Medication Management: 
Therapy Scope Versus Comfort Level

Presented By:

Cindy Krafft MS PT
President Home Health Section APTA
Director of Rehabilitation Consulting Services

August 17, 2011
Instructions and Handouts for: Medication Management

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:

1. Dial 1 (877) 615-4339 at least 10 minutes prior to the start of the webinar.

2. When asked, enter Conference ID 6072083#.

3. Give your agency’s name.

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

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

6. 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.

7. To view the presentation online you must click on the link sent to you from GoToWebinar.
Cindy Krafft MS PT is the Director of Rehabilitation Consulting Services for Fazzi Associates, Inc. She has 15 years of home health experience ranging from PRN Clinician to the Director of Rehabilitation for a six agency home care system. She serves as the President of the Home Health Section of the American Physical Therapy Association, Chair of the NAHC Therapy Advisory Committee, and is on the NAHC Regulatory Affairs Committee. She has published a variety of articles in Caring Magazine, The Remington Report, Success in Home Care, Home Healthcare Nurse, and the Home Health Section of APTA newsletter. As well as being an expert on therapy practice in home care she also assists agencies with achieving OASIS competency. She served as the Clinical Co-Director of the Delta National OASIS-C Best Practices Project and currently acts as the Clinical Director of the Delta Excellence in Therapy Project. She is a well received speaker at both the state and national levels on the topics of OASIS, therapy documentation, program development, therapy utilization, and recruitment.
Medication Management: 
Therapy Scope Versus Comfort Level

Cindy Krafft MS PT, COS-C
President Home Health Section APTA
Assistant Director of Operational Consulting
Fazzi Associates, Inc.

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, etc.
• 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

(M2002) Medication Follow-up: was a physician or the physician-designee contacted within one calendar day to resolve clinically significant medication issues, including reconciliation?

☐ 0 - No
☐ 1 - Yes

Best Practice

Clinically significant: Actual/potential threat to safety and well being based on assessing clinician's judgment.

Contact: communication with physician by any appropriate means.

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

Alert! Office based staff may collaborate and must document/communicate actions to the assessor.

May change M0090 assessment completed date.

M2004 Medication Intervention TIF/DC

(M2004) 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?

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

Select "NO" and "NA" carefully:

- Expect more "NA" responses

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

- 0 - No
- 1 - Yes
- NA - Patient not taking any high-risk drugs OR patient/caregiver 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, hypoglycemics, etc) identified by quality organizations (Institute for Safe Medical Practices, JCAHO, 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.

Complete within assessment time frames.

Select NO and NA carefully.

Office based staff may collaborate and must document/communicate actions to the assessor. May change M0090 assessment completed 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

(N2015) Patient/Caregiver Drug Education Intervention: Since the previous DASS assessment, was the patient/caregiver 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 (at time of or since previous assessment = TIF or DC) 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.
All p.o. meds all the time!

Alert! If ability varies from med to med, select the response for the medication needing the most assistance!

This is MORE than an OASIS item as it is ongoing throughout an episode of care.

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.

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: Patients current (day of assessment) level of alertness, orientation, comprehension, concentration, and immediate memory for simple commands.

- 0 - Fully oriented, able to focus and shift attention, comprehend, and recall task directions independently.
- 1 - Requires prompting (cuing, repetition, reminders) only under variable or unusual 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 - Requires considerable assistance in routine situations. Is not alert and oriented or is unable to shift attention and recall directions more than half the time.
- 4 - Totally dependent due to disturbances such as constant disorientation, coma, persistent vegetative state, or delirium.

Day of assessment: Time of assessment and 24 hrs preceding

M1860 - Ambulation

(Ambulation) Common term: Current ability to walk safely, once in a standing position, or use a wheelchair once in a seated position, on a variety of surfaces.

- 0 - Able to independently walk on even and uneven surfaces and negotiate stairs with or without railings. (i.e. needs no human assistance or assistive device).
- 1 - With the use of a one-handed device (e.g. cane, single crutch, semi-walker), able to independently walk on even and uneven surfaces and negotiate stairs with or without railings.
- 2 - Requires use of a one-handed device (e.g. walker or crutches) to walk alone on a level surface. Requires human assistance or may require supervision or help or direction in uneven or stairs.
- 3 - Able to walk only with the supervision or assistance of another person at all times.
- 4 - Requires, able to ambulate but is able to walk self independently.
- 5 - Requires, unable to ambulate and requires personal assistance to walk or wheel self.
- 6 - Bedfast, unable to ambulate or be up in a chair.

M2030 Management of Injectable Medications

(Injectable Medications: Patients current ability to prepare and take all prescribed injectable medications safely and properly, including administration of correct dosage at the appropriate times/interv. Excluding 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. (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(s) unless administered by another person.
- 4 - No injectable medications prescribed.

Alert! If ability varies from med to med, select the response for the medication needing the most assistance! Reminders by a device, chart or diary that a patient can independently manage are not considered in person assistance or "reminders"...score as independent.
M2040 Prior Medication Management

(M2040) Prior Medication Management: Indicate the patient’s usual 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>Oral medications</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injectable medications</td>
<td></td>
<td></td>
<td></td>
<td></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)

(M2100) 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.

Row c – Medication administration (e.g. oral, inhaled or injectable)

<table>
<thead>
<tr>
<th>Type of Assistance</th>
<th>No assistance needed in this area</th>
<th>Caregiver(s) currently provide assistance</th>
<th>Caregiver(s) need training to provide assistance</th>
<th>Unclear if Caregiver(s) will provide assistance</th>
<th>Assistance needed, but no Caregiver(s) available</th>
</tr>
</thead>
<tbody>
<tr>
<td>i. ADL assistance (e.g., transfer, ambulation, eating, toileting, eating/feeding)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>ii. IADL assistance (e.g., meals, housekeeping, laundry, telephone, shopping, finances)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>iii. Medication administration (i.e., oral, inhaled or injectable)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

Row f – 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).

Row g – Advocacy or facilitation of patient’s participation in appropriate medical care (includes transportation to or from appointments).
M2310 Reasons for Emergent Care

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

- Injury caused by fall
- Respiratory infection (e.g., pneumonia, bronchitis)
- Other respiratory problem
- Heart failure (e.g., fluid overload)
- Cardiac arrhythmia (irregular heartbeat)
- Myocardial infarction or chest pain
- Other heart disease
- Hyperglycemia, diabetes out of control
- Bleeding, obstruction, constipation, infection
- Dehydration, malnutrition
- Urinary tract infection
- Intestinal obstruction or complication
- Wound infection or deterioration
- Uncontrolled pain
- Acute mental/behavioral health problems
- Deep vein thrombosis, pulmonary embolus
- Other than above reasons
- Reason unknown

M2430 Reason for Hospitalization

Reason for Hospitalization: For what reason(s) did the patient require hospitalization? (Mark all that apply.)

- Injury caused by fall
- Respiratory infection (e.g., pneumonia, bronchitis)
- Other respiratory problem
- Heart failure (e.g., fluid overload)
- Cardiac arrhythmia (irregular heartbeat)
- Myocardial infarction or chest pain
- Other heart disease
- Hyperglycemia, diabetes out of control
- Bleeding, obstruction, constipation, infection
- Dehydration, malnutrition
- Urinary tract infection
- Intestinal obstruction or complication
- Wound infection or deterioration
- Uncontrolled pain
- Acute mental/behavioral health problems
- Deep vein thrombosis, pulmonary embolus
- Other than above reasons
- Reason unknown

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:
  — www.apta.org
  • Home Health Section
  • State Level Associations

• American Occupational Therapy Association:
  — www.aota.org

• American Speech and Hearing Association:
  — www.asha.org

• National Association of Home Care
• State Home Care Associations

Contact Information

Website
Fazzi.com

E-Mail
ckrafft@fazzi.com

Twitter Account
FazziRehab