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Medications: Defining the Role and Responsibility of Physical Therapy Practice

A physical therapist (PT) needs to review a patient's medications for many reasons, particularly in home-care settings where the PT may be the first, and at times, the only medical provider the patient is currently seeing. It's a necessity recognized for patient safety by the federal Center for Medicare and Medicaid Services (CMS) and the Joint Commission. Some states, however, continue to grapple with the issue.

As the population ages, medicine reviews by PTs will become an increasing issue.

The United States is pushing about 45 million persons over the age of 65 today. By 2030, the number is expected to be around 73 million — or 20% of the U.S. population. With age comes a number of health issues — chronic diseases, depression, physical limitations, cognitive decline, the clinical complexity of care, and comorbidities.

It also means an increase in medications. In 2013-2014, just shy of 14% of 65 and older Americans were taking greater than five medications. Today, more than 40% of patients in that age group take five or more medications. That is a significant shift. And as we look at the entire gambit, almost 91% of 65 and older patients consume at least one prescription drug.

A PT once entered the home of a patient recently discharged from the hospital. The patient provided a printed list of medications the hospital provided. But then the patient came out with a straw basket of medications. There were about 17 different medications in the basket, some dating about 10 years old.

Clearly there are issues with polypharmacy, which is why it is important to do a medication review. First, the therapist must document that there are no changes to the medications. If the therapist has a discharge list and certain reconciliation, s/he can look at what the patient is supposed to be taking from a prescription and non-prescription perspective, as well as any type of supplemental or herbal type of medicines. When a patient changes their medication regimen, it could impact their physical therapy outcomes or functional status. There could be an increased fall risk or changes in cognition, balance, or motor function.

What a Medicine Review Provides

Adverse Drug Reaction (ADR) is a form of adverse consequences. It may be either a secondary effect of a medication that is usually undesirable and different from the therapeutic effect of the medication or any response to a medication that is noxious and unintended and occurs in doses for prophylaxis, diagnosis, or treatment.

The term "side effect" is often used interchangeably with ADR. However, side effects are but one of five ADR categories, the others being hypersensitivity, idiosyncratic response, toxic reactions, and adverse medication interactions. A side effect is an expected, well-known reaction that occurs with a predictable frequency and may or may not constitute an adverse consequence.

ADRs are one of the most common types of medication interactions after a hospital discharge. PTs often serve as the first provider following discharge from the hospital, long-term acute-care hospital (LTACH), inpatient rehabilitation facility (IRF), or skilled nursing facility (SNF). They must review the discharge paperwork, the instructions, the reconciliation, and the medications.

The Improving Medicare Post-Acute Care Transformation (IMPACT) Act of 2014 requires a Drug Regimen Review. It's a quality measure to be adopted across all post-acute care settings. In 2017 it was required in home health settings. Starting in 2018, it will be required in LTACHs, IRFs, and SNFs.

The 2017 Joint Commission Home Care National Patient Safety Goals focus on the risk points of medication reconciliation. Goal number three includes coordinating information during transitions in care both within and outside of the organization, patient education on safe medication use, and communications with other providers.

Multiple factors place community-dwelling, older persons at risk of medication mismanagement.

These include a decreased comprehension of medication instructions and adherence, and living arrangements — in particular, older persons who live alone are more prone to medication errors. They also include chronic diseases, particularly depression, physical limitations, and cognitive decline. Other factors include the clinical complexity of care and treatment and having more than one prescribing provider.

Practice Consideration

Medication interaction is the impact of another substance (such as another medication, nutritional supplement including herbal products, food, or substances used in diagnostic studies) upon a medication.

The interactions may alter absorption, distribution, metabolism, or elimination. These interactions may decrease the effectiveness of the medication or increase the potential for adverse consequences.

Medication use can lead to the onset of fatigue. A patient who is taking one or more medications might fatigue more quickly. Sedation could be either rapid or delayed. There could be changes in cognition and awareness or interference in normal expected motor

function. There is also a fall risk. PTs must be aware of certain medications that may impact the patient's risk for falls.

Guides and Tools

The American Physical Therapy Association (APTA) Guide to Physical Therapy Practice lists risk factors for impaired mental functions. Number one on the list is chronic stress. Number two is depression or other psychological or psychiatric diagnoses. But number three is medication side effects.

The Federation of State Boards of Physical Therapy (FSBPT) Supervised Clinical Practice Performance Tool (SCPPT) examines 24 specific performance areas PTs should execute. The twenty-fourth performance area specifies medication duties to execute. PTs must review and identify the implications of current medications, giving consideration to the physiologic effects of current medications and PT treatment implications. The PT also must identify the purpose and rehabilitation implications of medication.

Much of a PT's practice points to the inclusion of their responsibility to thoroughly review medications, examine the impact of medications on treatment and the patients' outcome, and ensure they are safe and not experiencing any type of adverse reaction under the clinician's care. The APTA House of Delegates looked at defining that a physical therapist's patient/client management integrates an understanding of patients' prescription and non-prescription medication regimen with the considerations of impact on health, functioning, and disability.

CMS Provides an OASIS

The Outcome and Assessment Information Set (OASIS) is a group of standard data elements developed, tested, and refined over two decades through a research and demonstration program. OASIS data elements were designed to enable systematic comparative measurement of home health care patient outcomes at two points in time. OASIS items were designed to be discipline-neutral and have been tested and validated with clinicians from various disciplines.

Since 1999, the Centers for Medicare & Medicaid Services (CMS) has required Medicare-certified home health agencies to collect and transmit OASIS data for all adult patients whose care is reimbursed by Medicare and Medicaid.

It's a standard data set, and the elements allow collection at an initial point and a subsequent point, typically on discharge or transfer to another facility, and allows comparison for outcomes.

CMS wants to know which discipline is completing the assessment. Of course, there is a form for that. The discipline who is completing that comprehensive assessment completes form M0080. It includes the discipline-specific evaluation and the completion of the data set elements of the OASIS. It can be conducted by a registered nurse or any of the therapists, including physical therapists, speech language pathologist, or occupational therapist. However, in the cases where nursing is involved, a Registered Nurse should complete the initial assessment and data collection.

To have a favorable, measurable outcome, three conditions must be met for the care episode: completion of a drug regimen review at the beginning of the care episode,

physician contact and follow-up if medication issues are identified at SOC/ROC, and physician contact and follow-up each time significant medication issues are identified throughout the care episode.

The Guidance Manual

OASIS-C2 is the current guidance manual. And the guidance manual states, related to these items, "If portions of the drug regimen review are completed by agency staff other than the clinician responsible for completing the start of care, OASIS or recert OASIS, this information must be communicated to that responsible clinician." CMS is clear that collaboration does not violate the base requirement that only one clinician be responsible for the completion of the data set. The way collaboration happens is determined by agency policy. Most agencies, in their best practices to address the medication regimen review, have procedures for therapy-only admissions that lay out how this should be handled. The 397-page guidance manual identifies the three items and provides the intent of these items. It also directs when they should be completed in the episode of care, the response choices, and how to choose them. Further, it gives scoring examples.

Here's one scoring example: During the comprehensive assessment visit, the PT reviews all the patient's medications and identifies no problems except that the patient's newly prescribed pain medication is not in the home. The daughter states they were only going to pick it up from the pharmacy if "the pain got bad enough." The PT emphasizes the need to comply with the physician's instructions for the new medication and prior to the PT leaving the home, the daughter has gone to the drugstore and returned with the medication.

The score choices are, "No issues found," "Yes issues found," or "N/A." The answer is "No issues found" because the medications were in the home prior to the PT leaving.

The term "potentially clinically significant medication issues" could make PTs uncomfortable. But it's clearly defined as an issue in the care provider's clinical judgement that requires the physician or physician designee to be notified. A potentially significant medication issue could be drug-to-drug interactions. Many electronic medical records (EMRs) have drug-to-drug interactions that pop up when the medications are electronically entered into the medical record.

Another process measure is item M2016, which talks about drug education. It asks, if from the time the PT had begun care to any of those subsequent collection time points, was the patient or caregiver instructed at all by the agency. PTs are required to answer these questions even though drug education is not in the PT's scope of practice. It's important, however, to show good policy, good practice, best practice, when the PT applies for licensure or survey renewal that they have demonstrated this.

Medication intervention and drug intervention, as well, are two other items that PTs are required to answer. This is another one that scares people: management of oral medications and injectable medications. PTs, by law, do not manage medications. The problem is CMS has not changed the terminology of these items, which are used to calculate outcomes or process for consistency and data analysis. Each time CMS updates them, they keep those same statements, but they interpret them specific to what is happening in the industry. The intent of this item, as stated in the guidance manual, is to ensure the patient has the ability to take their medications reliably and safely at all times.

It goes on further to discuss the drug regimen review and what is included. It gives agencies clear direction on which to build policies. These are the items surveyors look for when they come to evaluate and to determine the agency is meeting the requirements of the plan and to re-issue or continue licenses for an organization or an agency.

States Disagree on PTs' Authority to Review Medications

State auditors have informed APTA that their interpretation of the state practice act for PTs and OTs is that they cannot do what the federal government requires. When statutes are silent, it is interpreted by surveyors as not authorized.

The APTA document on medications by the physical therapist gives some examples of where the profession sees this disconnect with best practice, patient safety, home care requirements and regulations, and data set completion. APTA believes the difficulty and the misunderstanding are in the definitions. PTs are not doing medication management, they are doing drug regimen review.

In this situation, discussions between CMS and the state PT board determined that the comprehensive assessment may be completed by a physical therapist only if the agency has implemented a policy and procedure that requires collaboration between the PT and other agency staff. That works because the guidance manual states that collaboration does not break the rule of one person completing it. That's a best practice and that's what agencies do.

Role is to Keep People out of Hospitals

Another interpretation of the role of PTs in home health care is to keep people out of the hospital. That's what makes PTs a desirable discipline, reducing risk for re-hospitalization. PTs identify these risks such as polypharmacy, medication problems, disconnect with discharge summaries for medications, what the patient has in the basket, and what they say they're taking.

Gathering information on the medication a patient is taking and the patient's ability to take the proper dosage would be considered within the scope of practice for a physical therapist, if the preconditions agreed to by CMS and the states were met. It would also be appropriate for a physical therapist to provide basic information on medications that may have an impact on the PT plan of care.

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