Case Study

Medication Management in Action: A New System Reduces Errors, Improves Adherence

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Mrs. Jones is a 70-year-old woman who lives in an independent retirement home. Her income is below the federal poverty line and she receives both Medicare and Medicaid. She insists on self-medicating, but is forgetful and disorganized. She often skips doses, and last year was hospitalized because of an adverse drug event.

Mr. Adams is an 82-year-old man who resides in an assisted living facility. He receives Medicare, and his family pays out-of-pocket for uncovered services. Mr. Adams takes 7 different prescription medications. He receives medication assistance from facility staff, which eliminates the possibility of self-administration errors. However, the aide recently mixed up the medications in Mr. Adams' pill pack. Fortunately, Mr. Adams' daughter—who is a nurse—noticed the error and corrected it before administration. The daughter and her family already were upset with the facility because of an incident 4 months previously, in which they were charged for extra pills when the original ones fell on the floor and had to be replaced. In fact, they were considering moving him to another setting closer to their home in a different state.

These kinds of situations are not uncommon in senior care settings nationwide. In fact, the cost of medication-related problems (MRPs) is estimated to exceed $175 billion annually, with an average hospitalization cost of more than $12,000.

In recent years, facilities and practitioners increasingly have looked to medication management systems that rely on technology and automation to help reduce errors. Dawn Strickland, President of Healthlynx Management Resources, Inc., of Mableton, Georgia, has spent much of her time researching medication management issues and implemented a system that has significantly helped to reduce MRPs and the associated hospitalizations and costs for seniors—many of them Medicare patients—in a variety of settings.

Step One:
Talking, Listening, Studying

In talking with senior care directors of nursing, case managers, admissions directors, and others, Strickland discovered that caregivers, family members, and patients alike make packaging errors, such as misplacing pills or capsules in the bubble pack or strip. She also learned that in senior settings where there is less supervision of medication management and where individuals have the opportunity to self-medicate, there are more MRPs, including taking expired or discontinued medications, taking medications from different prescribers that cause drug-drug interactions, taking over-the-counter drugs that interact with their prescriptions, and missing dosages.

Of course, determining the right medication management system for any group of patients requires listening and studying the patients themselves and tailoring the medication system to their individual needs, habits, and personal situations. For instance, Strickland interviewed her patients about their medication regimens and medication-taking habits. She submitted the drug regimen she obtained from each patient to his or her physician to confirm that it was current and accurate. "You would be surprised what you discover when you do this," said Strickland. "Patients were taking meds that had been discontinued, and they were taking incorrect dosages. With many low-income patients, they just won't get a prescription filled if Medicaid doesn't pay for the drug. This last practice is likely to continue under Part D. If

seniors can't afford an uncovered drug, they won't take it."

Another problem Strickland uncovered was that seniors sometimes were confused between brand and generic drugs. As a result, some were taking both a brand drug and the generic version, prescribed by 2 different physicians simultaneously. "This is one reason that it is important for patients to get all of their medications from the same pharmacy," she suggested.

Step Two:
Choosing a System

Strickland emphasized that it is essential to overcome these medication issues and problems before implementing any medication management system. "The best system in the world won't work if the drug regimen isn't accurate and patients are taking the wrong meds to begin with," she offered. "Once I knew what we were dealing with, I was confident that this system would help resolve the difficulties these patients and their caregivers were having."

The medication management system that Strickland chose to implement with her patients and facilities is a personal prescription system designed to simplify self-medication for patients taking multiple drugs. The system enables a pharmacist to custom sort, package, and label multiple medications for the patient into a series of personalized dosage cups. Time-specific dosage cups are organized in a color-coded calendar card and hermetically sealed. Each tamper-evident cup is labeled with the patient's name, the contents, and the precise time to take the medications.

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The benefits of the medication management system Strickland chose are numerous and included:

- reducing the number of people involved in preparing, packaging, and administering medications, thereby decreasing the opportunities for errors;
- computerized record-keeping that prints medication details directly from physician order sheets, which are then sent to the physicians for sign-off before the medications are filled and administered; and
- taking medications accurately and safely, even if patients are illiterate or visually impaired.

Step Three:
Introducing the System

Strickland introduced the medication management system in a way that was designed to increase patient buy-in, understanding, and adherence. "I showed them the med packs, and I explained how the system worked and what it would do for them. Generally, I had a family member or caregiver with me when I had this conversation," she said. The presence of these other individuals was important, she emphasized, "Partly because I was going to train them to use it." While Strickland stressed that overall it is "a simple system," nonetheless, some training is useful and helps to increase buy-in and use over time.

According to Strickland, the conversations and training helped ensure that patients used the system. "For the most part, they understood that what they were doing before was not working. They realized that they needed something different," she said, adding, "Overall, people understand that if their health is dependent on them changing something, they will make that change."

However, Strickland cautioned that there will always be some resistance to change. "We probably had about 6 patients out of 50 who resisted using the system. They were accustomed to what they were doing and didn't want to change."

Overcoming such resistance can be challenging. It is important to help patients understand the benefits of effective medication management—as well as the dangers and risks of

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Part D Fraud and Abuse: PDPs Will Be Key to Detection

Opportunities for fraud in the new Medicare Part D prescription drug program exist and will become more frequent as the benefit continues to gather momentum. At the same time, federal compliance program requirements will be taking effect for the prescription drug plans (PDPs), and CMS is prepared to fight fraud and abuse with the hiring of Medicare Integrity Drug Contractors (MEDICs) to oversee the audits of PDPs required under the Medicare Prescription Drug Improvement and Modernization Act of 2003 (MMA). These contractors have specialized skill sets that enable them to detect fraud, waste, and abuse, now to be known as "FWA" in the new prescription drug program.

Plans that offer the drug benefit also are required to have in place programs to detect, prevent, and correct FWAs. Although the vast majority of PDPs have subcontracted with pharmacy benefit managers (PBMs) to administer the benefit, CMS has made it clear that the PDP will be held responsible for violations, even for an FWA at the PBM or network pharmacy level. It is CMS' expectation that PDPs will self-report fraud to the federal government. The MMA specifically requires that the PDP compliance plan "*should include procedures to voluntarily self-report potential fraud or misconduct related to the Part D program to the appropriate government authority*."

The Office of the Inspector General (OIG) will look at relationships PDPs have with drug manufacturers, wholesalers, and pharmacies. It is expected that the OIG will get cases for possible investigation both from False Claims Act relators who see Part D problems and from CMS referrals. Examples of the types of complaints to be investigated may be found on the Health Integrity's Web site (http://www.healthintegrity.org/index.html), by calling (877)7SafeRx (1-877-772-3379), or by faxing (410-819-8698). MPM

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poor adherence—and do everything possible to get them to do what is best. However, when resistance affects adherence and results in MRPs, it will be important for the patient's physician and family members to support participation in a plan in which medications are administered by facility staff.

What's the Cost?

How much such a medication management system would cost is a serious concern for many patients. Strickland admitted that good systems can be costly to implement and utilize. Approximately 75% of pharmacies currently charge an average of $15 to $20 per patient for packaging this type of system. She suggested that facilities work with pharmacy providers to get them to support or share the system's cost in return for increased business or status as a result of being a facility's or health system's preferred provider.

Currently, neither Medicare nor Medicaid pays for medication management systems. Likewise, they will not be covered under the new Medicare prescription drug benefit. However, the details of the medication therapy management services (MTMS) component of the benefit have yet to be worked out, and there is a possibility that such systems could be covered for high-risk patients taking a large number of prescriptions.

Nonetheless, Strickland insisted that even if the facility has to foot the bill itself, a good medication management system pays for itself in short order. In her study, adherence increased and MRPs and related hospitalizations decreased significantly.

The money these systems save in terms of reduced medication errors is only part of the equation, she suggests. Fewer medication errors generally mean that seniors remain functional longer and have a better quality of life. And that, she stressed, is an important goal in any aspect of senior care. MPM

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