpload/OFRData/2012-19079_PI.pdf. Accessed 8/13/2012

MATCH Toolkit: A Step-by-Step Guide to Improving the Medication Reconciliation Process

MATCH Toolkit, with customizable, actionable information, is available at: http://www.ahrq.gov/qual/match/match.pdf

MATCH Toolkit: Excerpts on Medication History Taking and Patient Counseling

- Asking open-ended and closed-ended questions
- Inquiring about the types of physicians that prescribe their medications
- Asking patients if their doctor recently started them on any new medicines, stopped medications they were taking, or made any changes to their medications
- Asking patients to describe their medication by color, size, shape, etc., may help to determine the dosage strength and formulation
- Educating about how and when to take their medications
- Educating about the purpose of each medication

Better **O**utcomes for **O**lder adults through **S**afe **T**ransitions

- Guide and tool-kit that promotes safe and high quality hospital discharge as they transition through the hospital setting

Project BOOST Team. The Society of Hospital Medicine Care Transitions Implementation Guide: Project BOOST: **B**etter **O**utcomes for **O**lder adults through **S**afe **T**ransitions. Society of Hospital Medicine website, Care Transitions Quality Improvement Resource Room http://www.hospitalmedicine.org accessed 8/13/12.

Better **O**utcomes for **O**lder adults through **S**afe **T**ransitions

- Goals
  - Reduce 30 day readmissions
  - Improve patient satisfaction scores
  - Improve flow of information
  - Identify high risk patients and develop interventions
  - Improve discharge preparation

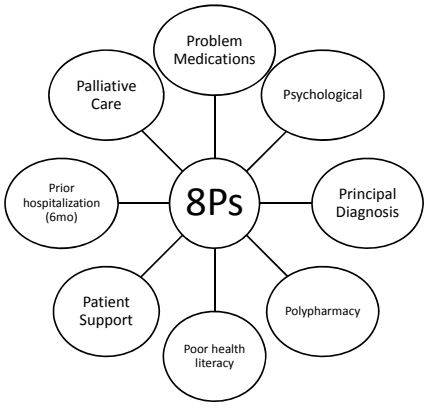
Better **O**utcomes for **O**lder adults through **S**afe **T**ransitions

Interventions include:

- Using teach back process during discharge education
- Identifying readmission risk factors
- Scheduling follow up visit or 72 hour phone call for high risk patients

BOOST Resources

- Risk Assessment Tool: The 8Ps
- Plan Risk Specific Interventions



Risk Specific Interventions

- General Assessment of Preparedness (GAP)
- Medications reconciled with preadmission list
- Medications use and side effects reviewed using teach back with patients/caregivers
- Teach Back used to confirm:
  - patient/caregiver understanding of diagnosis prognosis
  - self-care requirements
  - symptoms of complications requiring medical attention

Teach Back Process

- Step 1 Explain information
- Step 2 Patient repeats back in own words
- Step 3 Identify and correct misunderstandings or incorrect procedures
- Step 4 Ask patient to demonstrate their understanding or procedural ability again to insure misunderstanding is corrected
- Step 5 Repeat Steps 4 and 5 until clinician is convinced the pt comprehends the concept or ability

Source: Schillinger D, Grumbach K, et al. Closing the Loop: Physician Communication With Diabetic Patients Who Have Low Health Literacy. *Arch Intern Med*. 2003;163(1):83-90.

Medication Reconciliation/ Patient Counseling Activity

Thank You

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Medication Reconciliation Discharge Paperwork
Patient Discharge Medication List/Prescription Form

LR 54 year old male

I was in the hospital because: fluid overload, pneumonia
The medical name for this condition is: acute heart failure
I have these medical conditions: coronary artery disease, atrial fibrillation, diabetes, heart failure, high cholesterol, high blood pressure.

Prescription Given?	Medication name (use both names)	How and how much?	How often?	What is it for?	Next time I take?	Medications that have changed
No	Cordarone (amiodarone) 200mg	1 tablet by mouth	once daily	heart rhythm	9/14/2012	
No	Aspirin 81mg	1 tablet by mouth	once daily	heart	9/14/2012	
No	Folic acid 1mg	1 tablet by mouth	once daily	supplement	9/14/2012	
No	Glucotrol (glipizide) 2.5mg	1 tablet by mouth	once daily	diabetes	9/14/2012	
Yes	Cozaar (losartan) 25mg	1 tablet by mouth	once daily	blood pressure	9/14/2012	Dose increased from 12.5 mg to 25mg once daily.
Yes	Levaquin (levofloxacin) 750mg	1 tablet by mouth	once daily	pneumonia	9/14/2012	Added. Take for 3 days to complete treatment.
No	Toprol XL (metoprolol succinate) 25mg	1/2 tablet by mouth	once daily	heart, blood pressure	9/14/2012	
No	Protonix (pantoprazole) 20mg	1 tablet by mouth	once daily	reflux	9/14/2012	
No	Kdur (potassium chloride)	1 tablet by mouth	twice daily	supplement	9/13/12 evening	
No	Zocor (simvastatin) 40mg	1 tablet by mouth	once daily at bedtime	cholesterol	9/13/2012	
No	Aldactone (spironolactone) 25mg	1 tablet by mouth	once daily	water pill	9/14/2012	
Yes	Demadex (torsemide) 20mg	4 tablets by mouth	once daily	water pill	9/14/2012	Dose increased 40mg to 80mg.
Yes	Coumadin (warfarin) 1mg	3 tablets by mouth	once daily in pm	blood thinner	9/13/2012	Dose decreased. Stop warfarin 5mg
If you have problems or questions about your health after leaving the hospital, please call the nursing unit.			MD Signature _____		RN Signature_____	
			Pharmacist Signature_____		Date_____	

Questions for Consideration and Discussion during this Exercise

Using the patient's Discharge Paperwork provided:

1. How would you approach education and counseling for this patient taking into account your clinical practice site? 2.
2. Is the patient's medical history helpful when preparing to counsel patients? Why or why not? Do you receive the information you need in order to prepare for counseling sessions with your patients based on your practice site? Why or why not?
3. What do you perceive are the barriers to effective counseling and education?
4. What are the salient points that need to be conveyed to this patient during a counseling session? Why did you select those elements to counsel the patient on?
5. The patient was admitted to the hospital for fluid overload and pneumonia. The patient was treated for acute heart failure. Please describe the educational elements that should be conveyed to a patient with heart failure during the counseling session, taking into account the heart failure process of care (e.g., core measures) (see below).
6. How would you assess the patient's understanding of the information you provided during the patient counseling session?

Heart Failure National Hospital Inpatient Quality Measures [Process of Care ("Core") Measures]

HF-1: Discharge Instructions:
Heart failure patients with documentation that they or their caregivers were given written discharge instructions or other educational material addressing *all* of the following:
1. activity level
2. diet
3. discharge medications (list of discharge medication names in the patient's discharge summary and discharge instructions must match)
4. follow-up appointment
5. weight monitoring
6. what to do if symptoms worsen

HF-2: Evaluation of LVS Function:
Heart failure patients with documentation in the hospital record that LVS function was evaluated before arrival, during hospitalization, or is planned for after discharge.

HF-3: ACEI or ARB for LVSD:
Heart failure patients with left ventricular systolic dysfunction (LVSD) who are prescribed an ACEI or ARB at hospital discharge. For purposes of this measure, LVSD is defined as chart documentation of a left ventricular ejection fraction (LVEF) less than 40% or a narrative description of left ventricular systolic (LVS) function consistent with moderate or severe systolic dysfunction.

Source: http://www.qualitynet