Safe and Effective Use of Medications in Older Adults

Credit Information

- If you are a **physician** or **social worker** in a **National Association of Social Workers (NASW) state** and would like to receive CME credits through the American Geriatrics Society or CE credits through NASW for this event, please complete the pre-test posted here: [https://www.research.net/r/Rx_OlderAdults_PreTest](https://www.research.net/r/Rx_OlderAdults_PreTest)
  - You will also be required to complete a post-test; a link to this test will appear at the end of the presentation.

- For more information about obtaining CEUs for **social workers in non-NASW states, psychologists, PAs, nurses (NP, APRN, RN, LPN), pharmacists, marriage and family counselors, etc.** via the Centers for Medicare & Medicaid Service’s Learning Management System, please visit: [https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Medications](https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Medications)

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Safe and Effective Use of Medications in Older Adults
Overview

- This is the first session from the “2018 Geriatric-Competent Care Webinar Series.”

- Each session will be interactive (e.g., polls and interactive chat functions), with 60 minutes of presenter-led discussion, followed by 30 minutes of presenter and participant discussions.

- Video replay and slide presentation are available after each session at: https://www.resourcesforintegratedcare.com.
Accreditation

- This activity has been planned and implemented in accordance with the accreditation requirements and policies of the Accreditation Council for Continuing Medical Education (ACCME) through the joint providership of the American Geriatrics Society and the Centers for Medicare & Medicaid Services (CMS) Medicare-Medicaid Coordination Office (MMCO). The American Geriatrics Society is accredited by the ACCME to provide continuing medical education for physicians.

- The American Geriatrics Society is accredited the National Association of Social Workers (NASW) to provide continuing education for social workers.

- The Centers for Medicare & Medicaid Services is accredited by the International Association for Continuing Education and Training (IACET). The Centers for Medicare & Medicaid Services complies with the ANSI/IACET Standard, which is recognized internationally as a standard of excellence in instructional practices. As a result of this accreditation, the Centers for Medicare & Medicaid Services is authorized to issue the IACET CEU.
## Continuing Education Information

<table>
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<th>If You Are A:</th>
<th>Credit Options</th>
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| **Option 1: American Geriatrics Society** | The American Geriatrics Society designates this webinar for a maximum of 1 Continuing Education (CE) credit hour | 1. Complete the pre-test at the beginning of the webinar  
2. Complete the post-test with a score of 80% or higher by midnight April 19, 2018 |
| Social Worker                      | **Please note:** New York, Michigan, and West Virginia do not accept National CE Approval Programs for Social Work. New Jersey, Idaho, and Oregon do not recognize NASW National Approval |                                                                                                                                            |
| **Option 2: Centers for Medicare & Medicaid Services** | The Centers for Medicare & Medicaid Services (CMS) is authorized by IACET to offer CEUs. CEUs will be awarded to participants who meet all criteria for successful completion of this educational activity | Complete the post-test through CMS’ Learning Management System with a score of 80% or higher by midnight May 7, 2018 |
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| Other (social worker in non-NASW states, psychologist, PA, nurse (NP, APRN, RN, LPN), pharmacist, marriage and family counselor, etc.) |                                                                                                                                            |
Support Statement

- This webinar is supported through the Medicare-Medicaid Coordination Office (MMCO) in the Centers for Medicare and Medicaid Services (CMS) to help ensure beneficiaries enrolled in Medicare and Medicaid have access to seamless, high-quality health care that includes the full range of covered services in both programs. To support providers in their efforts to deliver more integrated, coordinated care to Medicare-Medicaid enrollees, MMCO develops technical assistance and actionable tools based on successful innovations and care models, such as this webinar.

- To learn more about current efforts and resources, visit Resources for Integrated Care at: https://www.resourcesforintegratedcare.com.
Introductions

- **Todd Semla, MS, PharmD**  
  National PBM Clinical Pharmacy Program Manager – Mental Health & Geriatrics, U.S. Department of Veterans Affairs  
  Feinberg School of Medicine, Northwestern University

- **Thomas von Sternberg, MD**  
  Senior Medical Director, HealthPartners Community Seniors, Home Care and Hospice; Medical Director, HealthPartners Dual Eligible Program

- **Donna Fick, RN, PhD**  
  College of Nursing, Pennsylvania State University  
  Director, Penn State Center for Geriatric Nursing Excellence

- **Marisilis Tejeda**  
  Health Coach, City Health Works
Webinar Outline/Agenda

- Polls
- Prescribing for Older Adults
- Medication Use in Older Adults
- Individual, System & Provider Factors in Medication Mismanagement
- Health Coach Perspective
- Q&A
- Evaluation
Prescribing for Older Adults

Todd Semla, MS, PharmD, BCGP, FCCP, AGSF

National PBM Clinical Pharmacy Program Manager – Mental Health & Geriatrics, U.S. Department of Veterans Affairs

Feinberg School of Medicine, Northwestern University
Disclosures

- Dr. Semla has received honorarium for his services as an editor for LexiComp, Inc. and the American Geriatrics Society as a Section/Associate Editor to the Journal of the American Geriatrics Society, author of the Geriatrics At Your Fingertips, and for co-chairing the AGS Beers Criteria panel.
- Dr. Semla’s spouse is an employee of Abbvie and owns stock in Abbvie and Abbott Labs.
- Dr. Semla’s views are his own and do not necessarily reflect those of the U.S. Department of Veterans Affairs or the U.S. Government.
Individuals Dually Eligible for Medicare and Medicaid

- On average have a 25 percent higher rate of chronic conditions than beneficiaries who are not dually eligible
- Tend to use a variety of medications and have higher Medicare Part D prescription drug costs than Medicare-only beneficiaries

Sources:
3. http://bulletin.facs.org/wp-content/uploads/2014/04/Medicare's_Role__Figure_3_V2-edited.jpg
Dual Eligible Beneficiaries vs. All Other Medicare Beneficiaries

Share of beneficiaries with:

- Cognitively or Mentally Impaired: 58% Dual Eligibles, 25% All other Medicare beneficiaries
- 3+ Chronic Conditions: 55% Dual Eligibles, 44% All other Medicare beneficiaries
- In Fair or Poor Health: 50% Dual Eligibles, 22% All other Medicare beneficiaries
- Require Assistance with 1+ ADLs: 44% Dual Eligibles, 26% All other Medicare beneficiaries
- Long-term Care Facility Resident: 13% Dual Eligibles, 1% All other Medicare beneficiaries

Source:
3. http://bulletin.facs.org/wp-content/uploads/2014/04/Medicarees_Role__Figure_3_V2-edited.jpg
Prescription Drug Use by Individuals 65 Years or Older

- As the number of older adults in the U.S. increases as a percentage of the total population, their share of prescription drug use will also increase.

Factors Influencing Medication Use

- Individual characteristics
- Disease states
- Psychosocial attributes
- Physicians
- Advertising
Prescribing Cascade

Starting one drug to treat the side effects of another

Back pain $\rightarrow$ Ibuprofen $\rightarrow$ $\uparrow$ BP $\rightarrow$ Amlodipine $\rightarrow$ LE edema $\rightarrow$ Furosemide

$\downarrow$

Alfuzosin $\leftarrow$ Urinary frequency

Anticholinergics $\rightarrow$ Cognitive impairment $\rightarrow$ Cholinesterase inhibitor
Consequences of Inappropriate Medication Use in Older Adults

- Increases mortality, morbidity, and risk of adverse drug events
- Increases healthcare costs and utilization
- Increasing use in the oldest and most vulnerable adults
- Is highly common but preventable

Sources:
Prevalence of Inappropriate Prescribing

- During 2009 – 2010, 41 percent of community-dwelling elderly individuals filled at least one inappropriate medication per 2012 AGS Beers Criteria
  - NSAIDS: 10 percent
  - Benzodiazepines: 9 percent
Two Drug-Drug Interactions

- Use of three or more drugs with central nervous system (CNS) effects
  - Refers to CNS polypharmacy with selective serotonin reuptake inhibitors (SSRIs), Tricyclic antidepressants (TCAs), antipsychotics, benzodiazepines, Z-drugs, and opioids
  - Increased risk for falls
- Prescribing multiple drugs with anticholinergic activity
  - Increased risk of impaired cognition
Medications with Anticholinergic (ACH) Activity

- Anti-emetics/vertigo - (e.g., meclizine, promethazine)
- Antiparkinson - (e.g., trihexyphenidyl)
- Antipsychotics - (e.g., thioridazine)
- Antispasmodics - (e.g., belladonna, oxybutynin)
- Cold and allergy drugs - (e.g., hydroxyzine)
- Sleep aids - (e.g., diphenhydramine)
- Skeletal muscle relaxants - (e.g., cyclobenzaprine)
- Tricyclic antidepressants - (e.g., amitriptyline)
Reasons Why Older Adults are Vulnerable to ACH Drugs

- High probability of exposure
- Greater sensitivity
  - Age-related pharmacokinetic effects
  - Increased blood-brain barrier permeability
  - Decreased central cholinergic activities
- Pre-existing cognitive impairment
What Can Be Done?

- Regulatory Mandates
  - AGS Beers Criteria – used by CMS and insurers to reduce inappropriate prescribing
  - OBRA ’87 – Reduced inappropriate medication use in nursing homes
- Medication Reconciliation – transitions of care
- Drug regimen review/cross – check lists
- Chart out medication regimen
2015 AGS Beers Criteria Online Resources

- Free to use
- Criteria
  - AGS Updated Beers Criteria
  - How-to-Use Article
  - Alternative Medications List
- Easy Clinical Use for Providers
  - Updated Beers Criteria Pocket Card
  - Updated Beers Criteria section in iGeriatrics App
- Public Education Resources for Individuals & Caregivers
  - AGS Beers Criteria Summary
  - 10 Medications Older Adults Should Avoid
  - Avoiding Overmedication and Harmful Drug Reactions
  - What to Do and What to Ask Your Healthcare Provider if a Medication You Take is Listed in the Beers Criteria
  - My Medication Diary - Printable Download
  - Caregiver Tips: Using Medicines Safely - Illustrated PowerPoint Presentation

Available at: GeriatricsCareOnline.org
STOPP/START Criteria

- **STOPP**
  - Tool for providers to screen older adults potentially using inappropriate prescriptions
  - 65 indicators of drug-drug, drug-disease interactions and therapeutic duplication

- **START**
  - Tool to alert providers to correct treatment
  - 22 evidence-based indicators of common prescribing omissions
**Discontinuing Medications**

**Deprescribing:**
“Use of some medication, especially as people get older or more ill, can cause more harm than good. Optimizing medication through targeted deprescribing is a vital part of managing chronic conditions, avoiding adverse effects and improving outcomes.”
– www.deprescribing.org

- Refer to the 2015 AGS Beers criteria, STOPP/START and other lists
- **Target medications:**
  - Without indication
  - Have not had the intended response
  - No longer needed
  - Duplicate effects – benefit and harm
  - Not being taken and adherence is not critical
Discontinuing Medications: Deprescribing

- Events that should trigger deprescribing
  - Care transitions
  - Annual/semiannual medication review
  - Starting a new medication
  - New problem

- Educate individuals and caregivers
  - What to expect and intent
  - Instructions
  - Monitoring
    - Withdrawal
    - Exacerbation of condition
Medications Prime for Deprescribing

- Anticholinergic
  - Allergy meds
- Antihistamines
- Antacids
  - Proton-pump inhibitors
  - H2 antagonists
- Bone Meds
  - Bisphosphonates
- Cardiovascular
  - Statins
- Diabetes Meds
- Memory Meds
  - Cholinesterase inhibitors
  - Memantine
- Psych Meds
  - Antipsychotics
  - Antidepressants
- Other
  - Iron
  - Aspirin

Many drugs will need to be tapered off and should not be stopped abruptly.
Deprescribing.org

- Free, useful resource
- Algorithms for deprescribing antipsychotics, antidiabetic agents, benzodiazepines, and PPIs
- Brochures and other materials to help prescribers and individuals decide if and how to stop a medication
Screening & Medication Review

Screening

- Annual medication review, starting a new medication or change in dose

Medication Review (collaborate with a pharmacist)

- Review all medications in person
  - Including OTC, supplements, herbs and medications from other providers
  - Look for drug-drug interactions
- Screen for adherence
  - Difficulties and adverse events
  - Ask how medications are actually taken
  - Refill history
  - Ask caregivers
# Medication Summary – Deprescribing, Adverse Drug Events (ADEs), Drugs to Avoid

<table>
<thead>
<tr>
<th>Medications prime for deprescribing</th>
<th>Most common types of medications associated with ADEs</th>
<th>Drugs to Avoid</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticholinergics</td>
<td>Anticholinergics</td>
<td>Benzodiazepines</td>
</tr>
<tr>
<td>Antihistamines</td>
<td>Antihistamines</td>
<td>Ex: lorazepam</td>
</tr>
<tr>
<td>Antacids</td>
<td>Antibiotics</td>
<td>Risk of confusion, falls, and injury</td>
</tr>
<tr>
<td>Bone Medications</td>
<td>Analgesics</td>
<td>Anticholinergics</td>
</tr>
<tr>
<td>Cardiovascular Medications</td>
<td>Anticonvulsants</td>
<td>Ex: diphenhydramine</td>
</tr>
<tr>
<td>Diabetes Medications</td>
<td>Cardiovascular Medications</td>
<td>Proton-pump inhibitors</td>
</tr>
<tr>
<td>Memory Medications</td>
<td>Diabetes Medications</td>
<td>Risk of C. diff infection, bone loss and fractures</td>
</tr>
<tr>
<td>Psychology Medications</td>
<td></td>
<td>NSAIDS, oral</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Ex: ibuprofen</td>
</tr>
</tbody>
</table>

- Proton-pump inhibitors
- Risk of gastrointestinal bleeding
Seven Features of Unnecessary/Excessive Drug Use

1. No apparent indication
2. Use of duplicate medications
3. Use of interacting medications
4. Use of a contraindicated medication
5. Use of inappropriate dosage
6. Use of one drug to treat adverse effects
7. Improvement following discontinuation
“The trend of multiple drug use by elderly people will likely increase in the future as a result of an increasing burden of chronic disease and success of researchers who develop new drugs.”

Ron Stewart, MS Pharm.

*The Annals of Pharmacotherapy, 1990*
Medication Use in Older Adults

Thomas von Sternberg, MD
Senior Medical Director, HealthPartners Community Seniors, Home Care and Hospice; Medical Director, HealthPartners Dual Eligible Program
Older Adults and Medication Use

- What is the importance of medications in the treatment of chronic conditions?
- Why are older adults at more risk for adverse drug reactions (ADRs)?
- What is the impact of ADRs on individuals and health care costs?
Case Study: Ms. Smith

- 87 year old woman fell last night and complains of left hip and back pain
- Unable to recall events and is agitated; she says “yes” when asked if she is in pain
- Able to ambulate short distances with a walker at baseline, but needs assistance with dressing, bathing, toileting; she is able to feed herself
- Experienced rectal bleeding two days ago
- Was in the ED last month for a heavily bleeding laceration after a fall and supratherapeutic international normalized ratio (INR) of 5.6, while on antibiotics for a urinary tract infection
# Case Study: Ms. Smith’s Past Medical History

<table>
<thead>
<tr>
<th>1. Dementia (MMSE 20/30)</th>
<th>11. Hyperlipidemia</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Parkinson’s disease</td>
<td>12. Osteoarthritis, especially hips &amp; knees</td>
</tr>
<tr>
<td>3. Cerebrovascular accident (CVA) with residual L-sided weakness</td>
<td>13. Macular degeneration</td>
</tr>
<tr>
<td>4. Osteoporosis</td>
<td>14. Type 2 diabetes mellitus</td>
</tr>
<tr>
<td>5. Urinary incontinence</td>
<td>15. Peripheral neuropathy</td>
</tr>
<tr>
<td>6. Recurrent UTIs</td>
<td>16. Chronic renal insufficiency</td>
</tr>
<tr>
<td>7. Hypertension</td>
<td>17. Anemia</td>
</tr>
<tr>
<td>8. Coronary artery disease, stent 2 years ago</td>
<td>18. Hypothyroidism</td>
</tr>
<tr>
<td>9. Congestive heart failure</td>
<td>19. COPD on oxygen</td>
</tr>
<tr>
<td>10. Atrial fibrillation</td>
<td>20. Diverticulitis</td>
</tr>
</tbody>
</table>
Case Study: Ms. Smith’s Medications

1. Donepezil (Aricept)
2. Carbidopa/Levodopa
3. Aspirin
4. Warfarin (Coumadin)
5. Tolterodine (Detrol)
6. Atorvastatin (Lipitor)
7. Insulin (long-acting and sliding scale)
8. Gapapentin (Neurontin)
9. Iron sulfate
10. Trazodone
11. Levothyroxine
12. Furosemide (Lasix)
13. Potassium chloride
14. Metoprolol
15. Lisinopril
16. Amlodipine
17. Acetaminophen
18. Docusate sodium
19. Polyethylene glycol powder (Miralax)
20. Tiotropium (Spiriva)
21. Montelukast (Singulair)
22. Fluticasone/salmeterol (Advair)
23. Albuterol/Atrovent nebulizers for wheezing
24. Multivitamin
25. Vitamin E
26. Calcium carbonate
27. Vitamin D
28. Nitrofurantoin (Macrodantin)
Challenges of Prescribing for Older Adults

- Multiple medical conditions
- Multiple medications
- Multiple prescribers
- Different metabolisms and responses
- Lack of evidence for use in elderly
- Adherence and cost
- Supplements, herbals, and over the counter drugs

Source:
Prescription, Over the Counter (OTC), and Diet Supplement Use Among Older Adults in the U.S. 2010

- Prescription drug use: 84 percent of older adults in U.S.
- OTC use: 39 percent of older adults in U.S.
- Supplement use: 64 percent of older adults in U.S.
- Use of more than five prescription drugs: 36 percent of older adults in U.S.
- Use of more than five prescription drugs, OTC and supplements: 67 percent of older adults in U.S.

Source:
Polypharmacy

- Occurs when an individual is regularly prescribed five or more medications
- May lead to the use of multiple unnecessary medications, use of more medications than clinically warranted or indicated, or the use of unnecessary, ineffective, and harmful prescribing

Sources:
Polypharmacy (continued)

- Two-thirds of older adults are on regular medications
- Individuals aged 65 years and older account for one-third of all prescriptions written, but they represent only 15 percent of the U.S. population
- Dangers of multiple medications ("polypharmacy")
  - Adverse effects
  - Drug-drug interactions
  - Duplication of drug therapy
  - Poor adherence
  - Cost
  - Decreased quality of life
Adverse Drug Events (ADEs)

- Adverse symptoms
- Adverse clinical outcomes
  - Doctor visits or hospitalizations
  - Falls
  - Functional decline
  - Changes in cognition (delirium)
  - Death
- Poor medication management and poor quality of life
- Increased cost
ADEs and Older Adults

- One-third of community-dwelling older adults experience an ADE annually
- ADEs commonly cause trips to the emergency department
- Two-thirds of nursing home residents experience an ADE over a four year period
- Nearly one-third of all geriatric hospital admissions are due to ADEs

Sources:
# Most Common Types of Medications Associated with ADEs in Older Adults

<table>
<thead>
<tr>
<th>Types of medications</th>
<th>Most dangerous and commonly associated with ER visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anticholinergics</td>
<td>Warfarin (17%)</td>
</tr>
<tr>
<td>Antipsychotics</td>
<td>Insulin (13%)</td>
</tr>
<tr>
<td>Antibiotics</td>
<td>Digoxin (3%)</td>
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<tr>
<td>Analgesics</td>
<td></td>
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<tr>
<td>Anticoagulants</td>
<td></td>
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<tr>
<td>Antihistamines</td>
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<td>Anticonvulsants</td>
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<td>Cardiovascular medications</td>
<td></td>
</tr>
<tr>
<td>Diabetes medications</td>
<td></td>
</tr>
</tbody>
</table>

**Sources:**
Case Study: Is Ms. Smith at risk of an ADE?

- Six chronic diseases: yes
- More than 12 doses/day: yes
- Nine or more medications: yes
- Low weight: likely
- Over 85 years old: yes
- Decreased kidney function: yes
- History of prior ADE: yes
Why is Ms. Smith at Risk?

- **Multiple chronic diseases** with their own prescription options
- **Multiple drugs** (high “exposure”)
  - Risk of ADE is proportional to number of drugs
  - Increased probability of drug-drug interactions
- **Physiologic changes** (increased susceptibility)
  - Associated with disease states
  - Associated with normal aging
  - Decreased reserve capacity
Physiological Changes

- Normal Aging
  - Less water/more fat
  - Less muscle
  - Brain sensitivity

- Disease States
  - Heart problems
  - Kidney and liver disease
  - Neurological diseases

- Changes in the effect of medications
  - Same amount of drug will have more effect and stay in the body longer
  - More adverse effects
  - Start low and go slow
Excretion and Aging

- Renal
  - Renal clearance reduced
  - Serum creatinine may not be an accurate reflection of renal clearance in elderly individuals (decreased lean body mass)
- Active drug metabolites accumulate
  - Prolonged therapeutic action
  - STRONGER adverse effects
Individual, System & Provider Factors in Medication Mismanagement

Donna Fick, RN, PhD
College of Nursing and College of Medicine, Pennsylvania State University
Individual Dually Eligible for Medicare and Medicaid Case Study: Mrs. Ryan

- 82 year old retired baker with COPD with an 8th grade education
- History of cognitive impairment and is on 13 medications
- Did not refill her inhaler and stopped taking her antidepressant
- Son lives with her, is unemployed, and does not help with her care
- Not able to tell the nurse what the medications she takes are used for and is not sure what she should be taking since she came home from the hospital
Increased Risk for Medication Mismanagement: Mental State

- Depression
- Lower cognitive function
- Memory
- Executive function
- Anxiety
- Sleep disturbances
Increased Risk for Medication Mismanagement: Physical Health

- Poor dexterity
- BMI ≥25.0 kg/m2
- Physical function
- Impaired hearing
- Lower self-rated health
- History of dizziness
Increased Risk for Medication Mismanagement: Behavior and Beliefs

- Lack of perceived benefit of medications
- Lack of medication knowledge
- Lack of knowledge about condition
- Low health literacy
- Lack of threatening view of illness
- Higher perceived illness burden
- Concurrent use of OTC
- Lack of interpersonal relationships
- Lower self-care
Increased Risk for Medication Mismanagement: Other Factors

- Living alone
- Lack of social support
- Lack of caregiver or caregiver burden
- Low socioeconomic status
- Hospitalization in the past six months
- Provider communication and system issues
- Medication issues (pill delivery, complexity, etc.)
- Chronic obstructive pulmonary disorder (COPD)
Person-Centered Approaches for Medication Management

- Tailor intervention based on individual factors, system factors, and the problem at hand
- Ask individuals “what matters” and understand their beliefs and values around medication use and OTC medications
- Assess mental status, vision, and hearing
- Know how medications are accessed and paid for
- Simplify instructions and medication regimen when possible
  - Use images rather than numbers
- Address system and provider communication—especially during transitions of care
- Use technology if needed and appropriate
Person-Centered Approaches for Medication Management (continued)

- Get to know the individual by having them complete an “all about me” form
- For example, the form can ask individuals to complete the following sentences:
  - “I am from…”
  - “The name of my family members are…”
  - “I enjoy…”
  - “Things that make me feel happy are…”
  - “I enjoy listening to…”
  - “I don’t like…”
Using Technology to Address Medication Mismanagement – The Future?

- **University of Denver AI Robot** reminds older adults to take their medications, holds conversations, and projects videos and stories for reminiscence therapy

- **Tiger Place** uses sensors, pattern recognition and analytics to help older adults age in place (Rantz et al., 2008)
Inter-Professional TEAM Intervention: Shared Purpose and Cooperative Approach

- **Registered Nurse** conducts a home visit and addresses mental status and memory issues with a brief cognitive and delirium screen and assesses beliefs and knowledge about medications by asking Mrs. R. to show him/her the medications and talk about what she knows about each one of them.

- **Social Worker** gives assessment to further understand financial and social conditions—including ability to pay for medications and need for an additional formal caregiver or community aging resources (transportation, home aides, financial assistance).

- **Pharmacist** does a medication reconciliation and develops a schedule to decrease the pill burden and complexity of her daily pill intake; physician considers referral for Medication Therapy Management (MTM) covered by Medicare Part D.

- **Case Manager** assists with chronic conditions and non-drug alternatives and adjuncts (i.e. sleep hygiene, exercise).
Pearls of Wisdom – Medication Use Considerations

- Reinforce with older persons to NEVER stop a drug without first consulting their clinical provider (MD, NP, etc.).
- Use clinical judgement and common sense.
- Use the Beers Criteria as a starting point to identify high-risk medications.
- Consider non-pharmacological (eco-bio-psychosocial-behavioral) approaches first, such as a sleep hygiene protocol.
What is Needed to Ensure Safe and Effective Use of Medications?

- Systems (and innovations) that support an ongoing process of monitoring medication—helping to assess the benefits, harm and ongoing need for each medication and the regimen as a whole while addressing the individual's needs and preferences.

- An ideal system would engage individuals & caregivers as true partners wherever they are in their life trajectory and wellness.

- A comprehensive, portable and truly informative list that has consumer friendly indications and target symptoms engaging the individual in language and goals they understand.

- A team approach: physicians, social workers, therapists, pharmacists, engineers.

Source:
Parting Message: Cooperation

We can meet the challenge with innovative systems and a team approach with **cooperation** and a vision to improve adherence, decrease adverse drug events, and improve medication use in vulnerable adults and older persons.
Health Coach Perspective

Marisilis Tejeda
Health Coach, City Health Works
What Does City Health Works Do?

- Coach clients to better manage chronic illnesses
  - Coaching is done in the home, or wherever it is most convenient
- Hire and train workers from the neighborhood to become Health Coaches
  - Clinicians supervise teams of Health Coaches
- Use motivational health coaching and ongoing care coordination to provide clients with the knowledge, capabilities and confidence to take control of their health
- Inform referring providers about urgent and routine medical, psychological and social needs of individuals to ensure access to the right care, from the right person, at the right time
Health Coaching and Care Coordination

- **Referral and Enrollment**
  - Clinical referrals
  - Cold-call outreach via population health lists

- **Health Coaching**
  - Weekly in-person sessions
    - Disease knowledge
    - Medication adherence
    - Risk reduction, symptom, control and monitoring
    - Healthy eating
    - Physical activity
    - Health coping and support
  - Biweekly and monthly in-person and phone check-ins
    - Escalation of urgent/semi-urgent needs
    - Evaluation and management of socioeconomic and psychosocial barriers
    - Scheduling and navigation support
    - Accompany client to medical visits
    - Regular progress updates to clinicians on goals and issues
    - Accompany clients to social services to reduce stigma and ensure needs are met
Case Study: Mr. M

- Doctor prescribed 1500 mg of their diabetes management medication but client only received thirty 750 mg pills from the pharmacy.
- Health coach contacted the health coach supervisor who called the certified case manager.
- Certified case manager emailed the client’s primary care physician to confirm the correct dosage.
- Client’s physician confirmed the 1500 mg dosage and realized that the script went over to the pharmacy wrong.
  - The pharmacy gave the client a 15 day supply by mistake.
- Physician sent over new script to the pharmacy with the correct amount of 60 pills.
Questions
Stay tuned for our next webinar in the 2018 Geriatric-Competent Care series:

Supporting Older Adults with Substance Use Disorders
Date: Wednesday, May 16, 2018
Time: 12:00pm to 1:30pm ET

To register, go to:
https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/SUD
Thank You for Attending!

- The video replay, slide presentation, and a summary of the Q&A will be available at: [https://www.resourcesforintegratedcare.com](https://www.resourcesforintegratedcare.com)

- If you are applying for CME or NASW CEU, you must complete the post-test in order to receive credit: [https://www.research.net/r/Rx_OlderAdults_PostTest](https://www.research.net/r/Rx_OlderAdults_PostTest)

- For more information about obtaining CEUs via CMS’ Learning Management System, please visit: [https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Medications](https://resourcesforintegratedcare.com/GeriatricCompetentCare/2018_GCC_Webinar_Series/Medications)

- Questions? Please email [RIC@lewin.com](mailto:RIC@lewin.com)

- Follow us on Twitter at [@Integrate_Care](https://twitter.com/Integrate_Care) to learn about upcoming webinars and new products!
Webinar Evaluation Form

- Your feedback is very important! Please take a moment to complete a brief evaluation on the quality of the webinar. The survey will automatically appear on the screen approximately a minute after the conclusion of the presentation.
Resources

- Deprescribing Guidelines
  - https://deprescribing.org/
- Public Education Resources for Patients & Caregivers
  - https://geriatricscareonline.org/
- University of Denver AI Robot
- Tiger Place
- 2015 Beers Criteria
  - https://geriatricscareonline.org/ProductAbstract/beers-criteria-pocketcard/PC001
- STOPP/START Criteria for Potentially Inappropriate Prescribing in Older People
Sources


3. http://bulletin.facs.org/wp-content/uploads/2014/04/Medicare's_Role_-_Figure_3_V2-edited.jpg


Sources


