Primer on Medication Management: What Practitioners Need to Know

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Ever since the Institute of Medicine (IOM) released its eye-opening report, "To Err is Human," concerns about medication errors have been on the front burner of health care issues. While the IOM report focused mainly on hospitals, its startling contents led clinical leaders in many settings—including long-term care—to reassess how they address medication management and efforts to prevent medication errors and adverse drug events (ADEs).

Clearly, assisted living facilities are not exempt from medication errors; and these problems are of great concern in this setting. Not only do medication-related problems put residents at risk for preventable hospitalizations or even death, but they also may necessitate transfers that take residents from their homes and keep them from aging in place. Working with physicians and pharmacists, however, ALF staff and residents can reduce the instances of medication-related problems and help residents to enjoy fewer transfers and health risks.

Solutions Start with a Philosophy

How practitioners and staff view medication management in an ALF depends partly on their philosophy of assisted living, suggested Harlan Martin, RPh, President of PharmaCare in Clark, NJ. "If the philosophy is that the facility is a home environment, there often is an assumption that patients should be cognitively aware enough to take medications the same as community-dwelling seniors," he noted. The problem with that, he cautioned, is that there are "lots of medication errors in the community."

ALFs need to start recognizing that the facility model increasingly is moving from social to medical, suggested Rich Marasco, BSPharm, FASCP, CGP, President of Florida-based SeniorPharm.com. "The types of residents I was seeing in nursing

homes in the '80s are now ALF residents. People in assisted living are getting sicker but staying in this setting," he noted. In facilities without the presence of a medical component, Mr. Marasco stated, "we see untreated conditions, unrecognized adverse events, and other problems." He added, "We need to be involved in ALFs to evaluate for inappropriate medications and to eliminate unnecessary drugs and those that cause adverse effects."

Why Don't Residents Take Their Medications?

Mr. Marasco conducted a survey of his assisted living clients and found that "the biggest reasons residents weren't taking medications were that they didn't want to take so many medications, they didn't think the medication was working, and they didn't like the way it made them feel." However, he added that sometimes a resident's reason for not taking a medication is less rational. "I had one resident who simply refused to take any pink pills. No matter how much we tried to persuade her that a pink pill was necessary and would make her feel better, she wouldn't budge," Mr. Marasco said.

Residents have the right to refuse any intervention, including medications. However, if a resident won't take a medication, it is important for staff or practitioners to uncover the reason behind the refusal. "We can't overcome an objection if we don't know what it is," Mr. Martin observed. If the resident's concern is a side effect, it will be useful to look at possible alternatives. When this isn't possible, it is important to work with the resident to minimize discomfort.

It is important to note that medication cost may be a concern for many residents, especially when medications must be paid out of pocket. Mr. Martin recalled an instance where a resident needed a drug that cost $1,900 per month. "Fortunately, her family was able to foot the bill," he noted, adding, "But this is the exception, rather than the norm." Especially as facilities plan for implementation of the Medicare prescription drug benefit, physicians and pharmacists will have to be more creative about finding ways to ensure that residents have access to the drugs they need or reasonable safe and effective alternatives.

Jerry Gurwitz, MD, Executive Director, Meyers Primary Care Institute, and Doctor John Meyers Professor of Primary Care Medicine at the University of Massachusetts Medical School, suggested that one way to improve adherence is to educate residents about the medications they are taking. "Education is key," he observed. "I really think it is the responsibility of residents to understand not only the name of any drug they're taking but what the drug does and what side effects it may have." Mr. Marasco added, "Residents may know inherently that a lower cholesterol level is better. But if they don't feel different, they don't think the drug is working."

Medication management depends partly on a facility's philosophy of assisted living.

In addition to residents who refuse to take medications or who take meds improperly, facilities also must deal with families who often are demanding, Mr. Marasco noted. "They may say, 'I don't care what mom says. Give her the medication,'" he stated. So involving family members in the monitoring process is important. "They need to know what signs to watch for that may indicate a side effect or adverse reaction," noted Dr. Gurwitz.

For educating residents and family members, Mr. Marasco suggested "sitting down with them one on one and explaining what the drug is, what it's for, how it works, and so on." Keep it simple, he offered, with a minimum of writing and a few basic illustrations or charts.

Possible Policies, Other Answers

Should facilities have a policy in place that patients with diminished capacity can't self-administer? Mr. Martin suggested that this is one possible way to keep residents safe from medication errors, but he suggested that ALFs may resist implementing such policies as being too restrictive. At the same time, there are other, less overtly invasive means of monitoring residents' medication management. These include computerized vial caps that register every time the container is opened and pharmacy services that will call patients daily to remind them to take medications. However, Mr. Martin explained, these measures are not without their faults. "A computerized vial doesn't prevent someone from taking too many or too few tablets or capsules when he or she opens the container; and the pharmacy service can be expensive," he cautioned.

While there are no foolproof means of preventing medication errors for residents who self-medicate, Mr. Martin offered some ideas that can go a long way toward eliminating problems:

- Minimize the number of times a patient takes medications (eg, use combination products or products that can be taken weekly instead of daily)
- Schedule medications around key times (eg, waking up, going to bed)
- When possible, avoid medications that diminish cognitive capacity

Mr. Martin also suggested that facilities have a means to conduct an objective analysis to determine if a resident's drug regimen is too complex for him or her to self-manage or –administer. "We're not doing this yet," he noted; but he predicted that it will be a key tool in the future to protect residents and keep them safe in their residences.

High Tech, Low Priority

The federal government has been pushing for greater implementation of health information technology (HIT) such as e-prescribing, and studies have begun to show the positive impact HIT can have on outcomes, safety, and reduced medication errors. However, Phillip Sloane, MD, MPH, Elizabeth and Oscar Goodwin Distinguished Professor and Associate Chair in the Department of Family Medicine at the University of North Carolina at Chapel Hill School of Medicine, said not to expect widespread HIT use to hit ALFs any time soon. "I think that long-term care [including assisted living] will be the last component of the health care system to develop IT because it is the least advanced at this point," he noted. This is partly because the costs and time involved in IT adoption and implementation often are prohibitive.

Nonetheless, Dr. Sloane observed that HIT and e-prescribing could help solve many problems. For example, he said, "One of the biggest hassles for physicians caring for LTC residents is the literal flood of phone and fax requests they get from facilities. I read an article about one practice that got approximately 30,000 such requests per year." Dr. Sloane suggested that widespread use of electronic medical records in long-term care settings not only could help solve the fax and phone volume problem but also prevent inadequate transmission of information across settings. "Anything that can increase efficiency and help improve medical information around transitions will be helpful," he concluded.

IT is more advanced in some states, Mr. Marasco indicated. For instance, Florida has a new Medicaid program that provides physicians with a PDA-phone combination device that gives them full access to every prescription medication their Medicaid patients are taking. The data are updated electronically in real time, and all Medicaid formularies are built right into the program. "The state loves this program because it eliminates prior authorizations and helps prevent prescribing errors, and the physicians seem to be very excited about it," said Mr. Marasco. Other states will be watching to see what impact this program has in Florida. "States are very interested in ways to reduce costs for their geriatric populations. If this program saves money in Florida, other states likely will look seriously at this idea as something that may work for them as well."

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Calling Knowledgeable Practitioners

Unlike nursing facilities, where the involvement of a qualified physician medical director and consultant pharmacists is mandated, physicians that care for assisted living residents often are primary care physicians with limited knowledge of geriatrics. As a result, Mr. Marasco noted, "They may be treating these senior residents the same way they treat their younger patients in the community." Dr. Gurwitz emphasized the need for physicians to have specific knowledge of geriatrics and medications that are appropriate and inappropriate for this population. Mr. Marasco added that "the involvement of a senior care pharmacist also is key to ensuring safe and effective medication therapy for assisted living residents."

To see the value of specialized physician education on resident outcomes, assisted living facilities need only look as far as the nursing home industry. "Nursing homes that are rated the best tend to have more geriatrics-educated professionals doing the prescribing," said Dr. Sloane. "If physicians are more knowledgeable about geriatrics, they make better prescribing decisions for this population," he noted, adding, "It also helps to have pharmacists doing medication reviews who have a sophisticated level of knowledge about geriatric pharmacotherapy."

Often, Dr. Gurwitz said, physicians don't really know what medications their patients are taking and rely on these individuals for this information. "We need to encourage AL residents to take all medications or an updated list to physician visits," he noted, adding, "There are always some surprises when the patient does this."

It is important to emphasize that education, training, and communication can't stop when the medication is prescribed, dispensed, or even administered. Ongoing monitoring is an essential part of the medication management loop. "Somehow, we need to develop more effective means of monitoring for side effects and drug interactions in assisted living," said Dr. Gurwitz. He added, "Providers need to be better educated about what to watch for and how monitoring should be done." ALC

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