Mr. [insert name]'s Medication and Health Summary

COMET: Care Planning for Older Persons with Multiple Conditions: Encouraging a Tailored Approach

Mr. Richard Feynman engaged in a thorough review of his medications. Here are some areas that you may want to discuss with your patient.

MEDICATION RECONCILIATION

A medication reconciliation has been completed with your patient. The CPRS medication list and the patient's medication list **do not match**.

DISCREPANCY	MEDICATIONS	
Dose and/or schedule is different:	Prescribed/CPRS	Home
	CYCLOBENZAPRINE 10MG. TAKE ONE TABLET BY MOUTH THREE TIMES A DAY AS NEEDED FOR MUSCLE SPASM	Cyclobenzaprine 10mg tab. Take one table by mouth once daily as needed for muscle spasm
	LORAZEPAM 1MG. TAKE ONE TABLET BY MOUTH EVERY NIGHT	Lorazpepam 1mg tab. Take one table by mouth at night as needed for anxiety
	ASPIRIN 325MG. TAKE ONE TABLET BY MOUTH ONCE DAILY	Aspirin 81mg by mouth once daily
Patient taking the following medication(s) NOT listed in CPRS:	Naproxen 220mg by mouth once daily as needed for arthritis (Takes 2 times per week)	
	Gabapentin 600mg tab. Take two tablets by mouth at night	
Patient is NOT taking the following medication(s) listed in CPRS:	METOPROLOL TARTRATE 50MG. TAKE ONE TABLET BY MOUTH TWICE DAILY	

Recommendations

- Discuss the discrepancies with your patient today.
- A pharmacist is available to make the changes to the prescriptions in CPRS. Indicate your preference at the end of this document.
    - CPRS prescriptions: will show up in your view alert for your final signature.
    - Non-VA prescriptions: will be updated by the pharmacist and will not require your signature.

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MEDICATION MANAGEMENT

Your patient's medication regimen may be too complicated. He has the following factors that put him at risk for not taking his medication correctly:

- Your patient scored **LOW** on a measure of medication adherence. This is a strong indicator that he may be missing pill doses. Persons with similar scores in one study were demonstrated not to refill their medications correctly.
- Your patient scored **LOW** on a test of executive function. This is a strong indicator that he has impairment in cognitive function that can lead to medication errors.
- Your patient has **NO** help with his medications, but a VNA can help with:
  - Refilling prescriptions
  - Picking up prescriptions
  - Reminding him when to take his medications
  - Filling his pillbox
  - Giving him medications when it's time to take them

Recommendations

- Your patient's regimen needs to be as simple as you can possibly make it. If we identified medications that could be removed, these will be outlined below. Otherwise, you can look at the general tips for simplifying medications.
- A pharmacist is also available to do a more thorough personalized medication review to make additional recommendations for reducing complexity and to contact the social support your patient identified in order to make a plan for increased medication oversight. Indicate your preference for pharmacist intervention at the end of this hand-out.

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POLYPHARMACY

Patients on four or more medications are at risk of decreased adherence, adverse drug events, hospitalization, falls, cognitive impairment, mortality, and increased cost for the patient and healthcare system. Many times there are good indications for medications and it is really difficult to balance the risks and benefits. The following are some potential justifications for discontinuing one or more of the patient's medications.

POTENTIALLY HARMFUL MEDICATIONS

Your patient is on one or more medications that have been identified by expert consensus as being potentially inappropriate for older persons, either because of the medication itself, a drug-drug interaction, or a drug-disease interaction. These are known as either 'Beers list' or 'STOPP' medications. The medication(s) and potential problem(s) are provided below.

MEDICATION	DISEASE or DRUG INTERACTION (if relevant)	CONSEQUENCE
Lorazepam		Increases the risk of cognitive impairment, delirium, fractures and falls
Temazepam		Increases the risk of cognitive impairment, delirium, fractures and falls
Naproxen	Chronic kidney disease	Increases the risk of worsening renal function
Naproxen	Hypertension	Increases the risk of worsening the hypertension
Naproxen	Age > 75	Increases the risk of bleeding, which is reduced but not eliminated by a PPI or misoprostol
Cyclobenzaprine		Increases the risk of sedation and fracture due to anticholinergic properties.
Digoxin > 0.125 mcg/day		Increases the risk of digoxin toxicity

Recommendations

Discontinuation of the medication if possible, or, if not, either substitution of another medication or dose reduction.

POTENTIAL INCORRECT DOSING

MEDICATION	TOTAL DAILY DOSE	RECOMMENDATION
Gabapentin	1200	Increased risk of drowsiness/sedation, dizziness, and falls with daily dose greather than 600 mg

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POTENTIAL OVERTREATMENT

There is a growing body of evidence suggesting that older individuals may be over treated for diabetes and hypertension, depending upon their health status. The following are recommendations based on clinical guidelines and expert opinion.

DISEASE AND HEALTH STATUS	RECOMMENDATION
• Hypertension • One or more falls past year • BP is 125/68.	Consider liberalizing blood pressure control to a target of <150/90. Studies have shown a relationship between intensity of blood pressure treatment & fall risk. Decreasing antihypertensive load may lower this risk.
• Diabetes • Life expectancy less than 5 years • A1C is 5.5.	Consider liberalizing treatment of diabetes to a target A1C of <8%. Your patient might not live long enough and/or has too many competing risks to benefit from tighter control.

YOUR PATIENT'S VIEWS

Your patient reports:	MEDICATIONS
Side effects, unwanted reactions, or other problems from medications:	• Cyclobenzaprine (dizziness).The patient reported that he is bothered by this medication a lot.
If he could stop one medication, it would be:	• Lorazepam (doesn't help)
If all of his medications were stopped except for one, he would not want to stop:	• Fluoxetine (needs for depression)

YOUR PATIENT'S KIDNEY FUNCTION

MEDICATION	KIDNEY FUNCTION	TOTAL DAILY DOSE	RECOMMENDATION
Metformin	GFR is 40.	2000	Use half-maximal dose and closely monitor renal function every 3 months

Pharmacist Consultation:

A pharmacist is available for referral if you believe your patient could benefit from an in-depth medication review or tapering/discontinuing medications. Indicate your preference at the end of this document.

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GENERAL TIPS FOR SIMPLIFYING MEDICATION REGIMENS

1. Is there an indication for every drug?
2. Are there any drugs started for conditions that no longer exist?
3. Is there a formulation to reduce the frequency of administration?
4. Will the patient live long enough to benefit from drugs for primary/secondary prevention?
5. Is the risk reduction from primary/secondary prevention drugs sufficiently large?

REFERRALS

If a **pharmacist** follow up is needed, please check the boxes below regarding which areas you would like for the pharmacist to discuss with your patient and give sheet to research assistant. The pharmacist will contact your patient to schedule appointment times.

- ☐ Pharmacist will update patient's prescriptions in CPRS
- ☐ Contact social support for medication management oversight
- ☐ Medication Adherence
- ☐ Medication Management Review (Recommendations will be put in a note in CPRS with you added as an additional signer)
- ☐ Discontinuing/Tapering Medications: If so, which one(s):

  _____
- ☐ Decreasing Medication Dosage: If so, which one(s):

  _____