Instructions and Handouts for:
Interdisciplinary Medication Management

Eastern Standard Time
12:00 PM to 1:30 PM

Central Standard Time
11:00 AM to 12:30 PM

Mountain Standard Time
10:00 AM to 11:30 AM

Pacific Standard Time
9:00 AM to 10:30 AM

It is very important that you have these materials printed and ready to use prior to the start of the training.

In order to participate in this training you will need to do the following:
Dial 1 (877) 615-4339 at least 10 minutes prior to the start of the webinar.

1. When asked, enter Passcode 9101956#

2. Give your agency’s name.

3. At this time you will be entered into the call and in “listen mode.”

4. If at any time you need assistance you may press *0 for the operator.

5. There will be a Q & A period toward the end of the session. Questions will be answered in the order in which they are received. To ask a question, press *1. You will have the opportunity to ask your question and then be returned to “listen mode.” Do not press *1 prior to this time.

6. To view the presentation online you must click on the link sent to you from GoToWebinar.
Interdisciplinary Medication Management

April 19, 2012

Cindy Krafft PT, MS
Director of Rehabilitation Consulting Services

Objectives

• Define the expectations of drug regimen review.
• Explore the issues surrounding medication management in the home setting.
• Discuss the challenges and opportunities surrounding interdisciplinary management of medications.
• Examine scope of practice issues for therapists and medications.

What did Cindy learn?
Patient Safety

- Not just the responsibility of the admitting service
- Involves the entire care team:
  - Nursing
  - Therapy
  - Home Health Aide
  - Medical Social Worker

Drug Regimen Review COP

G337 – 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 Comments

"Medication management and education: Physical therapists are more than capable of completing the drug regimen review item. It is within the scope of the physical therapist to perform a patient screen in which medication issues are assessed even if the physical therapist does not perform the specific care needed to address the medication issue."
APTA Position

APTA has a position statement adopted by its House of Delegates which states:

“Physical therapist patient/client management integrates an understanding of a patient’s/client’s prescription and nonprescription medication regimen with consideration of its impact upon health, impairments, functional limitations, and disabilities. The administration and storage of medications used for physical therapy interventions is also a component of patient/client management and thus within the scope of physical therapist practice.”

“I will NOT risk my license”

- Record Medication(s).
  - Prescription
  - Over the counter
- Assess patient.
  - Side effects
  - Ineffective therapy
  - Compliance
- Relationships
  - Duplicates
  - Interactions

Who is Responsible?

- The discipline completing the comprehensive assessment bears the initial responsibility for DRR.
- Each and every visit should include a degree of medication management within the scope of the discipline.
  - Orders?
  - Education?
  - Communication to the MD? To the team?
Components of the DRR

- Recording the medications
- Assessing the patient
- Interpreting relationships of medications

Recording the Medications

- Everything we find in the home on admission:
  - Oral, inhaled, and injectable
  - Prescriptions filled
  - Prescriptions yet to be filled
  - Over the counter
  - Herbals, vitamins, supplements.....

- Accurately record the start date, name, dose, frequency, route and if new or changed.

Assessing the Patient

- Looking for:
  - Ineffective drug therapy
  - Significant side effects
  - Noncompliance with drug therapy

- Required as part of the comprehensive assessment but is NOT where it stops
Areas to Assess

- Patient / Caregiver knowledge
- Impact of medication on physical conditions
  - Vital signs
  - Pain scale
  - Depression / anxiety
- Side effects / undesirable results
  - Consultation with physician
- Compliance with regimen

Medication Relationships

- Watching for:
  - Duplications
  - Interactions
- Assistance can be provided by an office based clinician and/or computer program.

Policies and Procedures

- Admission completed by nursing?
- Admission completed by therapy?
- Admission completed by nursing AND the case becomes therapy “only”?
M2002 Medication Follow-up SOC/ROC

(M2040) Medication Follow-up: Was a physician or the physician designee contacted within one calendar day to receive clinically significant medication issues, including reconstitution?

- 0 - No
- 1 - Yes

Best Practice conducted within assessment time frame.

Select YES if agency contacts and physician responds to the communication with acknowledgment of receipt of information and/or further advice or instructions by the end of the next calendar day and within assessment timeframe.

Alert! Agency staff may collaborate. Must communicate actions to the assessor. May change M0090 assessment completed date.

M2004 Medication Intervention TIF/DC

(M2014) Medication Intervention: If there were any clinically significant medication issues since the previous OASIS assessment, was a physician or the physician designee contacted within one calendar day of the assessment to receive clinically significant medication issues, including reconstitution?

- 0 - No
- 1 - Yes
- NA - No clinically significant medication issues identified since the previous OASIS assessment

Captures use of Best Practice during the quality episode (previous episode >TIF or DC).

"YES"—Communication with physician by any appropriate means AND by the end of the next calendar day AND acknowledgement by physician that information was received or further instructions given.

Roles and Responsibilities

• "Clinically significant" Setting a standard for the agency

• Communication between clinicians throughout the episode
  Don't assume this will just happen...

• Communication to physician / designee
  Defining a process

• Documentation of activities
  Key component that cannot be overlooked
M2010 High Risk Drug Education SOC/ROC

(M2010) Patient/Carer/High Risk Drug Education: Has the patient/carer received instruction on special precautions for all high-risk medications (e.g. anticoagulants, insulin, etc.) and how and when to report problems that may occur?

☐ 0 = No
☐ 1 = Yes
☐ NA = Patient not taking any high-risk drugs, or patient/carer fully knowledgeable about special precautions associated with all high-risk medications.

High risk medications: Increased risk of causing significant harm when used in error (e.g. anticoagulants, insulin, etc.)

Best Practice occurs during assessment time frames (SOC 5 days, ROC 2 days).

Instructions include:
- Precautions for taking
- How to monitor for side effects and adverse effects
- When, who, and how to contact health care provider

Alert! Agency staff may collaborate. Must communicate actions to the assessor. May change M2000 assessment completion date.

Managing Education

- Defining “High Risk” and keeping all clinicians up to date
- Evaluating educational materials provided to patients
- Assessing competence with reviewing information
- Establishing criteria for collaboration
  - Office based
  - Referrals

M2015 Drug Education Intervention TIF/DC

(M2015) Patient/Case/Drug Education Intervention: Since the previous OASIS assessment, was the patient/carer instructed by agency staff or other health care provider to monitor the effectiveness of drug therapy, drug reactions, and side effects, and how and when to report problems that may occur?

☐ 0 = No
☐ 1 = Yes
☐ NA = Patient not taking any drugs

Captures Best Practice during quality episode for general medication instruction.

Instructions include:
- Precautions for taking
- How to monitor for side effects and adverse effects
- When, who, and how to contact health care provider
M2020 Management of Oral Meds

You determine the patient is able to set up and prepare his medications correctly and reliably with the use of a multi-day pill planner. He reports remembering to take them, but you notice the Coumadin from yesterday is still in the box. He is alert and oriented and there is no evidence of confusion or noncompliance or a physician’s order to hold the medication. Upon questioning he says “I didn’t take it?”

Improvement in Oral Med Management

- Don’t overlook the mobility and cognitive aspects of medication management.
  - Can the patient safely get them from where he or she keeps them?
  - Can he or she open them?
  - Can he or she remember when to take them and what they are for?
M1700 Cognitive Functioning

- Cognitive Functioning: Patient's current day of assessment: level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.
  - 0: Alert/oriented, able to focus and shift attention, consistent and steady task directions
  - 1: Requires prompting (i.e., repetition, reminders) only under stressful or extreme conditions
  - 2: Requires assistance and some direction in specific situations (e.g., on all tasks involving shifting of attention), or consistently requires low-stimulus environment due to distractibility
  - 3: Totally dependent due to disturbances such as severe disorientation, coma, persistent vegetative state, or delirium.

Day of assessment:
Time of assessment and 24 hrs preceding.

M1860 - Ambulation

- Ambulation/Locomotion: Current ability to walk safely, once in a standing position, or use a wheelchair, once in a seated position, or in a wheelchair.
  - 0: Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings
  - 1: Within the use of a one-handed device (e.g., cane, walker, handcrip, hemi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings
  - 2: Requires use of a two-handed device (e.g., walker, rolator) to walk down a level surface
  - 3: Requires assistance in routine situations (e.g., not able to walk alone on a level surface)
  - 4: Unable to maintain upright posture on level surface
  - 5: Unable to transfer from lying to sitting

M2030 Management of Injectable Medications

- Management of Injectable Medications: Patient's current ability to prepare and take all prescribed injectable medications correctly and safely, including administration of correct dosage at the appropriate times/locations except IV medications.
  - 0: Able to independently take the correct medication(s) and proper dosage(s) at the correct times.
  - 1: Able to take injectable medication(s) at the correct times if:
    a. Individual syringes are prepared in advance by another person;
    b. Another person develops a drug diary or chart
  - 2: Able to take medication(s) at the correct times if given reminders by another person based on the frequency of the injection
  - 3: Unable to take injectable medication unless administered by another person
  - 4A: No injectable medications prescribed.

Consider all medications by injection using a needle and syringe ordered to be given SQ or IM in the home during the episode of care, including a flu shot.

- Excludes IV meds, meds via pump or given outside the home.
### M2040 Prior Medication Management

**Rationale:** Prior Medication Management: Indicate the patient’s ability with managing oral and injectable medications prior to this current illness, exacerbation, or injury. Check only one box in each row.

<table>
<thead>
<tr>
<th>Functional Area</th>
<th>Independent</th>
<th>Needed Some Help</th>
<th>Dependent</th>
<th>Not Applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td>a. Oral medications</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>&gt;2</td>
</tr>
<tr>
<td>b. Injectable medications</td>
<td>0</td>
<td>1</td>
<td>2</td>
<td>&gt;2</td>
</tr>
</tbody>
</table>

- Used for risk adjustment.
- 3 levels of **in person** assistance to safely complete tasks:
  - Independent: Required no human assistance.
  - Needed some help: Required some help from another.
  - Dependent: Incapable of performing any task/activity.
- If ability varied from med to med, select the response for the medication that needed the most assistance.

### M2100 Types and Sources of Assistance

**SOC/ROC/DC**

**Rationale:** Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. Check only one box in each row.

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>No assistance needed in this area</th>
<th>Caregiver’s current ability to provide assistance</th>
<th>Caregiver’s need training/supervision to provide assistance</th>
<th>Caregiver(s) not likely to provide assistance</th>
<th>Unlikely of caregiver(s) will provide assistance</th>
<th>Assistance needed, but caregiver(s) available</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. ADL assistance (e.g., toilet, ambulation, bath, dressing, toileting, eating, feeding)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. IADL assistance (e.g., meal, housekeeping, laundry, telephone, shopping, finances)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Medication administration (e.g., pill, intravenous, injection)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Row a – ADLs include basic self-care activities such as the examples listed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Row b – IADLs include activities associated with independent living necessary to support the ADLs such as the examples listed.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Row c – Medication administration refers to any type of medication (prescribed or OTC) and any route of administration including oral, inhalant, injectable, topical, or administration via g-tube/j-tube, etc.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Row d – Medical procedures/treatments include procedures/treatments that the physician or physician designee has ordered for the purpose of improving health status. Some examples of these procedures/treatments include wound care and dressing changes, range of motion exercises, intermittent urinary catheterization, postural drainage, electromodalities, etc.**

**Row e – Management of equipment refers to the ability to safely use medical equipment as ordered. Examples of medical equipment include oxygen, infusion equipment, enteral/parenteral nutrition, ventilator therapy equipment or supplies, continuous passive motion machine, wheelchair, hoist lift, etc.**
M2100 Types and Sources of Assistance

SOC/ROC/DC

(M410) Types and Sources of Assistance: Determine the level of caregiver ability and willingness to provide assistance for the following activities, if assistance is needed. (Check only one box in each row.)

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>No assistance needed, but caregiver(s) available</th>
<th>Caregiver(s) need training or services to provide</th>
<th>Caregiver(s) currently provide assistance</th>
<th>Unable to Caregiver(s) will provide assistance</th>
</tr>
</thead>
</table>

1. Supervision and safety (e.g., due to cognitive impairment)

   NOTE: Supervision and safety includes needs related to the ability of the patient to safely remain in the home. This category of assistance needs includes a wide range of activities that may be necessary due to cognitive, functional, or other health deficits. Such assistance may range from calls to remind the patient to take medications, to in-person visits to ensure that the home environment is safely maintained, to the need for the physical presence of another person in the home to ensure that the patient doesn’t wander, fall, or for other safety reasons (i.e., leaving the stove burner on).

2. Advocacy or facilitation of patient’s participation in appropriate medical care (includes transportation to and from appointments).

M2310 Reasons for Emergent Care

(M310) Reason for Emergent Care: For what reasons did the patient receive emergent care (with or without hospitalization)? (Mark all that apply.)

1. Improper medication administration, medication side effects, toxicity, anaphylaxis
2. Injury caused by fall
3. Respiratory infection (e.g., pneumonia, bronchitis)
4. Other respiratory problem
5. Heart failure (e.g., fluid overload)
6. Cardiac arrhythmia (irregular heartbeat)
7. Myocardial infarction or chest pain
8. Other heart disease
9. Stroke (CVA) or TIA
10. Hypoglycemia, diabetes out of control
11. GI bleeding, obstruction, constipation, impaction
12. Dehydration, malnutrition
13. Urinary tract infection
14. N我和related infection or complication
15. Renal failure or dialysis
16. Uncontrolled pain
17. Acute mental/behavioral health problem
18. Deep vein thrombosis, pulmonary embolism
19. Other than above reasons
20. Reason unknown

- Used for Potential Avoidable Events, risk adjustment and in care planning
- Reasons patient “sought” care

M2430 Reason for Hospitalization

(M430) Reason for Hospitalization: For what reasons did the patient receive hospitalization? (Check all that apply.)

1. Improper medication administration, medication side effects, toxicity, anaphylaxis
2. Injury caused by fall
3. Respiratory infection (e.g., pneumonia, bronchitis)
4. Other respiratory problem
5. Heart failure (e.g., fluid overload)
6. Cardiac arrhythmia (irregular heartbeat)
7. Myocardial infarction or chest pain
8. Other heart disease
9. Stroke (CVA) or TIA
10. Hypoglycemia, diabetes out of control
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15. Renal failure or dialysis
16. Uncontrolled pain
17. Acute mental/behavioral health problem
18. Deep vein thrombosis, pulmonary embolism
19. Other than above reasons
20. Reason unknown

- Used for Potential Avoidable Events, risk adjustment and in care planning
**Documentation Implications**

- Medication issues should be included on a routine basis.
  - Admission
  - Evaluation
  - Follow up visits
  - Discharges

- Watch for “supposed to.”

**Questions to Consider**

- Since the last visit, has the patient:
  - Started any new medications?
  - Changed anything about current medications?
  - Stopped taking any medications?
  - Noticed any new symptoms or different than usual (looking for side effects or interactions)?

- Don’t forget over the counter, herbals, vitamins and supplements.

**Evaluation vs. Reassessment**

- Evaluation of the patient for the purposes of forming a diagnosis and plan of treatment.

- Reassessment focuses on the plan of care using relevant patient information.
Establishing a Program

- Determine current status of the patient.
- Assess rehabilitation potential.
- Create program based on patient specific needs.
- Ascertain teaching needs of patient and caregiver.

Skilled Assessment

**Measurements**
- ROM
- Strength
- Balance
- Vision
- Pain
- Sensation
- Communication
- Cognition
- Environment
- Equipment

**Functional Impact**
- Ambulation
- Transfers
- Bathing
- Dressing
- Toileting
- Incontinence
- Medication Management
- Swallowing
- Home Management

What Does a Therapist See?

- **“Gait Deficits”**
  - Patient 1 – Visual and cognitive issues
  - Patient 2 – Leg length discrepancy and pain

- **“ADL Deficits”**
  - Patient 3 – Anxiety and lack of transfer bench
  - Patient 4 – Balance and arm in a sling

- **“Swallowing Deficits”**
  - Patient 5 – Posture and muscular weakness
  - Patient 6 – Attention and memory
Added Work or Opportunity

The involvement of all staff visiting the home in the management of medications is not an attempt to replace the role of the nurse but to expand the reach of the home health care team to impact this very important patient safety issue.

Helpful Resources

• American Physical Therapy Association:
  o www.apta.org
  • Home Health Section
  • State Level Associations
• American Occupational Therapy Association:
  o www.aota.org
• American Speech and Hearing Association:
  o www.asha.org
• National Association of Home Care
• State Home Care Associations

Contact Information

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FazziRehab
Please note: The certification process for therapy CEUs varies from state-to-state. In order to assist therapists with getting a session approved, we have provided the following objectives sheet that you can submit to your state licensing board to apply for a therapy CEU.

**EDUCATIONAL ACTIVITY CONTENT OUTLINE**

**Title of Activity:** Interdisciplinary Medication Management  
**Date:** April 19, 2012

<table>
<thead>
<tr>
<th>OBJECTIVES</th>
<th>CONTENT (Topics)</th>
<th>TIME FRAME</th>
<th>PRESENTER</th>
<th>TEACHING METHODS</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Define medication management</td>
<td>- Reference regulations and best practice discussions</td>
<td>10 mins</td>
<td>Cindy Krafft PT, MS</td>
<td>PowerPoint, Lecture</td>
</tr>
</tbody>
</table>
| 2. Examine issues that impede interdisciplinary medication management | - “can” versus “should”  
- Scope of Practice  
- Clinical Competence | 20 mins | Cindy Krafft PT, MS | PowerPoint, Lecture |
| 3. Discuss impact of medications on the plan of care | - Impact on functional ability  
- Impact on teaching | 10 mins | Cindy Krafft PT, MS | PowerPoint, Lecture |
| 4. Explore the clinical and functional issues that impact medication management | - Ambulation  
- Fine motor  
- Cognition | 10 mins | Cindy Krafft PT, MS | PowerPoint, Lecture |
| 5. Question and Answer | | 10 mins | Cindy Krafft PT, MS | Open phone lines, Question and Answer |